

NHS Employers' submission to the Doctors' and Dentists' Review Body 2027/28

9 September 2026

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Informing our evidence

NHS Employers welcomes the opportunity to submit this evidence on behalf of NHS-employing organisations in England. We recognise the 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 written submission has been shorter than in previous years, the evidence draws on engagement with a broad range of NHS organisations. The impact of industrial action and its aftermath has required rapid contingency planning and limited the capacity for more extensive engagement.

Employers welcome the progress made during the 2026/27 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. Employers 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 and engagement included:

- our [policy board](#), regular consultation comprising very 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, specialty, associate specialist and specialist (SAS), trainees, and dentists
- our contracts experts' group (medical staffing leads) and the medical and dental workforce forum, a subcommittee of the NHS Employers policy board
- discussions with chief people officers and deputy chief people officers through regional networks.

In addition, we surveyed senior NHS HR leaders on a range of topics, including recruitment, retention and staff morale. A total of 61 NHS organisations responded to the survey. Survey participation improved significantly this year, with responses rising from 26 last year, an increase of approximately 135 per cent. We recognise and appreciate the time employers have taken to contribute, particularly given the significant operational pressures and competing priorities facing NHS organisations. Despite these challenges, the responses received were rich in detail and provided valuable insights into the workforce and employment issues currently facing employers.

From 1 April 2026, NHS Providers and the NHS Confederation merged to form the NHS Alliance. The coming together of these organisations means that the NHS Alliance is positioned to represent the views of the NHS in England, Wales and Northern Ireland and influence national policy, share intelligence and support the spread of effective workforce practice. In our evidence, we have drawn on a range of publications and resources from [the NHS Alliance's website](#) that represent views and experiences from across a broad range of employer networks.

Our evidence is supported by a range of data sources. We have focused primarily on the period from our last submission through to the time of writing in June and July 2026. Due to differences in

publication timelines across datasets, not all sources cover identical reporting periods; however, we have used the most recent and relevant data available to us in each case. All data presented is clearly dated, and full source details are provided to ensure transparency.

Shaping the future NHS workforce

Refreshed workforce plan

The NHS is currently awaiting a new 10 Year Workforce Plan that is expected to set out the workforce required to enable delivery of the 10 Year Health Plan. At the time of writing, the updated plan has not yet been published, and employers continue to plan workforce capacity and capability within existing policy and financial frameworks.

In the absence of a finalised workforce plan, employers report that there remains:

- limited national clarity on future workforce supply, growth and skill mix assumptions
- continued reliance on local workforce planning and system-level prioritisation, aligned to financial constraints
- a need to balance short-term service delivery and recovery objectives with longer-term workforce transformation, alongside maintaining staff experience and supporting workforce wellbeing
- continued reliance on reactive workforce measures in response to system pressures, rather than consistently planned and sustainable approaches.

Employers report that workforce challenges are no longer temporary pressures, but are becoming embedded, long-term issues. This reflects sustained service pressures, changing models of care, and the need to design a workforce that can respond to rising demand, system volatility and long-term transformation.

The current workforce and operational planning guidance is focused on delivering the three strategic priorities set out in the [10 Year Health Plan for England](#);

- 1 shifting care towards community-based models
- 2 greater use of digital technologies
- 3 stronger focus on prevention

Employers recognise that the workforce will be central to delivering these ambitions and remain committed to creating positive staff experiences, strengthening organisational culture and building leadership capability. However, they report that sustaining this focus is increasingly challenging in the context of significant financial constraint, operational pressure and ongoing organisational change across the NHS. Employers report that where staff do not feel able to consistently deliver the standard of care they aspire to, this can have implications for morale, engagement, and retention.

Employers have highlighted the importance of a new national workforce plan that:

- is deliverable within the financial context, including realistic assumptions on funding and productivity
- focuses on skills, flexibility, and new ways of working, rather than workforce growth alone
- supports education, training capacity, and career development pathways across all staff groups
- strengthens leadership capability at all levels

- supports more inclusive and supportive working environments
- embeds equality, diversity and inclusion throughout workforce planning and transformation, supporting fair access to roles, improving experiences at work across all staff groups and ensuring workforce redesign does not inadvertently widen existing inequalities.

Employers consistently emphasise the importance of workforce wellbeing and the extent to which staff feel valued within organisations is well understood. Employers report that workforce engagement and retention are influenced not only by formal policies, but also by local culture, leadership behaviours and the way workforce change is managed. Factors such as flexibility, autonomy and role clarity are increasingly important in shaping engagement and retention, particularly among newer entrants to the workforce.

Until the publication of the plan, employers continue to operate within a context of ongoing uncertainty, particularly in relation to the:

- scale and pace of future workforce expansion
- balance between different staff groups and roles
- extent to which workforce transformation can be supported within current resource envelopes
- impact of ongoing organisational change and system reform on workforce capacity, morale and retention.

Overall, while there is an intended direction of travel for workforce policy, there is limited detail on how this will be operationalised. The workforce plan is expected to provide further clarity on future workforce requirements and delivery mechanisms, including how workforce capacity, capability and experience will enable delivery of the 10 Year Health Plan.

NHS finances

Operational financial pressures

While the Spending Review sets the overall funding envelope, the financial position for NHS organisations reflects how these allocations translate into day-to-day operational pressures. The current context is characterised by a continued emphasis on financial discipline, system control, and delivery within fixed resources, rather than there being a reduction in underlying demand or cost pressures.

[The 2026/27 planning framework](#) reinforces the requirement for system-wide financial balance, with integrated care boards (ICBs) expected to manage expenditure collectively and operate within allocated budgets. Delivering these plans requires sustained efficiency improvements, including productivity gains and cost reductions, with high savings requirements across systems.

National financial balance continues to mask underlying pressures within organisations. Employers report ongoing financial strain, limited headroom, and reduced flexibility, with organisations required to deliver challenging operational priorities, including elective recovery, urgent and emergency care performance, and cancer standards, within constrained funding.

Workforce costs remain a key focus in financial plans. Employers highlight continued measures to control expenditure, including:

- reducing reliance on temporary staffing, building on recent reductions in agency spend
- reducing corporate services costs
- maintaining tight controls on recruitment and vacancy filling

- increasing scrutiny of workforce utilisation, productivity, and job planning.

Capital constraints further limit organisations' ability to invest in infrastructure, estates and digital transformation, which are critical to supporting long-term service reform. At the same time, financial planning continues to be affected by ongoing pressures, including industrial action, inflation and demand growth.

Overall, employers report that financial balance is increasingly achieved through the active management of the workforce, activities, and service provision, with limited scope for discretionary investment. This operating environment continues to shape the experience of medical staff, including workload, workforce supply and access to development and improvement opportunities.

Wider government policy

The government's [Make Work Pay](#) agenda continues to form a central component of its economic and labour market strategy. The Employment Rights Bill received Royal Assent in December 2025, and is now the [Employment Rights Act 2025](#), with reforms being implemented in phases across [2026 and 2027](#).

Employers are now focusing on the Act's implementation and operational impact. While the NHS already meets many of the proposed standards, new measures, including expanded day-one rights, changes to statutory entitlements, and strengthened employment protections, introduce a renewed focus on consistency, compliance, and the review of existing policies and practices.

Employers are considering the interaction between the new legislative framework and existing contractual arrangements, particularly where provisions relate to contractual flexibility and workforce management.

The reforms are being introduced alongside a programme of ongoing consultation and secondary legislation, meaning that further detail on the scope and timing of individual measures is still emerging. As a result, employers continue to operate amid evolving policy and implementation uncertainty while preparing for the full impact of the changes. We continue to support employers with implementation through our [online resources](#).

Flexible and temporary workforce

Zero hours contracts consultation

As part of the Employment Rights Act, the [government has launched a consultation on reforms to zero hours](#) and similar contracts, intended to implement measures to end one-sided flexibility. The proposals include rights to guaranteed hours where working patterns meet qualifying criteria, reasonable notice of shifts and changes, and payment where shifts are cancelled, curtailed or moved at short notice. The proposed changes could have a significant impact on the NHS, in terms of both cost and increasing the size of the substantive workforce to manage the processes under consultation. NHS Employers is supportive of the aim to eliminate exploitative contracts and practices but does not feel the proposed framework is the correct way to do this for the following reasons:

- NHS bank arrangements are not typically used to transfer business risk onto workers but instead provide two-way flexibility to both the NHS organisation and to the worker. The flexible workforce is a core part of maintaining safe patient care.
- Many NHS bank workers choose to work through an internal bank and/or undertake agency work because it gives them total control of when, where and how often they work.

- The current proposals could create major new bureaucracy at odds with the NHS drive for efficiency, productivity and digital-first people services.
- Flexible staffing is essential for responding to patient acuity, sickness absence, seasonal pressures and major incidents. Guaranteed hours administration and short-notice compensation rules could add up to £900m in annual costs to the NHS and reduce the availability of bank workers, undermining national efforts to reduce agency spend and improve value for money.

We propose the government has further engagement with sectors, like the health sector, to understand the full financial, equality and productivity impacts of the proposals on the temporary workforce and patient care and at least, reframe and redraft the proposals before proceeding with legislation.

NHS temporary staffing

The proposed reforms are particularly relevant given the NHS' increasing reliance on bank staffing as part of efforts to reduce agency expenditure and maintain safe staffing levels. They also coincide with implementation of the 2026 resident doctors' deal, which includes provisions aimed at improving employment security and reducing the use of fixed-term arrangements for locally employed doctors (LEDs). Employers will need to consider the combined impact of these changes on workforce flexibility, temporary staffing models and medical workforce supply.

The [NHS month 12 financial position 2025/26 reports](#) that since 2024/25: “agency spend was almost halved, from £2.1 billion to £1.2 billion”.

Demonstrating that NHS organisations continue to make progress towards the government’s objective of reducing expenditure on temporary agency staff, including within the medical workforce.

Alongside a targeted reduction in agency expenditure, NHS trusts have also been expected to reduce the use of bank staffing by at least 10 per cent.

Many employers have reduced their reliance on agency and locum doctors by expanding internal staff bank models and introducing more robust controls on agency use, including tighter rate caps and approval processes. Some employers also report ongoing challenges managing expectations around internal locum rates, particularly where the British Medical Association's (BMA's) rate cards are used to inform negotiations for temporary medical cover. Employers note that this can create tensions between securing sufficient medical cover and achieving financial objectives aimed at reducing temporary staffing expenditure.

However, ongoing financial pressures and workforce constraints mean that demand for temporary medical staff remains significant. Workforce reductions in some organisations, alongside persistent rota gaps and recruitment challenges in certain specialties, are increasing pressure on substantive medical staff. This can contribute to fatigue, burnout and sickness absence, in turn sustaining the need for locum cover to maintain safe staffing levels and service continuity.

As organisations seek to reduce agency spend and increase use of internal banks, greater reliance is being placed on a flexible medical workforce to fill gaps at short notice. While this approach can offer cost efficiencies and increase the range of NHS settings doctors can develop their experience within, it also introduces challenges regarding continuity of care, team integration, and supervision, particularly when locum doctors work across multiple organisations or in unfamiliar settings.

At the same time, demand for flexible working continues to grow within the medical workforce. There is a tension between increasing reliance on temporary medical staff and negative perceptions of their cost. These perceptions may have unintended consequences,

potentially undermining workforce sustainability, staff experience and patient safety if not carefully managed.

NHS England is currently developing national bank guidance to support organisations to improve bank worker experience. We are keen to contribute to this guidance, for this to be developed in partnership with unions, and for it to follow as soon as possible this year.

Key messages

Investment in headline pay awards

- Employers would like investment in headline pay award uplifts to be prioritised in the 2027/28 pay round. Awards should be fully funded and sustainable. 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

- Ongoing industrial action has driven repeated service disruption and operational strain, with short-notice changes increasing administrative burden, impacting patient care, and placing sustained pressure on workforce morale and organisational planning. In addition, the pace and scale of changes required to implement industrial action agreements continue to place pressure on employers and workforce capacity.

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

- Differences in pay awards between medical and dental and non-medical and dental staff across level, structure, and timing are driving concerns about fairness, wider staff morale, and team cohesion, with implications for engagement, retention, and multidisciplinary working.

Digital and workforce transformation

- Medical staffing, HR and payroll teams are under sustained pressure from rising workload and increasing complexity, while corporate cost constraints are contributing to a reduction in capacity and a loss of experienced staff, creating a risk of overstretch across critical workforce support functions.
- Fragmented and non-interoperable digital systems continue to limit workforce flexibility and increase the administrative burden on employers; while digital and AI offer productivity gains, benefits depend on parallel investment in workforce capability, leadership, and organisational change.

Doctors and dentists in training

- Resident doctor reforms are now moving into the implementation phase following acceptance of the June 2026 resident doctor deal; including pay reforms, expanded training opportunities, exam fee reimbursement, standardised LED contracts and wider improvements to doctors' working lives.
- Key initiatives within the 10 Point Plan includes full implementation of exception reporting reforms, publication of annual leave standards, payroll improvement programmes reducing errors by 51.5 per cent, named senior resident doctor leads, and ongoing work through the Medical Education Training Review to modernise medical training.
- While initiatives such as the 10 Point Plan and training reforms are welcomed, there is growing concern about the additional workload placed on already stretched medical staffing/HR teams, highlighting the need for greater recognition and support for staff who deliver and coordinate resident doctor training and employment services.

Specialty, associate specialist and specialist (SAS)

- Implementation of the 2024 SAS pay deal is well advanced, with publication of the [SAS eligibility and permanency framework](#) providing a clear route for eligible locally employed doctors to move into substantive SAS roles, improving career stability, retention and progression opportunities.
- The SAS workforce continues to expand, with growing numbers of doctors employed on the 2021 terms and conditions alongside a reduction in those remaining on legacy contracts. While the 2021 contract delivers improved pay outcomes for most doctors, some pay disparities remain and continue to influence individual decisions about transferring.
- Specialist doctor posts continue to rise, and employers are supported by national guidance and resources. However, funding constraints, inconsistent workforce planning and varying organisational commitment mean uptake remains uneven across the NHS, highlighting the need for continued focus on embedding specialist roles and recognising the contribution of SAS doctors and dentists.

Consultants

- Employers continue to emphasise the importance of retaining experienced consultants to support service delivery amid ongoing workforce pressures and shortages. Flexible working arrangements, retirement choices and broader employment conditions are seen as critical factors in retention. Recruitment challenges persist across a number of specialties, leading to vacancies and reliance on locum cover.
- While consultants have voted in favour of industrial action, no strike action has been announced. Employers would prefer the dispute to

be resolved before any strike action is taken to avoid disruption to patients and services. NHS Employers remains committed to strengthening partnership working with trade unions and supporting the reinstatement of the joint negotiating committee (consultants).

- Employers report that many aspects of the 2003 consultant contract no longer fully reflect modern healthcare delivery models and can limit flexibility, productivity and consistency. Employers support targeted contractual changes and clearer national guidance to improve consistency, reduce administrative burden and better enable modern, patient-focused services.

Salaried dentists

- Employers continue to report ongoing difficulties recruiting to entry-level posts, particularly at band A. Despite national advertising efforts, many vacancies remain unfilled, giving rise to concerns over the competitiveness of current pay structures and an NHS dentist career. Employers are reporting they no longer advertise for band A and recruit straight to band B due to the long-term failure to recruit.
- Both the DDRB 2025/26 and the DDRB 2026/27 recommended that the 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. A review has not been commissioned.
- 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 are adding to staff stress, undermining retention efforts and further emphasising the importance of sustained workforce support.

Locally employed doctors (LEDs)

- LEDs are an increasingly important part of the medical workforce, with rapid workforce growth reflecting their critical role in supporting service delivery. Employers continue to utilise LEDs to address workforce shortages, maintain rota resilience, provide opportunities for skills development and manage growing service demand, particularly in roles comparable to doctors in training.
- Greater consistency in employment arrangements would support fairness, transparency and workforce planning. While most LEDs are employed on terms aligned to nationally agreed contracts, variation remains across organisations. Employers support the principle of equal pay for work of equal value and favour greater standardisation of contracts and workforce data to improve consistency and strengthen understanding of this growing workforce group.
- Improving access to education, training and career development remains a key priority for the LED workforce. Current provision is variable and often reliant on local arrangements rather than dedicated funding or contractual entitlement. Employers believe a more consistent, nationally supported approach would improve retention, support career progression and deliver benefits for both patient care and workforce sustainability.
- The resident doctor reforms will introduce a national contract for LEDs working in equivalent roles. In addition, the SAS eligibility and permanency framework creates a route for eligible LEDs undertaking comparable work to move into substantive SAS roles. However, some LEDs are expected to continue to work in other locally defined posts on local terms and conditions. Employers are waiting for further details on the reforms but expect a mix of national and local employment arrangements to remain.

Section 1 – Context

Introduction

This section sets out the financial, operational, and workforce context in which NHS organisations operate. It highlights the continued pressures arising from constrained funding growth, rising demand, industrial relations challenges, and workforce supply gaps, and how these factors shape employers' ability to recruit, retain, and support staff, as well as the affordability and wider impact of pay decisions within the NHS.

NHS financial position

National funding context

Since the 2025 Spending Review, further clarity has emerged on the NHS funding settlement and its implications for employers. The spending review confirmed that the Department of Health and Social Care (DHSC) budget will grow by around 2.7 to 2.8 per cent in real terms to 2028/29, with NHS England funding increasing by approximately 3.0 per cent on average. While this settlement positions the NHS relatively favourably compared to other parts of the public sector, it remains below long-term historical growth and is insufficient to fully restore services or meet rising demand without significant efficiency gains.

Updated financial directions show that NHS England's revenue budget has increased to £215.4 billion for 2026/27, up from £205.1 billion in 2025/26. While this represents continued growth in funding, it also reflects rising cost pressures. The settlement is expected to cover not only demand growth, but also pay awards, inflation, and reform commitments, alongside an ambitious requirement to deliver around 2 per cent annual productivity growth, implying substantial efficiency savings over the spending review period.

Although overall financial balance was achieved at system level in 2025/26, [employers report](#) this was delivered through significant operational constraints. Financial pressures remain acute in 2026/27, with NHS leaders indicating that the financial challenge is expected to be at least as severe as, if not more severe than, the previous year, and that further prioritisation decisions may be required to remain within budget.

On capital, the spending review provides a multi-year settlement exceeding £44 billion to 2029/30, alongside continued investment in digital transformation and estate safety. However, capital funding remains constrained in real terms beyond initial uplifts, and delivery challenges persist. In particular, the reset of the new hospital programme, with delivery extending into the mid-2040s, highlights ongoing concerns about infrastructure capacity, pace of delivery, and long-term affordability.

Overall, while the spending review provides greater certainty through multi-year settlements and continued prioritisation of the NHS, the funding envelope remains tight. Delivering improvements in waiting times, productivity, staff experience and system reform within these constraints will require sustained efficiency measures, difficult prioritisation decisions, and continued service transformation.

Pay award funding

Pay awards remain a significant driver of financial pressure for NHS organisations, given that workforce costs account for the largest share of overall expenditure. While funding settlements include provision for pay, there are ongoing challenges in ensuring that allocations fully reflect the total and recurrent cost of pay awards, including associated on-costs.

A key issue is the alignment between pay decisions and funding, particularly regarding timing and the extent to which funding is recurrent. Where pay uplifts are not fully matched, organisations are required to absorb additional cost pressures within existing financial plans, despite already operating under tight financial constraints and delivering substantial efficiency programmes. These pressures are compounded by the exceptionally demanding financial and productivity requirements for 2026/27. [NHS Alliance analysis](#) found that almost nine in ten trust and ICB leaders expect their cost improvement programmes to be harder to deliver this year than in 2025/26, raising concerns about the sustainability of delivering efficiency savings at this scale year after year.

In this context, pay awards above the level assumed in financial planning present a material affordability challenge. Employers describe limited headroom to accommodate further cost increases, with any additional pressure necessitating difficult trade-offs. These may affect workforce plans, the pace of recruitment, and the ability to sustain investment in service improvement and staff development.

There is recognition that pay awards play an important role in supporting morale, retention, and financial wellbeing, particularly given wider cost-of-living pressures. However, where funding does not fully align with pay decisions, organisations face a tension between supporting staff through pay and maintaining financial and operational sustainability.

Employers emphasise the importance of fully funded, timely, and recurring pay awards to ensure that pay improvements can be realised without unintended consequences for workforce capacity, organisational stability, or service delivery.

Industrial action

Resident doctors first began industrial action in March 2023, as part of a dispute with the government over pay restoration. Although a pay deal was reached in 2024, concerns relating to pay, job security and training capacity persisted. In November 2025, the BMA announced it would re-ballot members, ahead of the expiry of the resident doctors' mandate for industrial action in January 2026. The ballot ran from 8 December 2025 to 2 February 2026 and sought a renewed mandate for industrial action.

In February 2026, resident doctors voted to extend industrial action for a further six months, allowing additional strike activity during 2026. There was a six-day strike in April, and a further four-day strike announced for June. The June strike was cancelled at short notice due to an offer made by the government. BMA members voted on the offer between 18 and 26 June.

On 29 June 2026, it was announced that the deal had been accepted, marking the end of the prolonged dispute and cessation of strike action. Attention now turns to implementation, with partners working together to deliver the agreement within ambitious timescales. Further details on the offer can be found in the doctors and dentists in training section in the remit groups chapter of this report.

Statutory ballots of consultants and specialist, associate specialist and specialty (SAS) doctors were held between 11 May and 6 July 2026, following limited progress in discussions between the BMA and government on contract reform and wider working conditions. On 6 July 2026, the BMA announced the results of its statutory ballots.

Consultant doctors voted in favour of industrial action, with 76 per cent of those who participated supporting it. While 90 per cent of participating SAS doctors also voted in favour of industrial action, the ballot turnout was 42 per cent and therefore did not meet the legal threshold required to mandate industrial action. At present, no industrial action has been announced.

Throughout the period that industrial action has been taking place, it has contributed to ongoing disruption to planned care, including postponed appointments and procedures, and has added to operational and financial pressures for NHS organisations. Employers have reported that strike planning and preparation are increasingly becoming business as usual; however, the scale, intensity, and resources required to manage this activity remain considerable and continue to divert capacity from other priorities. While organisations have established approaches to respond, these do not mitigate the wider disruption to services.

While employers report that they have become increasingly experienced in managing industrial action operationally, some also highlight a wider, less visible impact on workforce relationships. Employers described challenges in rebuilding trust and engagement following prolonged periods of dispute, with some reporting reduced collaboration, increased scepticism towards management processes, and broader effects on morale that extended beyond resident doctors to consultant colleagues and supporting teams. Several organisations noted that the cumulative effect of industrial action, ongoing workforce pressures, and continued uncertainty around pay has negatively impacted staff engagement and organisational culture, requiring continued focus on constructive local industrial relations and relationship-building.

We have continued to support organisations through guidance and resources during this period.

"The industrial action has placed significant strain on the team's morale and ability to deliver on organisational

and national priorities due to the amount of time it takes to manage this process."

Acute teaching trust, North East and Yorkshire

Operational pressures on medical workforce support services

Medical staffing, payroll, HR and wider corporate functions continue to play a vital role in supporting the medical workforce and enabling the delivery of workforce policy and reform. Over the past year, these teams have been central to implementing new pay arrangements, supporting the delivery of workforce initiatives, and coordinating responses to industrial action, including maintaining safe staffing and managing locum cover.

Employers consistently report a significant increase in pressure on these teams. Our survey asked:

Over the past 12 months, how would you describe the level of pressure on teams supporting medical and dental staff?

80 per cent of respondents reported increased pressure.

This is being driven by a combination of sustained industrial action alongside business-as-usual demands, increased workload associated with rostering, job planning and new processes such as exception reporting, and the continuing complexity of administering medical terms and conditions. In addition, HR teams are managing a growing volume of casework, including safeguarding, employee relations, and speaking-up concerns, further adding to operational pressures.

At the same time, organisations are responding to requirements to reduce corporate cost growth, which is leading to smaller teams and

the loss of experienced staff with specialist knowledge of medical and dental employment. Employers highlight that there is no corresponding reduction in demand, with more being asked of teams that are already operating at or beyond capacity.

This combination of rising demand, increasing complexity and reduced capacity is creating a risk of overstretch across these critical functions. Employers are concerned that, without sufficient investment in capability, capacity, and supporting infrastructure, including more efficient and interoperable digital systems, there is a risk to the effective implementation of pay and workforce policies, and to the consistency and quality of support provided to doctors and dentists.

"The whole employment offer is complex and requires dedicated resources to manage the associated processes. The resident doctors' dispute and the 10 Point Plan have added significantly to the workload for the team and the organisation more generally."

Mental Health Trust, London

Alongside growth in the medical workforce, there has been a continued increase in the number of doctors working less than full time (LTFT). Figure 1 shows that between April 2023 and April 2026, the gap between doctor headcount and full-time equivalent (FTE) numbers increased from 8,846 to 11,029, reflecting a growing proportion of doctors working LTFT. While LTFT working brings important benefits for workforce retention, wellbeing and workforce flexibility, it also increases operational complexity. Employers must support more bespoke rota arrangements, accommodate a wider range of working patterns, and dedicate additional administrative and management resource across medical staffing, workforce, payroll and rostering functions. In addition, LTFT working patterns can create gaps within rotas and shift schedules that require backfill arrangements to maintain safe staffing levels and service continuity.

Figure 1: NHS hospital and community services (HCHS) doctor workforce numbers: Full-time equivalent (FTE) and headcount, April 2023 to April 2026

		Apr-23	Apr-24	Apr-25	Apr-26	Growth % Apr-23 -> Apr26
FTE	HCHS doctors - All grades	133,815	141,006	148,011	153,389	14.6%
Headcount	HCHS doctors - All grades	142,661	150,532	158,537	164,418	15.3%
	Difference	8,846	9,526	10,526	11,029	

Source: [NHS Workforce Statistics - April 2026](#)

This trend is consistent with wider [evidence from the BMA](#), which highlights the increasing uptake of LTFT training and the importance of flexible rota design, individualised rostering and adequate workforce planning to support doctors working reduced hours. The BMA also recognises that rota arrangements can create additional operational and workforce challenges for employers and doctors alike.

Alongside these ongoing operational pressures, the NHS is progressing significant transformation of people services, which will further reshape how these functions operate and deliver support.

"The continued increase in less-than-full-time resident doctors creates a huge amount of pressure. It is extremely difficult to negotiate and agree a rota, publish work schedules and manage the huge workforce fluctuations from one rotation to the next."

Acute Teaching Trust, North East and Yorkshire

Transformation of people services and future operating model

[The transforming people services programme](#) aims to redesign how people services are organised and delivered across the NHS, enabling HR and OD teams to focus more on strategic workforce priorities such as workforce planning, organisational development, leadership and talent management.

Over the next few years, the programme will largely be focused on preparation and readiness activities, including service redesign, process standardisation, workforce planning, capability building and data quality improvement. A key component is the [future workforce solution transformation programme](#), that will deliver a replacement for the Electronic Staff Record (ESR). Early adopter organisations have been identified, but implementation will be phased over several years, with wider rollout expected towards the end of the decade.

Employers broadly support the ambition to modernise workforce systems and improve productivity. However, concerns remain around organisational readiness, including data quality, variation in digital maturity, implementation capacity and the scale of change management required. For HR and OD teams, the programme is likely to create additional pressures in the short to medium term as organisations balance transformation activity with ongoing operational demands.

Digital and AI as enablers of NHS transformation

Digital infrastructure is recognised as a key enabler of NHS transformation, particularly in supporting more integrated, efficient, and patient-centred care across organisational boundaries.

Employers highlighted the need to address system barriers and digital constraints that currently limit staff's ability to operate flexibly

across organisations and care settings. In particular, issues with interoperability and variation in digital systems hinder joined-up working at the neighbourhood and system level.

These constraints also restrict new ways of working, increasing administrative burden and reducing efficiency where systems are not aligned, or information cannot be easily shared. Employers emphasised the importance of removing these barriers to enable greater workforce flexibility and support integrated models of care.

Employers also identified the need for a more consistent national steer on digital infrastructure, to avoid a fragmented approach. Greater coordination was seen as important for supporting interoperability, reducing duplication, and limiting the financial costs associated with multiple systems across organisations.

Employers also highlighted the important role of clinical and medical leadership in delivering successful digital transformation. While technology can enable new ways of working, employers report that achieving meaningful improvements in patient care, productivity and service integration depends on active clinical engagement in the design, implementation and adoption of digital solutions. Leadership, culture and clinical engagement are key factors in translating digital maturity into improvements in productivity, patient care and experience. Employers noted that clinician involvement can help ensure that digital and AI-enabled solutions are effectively embedded within clinical pathways and support better outcomes for patients and staff.

The growing adoption of artificial intelligence (AI) is set to fundamentally reshape how NHS services are delivered. AI is often associated with improving productivity and reducing administrative workload, while concerns have been raised that it could replace people and jobs. A research report conducted by the Health Innovation Network South London in June 2026 [‘Beyond productivity: AI and NHS workforce implications’](#) suggests that while AI is already reshaping how work is carried out across the NHS, organisational

structures, workforce models and governance frameworks have not kept pace with this change.

Employers report that the adoption of AI presents both opportunities and challenges for the workforce, requiring organisations to consider not only the implementation of technology, but also how roles, skills and workforce models will evolve in response. There is recognition that investment in digital solutions alone will not deliver transformation without corresponding changes in workforce capability, leadership, and organisational design.

Employers also highlight that the pace of technological change can create uncertainty for staff and leaders, particularly where the implications for roles and career pathways are not yet clear. Emerging technologies, such as ambient voice technology and AI-enabled diagnostic and decision-support tools, have the potential to change how some clinical and non-clinical roles are delivered, altering the balance between administrative and value-added activities. Supporting staff through this transition, including developing the skills required to work effectively alongside new technologies, is therefore an important consideration.

For employers, this means that adopting AI is not simply a technology decision but a workforce transformation challenge. This requires employers to dedicate capacity and time to work through, alongside a backdrop of other competing priorities such as financial and productivity targets.

We know employers have started adopting AI within HR and people teams. We have developed an [AI hub on our website](#) to share emerging practice and lessons learnt of where employers have used AI in meaningful ways to improve elements of their employment journey.

Corporate cost reduction

NHS organisations continue to implement a number of measures to meet the national [objective](#) of reducing corporate costs, including recruitment freezes, the removal of posts and team restructuring.

Employers are concerned that reducing resources, in the absence of the NHS workforce plan, creates uncertainty about which roles are needed to deliver the plan's objectives. If reducing the workforce is part of cost-efficiency measures rather than the strategic design of services, this is a reactive approach that will have a profound impact on service delivery and patient care.

In March 2026, a [survey conducted by the NHS Alliance](#) indicated that more than half of NHS organisations anticipate reducing both clinical and non-clinical staffing levels in 2026/27, representing a significant increase compared with the previous year (35 per cent in 2025/26). In addition, 64 per cent of trust and ICB leaders reported that they expect to reduce or scale back patient services. This points to a clear trade-off between workforce reductions as a means of achieving financial savings and organisations' capacity to maintain service delivery.

Another risk is the impact on staff morale. The NHS Alliance survey identified declining staff morale as a key concern for 93 per cent of trust and ICB leaders and 91 per cent of GP leaders. Reductions in staffing levels may increase pressure on remaining staff, contributing to disengagement, heightened anxiety and reduced workforce resilience. If these impacts are not carefully managed, they could also undermine the delivery of financial savings plans by increasing turnover, sickness absence and reliance on temporary staffing.

"Morale is low primarily due to the cumulative impact of workload, fatigue, workforce gaps and ongoing uncertainty around pay and system pressures."

Community and Acute Provider, Midlands

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

The NHS workforce is covered by different pay determination arrangements, including the NHS Pay Review Body (NHSPRB), DDRB and the Review Body on Senior Salaries (SSRB). While these arrangements reflect the distinct roles, labour markets and contractual frameworks that apply to different staff groups, employers emphasise the importance of considering the wider workforce impact of pay decisions across review bodies. As healthcare delivery increasingly relies on multidisciplinary teams working collaboratively across professional boundaries, differences in pay outcomes can influence perceptions of fairness, value and recognition among staff working alongside one another.

Agenda for Change (AfC) and medical and dental pay awards

The 2026/27 pay round resulted in a different pay increase for medical and dental staff and those employed under AfC arrangements. Staff on AfC terms and conditions received a 3.3 per cent consolidated uplift. In comparison, the government accepted the DDRB recommendations of a 3.5 per cent increase to pay for resident doctors, consultants, SAS doctors, and salaried GPs, alongside a 3.75 per cent increase for salaried dentists working in community dental services.

Although all staff groups received pay uplifts, differences in the level, structure and timing of awards have continued to raise concerns

across the NHS workforce about fairness, morale and cohesion. Survey feedback from employers indicates that, while the immediate impact on team dynamics has been mixed, perceptions of relative pay continue to influence staff sentiment. Some employers reported that staff groups, particularly those in lower-paid roles, can feel undervalued compared with others, especially in the context of ongoing cost-of-living pressures and competition from external labour markets.

Differences in pay outcomes across staff groups can affect perceptions of fairness and value within multidisciplinary teams. While the NHS operates through separate pay determination mechanisms, staff work together to deliver integrated care, and variation in pay awards can influence team cohesion, engagement and organisational culture. Employer responses suggest that these perceptions are shaped not only by headline pay awards but also by broader factors including workload, career progression opportunities and the overall employee value proposition.

Employers also report that the existence of separate pay determination arrangements can make pay decisions more difficult to communicate clearly and consistently, particularly where staff compare outcomes across professions and roles within the same organisation. Some employers also highlight that differing pay outcomes can create wider employee relations challenges, including in engagement with AfC trade unions, where comparisons are drawn between staff groups working alongside one another in multidisciplinary teams. Maintaining staff morale, trust and constructive employment relations therefore remains an important consideration.

Perceived pay disparities for medical staff in VSM roles

Employers have highlighted a potential pay disincentive for medically qualified staff considering a move into very senior manager (VSM) roles. Although VSM pay awards are informed by recommendations

from the SSRB, doctors who remain on medical contracts may have seen greater overall earnings growth through DDRB pay awards and negotiated settlements. Employers report that this may affect the attractiveness of senior leadership roles, with implications for both recruitment and retention.

Recent work by [The King's Fund](#) highlights the role that clinicians play in driving service transformation, productivity improvement, innovation and workforce engagement. Against this backdrop, any perceived financial disadvantage associated with moving from a clinical contract into a VSM role may limit the NHS's ability to attract experienced clinicians into senior leadership positions and could weaken the pipeline of future clinical leaders.

DDRB pay review body process

We continue to support efforts to improve the timeliness of the pay review process, including earlier engagement and evidence submission. We submitted our evidence ahead of the deadline last year in support of this. However, delivering further improvement will require better alignment of the overall timetable, including earlier remit letters and sufficient time for comprehensive evidence gathering and consideration. A coordinated and realistic process remains essential to ensuring timely pay outcomes while maintaining the review's robustness and integrity.

For the 2027/28 pay round, DHSC submitted its remit letter in July 2026, consistent with the timing of the previous year's submission for the 2026/27 round. The 2026/27 pay award was paid in June 2026, backdated to 1 April, representing an improvement of two months compared to the previous year. While employers welcome this progress, further improvement is required to ensure pay uplifts can be applied from the beginning of the financial year (1 April). Given that the remit letter has again been submitted at a similar point in the cycle, employers recognise that further improvements in the implementation timescales will require time to be recovered

elsewhere in the process. This may be challenging as several stages of the annual pay award process are subject to fixed statutory and procedural timescales.

Pay and reward inequalities

Reducing inequalities in pay, reward and career progression remains an important priority for the NHS. A range of national initiatives are supporting improvement in this area, including the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), NHS England's equality, diversity and inclusion improvement plan, and wider work to improve leadership diversity, career progression and inclusive workplace cultures.

While progress has been made, evidence from workforce equality programmes continues to show that some staff groups, particularly those from ethnic minority backgrounds and disabled staff, experience poorer workplace outcomes, face barriers to progression and remain underrepresented in senior roles.

A range of national initiatives are supporting improvement in this area, including the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), NHS England's equality, diversity and inclusion improvement plan, and wider work to improve leadership diversity, career progression and inclusive workplace cultures.

However, the latest national data continues to highlight significant inequalities affecting medical and dental staff. [WRES 2025](#) shows that doctors and dentists from ethnic minority backgrounds make up 50 per cent of the medical and dental workforce overall, while ethnic minority staff account for 17.3 per cent of NHS board members. WRES also found that ethnic minority staff were more than twice as likely as white staff to report experiencing discrimination from managers or colleagues (15 per cent compared with 6.7 per cent) and were less likely to believe that their organisation provides equal

opportunities for career progression (49.6 per cent compared with 59.1 per cent).

[WDES 2025](#) highlights similar challenges for disabled medical and dental staff. Disabled staff account for 2.7 per cent of the medical and dental workforce. Across the wider NHS workforce, disabled staff were around 1.5 times more likely than non-disabled staff to experience bullying or harassment from colleagues (23.4 per cent compared with 15.1 per cent), and 1.8 times more likely to experience bullying or harassment from managers (13.9 per cent compared with 7.6 per cent). Disabled staff were also less likely to believe their organisation provides equal opportunities for career progression (51.8 per cent compared with 57.9 per cent) and more likely to report pressure to attend work when unwell (25.3 per cent compared with 17.6 per cent).

These findings show that, despite ongoing improvement activity, inequalities in staff experience, workplace culture and career progression remain evident across the NHS and continue to affect the recruitment, retention and progression of medical and dental staff. Continued implementation of WRES and WDES recommendations, alongside targeted action by employers, will be important in creating more inclusive workplaces and ensuring equitable opportunities for all doctors and dentists.

The [NHS Race and Health Observatory](#) has continued to play an important role in highlighting and addressing racial inequalities affecting the NHS workforce. During 2025/26, the Observatory has continued work to identify and reduce inequalities in workplace experience, including the development of [principles](#) and programmes focused on reducing racism, bullying, harassment and abuse. The Observatory has also highlighted the importance of inclusive leadership, fair access to development opportunities and tackling barriers to progression for ethnic minority staff.

The Observatory has additionally launched an independent review into the ethnicity pay gap within the NHS, undertaken in partnership

with the University of Surrey. The review, which runs for 18 months from July 2025, will examine differences in pay, career progression and pension contributions among staff from different ethnic backgrounds. The study aims to improve understanding of the factors contributing to ethnicity-related pay disparities and identify any unwarranted inequities within NHS employment practices. The findings, expected to be shared in December 2026, will inform recommendations to help reduce and eliminate these disparities, supporting broader ambitions to improve workforce equality, inclusion and retention across the NHS.

Equal pay and pay discrimination consultation

The UK government's office for equality and opportunity has launched a [consultation seeking evidence and views on reforming the UK's pay discrimination framework](#). The consultation aims to make pay discrimination less likely to occur, strengthen legal protections, and make disputes easier and less costly to resolve. It specifically seeks views on addressing gaps and inconsistencies affecting women, ethnic minority groups, disabled people and outsourced workers. The consultation closes on 27 October 2027. We will be participating in the consultation and will gather views from employers to provide an informed response.

2026/27 pay award and recommendations

Alongside the headline pay awards, the DDRB made two further recommendations:

- The DDRB recommended that the four governments work with dentists' representatives to develop an index of dental costs in each nation. These indices should then be used to determine the expenses element of dental contract uplifts in each nation.

- The DDRB recommended that government reviews pay and progression for salaried dentists working in community and public dental services to assess whether the reward structure is appropriate to support recruitment, retention, and service delivery.

The government has said that more time is required to carefully consider these and determine the best way forward.

The medical and dental workforce – key statistics

Our [2026/27 evidence](#) stated that there were 148,011 full-time equivalent (FTE) doctors and dentists. In May 2026, there were 153,036 FTE. This represents a 3 per cent increase.

Despite a continued year-on-year increase in the number of full-time equivalent (FTE) HCHS doctors, the monthly trend during 2026 indicates a slowing in workforce growth. Following a peak of 153,619 FTE earlier in the year, doctor FTE numbers have remained broadly stable before declining slightly in recent months. This represents a decrease of 353 FTE (-0.2 per cent) compared to the previous month. While the workforce remains higher than a year earlier, the recent plateauing and marginal decline suggest that growth in medical staffing has moderated in 2026, following several years of sustained expansion.

Figure 2 – FTE breakdown of doctor contracts as of 31/05/2026

Doctor contract	FTE
Consultant	61,306
SAS	13,982
Resident	76,972
Other / local	775
Total	153,036

Note: 'Other' refers to all doctors who are not employed under one of the national contracts.

Source: [NHS Workforce Data](#)

Vacancy rates

Vacancy levels remain a useful indicator of workforce supply pressures across the NHS. As shown in Annex A, the national vacancy rate has fallen from recent peaks, declining from 7.1 per cent in the first quarter of 2024/25 to 4.5 per cent in the fourth quarter of 2025/26. However, this overall improvement masks continuing recruitment difficulties in particular occupations, specialties and local labour markets. Survey respondents highlighted persistent challenges in a range of specialist clinical and medical roles. The evidence therefore suggests that workforce shortages are becoming more concentrated rather than being reflected in a uniformly high vacancy rate across the NHS.

Leavers

Annex A details NHS hospital and community health services (HCHS) doctor leavers, leaver rates and reasons for leaving. The data shows that the total number of HCHS doctor leavers has remained broadly stable in recent years, decreasing slightly from

19,280 in 2023/24 to 19,162 in 2025/26. Doctors in training continue to account for the majority of leavers each year. However, this reflects how the data are recorded: doctors in training are counted as leavers when moving between placements or trusts, even though they remain employed within the NHS. As a result, their comparatively high leaver rate should be interpreted in this context.

For the remaining contract groups, leaver rates have improved over the period. Consultant leaver rates remained low and stable at 4.5 per cent in 2025/26, while SAS doctor leaver rates fell from 8.1 per cent in 2023/24 to 7 per cent in 2025/26. Resignation remained the most common reason for leaving the NHS workforce, although the number of resignations fell from a peak of 141,585 in 2022/23 to 103,446 in 2025/26. The ending of fixed-term contracts remained the second most common reason for leaving, reflecting the nature of training and temporary employment arrangements within parts of the medical workforce. Overall, the data indicate an improving retention position across the HCHS medical workforce.

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 3 and 4 show that sickness absence rates have increased for the consultant and other staff groups, whereas doctors and dentists in training and SAS have reduced from the previous year. 'Other' is all doctors who are not employed on one of the national contracts.

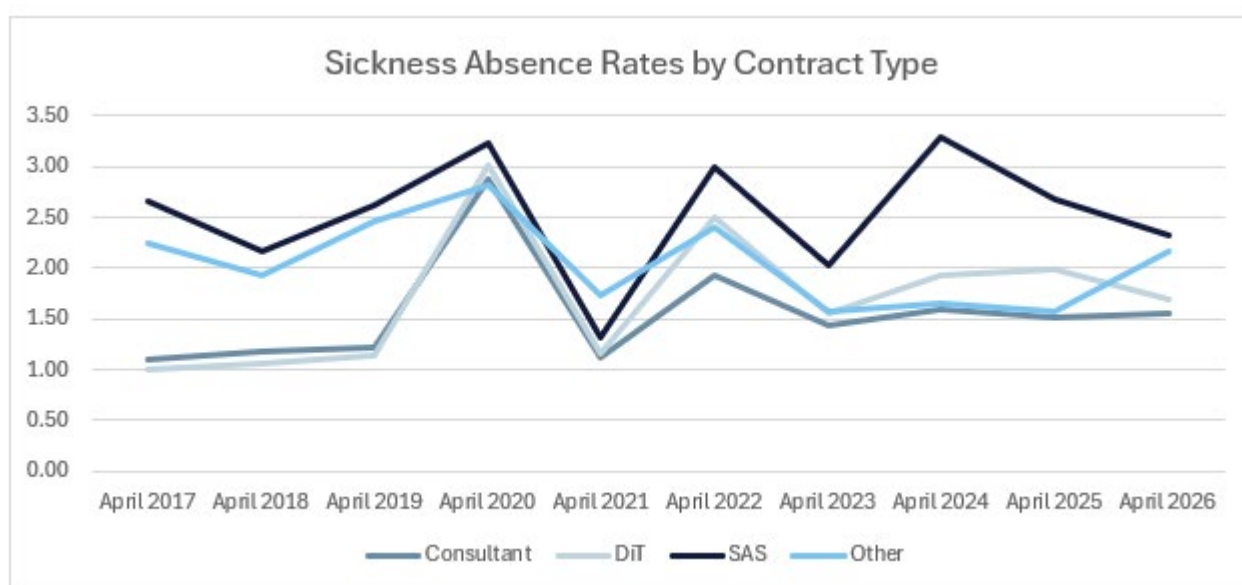
SAS doctors have the highest sickness absence rates of all the staff groups. The rate peaked at 3.29 per cent in April 2024 and fell to 2.32 per cent in April 2026.

Figure 3 - Average sickness absence rates (per cent)

Contract	April 2017	April 2018	April 2019	April 2020	April 2021	April 2022	April 2023	April 2024	April 2025	April 2026
Consultant	1.10	1.17	1.21	2.87	1.12	1.93	1.43	1.59	1.51	1.55
Doctors and dentists in training	0.99	1.07	1.13	3.02	1.15	2.50	1.56	1.92	2.00	1.69
SAS	2.67	2.17	2.63	3.23	1.32	3.00	2.04	3.29	2.68	2.32
Other	2.25	1.93	2.47	2.82	1.74	2.40	1.57	1.66	1.58	2.17

Source: [NHS Sick Absence Data April 2026](#)

Figure 4 - Average sickness absence rates (per cent)



[NHS sickness absence data for April 2026](#) also suggests that wellbeing-related issues remain a significant challenge within the medical workforce. Anxiety, stress, depression and other psychiatric illnesses accounted for 25.4 per cent of sickness absence among hospital doctors, making it the single largest cause of absence. Other notable causes included cold, cough and influenza (10.8 per cent), gastrointestinal conditions (8.4 per cent), injury and fracture (6.7 per cent), and musculoskeletal problems (8.5 per cent combined). This reinforces employer concerns about the impact of sustained service

pressures, workload and workforce shortages on staff wellbeing and workforce sustainability.

The increase in sickness absence rates among the 'Other' HCHS doctor grades between April 2025 and April 2026 appears to be driven primarily by a higher proportion of absence attributed to anxiety, stress, depression and other psychiatric illnesses, which increased from 33.5 per cent to 38.8 per cent of all sickness absence. Absence also increased for back problems, injuries/fractures, and other known causes, suggesting a broader range of health and wellbeing factors contributed to absence during the period.

A number of organisations have implemented targeted wellbeing and attendance initiatives to support staff and reduce sickness absence, with [case studies](#) showing how local approaches to health, wellbeing, and workforce support can improve staff experience and attendance. However, the [NHS 10 Year Health Plan](#) aspiration around absence is challenging. A lower sickness absence rate generally means more staff available to deliver services, which can positively impact on staff experience, productivity and patient care.

Workforce supply - international recruitment

[International medical graduates \(IMGs\)](#) are a key part of the workforce. They have brought essential clinical skills, valuable experience, and diversity to the NHS. Around 42 per cent of doctors working in the UK trained overseas, and more than two-thirds of new joiners to the medical register are non-UK graduates, underlining the NHS's ongoing dependence on international supply.

Given that internationally qualified doctors comprise a substantial proportion of the medical workforce, the [GMC's workforce report 2025: The state of medical education and practice in the UK](#), warrants close attention. The report illustrates that the growth in

international recruitment appears to be slowing, while departures from the workforce are increasing, raising questions about the long-term sustainability of supply and the impact of wider workforce and immigration policies on recruitment and retention.

While IMGs generally meet skilled worker salary thresholds, wider immigration reforms, including tighter visa rules, changes to dependant eligibility, and the direction of travel set out in the [Immigration White Paper](#) and 10 Year Health Plan may still affect the attractiveness of the UK as a destination for international healthcare workers. [Home Office statistics](#) show there were 9,600 Health and Care Worker Visa applications from main applicants, that is not a graduate or a dependent (who are covered by separate visa arrangements), in the year ending May 2026. This is a 62 per cent fall from the year ending May 2025. While this data covers the wider health and care route rather than doctors specifically, it illustrates the scale of change in international recruitment following recent policy reforms and the government's aim to reduce net migration.

The recent introduction of the Medical Training (Prioritisation) Act 2026, marks a shift in how training applications will be managed, with priority given to UK nationals and those who have studied in the UK over internationally educated doctors. The recently published report on the [impact of the Act](#) states that:

“competition ratios have halved, prioritised doctors have filled 98 per cent of roles, and in some specialties, like general practice, all posts have been filled by prioritised doctors.”

Additionally:

“In round 1, only 1.75 per cent of offers accepted to date are from non-prioritised applicants compared to 27.95 per cent last year, a reduction from 2,168 to 163 in one annual cycle.”

The Act prioritises UK trained medical graduates and those with significant NHS experience over IMGs for specialty medical training. The definition of “significant NHS experience” is currently being defined through regulations for the 2027 recruitment round. International graduates are expected to face additional barriers to entering training over UK graduates or other priority groups if the experience to be demonstrated is onerous. This may lead to international graduates being forced into less competitive specialties or localities, exploring alternative career pathways or leaving the NHS altogether.

The [closure of the Medical Training Initiative \(MTI\) scheme](#) to new applicants as of 31 March 2026, has also removed a well-established route for international doctors to gain training and experience in the NHS. At the point [the closure was announced](#), there were approximately 1,600 doctors participating in the scheme. A particular benefit of the scheme for employers was the support available to applicants who had yet to obtain GMC registration, which can otherwise be a lengthy process. Recruiting such candidates without the benefits the MTI scheme brings is likely to delay their start date. Additionally, the MTI has been of value for hard-to-recruit specialties and to trusts in remote or rural areas that might otherwise struggle to attract high-quality candidates.

While a replacement scheme is being considered, there is still uncertainty about what it will look like and when it will be introduced. This creates risks for workforce supply and for international partnerships.

Although growing the domestic supply is fundamental to the workforce, international doctors are of significant benefit to the provision of care, research and education. These changes could make the UK less attractive to international doctors, particularly when combined with longer or more uncertain immigration settlement processes for dependents. This risks undermining the NHS’s ability to retain international doctors already working here, particularly if confidence in the UK as a stable and attractive place to build a

career is reduced. They may also affect future international recruitment, which is especially important in specialties and locations that have historically relied on international recruitment to maintain services. These reductions are likely to occur before the system can sufficiently increase the domestic workforce.

These issues are directly relevant to the DDRB's consideration of pay. Pay levels and career progression affect how attractive NHS roles are to international doctors. They also affect employers' ability to recruit and retain staff within tighter immigration rules. If pay is not competitive internationally, or does not keep pace with immigration requirements, employers may find it harder to fill roles and maintain workforce supply, particularly in harder-to-recruit areas such as rural and coastal locations. Pay decisions therefore need to be considered alongside wider workforce and immigration policy.

Employers remain committed to supporting the recruitment, integration and retention of internationally trained doctors. As the policy landscape continues to change, it is important that international recruitment remains fair, responsive and aligned with workforce need. This includes ensuring that future immigration routes, training schemes and workforce policies support both domestic supply and continued access to international talent where needed.

Office for Students funding changes affecting clinical academics

[The Department for Education has issued guidance](#) to the Office for Students (OfS) on the allocation of strategic priorities grant funding for 2026–27, with changes taking effect from 1 August 2026. The guidance confirms that the OfS will cease funding allocations for NHS clinical academic consultants' pay, senior academic GP pay, and NHS pension scheme compensation. At the same time, protected funding arrangements will continue for medicine, dentistry,

nursing, midwifery, allied health professional programmes, veterinary science and other very high-cost subjects.

These changes are particularly relevant to the medical and dental workforce as NHS clinical academic consultants play a central role in the delivery of undergraduate and postgraduate education and training. The withdrawal of dedicated funding support may increase financial pressures on universities, medical schools and NHS partners involved in delivering clinical education.

The guidance was published on 6 July 2026, which gave institutions less than a month to prepare for implementation. An assessment of the potential impacts and risks of withdrawing this funding will be needed. This should include consideration of the effects on clinical academic capacity, consultant-led teaching, workforce recruitment and retention, training quality, and the long-term sustainability of clinical academic careers. The findings will help identify any mitigation measures needed to protect education and training capacity and minimise unintended consequences for future workforce supply. This may be particularly relevant to future workforce supply, training capacity, and the long-term sustainability of clinical academic careers.

Staff experience and workforce retention

General Medical Council (GMC) workplace experiences 2026 report

The GMC's [State of medical education and practice in the UK: Workplace experiences 2026](#) report found that several measures of doctors' workplace experience deteriorated in 2025, following two years of improvement. The report highlights ongoing workforce and operational pressures, with many doctors reporting that they cannot provide the level of patient care they aspire to because of workload,

staffing shortages, service capacity constraints and administrative burdens.

The GMC notes that doctors' overall satisfaction has declined and warns that recent improvements in workplace experience remain fragile amid wider system pressures. Early-career doctors, particularly foundation doctors and some locally employed doctors, reported significant challenges relating to career progression and development, while trainers reported increasing workload pressures and declining satisfaction. The report concludes that addressing workplace pressures and supporting doctors to deliver high-quality patient care will be critical to improving wellbeing, retention and workforce sustainability.

NHS Staff Survey

The [2025 NHS Staff Survey](#) showed little change in overall theme scores compared to 2024, with most NHS People Promise themes remaining stable and morale and motivation indicators showing minimal movement.

However, some key measures of staff experience declined. This was reflected in a reduction in staff willingness to recommend the NHS as a place to work, indicating ongoing challenges in maintaining staff engagement and advocacy.

At a national level and reflecting NHS-wide average results rather than the experience of every organisation or staff group, several health and wellbeing indicators declined compared with the 2024 survey. Indicators of stress, burnout and workplace pressure remained persistently high across the NHS. The proportion of staff who felt their organisation takes positive action on health and wellbeing fell from 57.5 per cent in 2024 to 54.8 per cent in 2025, while the proportion reporting work-related stress increased from 41.7 per cent to 42.3 per cent. Nearly one in three staff reported feeling burnt out. Despite these challenges, staff perceptions of

support from their immediate manager remained relatively stable, with 71 per cent reporting positive line-management support.

Most overall theme scores for doctors remained stable in 2025. Satisfaction with flexible working improved slightly, while willingness to recommend the NHS as a place to work declined slightly, although it remained higher among medical staff than for the wider NHS workforce.

Pay satisfaction among doctors showed a mixed picture in 2025. Consultants continued to report the highest pay satisfaction, with the proportion satisfied or very satisfied increasing from 56.2 per cent in 2024 to 58.5 per cent in 2025. Resident doctors also reported a small improvement, increasing from 31.6 per cent to 32.7 per cent. Satisfaction among SAS doctors remained broadly stable, while satisfaction among other doctors declined from 41.2 per cent to 37.2 per cent. These findings indicate that pay remains an important factor influencing staff experience, although perceptions of pay and reward continue to vary across medical staff groups, reflecting differing experiences, expectations and pressures at different career stages.

The survey findings reinforce the importance of continued action to improve staff wellbeing, reduce workplace pressures and support positive staff experience across the medical workforce.

We have developed a range of [resources](#) to support employers in addressing mental health, stress and burnout. These include a [guide to key actions](#) and a webinar in which organisations shared examples of ongoing initiatives.

We recommend an organisation-based, prevention-focused approach. Individual intervention techniques can help but are most effective when embedded in a comprehensive wellbeing framework. We are also involved through the Health, Safety and Wellbeing Group (HSWG) in wider research on fatigue, with further work on definitions and support to be published in due course.

To assist employers in relation to sickness absence, we have developed a [sickness absence toolkit](#). This is a highly utilised resource and continues to be actively promoted. Recent academic research on sickness absence policies in the NHS indicates that it is widely used.

Negative staff experiences

There continues to be high levels of violence, bullying, harassment and discrimination experienced by NHS staff, with significant consequences for staff wellbeing, workplace culture and retention. The NHS Staff Survey and Workforce Race Equality Standard findings show that substantial inequalities in workplace experience persist between white staff and staff from ethnic minority backgrounds.

In 2025, 29.2 per cent of staff from ethnic minority groups reported experiencing harassment, bullying or abuse from patients, service users, relatives or members of the public, compared with 23.5 per cent of white staff. Similarly, 23.4 per cent of staff from ethnic minority groups reported experiencing harassment, bullying or abuse from managers or colleagues, compared with 19.6 per cent of white staff. Staff from ethnic minority groups were also more than twice as likely to report experiencing discrimination from managers, team leaders or colleagues, at 13.9 per cent compared with 6.5 per cent of white staff.

While reporting rates have increased and some indicators have improved over recent years, progress in reducing these disparities has been limited. Continued action is required to improve inclusion, psychological safety and workplace culture across the NHS.

We continue to support work through the Social Partnership Forum to address these issues, including through our most recent [guidance on post incident support](#).

NHS Staff Standards

On 7 July 2026, the [NHS Staff Standards](#) were published. These provide a framework to improve staff experience in the NHS. The standards set out minimum expectations that all NHS organisations will be expected to meet and will be measured against. The aim is to provide minimum standards, reduce variation and promote improved staff experience. The standards build on some of the good work undertaken as part of the NHS People Promise. The standards cover line management, health and wellbeing, preventing and reducing violence against staff, championing sexual safety, tackling racism, and promoting flexible working. Their inclusion in the [NHS oversight framework](#) means that trusts will be assessed, supported and held to account across all the elements within the standards. This means staff experience will be more clearly linked to how NHS organisations are held to account. It shows that looking after staff is essential to providing safe, sustainable and high-quality care.

We have been involved in developing the standards and will support employers in implementing them effectively. The standards were developed in collaboration with the Social Partnership Forum and will be taken forward through local partnership working. Progress will be reflected in the NHS oversight framework.

Staff experience and retention

Recent independent research provides additional evidence of the relationship between pay, staff experience and retention. A UK-wide cohort study published in [The Lancet Regional Health – Europe](#), found that pay satisfaction among healthcare professionals remains low, with a significant proportion expressing dissatisfaction with their pay. The study identifies an association between lower pay satisfaction and an increased likelihood of considering leaving the NHS, with this relationship particularly evident among doctors in earlier stages of their careers. These findings suggest that perceptions of pay and value may influence workforce stability and retention across the medical workforce.

Section 2 – The remit groups

Doctors and dentists in training

Since our 2026/27 submission, significant progress has been made in addressing a range of issues affecting doctors and dentists in training. Following a prolonged period of industrial dispute, agreement was reached between the government and resident doctors in June 2026. The reforms extend beyond pay to include training capacity, career progression, working conditions and employment arrangements. As implementation begins, employers' attention is shifting from industrial relations to the delivery of these commitments and the operational impact of the changes across NHS organisations.

Industrial relations

In June 2026, the DHSC made an offer to resident doctors to end ongoing industrial action. The offer aimed to improve the fraught industrial relations by addressing key areas of concern to the resident doctor workforce, including proposing measures to incentivise productivity by supporting progression, providing greater employment security for locally employed doctors and addressing bottlenecks, enabling resident doctors to feel valued and secure in employment.

The offer aims to incentivise productivity by increased recognition of the competencies and experience of the resident doctor workforce, this is covered in five key themes:

- pay
- wider support
- access to training places
- measures to improve the working lives of resident doctors
- future working arrangements.

Measures broadly included nodal point reform, reimbursement of exam fees, additional training places, standardising LED contracts, driving improvement through the 10 Point Plan and the medical and education training review and establishing working arrangements for implementation. On 29 June 2026, it was announced that resident doctors had voted to accept the deal and efforts now turn to implementation.

Exception reporting

Exception reporting is a key tool for doctors and dentists in training to ensure safe working hours are maintained, secure patient safety and flag when their educational opportunities are missed. It also ensures fair compensation for work done.

On 4 February 2026, exception reporting reforms were fully implemented. Various guidance documents relating to the different parts of the deal were published to support employers in implementing it. This included guardian of safe working hours quarterly reports, which are standardised to a national template to allow central data processing. Data to be included in these reports includes detriment, threat of detriment via survey, and confirmed

information and access breaches. NHS England will collect this data every month.

Employers are also encouraged to offer exception reporting to locally employed doctors who work in roles comparable to those of doctors in training, but this is at the employer's discretion. However, changes as part of the residents' deal 2026 will mean that there is a new national contract being developed for LEDs that will extend exception reporting provisions to them.

Flexible pay premia (FPP)

As part of the government's offer to resident doctors, the flexible pay premia for clinical academics will increase to £10,000 effective from April 2027. This is in recognition of the increased impact on lifetime earnings the nodal point reform would make on clinical academics specifically.

The 2016 TCS categorises the GP FPP as part of the “hard-to-fill training programmes”. In recent years, there has been significant numbers of applications to general practice training posts and therefore would not meet the definition as “hard to fill”. As part of the offer, the GP flexible pay premia will be renamed to the general practice registrar enhancement.

The review and inclusion of the academic FPP and GP FPP in the resident doctor deal supports previous requests from employers for a review of FPP's currently in operation, particularly those covering hard to fill specialties with questions raised 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

A number of key steps have been taken to improve the experience of doctors in training posts.

The [10 Point Plan](#) sets out key areas of focus for employers and has issued guidance on the provision and management of annual leave for resident doctors.

Outputs from this area of work include:

- A payroll improvement programme with 31 trusts to identify and resolve the root causes of payroll issues for resident doctors, leading to a 48 per cent reduction in errors.
- Appointment of named senior resident doctors' leads with oversight of improving doctors' working lives issues.
- Establishment of a national project to explore extending lead employer arrangements.
- Publication of annual leave standards for resident doctors

The [medical education training review](#) published its case for change in late 2025 identifying several areas for improvement in the structure and delivery of medical training in the NHS. Work has since commenced on these priorities, led by Dame Jane Dacre and supported by key stakeholders. However, the relationship between the training review and the implementation of the resident doctors' pay deal has yet to be clearly defined. Clarity will be important to avoid any unnecessary confusion for employers.

General Medical Council National Training Survey

The [2026 GMC National Training Survey](#) indicates generally positive experiences of postgraduate medical training in England, with

strengths in clinical supervision and educational support. However, the findings continue to highlight challenges relating to workload, wellbeing, and workplace culture, including experiences of unprofessional behaviours and discrimination. The survey emphasises the importance of maintaining supportive learning environments and addressing these ongoing pressures to ensure a high-quality training experience for doctors in training.

Specialty and specialist grade doctors

Pay deal

In June 2024, BMA members voted in favour of the revised offer put forward by the government. Following this, the SAS deal implementation group was established in August 2024, bringing together representatives from DHSC, the BMA, NHS England and NHS Employers to oversee delivery of the agreement.

The agreement included reforms to the SAS pay scale to address the differences between the 2008 and 2021 contracts, alongside a strong emphasis on improving career development opportunities. National stakeholders within the implementation group have since published a range of supporting resources, including guidance on the introduction of the specialist grade and a dedicated support hub to support employers in embedding these roles across organisations.

"SAS doctors are supported through structured job planning and development opportunities, and the reforms have had a significant positive impact, particularly in improving satisfaction with pay."

Mental Health Provider, Midlands

The SAS deal workplan is now complete except for work to strengthen job planning arrangements and a joint programme focused on supporting SAS doctors to progress via the portfolio pathway, which will be taken forward in JNC (SAS).

In June 2026, a key milestone was reached with the publication of the [SAS eligibility and permanency framework](#), that sets out a clear, structured process for LEDs to transition to permanent SAS contracts where they are undertaking comparable roles. The framework establishes consistent national criteria, including requirements for 24 months' continuous service with the same employer, in a comparable role and outlines a staged process for assessment, employer review and transition. It also introduces an initial six-month window (September 2026 – March 2027) allowing eligible doctors to express interest in moving to a substantive SAS post, supported by competency evaluation and job planning processes.

The introduction of this framework improves career stability and progression for LEDs while supporting workforce retention and reducing reliance on temporary arrangements. Implementation will require local workforce planning, clear communication with eligible staff and appropriate resourcing to support the assessment and transition process.

In parallel, the [SAS doctor development guide](#) has been further updated to reflect new national resources, including expanded support for the specialist grade and aligned development opportunities.

Annex B in this report displays the latest data for 2027/28, showing continued expansion of the SAS workforce alongside further transition from the 2008 to 2021 contracts, building on the position reported in our 2026/27 evidence.

Adoption of the 2021 contract continues to increase, while numbers on the legacy 2008 contract continues to decline. This represents a

further consolidation of the 2021 contract compared with 2026/27, reinforcing it as the predominant contractual arrangement.

Although overall workforce numbers fluctuated slightly during the year, patterns were consistent with normal recruitment turnover and contract change activity, with no indication of a change in the overall trend towards the 2021 contract.

Pay comparison between the 2021 and 2008 contracts remain broadly unchanged from 2026/27. Most pay points continue to favour the 2021 contract, with advantages of up to £10,548 at certain stages of the scale, although a small number of pay points remain more favourable under the 2008 contract. As a result, while the overall financial position supports continued transition to the 2021 contract, individual pay differences may still influence decisions to transfer.

Overall, the data demonstrates continued progress in adoption of the 2021 contract, sustained growth of the SAS workforce and a broadly positive direction of travel. Employer feedback complements these findings, indicating generally positive experiences, while highlighting the need to continue monitoring the impact of remaining pay differentials.

Some organisations report clear benefits, particularly in relation to job planning and autonomy. One employer highlighted that SAS doctors are supported through structured job planning and development opportunities and noted that the reform has had a significant positive impact, particularly in improving satisfaction with pay. Similarly, another employer described improvements in job planning arrangements and increasing levels of autonomy, with moderate positive effects on progression, including routes such as the portfolio pathway.

Other employers report more moderate impacts, one indicated that while SAS doctors are supported in a comparable way to other medical staff groups, the reforms have had a more modest but still positive influence on recruitment, retention and morale.

However, this experience is not universal, as one employer noted that within their organisation, the SAS contract reforms have not yet had a noticeable impact, suggesting the benefits of the changes may not be consistently realised across all settings.

Together, this feedback suggests that while the reforms are beginning to deliver improvements in areas such as career development, job planning and workforce stability, the extent and pace of impact vary locally. Likely reflecting differences in implementation, organisational context and workforce composition.

Specialists

Employers have consistently expressed a desire for more specialist posts to be established, and the BMA remains particularly disappointed by the level of progress achieved to date. Although specialist roles continue to grow, stakeholders consider the rate of expansion to be below that envisaged during contract negotiations, contributing to ongoing concern about whether the intended benefits of contract reform are being fully realised. We have continued to emphasise and promote the specialist role through national guidance, resources and engagement activity, recognising that there remains a broader perception that uptake has been limited despite evidence to the contrary.

Updated workforce data for 2027/28 shows that the number of specialists has continued to increase beyond the April 2025 position previously reported. Between April 2025 and January 2026, specialist headcount rose from 1,584 to 1,866, representing an increase of 282 posts (18 per cent) over nine months. This builds on the strong growth trajectory observed in 2026/27 where headcount had already reached 1,558 by March 2025.

When compared to the earlier forecast model, actual numbers continue to exceed expectations. While the margin of outperformance has stabilised slightly compared to earlier years, the

sustained upward trajectory indicates continued demand for specialist roles rather than a plateau in uptake.

Despite this growth, employer feedback suggests that financial considerations remain a significant factor influencing local decision-making. Funding is frequently cited as a constraint, particularly where organisations are required to invest additional resource to establish specialist roles. This sits alongside wider structural, organisational and cultural challenges identified through commissioned research by the National Institute of Health Research, including varying levels of managerial buy-in, lack of clarity around progression pathways and a tendency in some organisations to prioritise consultant recruitment over alternative workforce models.

Implementation challenges also persist, including the absence in some organisations of fully embedded workforce planning approaches that incorporate the specialist grade, alongside variation in the use of job descriptions and inconsistent internal processes. While national guidance and resources have been developed to address these issues, their impact remains uneven across the system.

Alongside these challenges, national work to support implementation has continued including the development of a dedicated specialist hub and supporting guidance outlining when and how specialist roles can be created, for example, encouraging recruitment to specialist posts where associate specialist roles become vacant. These resources, alongside ongoing promotion of the role are intended to support more consistent adoption in workforce planning.

The distribution of specialist roles remains uneven across regions in 2027/28, consistent with previous years, indicating that local workforce strategies continue to play a significant role in determining uptake.

Overall, specialist roles continue to increase, demonstrating ongoing progress since the introduction of the contract reforms. However,

growth remains uneven across organisations and regions, suggesting local workforce priorities, funding constraints and implementation approaches continue to influence the pace of adoption.

SAS Week 2026

SAS Week is taking place from 5-9 October 2026 and continues to be a highly regarded national initiative to recognise the contribution of SAS doctors and dentists across the NHS.

Building on previous years, the focus of SAS Week 2026 will evolve to place greater emphasis on enabling employers to lead and shape their own local engagement activities. We have developed a suite of practical resources, including promotional materials, guidance and event planning tools to support organisations in delivering locally relevant and impactful programmes.

This shift reflects learning from earlier campaigns where locally tailored initiatives were shown to have the greatest impact on staff experience, visibility and recognition. By equipping employers with flexible resources rather than relying solely on centrally driven activity, SAS Week 2026 aims to encourage meaningful local recognition of SAS doctors and dentists. We will support organisations to showcase good local practice and innovation, strengthen engagement between staff, clinical leaders and senior management and embed recognition within wider workforce and organisational development strategies.

The national campaign continues to provide a unifying framework and shared identity (#SASWeek26), while enabling employers to adapt activities to their workforce needs. This includes facilitating events such as recognition ceremonies, leadership engagement sessions, career development workshops and opportunities to highlight SAS contributions to service delivery and patient care.

Overall, SAS Week represents a more sustainable and scalable model of engagement, moving from awareness-raising alone, towards empowering organisations to take ownership of recognition and inclusion. This approach aligns with broader workforce priorities around retention, career development and improving the working lives of SAS doctors and dentists.

Consultants

Employers continue to highlight the importance of retaining experienced consultants, particularly in the context of service pressures and workforce shortages. Flexible working arrangements, retirement behaviour, and broader employment conditions all play an important role in influencing retention, with employers emphasising the need for contractual arrangements that help consultants remain in the workforce.

Employers reported recruitment challenges across a range of consultant roles. National NHS vacancy data are available, but they are not reported by medical specialty, limiting the ability to identify consistently which specialties experience the greatest recruitment pressures.

Employers reported difficulties recruiting to certain consultant specialties, although the severity of these challenges varies between organisations and geographical areas. Recruitment can take a considerable period of time where vacancies require highly specialised expertise and the supply of suitably qualified candidates is limited. Competition for specialist staff may further constrain recruitment in some areas.

[The Royal College of Radiologists' 2025 Census Policy Briefing for England](#) provides evidence of the scale and variation of workforce pressures in highly specialised medical fields. The briefing reports a 17 per cent shortfall in clinical oncology consultants in England in 2025, which is forecast to increase to 24 per cent by 2030, if

workforce growth does not keep pace with demand. It also highlights geographical variation in workforce pressures, with some regions experiencing greater shortages than others. [The Royal College of Psychiatrists' Workforce Census 2025: England](#) found that 14 per cent of consultant psychiatrist posts were vacant at the end of March 2025. The census also identified geographical variation, with an 18 per cent consultant vacancy rate in the North compared with 11 per cent in the South.

These findings suggest that recruitment pressures are not evenly distributed across medical specialties and geographical areas. While the overall vacancy rate for consultant roles remains low, there are specialties where higher vacancy rates are experienced.

Industrial relations

Industrial relations activity involving the consultant workforce has remained a key consideration for us. The BMA undertook a statutory ballot of consultant doctors in England regarding potential industrial action. The ballot opened on 11 May 2026 and closed on 6 July 2026. Consultants voted in favour of industrial action, although no strikes have been announced at present.

Employers would like to see the current dispute resolved before any industrial action takes place, recognising that action involving the consultant workforce could significantly impact NHS services. Consultants play a critical role as senior clinical decision-makers and leaders within multidisciplinary teams, and any disruption to their availability has implications for patient flow, elective activity, training, and service continuity. Avoiding industrial action would help minimise disruption for patients, support timely access to care, and reduce the operational and financial pressures associated with contingency planning and service recovery.

We remain committed to strengthening the industrial relations environment across the NHS and we are keen to play our part in a constructive, partnership-based approach working with trade unions.

Reinstatement of the joint negotiating committee (consultants) (JNC(C))

Over the past year, a key area of focus has been the preparatory work for the reinstatement of the JNC(C), marking a return to formal national arrangements for maintaining the 2003 consultant contract. Employers are supportive of recommencing formal JNC(C) activity at the earliest opportunity; however, the timing of reinstatement is dependent on the wider industrial relations environment.

To support this, we have established and inducted a refreshed management-side team. This group includes a broad and representative range of employers, comprising senior leaders from across all regions and a variety of organisation types. This ensures that the employer voice reflects both geographical diversity and the range of operational contexts in which the consultant contract is applied.

The re-established JNC(C) will provide a structured forum for employers and trade unions to work in partnership to address contractual issues and support the ongoing maintenance of the consultant contract.

Employer priorities for reform of the 2003 terms and conditions

Through extensive engagement with employers across our medical networks, we have identified aspects of the 2003 consultant terms and conditions that employers believe would benefit from amendment, change or improvement, as well as areas where more

detailed or enhanced guidance would support effective service delivery.

Employers consistently report that several of the 2003 contract provisions no longer fully reflect modern clinical practice or evolving service delivery models. There is also a strong view that aspects of the current contractual framework can be rigid, cost-intensive and increasingly misaligned with system-wide priorities and productivity-driven models of care.

Key areas identified include:

Job planning

Variation in local approaches continues to create inconsistency and perceived inequity, particularly in relation to programmed activity (PA) allocation, objective setting and recognition of non-clinical activity. The increasing use of flexible, hybrid and annualised working arrangements, alongside the shift towards neighbourhood health and community-based models, has highlighted limitations in current provisions. Employers also highlight the need for more explicit support within the contractual framework for consultants to work across organisational boundaries, noting that models based on a single employing organisation are increasingly unsustainable.

On-call and emergency work

Contractual definitions are increasingly misaligned with modern service delivery, with particular challenges around rota categorisation, interpretation of intensity and the growth of resident on-call arrangements. A lack of clear definitions of emergency work continues to drive inconsistency and disputes, as well as challenges in distinguishing between scheduled and unscheduled activity.

Pay progression

Employers report administrative complexity in implementing the revised process, including challenges with ESR data accuracy, coordinating review meetings, and ensuring consistent interpretation of progression criteria.

Annual leave

Applying week-based entitlements to non-standard working patterns remains complex and administratively burdensome, with ongoing risk of inconsistency in how leave is calculated and applied.

Clinical Impact/Excellence Awards

Ongoing complexity persists following the transition to the National Clinical Impact Award (NCIA) framework, particularly in interactions with legacy Local Clinical Excellence Awards (LCEAs), creating misalignment in pay-related calculations and perceived inequities.

Seven-day services and contractual flexibility

Employers highlight that aspects of the current contractual framework can be rigid in the context of modern service expectations, particularly the expansion of seven-day services. The contractual opt-out from non-emergency work outside core hours is increasingly viewed as a significant constraint, limiting the ability to improve productivity, respond to patient demand, and deliver consistent seven-day services.

Seniority and flexible training pathways

Employers report increasing complexity in applying seniority provisions for consultants with less-than-full-time training or extended pathways, and a need for clearer guidance to ensure consistent and equitable application.

Contract clarity and definitions

Employers report that parts of the contract rely on outdated terminology, legacy organisational references and unclear definitions, which can create ambiguity in day-to-day application and increase reliance on local interpretation. There is also a growing view that the time-based nature of the contract does not adequately support outcome-focused, productivity-driven service models and may contribute to rising costs.

Employers have emphasised that addressing these issues through targeted amendments to the 2003 terms and conditions, alongside clearer and more comprehensive national guidance, would improve consistency, reduce administrative burden and better support effective service delivery. This includes ensuring that any changes enhance flexibility and productivity while remaining affordable and avoiding unintended cost pressures.

National Clinical Impact Awards (NCIAs)

As part of the 2026/27 pay award announcement, the 2025/26 DDRB recommendation to increase the value of NCIAs was accepted and backdated to 1 April 2025.

Figure 5: National Clinical Impact Award (NCIA) values before and after the 2025/26 pay award uplift

NCIA Level	Award values from 2022	Award values from 1 April 2025
Level 1	£20,000	£21,000
Level 2	£30,000	£31,500
Level 3	£40,000	£42,000

Source: [Doctors' and dentists' pay award announcement 2026 | NHS Employers](#)

Employers report a mixed picture on the effectiveness of clinical impact awards. While the scheme is intended to recognise and reward exceptional contributions, responses to our survey suggest that the NCIAAs can positively affect morale, recognition, and retention. However, many organisations report limited evidence of a consistent or measurable impact on service delivery, clinical outcomes, or organisational productivity, with benefits often more closely associated with individual motivation and satisfaction rather than system-wide change. Engagement with the scheme also varies, with some employers noting low application rates.

The [Advisory Committee on Clinical Impact Awards \(ACCIA\)](#) manages the NCIA scheme and remains committed to ensuring it does not contribute to pay disparities and to ensuring that award recipients are representative of the consultant workforce. The 2025 awards round saw a reduction in the diversity gains made in recent years, largely due to a significant increase in applications from holders of legacy awards. In response, ACCIA has engaged with under-represented groups, reviewed its guidance and application processes, and expanded outreach activities to improve accessibility and encourage broader participation in future award rounds.

The administration of the NCIA scheme continues to place demand on organisational resources, particularly when set alongside other workforce and operational priorities. Employers also continue to highlight complexity within the awards landscape, particularly the [interaction between legacy Local Clinical Excellence Awards](#), which remain consolidated and pensionable but [frozen in value](#), and the current national scheme. This can contribute to perceived inequities within the consultant workforce.

Partial retirement

Employers have continued to support the use of partial retirement flexibilities for consultants, which have been well received and can help retain experienced staff. However, employers are now reporting

increasing complexity as individuals reach the end of the initial 12-month partial retirement period.

Under current guidance, additional work undertaken during the 12-month period may be treated as non-pensionable, but this flexibility does not extend beyond that point. After the initial period, additional programmed activities revert to being pensionable under standard NHS Pension Scheme rules, up to whole-time equivalent. This limits employers' ability to maintain locally agreed working arrangements and can create challenges in managing both workforce expectations and pension implications.

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 continue to report persistent difficulties in recruiting entry-level salaried dentists, particularly to band A roles. Employers are reporting they no longer advertise for band A and recruit straight to band B due to the long-term failure to recruit. Pay competitiveness remains a concern, compared to general dental practice and other sectors, with many vacancies remaining unfilled despite widespread advertising. Employers feel that while there has been an increase in dental students this is not translating to an increase in students wanting to pursue a career in community dentistry or salaried dental roles.

The DDRB 2025/26 and the DDRB 2026/27 both recommended that the 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 current dentistry funding model requires continuous professional development (CPD) to be funded locally. This requires difficult choices to be made between supporting dentists' development and funding equipment or opportunities.

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 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 and reported increased anxiety of the population. 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

While we have not received evidence to suggest that differences in pay or terms and conditions between England and the devolved nations are resulting in significant relocation of doctors or dentists, these variations can influence the wider industrial relations

environment. Annex C provides a comparison of medical and dental pay scales across the devolved nations.

Comparisons are frequently drawn between arrangements in England and those available in Scotland, Wales and Northern Ireland. This is particularly the case where the devolved nations have implemented provisions perceived to be more favourable, whether in relation to pay awards, contractual arrangements, leave entitlements, working patterns, wellbeing measures, or other employment terms and conditions.

Although such comparisons do not appear to be translating into large-scale workforce movement, they can shape staff expectations and affect perceptions of fairness and value within the workforce. As a result, decisions taken in the devolved nations can have a bearing on industrial relations in England, with trade unions often referencing alternative approaches adopted elsewhere in the UK when engaging with employers and government. The comparison of pay scales set out in Annex C provides context for these discussions and highlights the extent of variation across the four nations.

The existence of differing employment frameworks across the four UK nations therefore remains a relevant factor in the broader context of workforce engagement, morale and industrial relations, even where there is limited evidence of a direct impact on recruitment, retention or staff mobility.

Section 3 – Locally employed doctors (LEDs)

Background

LEDs can be defined simply as any doctor or dentist 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 doctors and dentists in training. They will undertake similar roles, work similar patterns, and in many cases, will work on rotas alongside doctors and dentists in training.

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). While some employers offer educational support and access to provisions such as exception

reporting, this is not mandatory and is a recruitment and retention incentive.

The latest figures show that [over half of doctors](#) on neither the GP nor specialist register in England and Wales work in LE roles.

Reasons for the use of locally employed doctor (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. LEDs often work during the rotation changeover and provide much-needed stability to service. The [GMC's research](#) into doctors in LED roles cites that over two thirds of these doctors (66 per cent, or 43,924) had a contract record that described the department they work in specifically with the largest number working in medicine departments.

For doctors, taking up 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. It may also be an opportunity to obtain more experience in a specialty prior to applying to training posts which may be particularly important in highly competitive and/or craft specialties.

Post foundation LED posts (often referred to as FY3) are particularly attractive 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 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 doctors and dentists in training under pay protection arrangements. As the number of doctors and dentists in training 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.

"Clinical fellows are supported to train and develop alongside their trainee peers and we have developed locally employed posts specifically designed to assist doctors through the Portfolio Pathway."

Teaching Trust, North East and Yorkshire

Many employers advocate for central funding to enhance LED development, which could improve retention, patient safety and the readiness of LEDs for training roles. Some trusts have begun to designate LED tutors or leads to oversee their educational development, and while welcomed, this does bring a cost pressure. Some trusts have also extended LEDs the exception reporting provisions where they are working on doctors and dentists in training rotas.

However, there are some concerns that supporting LEDs should not undermine the training of doctors and dentists in training. If LED

posts fully replicate the outcomes of training it may call into question the need for the continued existence of a training programme.

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 and 2025/26 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 doctors and dentists in training colleagues.

Paying LEDs less than their doctors and dentists in training 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 does not address the fact that some LEDs such as trust appointed associate specialists are working at a more senior level and may therefore have a stronger case for enhanced pay.

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 doctors and dentists in training, 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 remain inconsistencies between trusts, with access to educational support, clinical supervision and exception reporting not being delivered consistently across employers. The resident doctor reforms are expected to reduce some of this variation through the introduction of a nationally agreed contract for LEDs working in equivalent roles.

Employers have expressed that a standard template contract, rather than a separate pay scale, would help standardise the employment of LEDs, suggesting this would improve consistency while retaining local flexibility. While the resident doctor reforms will introduce national arrangements for most LEDs, some will continue to work in locally defined roles. As a result, there remains a need for sufficient flexibility to develop local terms and conditions that reflect different service and workforce requirements.

It is essential to ensure that implementation of the new arrangements recognises the diversity of the LED workforce and remains sufficiently flexible for employers to meet local service needs. While greater consistency is welcomed, employers expect a mix of national and local employment arrangements to remain a feature.

Employers previously allowed their LED workforce to access parts of the 2016 TCS such as exception reporting, as a recruitment incentive and to compete against other trusts for retention.

Section 4 – NHS Pension Scheme

Pensions

The NHS Pension Scheme (NHSPS) is an important tool for attraction, motivation, and retention of the NHS workforce. The scheme remains one of the most generous and comprehensive schemes in the UK and is a major part of the overall reward package for working in the NHS.

The scheme continues to face considerable challenge managing the McCloud remedy, unprecedented redundancy and retirement estimate requests due to large scale restructuring across the system alongside ongoing challenges with the dated systems and interfaces that manage this workload. Employers tell us that continued long wait times for information, support and estimates from NHS Pensions is eroding trust in the scheme.

We reported in our last submission that employers face local pension administration pressures, reducing the amount of time available for vital scheme communications about the value of scheme membership. Continued financial constraints and facilitating the required redundancy and retirement traffic has increased the pressure on local pension administration considerably.

We believe that digitisation of the scheme and improved system interfaces will alleviate some of the pressures on local administration

and support employers to use the scheme strategically to meet the workforce challenges of the future.

NHS Pension Scheme membership data and trends

As we have reported in previous submissions, overall membership levels in the NHSPS are generally high. We noted last year that when we analyse data by categories such as pay band, role, gender, and ethnicity, it reveals certain groups of staff are less likely to be members of the scheme than others. Employers continue to tell us that the scheme should be inclusive and attractive to all NHS staff to ensure it remains an effective tool for recruitment, retention, and reward.

In terms of trends, we would refer to last year's submission and comment as follows:

- Opt out by pay grade – membership rates for consultants remain high. We reported a rise in last year's submission, possibly due to pension taxation changes. We recommend research to understand differing membership rates among staff grade SAS doctors and specialty doctors. Membership rates for resident doctors remain high, however, research would be needed to understand why there is generally lower rates of membership among resident doctors in core training.
- Opt out of international employees – opt outs for international recruits are higher than the average. Employers have suggested that short-term career plans may impact this, alongside cultural expectations and understanding of the scheme. Research would enable a better understanding of the reasons for these opt outs and how the scheme can encourage membership.
- Opt out by ethnicity – those with Asian and Black ethnicity have the highest opt out rates, compared to those with white ethnicity who have the lowest opt out rate. We believe it is

important to conduct further research to understand why these groups opt out and to inform next steps to increase scheme participation.

- Opt out by gender – as we reported last year, opt out data for males and females remains relatively similar.

Reasons for opting out

We reported last year that affordability is the main driver of opt outs from the scheme. This has not changed over the period since our last submission.

The scheme does not offer flexibilities to membership; a member must either opt in and pay full scheme membership or opt out and miss out on other valuable scheme benefits such as life assurance.

Introducing scheme flexibilities in relation to the member contribution rate would allow members greater control and autonomy over their pension savings and would enable more affordable access, ensuring the scheme remains valuable to all members of the workforce.

Communicating the value of the scheme, including important family benefits is a vital element of helping staff reach an informed financial decision about scheme membership. We support employers to promote the value of the scheme through a suite of resources such as:

- [The value of the NHS Pension Scheme poster](#)
- [Communicating the benefits of the NHS Pension Scheme.](#)

Scheme flexibilities

We continue to advocate for increased flexibilities for members over the level of contribution they pay into the scheme, and the value of

benefits they receive in return. We believe this could help to address some of the opt outs we see due to affordability. Flexibilities could increase member control, autonomy, and sense of transparency in relation to their pension savings. It could also increase member engagement through proactive, targeted member communications. As mentioned in our opt-out section, introducing scheme flexibilities may likely be a medium-term goal as successful implementation would require digital sophistication both centrally and locally that current systems are not able to offer. It is realistic that the introduction of scheme flexibilities follows the planned transformation and digitisation of the scheme.

Gender pension gap

We are aware through our work with the NHSPS Scheme Advisory Board (SAB) that there are differences in pension outcomes between men and women. This is an important topic for several reasons:

- Scheme opt out rates are similar for men and women.
- Scheme regulations do not discriminate between men and women.
- Pay scales are the same for men and women.
- Nearly 80 per cent of the NHS workforce is female.

We represented employer views during SAB discussions on the gender pension gap. Employers remain committed to providing a scheme that enables access for all and is valuable for the whole workforce, regardless of gender. Our representation influenced SAB's recommendations to DHSC around scheme change that may begin to close the gap. The recommendations consider that the scheme is facing considerable administrative challenges including McCloud and redundancy and asks that SAB's recommendations can be revisited once scheme administration is more stable. We understand publication of the [Pensions 2050: evidence and future](#)

[priorities – interim report](#) may increase interest in the gender pension gap across all public sector schemes.

SAB is also providing information to the NHS Staff Council to enable it to consider the impact of deliberations and negotiations around AfC terms and conditions of service (AfC TCS) may have on the gender pension gap.

Flexible retirement

Although the scheme doesn't offer flexible membership options, it does provide flexibility about how and when members retire. We reported in our previous submission about the uptake of partial retirement. We are seeing a slight reduction in partial retirements in 2026.

In October 2023, partial retirement was introduced for members of the 1995 Section. Members take between 20-100 per cent of benefits while remaining in work. We continue to support employers with implementation of the required change to terms and conditions and 10 per cent reduction to pensionable pay for the 12 months following partial retirement. However, the number of enquiries has reduced. We have updated our [partial retirement employment guidance](#) to include legal clarification from DHSC, particularly around the use of programmed activities and additional programme activities to administer the required 10 per cent reduction to pensionable pay for 12 months.

We continue to support employers with the interaction of partial retirement on the calculation of contractual redundancy payments. We have seen an increase in the number and complexity of these cases in 2026 due to the increase in redundancies across the service.

We are pleased that partial retirement continues to be a popular retirement flexibility for members, potentially supporting retention

where full retirement or retire and return was previously the only option for a member wanting to access their pension benefits.

We cannot track the number of members who retire and return. As we reported last year, we continue to support retire and return as an option to retain valuable, skilled staff in the workforce 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.

We recently shared examples of good practice in relation to flexible retirement. These have proved popular with employers and offer examples of how these valuable retirement flexibilities can support employers to meet their workforce challenges:

- [Partial retirement: a flexible retirement option.](#)
- [Retire and return: a streamlined approach.](#)

McCloud remedy implementation

A revised ministerial statement from 21 May 2026 includes the independent review findings that NHS Business Services Authority (NHS BSA) has made significant progress on McCloud remedy delivery planning. The [statement includes](#) a forecasted timeline. We eagerly await publication of the final report.

We continue to await a confirmed timeline for the introduction of choice on retirement. We plan to support employers with the changes required to retirement processes to support successful implementation of choice on retirement. We recommend that this implementation requires at least a 6-month lead in time for employers to understand the process and make relevant resource and local pension administration changes. While we wait for this important milestone, the number of members who will be required to enact a retrospective choice continues to increase.

We continue to support employers with the McCloud remedy and their understanding of complex issues such as McCloud and pension taxation, the cost claim back scheme and contingent decisions. We updated our [McCloud web page](#) to reflect the most recent Ministerial statement and will include choice on retirement guidance once the timeline is confirmed.

Pension taxation

We are seeing fewer enquiries from employers about pension taxation and less about the impact of pension taxation on members. Our focus has been to encourage employers to remind staff to take action when they receive RPSS, use the HMRC calculator and promote the cost claim back scheme for members who have paid for financial advice due to McCloud. Delays and errors with RPSS continue to cause member and employer confusion.

We continue to support employers with pension taxation through our range of pension tax related resources:

- [Pension tax guidance for employers](#)
- [Access to pension tax guidance and advice](#)
- [McCloud remedy](#)
- [Annual allowance](#)
- [Assessing annual allowance - ready reckoner tool and demonstration](#)

Introduction of real-time re-banding

We highlighted in previous submissions (2024/25 and 2025/26) that progressing an automated solution for re-banding member pension

contributions is urgently needed to help alleviate local pension administration pressures. A fully automated solution would increase accuracy of member contributions, remove potential inequity in the cost of membership and reduce manual administrative burden on employers.

In our 2025/26 submission, we noted that the SAB workplan for 2025/26 included exploration of a prototype real-time re-banding solution for all payroll providers. Unfortunately, this work was delayed. We are pleased that it is included in the SAB workplan for 2026/27. However, beginning this work in March 2027, means that this is not a short-term priority for the scheme and may be looking at implementation from the earliest 1 April 2028. We are happy to support this SAB workstream with preliminary work.

Employer contribution rate

The current employer contribution rate is 23.7 per cent. Employers are also required to pay a scheme administration levy of 0.08 per cent. Employers currently pay 14.38 per cent of contributions, with the remainder (9.4 per cent) being funded centrally. We would welcome clarity on the future of this funding arrangement.

The 2024 NHSPS valuation commenced in September 2025 with results due to be published by the end of June 2026.

Member contribution rate

Members pay a contribution rate based on their actual pensionable earnings. On 1 April each year, member contribution tier thresholds are increased (indexed) in line with the consumer price index (CPI) from the previous September. If the AfC pay award for England is more than CPI, there is a further uplift to member contribution tier thresholds. This two-stage approach was designed to reduce the likelihood of members moving up a tier and needing to pay a higher

contribution rate because of the pay award. Indexation has had a positive impact in reducing the number of these ‘cliff-edges’ and the negative impact this has on members perception of the scheme.

April 2026 saw implementation of the AfC pay award for England from 1 April 2026. This removed the need for a further assessment of member contribution tier thresholds within the year. Implementing and communicating changes to member contribution tier thresholds is complex and challenging for employers. Although uplifts to the pensionable pay ranges are automatically updated in ESR, employers must still reassess contribution rates against the tiers. This can involve significant manual intervention, adding to local administration pressures. Improved, automated processes are required to ensure efficient and accurate assessment of member contributions. We support employers by publishing new [member contribution rates](#) on our web page at the earliest opportunity to support them with implementation and communication.

Overall, the process has improved considerably and the application of the AfC pay award for England at 1 April, has supported this. NHS staff who receive pay awards that are higher than the AfC pay award for England would not benefit from full indexation.

NHS Pension Scheme member contribution rates for 2026/27

A table that shows the member contribution rates for 2026/27 indexed in line with September 2025 CPI rate of 3.8 per cent.

Salary threshold	Contribution rate
Up to £13,259	5.2%
£13,260 to £28,854	6.5%
£28,855 to £35,155	8.3%
£35,156 to £52,778	9.8%
£52,779 to £67,668	10.7%
£67,669 and above	12.5%

Source: [NHS Pension Scheme member contributions | NHS Employers](#)

Pension communications

We continue to keep employers up to date with pension policy, encourage them to use pension flexibilities to meet workforce challenges and support them to communicate the value of the NHSPS through our resources, all linked from our [central NHSPS web page](#).

We have been pleased to represent the views of employers on scheme specific communications through the NHS pension board and the McCloud engagement board and we look forward to renewed focus on communications through the pension board work streams for 2026-27. This work will be critical to ensuring the scheme has timely, simple pension communications, vital to supporting members to make informed financial decisions about scheme membership.

We have talked about the pressures facing local pension administration in this and previous year's submissions. Pressure on employer pension administration reduces the time and capacity for member engagement and communication, which are critical to member understanding of the value of the scheme and the benefits of scheme membership. We are pleased to hear that NHS BSA is embarking on a transformation project and hope that this will help streamline and modernise scheme administration. It is vital that employers are consulted early in planning and scoping phases and throughout implementation of any new systems, including the new ESR to ensure these are optimised for pension administration.

In your DDRB 54th Report (2026), you reported that indicative pension outcomes for consultants is around £81,000 per annum in the NHSPS. This compares favourably when considered against the [retirement living standards](#).

Retirement living standards estimated costs for one person:

- minimum £13,900 per annum
- moderate £32,700 per annum
- comfortable £45,400 per annum.

While the [retirement living standards update in 2022](#) showed that retirement living costs have increased, the NHSPS still offers a comprehensive and attractive savings vehicle for retirement living.

Looking to the future

We continue to support the NHSPS to remain an attractive scheme for the benefit of all members so that it continues to be an effective tool for attracting, motivating, and retaining talent in the service. We believe that digitisation of the scheme would support this aim.

We will continue to work with colleagues across SAB and the pension board and other forums to help the scheme meet the needs of the future workforce. We are pleased to see that the SAB workplan for 2026/27 includes mobilising scheme value, an exploration of the value of benefits delivered at different ages and how pension adequacy models can help to highlight the value of the scheme.

Annex A

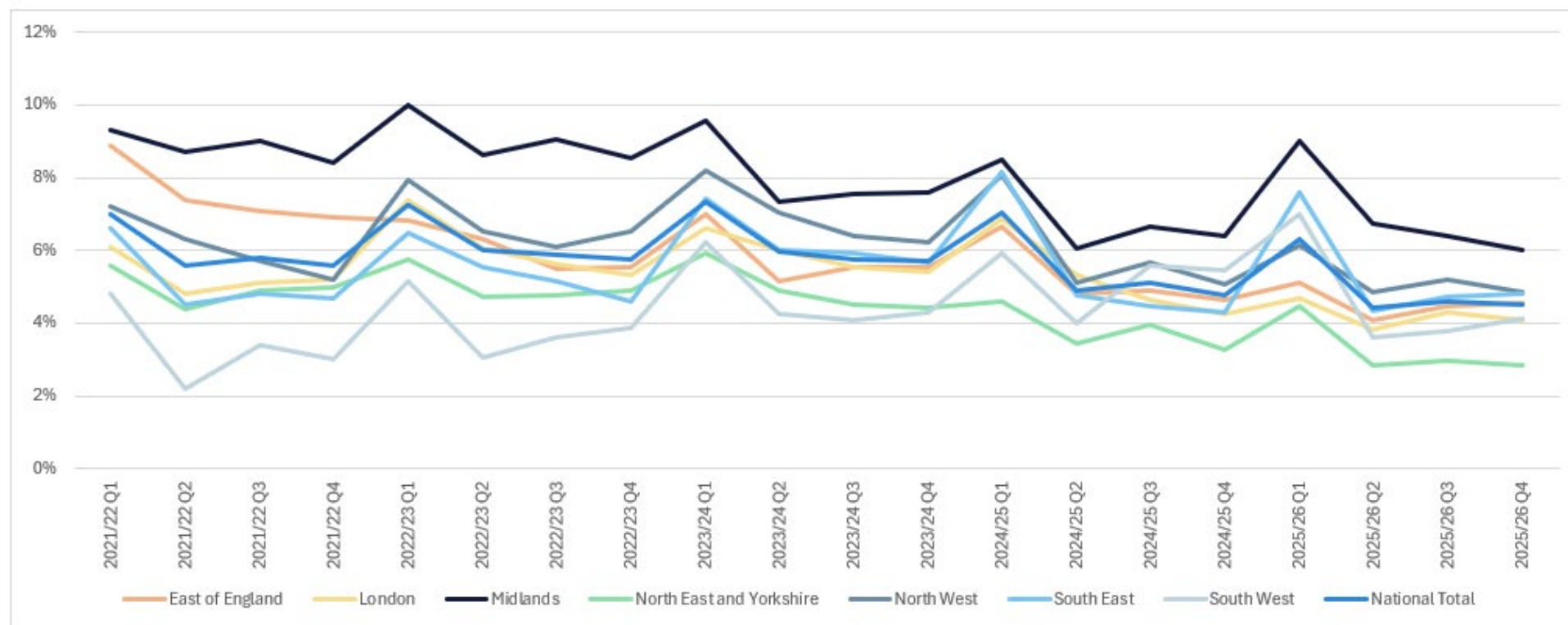
Vacancy and leaver data

Figure 6: Vacancy data

Quarter	East of England	London	Midlands	North East and Yorkshire	North West	South East	South West	National Total
2021/22 Q1	8.9%	6.1%	9.3%	5.6%	7.2%	6.6%	4.8%	7.0%
2021/22 Q2	7.4%	4.8%	8.7%	4.4%	6.3%	4.5%	2.2%	5.6%
2021/22 Q3	7.1%	5.1%	9.0%	4.9%	5.7%	4.8%	3.4%	5.8%
2021/22 Q4	6.9%	5.2%	8.4%	5.0%	5.2%	4.7%	3.0%	5.6%
2022/23 Q1	6.8%	7.4%	10.0%	5.7%	7.9%	6.5%	5.1%	7.3%
2022/23 Q2	6.3%	6.1%	8.6%	4.7%	6.5%	5.5%	3.0%	6.0%
2022/23 Q3	5.5%	5.6%	9.1%	4.8%	6.1%	5.1%	3.6%	5.9%
2022/23 Q4	5.5%	5.3%	8.6%	4.9%	6.5%	4.6%	3.9%	5.8%
2023/24 Q1	7.0%	6.6%	9.6%	5.9%	8.2%	7.4%	6.2%	7.3%
2023/24 Q2	5.2%	6.0%	7.3%	4.9%	7.0%	6.0%	4.3%	6.0%
2023/24 Q3	5.6%	5.6%	7.5%	4.5%	6.4%	5.9%	4.1%	5.8%
2023/24 Q4	5.5%	5.4%	7.6%	4.4%	6.2%	5.7%	4.3%	5.7%
2024/25 Q1	6.6%	6.9%	8.5%	4.6%	8.0%	8.2%	5.9%	7.1%
2024/25 Q2	4.8%	5.3%	6.0%	3.4%	5.1%	4.8%	4.0%	4.9%
2024/25 Q3	4.9%	4.6%	6.7%	3.9%	5.7%	4.5%	5.6%	5.1%
2024/25 Q4	4.7%	4.3%	6.4%	3.3%	5.1%	4.3%	5.5%	4.8%
2025/26 Q1	5.1%	4.7%	9.0%	4.5%	6.1%	7.6%	7.0%	6.3%
2025/26 Q2	4.1%	3.8%	6.7%	2.8%	4.9%	4.3%	3.6%	4.4%
2025/26 Q3	4.5%	4.3%	6.4%	3.0%	5.2%	4.7%	3.8%	4.6%
2025/26 Q4	4.5%	4.1%	6.0%	2.8%	4.8%	4.8%	4.1%	4.5%

Source: [NHS Digital, vacancy survey](#) (April 2021 - March 2026)

Figure 12.2 - Vacancy data



Leaver data

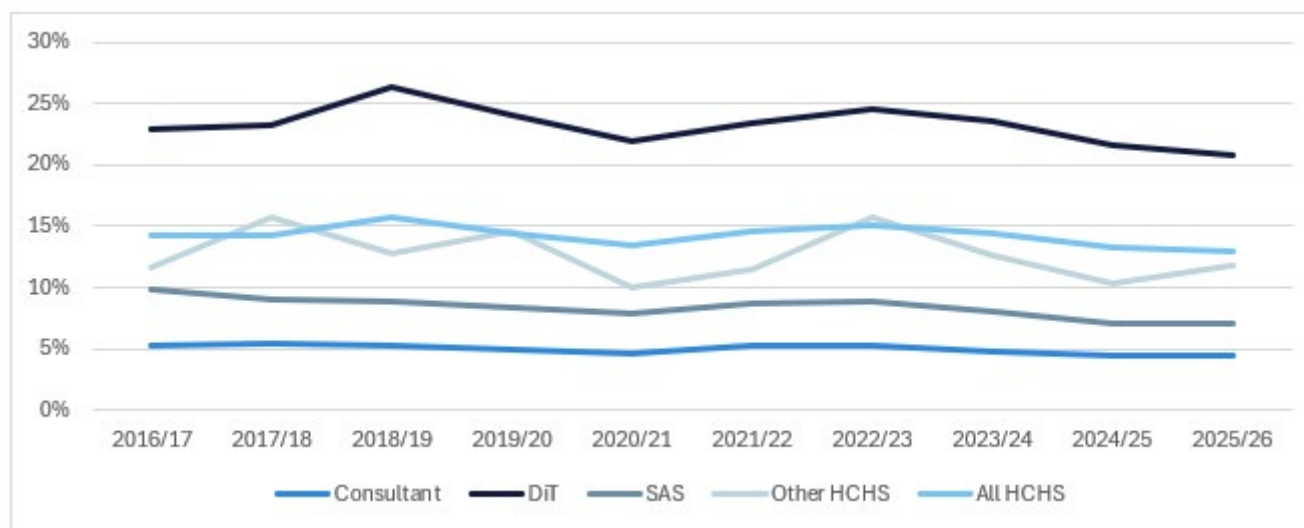
(Due to the availability of data, the years are calculated from March-March)

Figure 7: HCHS leavers

Contract Type	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Consultant	2,304	2,419	2,418	2,362	2,280	2,756	2,783	2,601	2,503	2,631
Doctors and dentists in training	11,455	11,762	13,707	12,775	12,583	14,297	15,553	15,626	15,327	15,496
SAS	902	837	829	825	817	917	976	951	875	935
Other HCHS	105	141	109	135	86	95	130	103	85	100
All HCHS	14,766	15,159	17,063	16,097	15,765	18,065	19,443	19,280	18,789	19,162

Figure 8: HCHS leaver rate

Contract Type	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Consultant	5.3%	5.4%	5.2%	4.9%	4.6%	5.3%	5.2%	4.7%	4.4%	4.5%
Doctor and dentists in training	23.0%	23.2%	26.3%	24.1%	22.0%	23.5%	24.5%	23.5%	21.6%	20.8%
SAS	9.8%	9.0%	8.8%	8.4%	8.0%	8.7%	8.9%	8.1%	7.1%	7.0%
Other HCHS	11.7%	15.7%	12.8%	14.6%	10.1%	11.5%	15.8%	12.7%	10.3%	11.9%
All HCHS	14.3%	14.3%	15.7%	14.4%	13.4%	14.6%	15.1%	14.4%	13.3%	13.0%



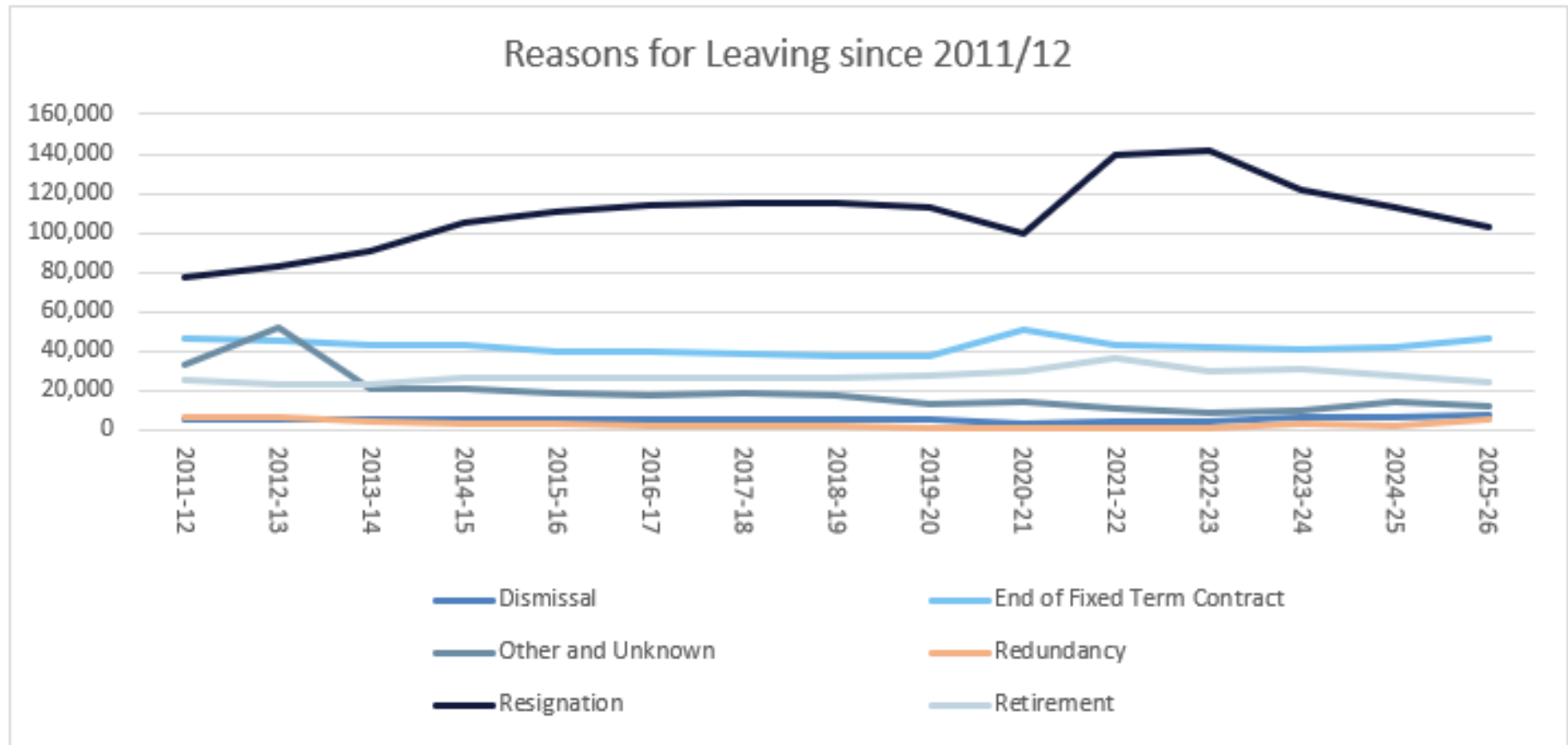
Note: HCHS refers to Hospital and Community Health Services. Data relate to HCHS doctors across all grades.

Source: [NHS Digital, Workforce statistics \(March 2026\)](#)

Figure 9: Reason for leaving

Year	Dismissal	End of fixed term contract	Other and unknown	Redundancy	Resignation	Retirement	Grand total
2011-12	5,570	45,897	33,453	6,826	77,022	25,503	194,271
2012-13	5,394	45,220	52,421	6,753	83,058	22,683	215,529
2013-14	5,343	43,610	20,384	4,637	91,241	23,541	188,756
2014-15	5,406	42,905	20,742	3,690	10,4967	26,888	204,598
2015-16	5,886	39,354	18,610	3,221	11,0715	26,805	204,591
2016-17	5,785	39,748	17919	2,408	114,148	26,679	206,687
2017-18	5,601	38,785	18,582	2,243	115,465	26,493	207,169
2018-19	5,265	37,244	17,120	1,576	114,887	26,413	202,505
2019-20	4,921	37,317	13,084	1,475	113,103	27,679	197,579
2020-21	3,745	51,220	13,900	1,073	99,113	29,342	198,393
2021-22	4,028	43,029	10,415	645	139,509	36,057	233,683
2022-23	4,698	41,864	9,177	656	141,585	30,334	228,314
2023-24	6,137	40,672	9,392	2,703	122,228	30,610	211742
2024-25	6,925	42,088	14,665	2,025	112,506	28,100	206,309
2025-25	7,766	45,889	12,144	5,163	103,446	24,768	199,176

Figure 10: Reason for leaving



Note: Data relate to the entire NHS workforce in England. Values shown are headcount.

Source: [NHS Leavers Data March 2026](#)

Annex B

Figure 11: Growth of the SAS workforce and transition to the 2021 contract

Overall SAS headcount April 2025 - November 2025								
	April	May	June	July	Aug	Sept	Oct	Nov
New contracts	8,656	8,789	8,913	9,020	9,502	9,323	9,442	9,569
Old contracts	5,200	5,133	5,076	5,020	5,072	4,908	4,845	4,810
Total	13,856	13,922	13,989	14,040	14,574	14,231	14,287	14,379

Source: [ESR database](#)

Annex C

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.

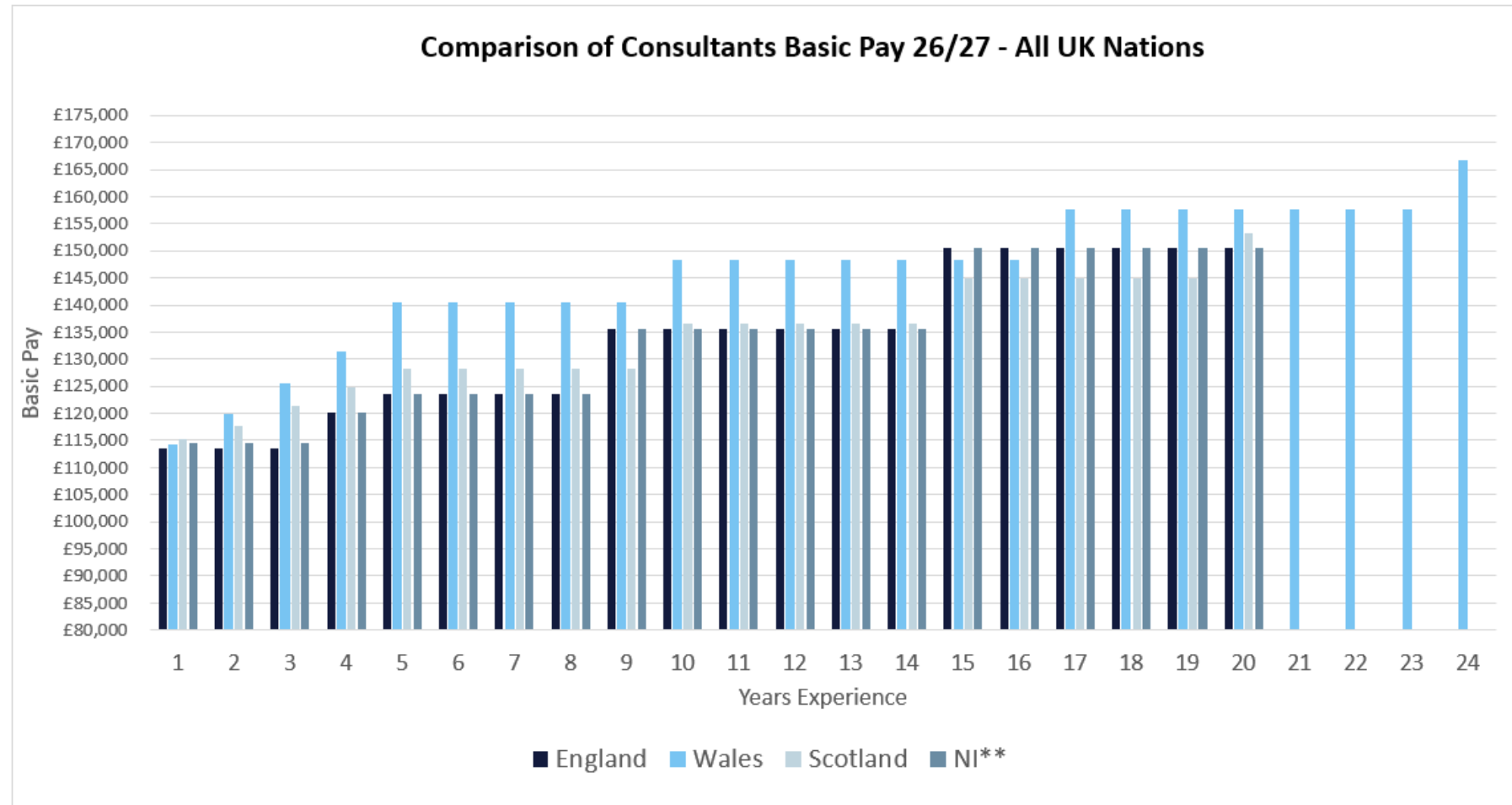
To note:

- Northern Ireland – the pay award for 2026/27 has not yet been implemented, so the forecasted figures reflect the DDRB's recommended uplifts for 2026/27

Sources:

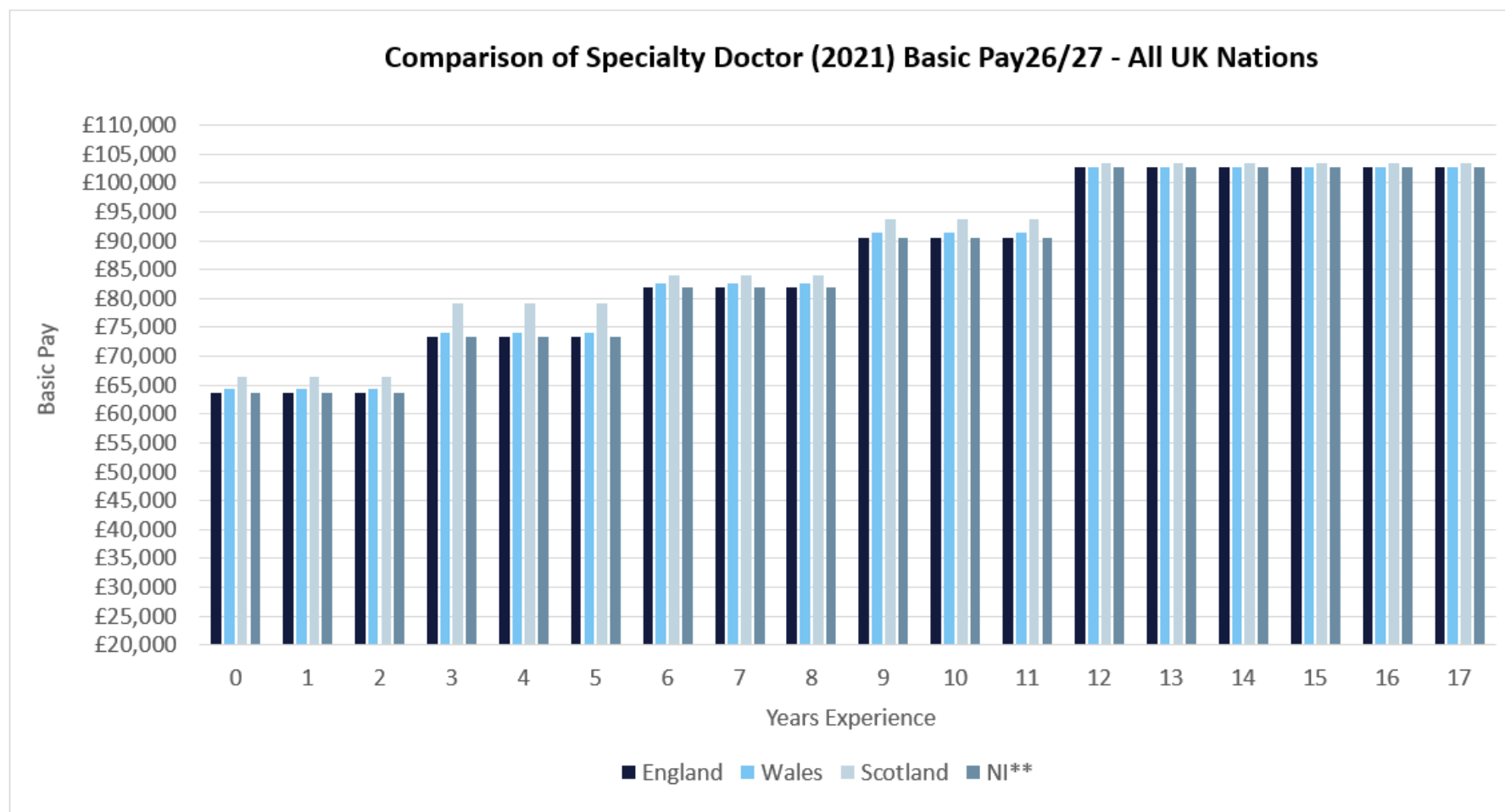
- England - [\(M&D\) 1/2026 R2](#)
- Wales - [M&D\(W\) 01/2026 V2](#)
- Scotland (2025/26) - [PCS\(DD\)2025/01](#)
- Northern Ireland (2025/26) - [HSC \(TC8\) 05/2025](#)

Figure 12: Consultants



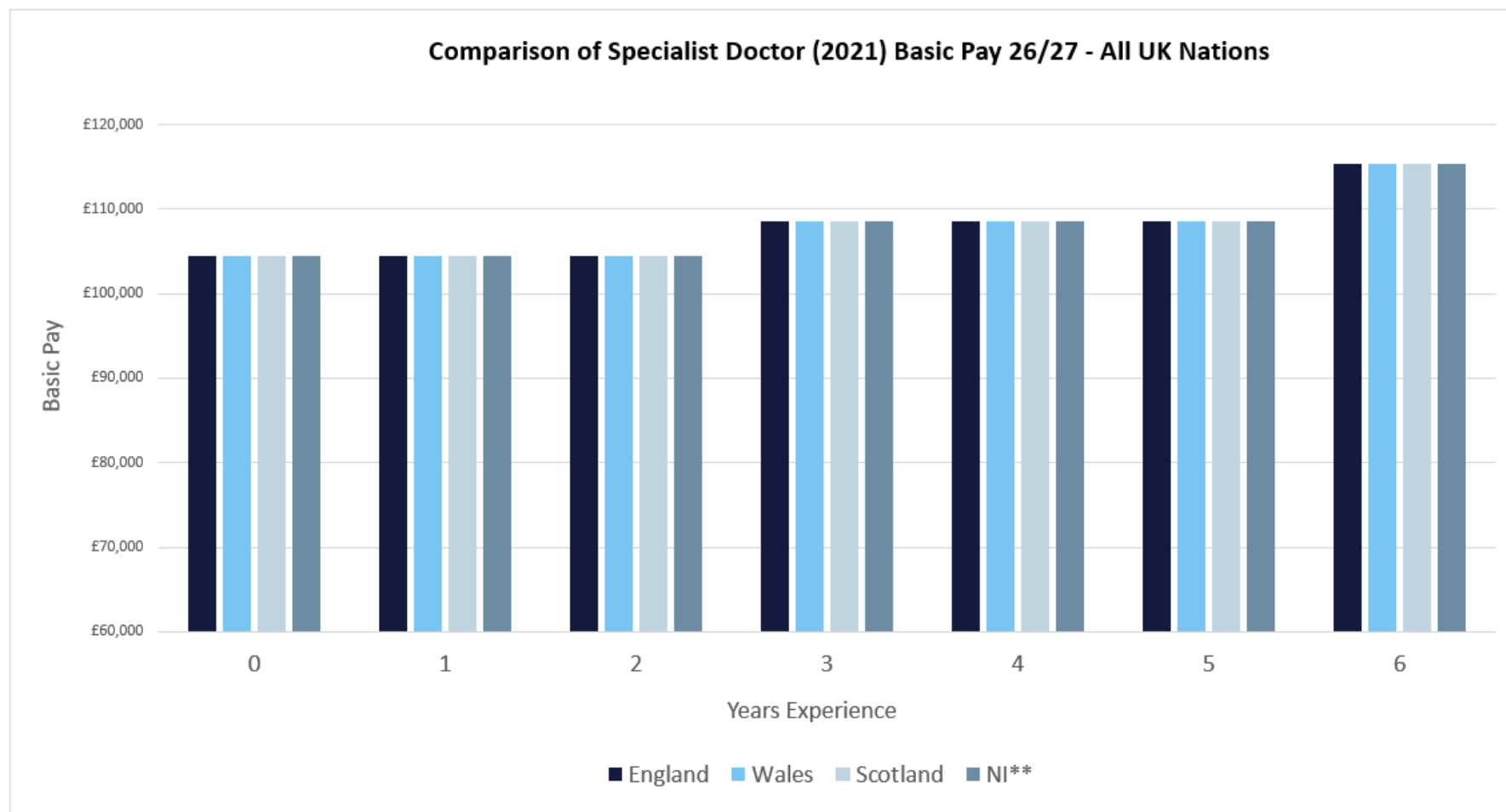
** Forecasted values used in lieu of a published Pay Circular

Figure 13: Specialty doctor (2021)



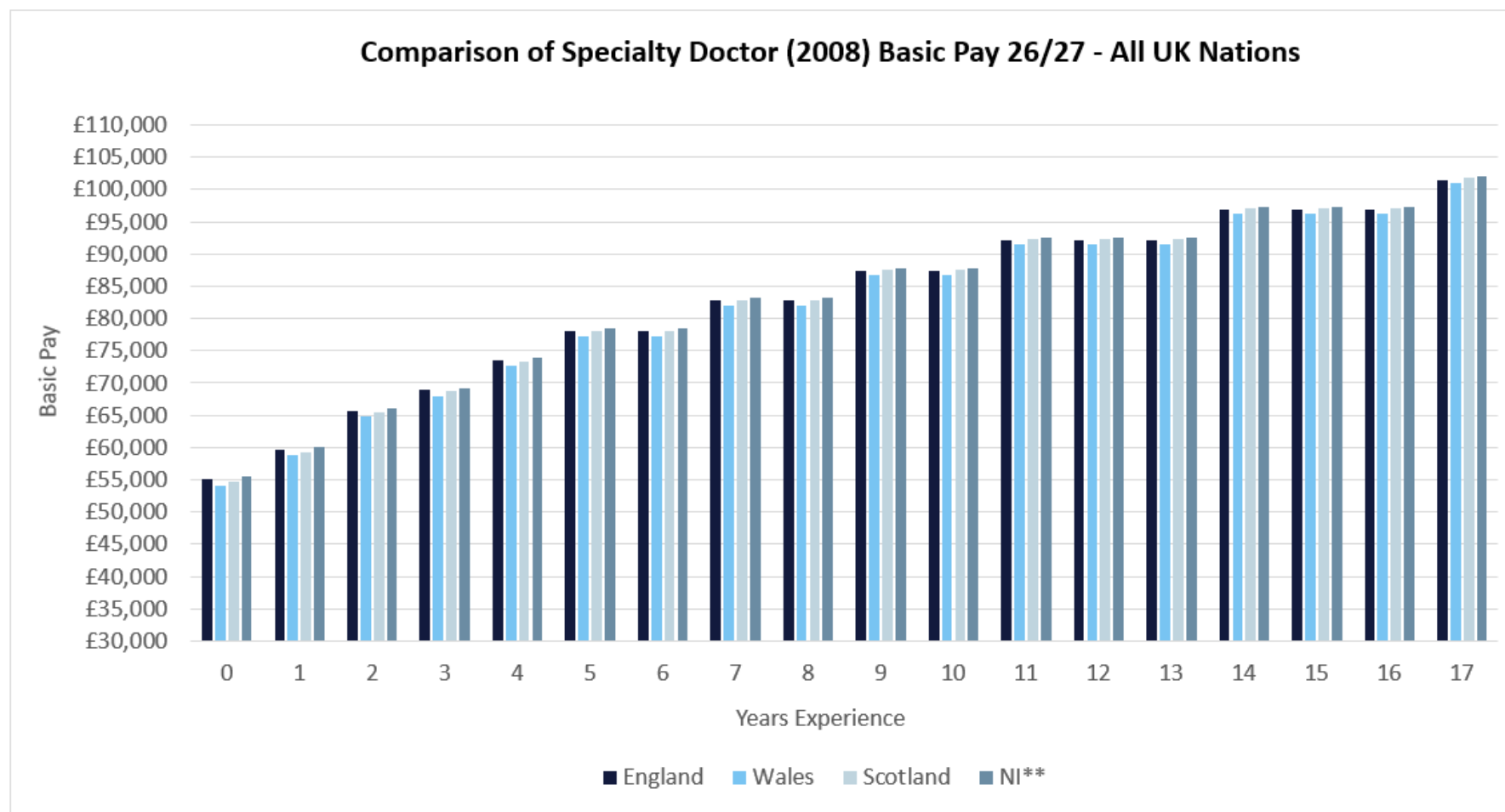
** Forecasted values used in lieu of a published Pay Circular

Figure 14: Specialist doctor (2021)



** Forecasted values used in lieu of a published Pay Circular

Figure 15: Specialty doctor (2008)



** Forecasted values used in lieu of a published Pay Circular

Figure 16: Associate specialist (2008)



** Forecasted values used in lieu of a published Pay Circular

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