

NHS Employers' submission to the NHS Pay Review Body 2027/28

4 September 2026

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Informing our evidence

NHS Employers is pleased to submit evidence on behalf of NHS organisations in England. We continue to recognise and value the independent, expert role of the NHS Pay Review Body (NHS PRB) in examining pay and reward issues affecting staff employed under Agenda for Change (AfC) contracts.

Employers welcomed the return of the 2026/27 pay round to an April implementation date, recognising this as an important step towards a timelier and more effective pay-setting process and achieving an on-time pay award for all NHS AfC staff. They remain supportive of further improvements that strengthen the timeliness, predictability and efficiency of future pay rounds.

To ensure the pay round for 2027/28 remains on track, we understand the requirement for a shortened timetable which enables all parties involved to complete the necessary work. Despite a shorter window of engagement this year, our evidence has been shaped by engagement with a wide range of NHS organisations.

This has included:

- engagement with our policy board, made up of senior leaders from across the NHS
- discussions with chief people officers and deputy chief people officers through regional networks

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- contributions from employers participating in our specialist networks covering reward and recognition, wellbeing, education, recruitment, terms and conditions, and staff experience.

In addition, we surveyed senior NHS HR leaders on topics including structural pay issues, 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 are pleased that the data collected from our survey reflects employer views from a range of sectors and regions. 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.

We surveyed our reward and recognition network members to understand the current priorities, issues and challenges reward professionals in the NHS are facing. We received 23 responses. We also ran four virtual network sessions in 2026; insights and feedback from these sessions have been instrumental in shaping our evidence.

We request that the NHS PRB considers an improvement to its process, by providing parties with an earlier sight of their forward look, including the likely areas of focus and specific evidence requests for the forthcoming round. This would enable us to begin engagement with employers at an earlier stage, allowing more time to gather evidence in a more structured and meaningful way. We believe this would support stronger levels of participation, improve the breadth and depth of feedback received, and help ensure that employer views are captured more fully across the range of issues identified by the NHS PRB.

From the 1 April 2026, NHS Providers and NHS Confederation merged to form the NHS Alliance. The coming together of these organisations means 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 data and information from a number of NHS Alliance reports and briefings, that represent views and experiences from across a broad range of employer networks.

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

This submission builds on our 2026/27 evidence and sets out employer perspectives on the financial, economic and workforce pressures facing the NHS. It also reaffirms the strategic pay priorities needed to strengthen and future-proof the AfC pay and reward structure.

Shaping the NHS future 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 the existing policy and financial frameworks.

In the absence of a finalised workforce plan, employers report 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
- a 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 ensuring that the new national workforce plan:

- 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 and supports 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.

Importance of workforce wellbeing and the extent to which staff feel valued within organisations is well understood. Employers report this is 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 workforce engagement and retention, particularly among newer entrants to the workforce.

There remains continued concern from employers around a lack of alignment for some occupations with workforce supply and service demand, including instances in which newly qualified staff cannot secure substantive roles. This highlights the importance of coordinated workforce planning across the training and employment pipeline.

Until 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 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
- reduce the growth in 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.

Feedback from regional networks highlighted substantial workforce reduction requirements across a range of NHS organisations, which vary in scale and approach between employers. In the South West, one employer reported using mutually agreed resignation schemes (MARS), releasing approximately 65 staff, following a high volume of applications, achieving an in-year saving of £1.5 million. Another employer ran non-clinical MARS only, with end of and early career applications received, achieving an in-year saving of £1.3 million.

Some employers are planning much larger reductions, including requirements for a 3 per cent headcount reduction, current-year reductions of more than 160 posts and future cost improvement plans that could equate to workforce reductions of several hundred to over 1,000 whole-time equivalent staff. While some organisations had utilised MARS to support workforce reductions, employers reported that MARS alone were often insufficient to deliver the scale of workforce reductions required. Feedback from Midlands employers similarly indicated that workforce plans were increasingly driven by affordability requirements, with organisations struggling to achieve headcount reduction targets and citing a lack of funding for redundancy schemes as a significant barrier.

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 affects staff experience because tighter financial controls can lead to higher workloads, fewer recruitment opportunities and less time or funding for staff development and service improvement.

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 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](#).

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 NHS relies on a flexible workforce, with a range of flexible workforce models, including staff banks, lead employer models and where needed agency supply. This is to respond to peaks and troughs in demand, maintain safe staffing levels, support urgent operational pressures and manage short-notice gaps in rota cover. The reforms could require employers to rethink how flexible workforce models are designed, how shifts are offered and changed, and how organisations balance predictability for workers with the need to respond rapidly to fluctuating service demand.

The proposed changes could have a significant impact on the NHS, in terms of both cost and increasing the size of the substantive workforce. We are supportive of the aim to eliminate exploitative contracts and practices but do not feel the proposed framework is the correct way to do this because:

- 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 £900 million 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 impacts of the proposals on the temporary workforce and patient care and at least, reframe and redraft the proposals before proceeding with legislation.

Working in partnership to improve the experience of bank and temporary workers is a key component of this work. NHS England is currently developing national bank guidance to support organisations in enhancing the experience of bank workers. This work is being progressed in collaboration with employers and trade union representatives through the Workforce Issues Group, a subgroup of the national Social Partnership Forum.

In addition, the national survey of NHS bank-only workers provides valuable insight into the experiences, perspectives and priorities of an important part of the workforce who do not hold a substantive contract. Together, these activities will support the evidence base to inform the consultation and support the development of recommendations that reflect the needs and experiences of bank and temporary workers across the NHS.

Key messages

NHS people

- Employers are reporting a significant or moderate impact on recruitment decisions due to operating within tight financial plans and efficiency savings. Trusts are also using mutually agreed resignation schemes (MARS) and voluntary redundancy schemes to reduce headcount as part of wider cost reduction plans. As a result, recruitment is increasingly restricted to roles deemed critical for patient safety, statutory compliance or essential service delivery, with non-critical vacancies often delayed or left unfilled despite operational need.
- Mental health conditions, including stress, anxiety and depression, remain the leading cause of sickness absence in the NHS, accounting for almost a third of all days lost. The increase in mental health-related absences highlights the sustained pressure the NHS workforce is facing.
- Vacancy levels have fallen consecutively across all sectors since quarter one of 2025/26. This is consistent with the financial constraints facing NHS organisations, many of which are operating vacancy controls and restricting recruitment activity to deliver challenging savings plans and meet financial targets.

Pay and reward: challenges

Pay awards should be fully funded to prevent additional financial pressure being placed on NHS organisations. Where funding does not fully align with pay decisions, employers are required to absorb costs within already constrained budgets. Given organisations' regulatory and legal duty to deliver on financial plans, unfunded pay decisions may necessitate difficult decisions in relation to staff support, with implications for workforce planning, recruitment, staff experience and service improvement. A lack of fair and sustainable funding may also undermine staff motivation and trust.

Access to salary sacrifice and net deduction schemes, a significant part of the NHS total reward offer, continues to be restricted for many staff. This issue has worsened over the past year, with a smaller pay gap above National Minimum Wage (NMW) and a growing proportion of lower-paid employees unable to benefit from these schemes.

Pay and reward: priorities

Entry level pay needs to remain competitive and keep a meaningful gap ahead of statutory minimums so the NHS is seen as an attractive and rewarding employer for the lowest paid staff.

NHS graduate starting pay (band 5) remains broadly similar when compared to the wider economy. Attention is still required on the long-term earnings potential, pay growth and career progression for graduates to support retention and ensure NHS careers remain an attractive option for both current and prospective recruits.

Greater differentiation between pay bands is needed to recognise higher levels of responsibility and encourage staff to pursue career development opportunities.

Job evaluation

The NHS Job Evaluation Scheme (JES) has not kept pace with the changing workforce, with outdated factors, weightings and thresholds creating a growing disconnect between modern NHS roles and how they are evaluated.

National work to improve the NHS JES application has progressed well at national level, but successful delivery will depend on sufficient local capacity, realistic expectations and timely digital support to improve consistency without creating unmanageable demand for reviews. The first annual audit of Job Evaluation practice has provided evidence of a lack of trained practitioners to sit on panels and a pressing need to establish processes to ensure job description accuracy.

The review of band 5 nursing roles is progressing locally following the government's commitment to '[a fairer deal for nurses](#)'. Employers have reported facing pressure from some unions to progress at a pace they do not have the capacity to meet. They are concerned about managing staff expectations around widespread up-banding while retaining the ability to define roles in line within service needs and financial realities.

Shape of the workforce

The 2025 NHS Staff Survey indicates that overall staff morale remains stable from 2024, increasing levels of stress, burnout and wellbeing concerns demonstrate that workforce pressures continue to affect staff experience, retention and the NHS's attractiveness as an employer.

The NHS workforce will need to become more digitally skilled and flexible as AI and digital technologies are reshaping roles and ways of working. This is creating a need for ongoing workforce development and new digital capabilities.

Financial and productivity pressures are reducing recruitment into entry-level NHS roles, with a decline in band 2 posts and fewer opportunities for new entrants. This risks weakening future workforce supply pipelines, limiting career progression routes into clinical professions and hindering efforts to attract and develop young people into NHS careers.

A lack of alignment between workforce supply and available funded roles in some professions (for example nursing and midwifery), means some newly qualified graduates are struggling to secure substantive posts, creating a risk that early-career staff may be lost from the NHS pipeline.

International recruitment formed a significant part of the NHS' workforce supply strategy between 2019 and 2024. The colleagues who have joined the health and social care sector are critical to service delivery and are valued members of the team. While there is very little current recruitment of internationally educated staff, we need the immigration rules to remain open to support the recruitment into hard-to-fill skilled roles in those areas of the country where they are needed. Employers also need the immigration rules to enable those individuals who already work with us to be able to stay – the rules for over 100,000 NHS staff should not be changed retrospectively. In particular, the proposed changes to 'settlement', which would apply retrospectively to international staff, will carry a cost of £169 million to the NHS and risk large numbers of people leaving who are needed to deliver essential care to patients and citizens.

Strategic pay priorities

Our evidence to the [NHS PRB for 2024/25](#), [2025/26](#) and [2026/27](#) has continued to set out several pay priorities that employers identify as areas requiring action. Making progress in these areas remains a priority for employers for the 2027/28 pay round.

1. **Competitive pay for entry-level roles:** Establish a futureproofed plan to create and retain a sustainable competitive market position on pay for entry-level roles to align with planned changes to the statutory National Living Wage (NLW) and the expected trajectory of Living Wage Foundation rates of pay (band 2 and closed spot salary for band 1).
2. **Competitive pay progression for graduate roles:** Ensure NHS pay progression remains competitive to attract and retain graduates in an increasingly competitive labour market, while enhancing the band 5 entry point to strengthen the NHS's position as an attractive career destination for new graduates.
3. **Pay incentives for promotion:** Develop a sustainable and targeted plan for more appropriate pay increases to be received on promotion between the pay bands. This process begins with actions to address the gaps between bands 2 and 3, bands 6 and 7, and bands 7 and 8a. Further structural reform is required across the whole system. But given affordability constraints, it is recognised this will need to be addressed over the longer term.

4. **Anomalies in unsocial hours payments:** Targeted action to address anomalies created by the implementation of consolidated pay changes in 2023/24 and successive years of investment in base-pay changes to band 1 (closed) and band 2 in relation to unsocial hours premium payments.
5. **Pay for apprentice roles:** Introduction of a consistent national pay framework to govern the rate of pay for apprentices in the NHS

We continue to recommend that all pay awards are fully funded and funding is provided across the entire health sector, including provider trusts and other NHS organisations. Full funding is essential to support financial sustainability, avoid placing additional pressures on employer budgets and ensure organisations are not required to divert resources from frontline services delivery. We cover this in more detail in section one of our evidence.

At the time of writing our 2027/28 evidence, the AfC pay structure reform negotiations are ongoing with the outcome unknown. Employers continue to view all the priorities outlined above as equally important and wish to see progress made across all areas wherever possible. It is not clear what the outcome of the negotiations will be, and which, if any, of these priorities may be addressed and to what extent. The NHS PRB will therefore need to consider this evidence alongside the outcomes of the negotiations once they are known.

Section 1 – Context

This section outlines the current economic and labour market conditions affecting NHS organisations ahead of the 2027/28 pay round.

Economic factors and labour market statistics

Inflation, cost of living and pay growth

[Latest data](#) shows the UK Consumer Prices Index (CPI) inflation rate was 2.9 per cent in the 12 months to July 2026, up from 2.6 per cent the previous month, and [forecasts](#) suggest it may rise further. Further increases could impact higher future NLW rates, placing additional pressure on entry-level NHS pay.

Latest ONS data from the [public opinions and social trends survey highlights](#) the cost of living remains the public's greatest concern in the UK. Of the 3,650 adults surveyed, 90 per cent identified the cost of living as a major issue (up from 87 per cent in the previous month). This was 10 percentage points higher than concerns about the NHS (80 per cent) and 16 percentage points above concerns about the economy (74 per cent). There were also differences [in the survey](#) in terms of how the cost of living was felt by different demographic

groups, with 96 per cent of 16 to 29-year-olds and 90 per cent of 30 to 49-year-olds reporting it as the biggest issue.

We continue to hear from employers about the continued pressures NHS staff face with rising living costs and the impact this is having on individuals, particularly on the lower pay bands. Several employers who responded to our survey reported that staff are increasingly focused on take-home pay over longer-term benefits, with staff more willing to move between employers for relatively small pay increases. One employer noted that current graduates are prepared to job hop for smaller increases and financial pressures are influencing career decisions. Additionally, employers told us that cost-of-living challenges remain acute in high-cost areas such as London, Oxford and the South East, where housing, childcare and transport costs continue to impact workforce supply and retention. These findings are consistent with the [Milburn Review](#), which identified the removal of socioeconomic barriers to NHS careers as a key priority.

Rates of employment, unemployment and economic inactivity

[As of August 2026](#), the UK employment rate stands at 75.1 per cent, which has decreased by 0.2 per cent since the same period 12 months previous (April - June 2025). Between April – June 2026, the rate of unemployment is 4.9 per cent, which remains unchanged since the previous quarter, however the rate is still up on the previous year, which was 4.7 per cent. This suggests that while overall employment levels have been maintained, demand for labour may be easing, resulting in more people actively seeking work and potentially reducing some upward pressure on wages.

For employers, these trends may be contributing to the high levels of applications being received for many vacancies, reflecting a larger pool of potential applicants for many roles. However, this is not experienced uniformly across all roles. Employers continue to report recruitment difficulties in specialised roles and recognised shortage occupations, where labour supply remains constrained despite an overall increase in applicant numbers for many posts.

The [UK economic inactivity](#) rate remains largely unchanged between April - June 2025 and April - June 2026. The largest group of economically inactive individuals are those unable to work due to long-term sickness or ill health. This highlights the growing impact of health-related issues on labour market participation and suggests that improving health outcomes and supporting individuals back into work could play an important role in increasing workforce participation and addressing labour shortages.

Young people who are classified as not in education, employment or training (NEET) remain a key area of focus within the labour market. [ONS data](#) shows there were an estimated 981,000 young people aged 16 to 24 years in the UK who were NEET in April - June 2026; this number increased by 30,000 when compared on the year, but a decrease of 30,000 on the quarter. High levels of economic inactivity among 16 to 24-year-olds are often linked to full-time education, however those who are NEET face an increased risk of long-term unemployment, lower lifetime earnings and reduced career progression.

The NHS has a role to play in supporting this group into education, training or employment, helping to realise the government's ambition of reducing skills shortages and supporting future economic growth.

Employers have shared concerns about the impact of digital advancement on entry-level roles and recruitment into the NHS. Discussions have highlighted the challenges of recruiting from local communities, considered against the backdrop of high levels of youth unemployment. Employers have stressed the NHS's role as an anchor institution and the importance of maintaining a focus on creating roles that are accessible, attractive and offer clear routes into NHS employment. They also highlighted that part of the solution will be to invest in training and development that equips new and existing staff with the digital skills needed to work confidently alongside new technologies, ensuring that digital advancement supports workforce inclusion, progression and future NHS careers.

NHS staff standards

In July 2026, the new [NHS staff standards](#) were introduced which set minimum expectations for employers across a range of workforce practice and processes with the goal of improving staff experience in a consistent way across the NHS. Achievement of the standards will be assessed through the NHS Oversight Framework, reinforcing that improving staff experience is essential to safe, sustainable and high-quality care. We provide more information in section 6 of our evidence.

Sickness absence

[NHS sickness absence rates](#) have increased since late 2025. At 5.1 per cent in March 2026, the rate remained above the level recorded a year earlier (4.9 per cent in March 2025), indicating staff absence continues to be a key workforce challenge. Mental health conditions, including anxiety, stress and depression, remain the leading cause of sickness absence, accounting for over 678,900 full-time equivalent days lost and 29.3 per cent of all sickness absence in March 2026. The increase in mental health related absences compared with the previous year (27.5 per cent in March 2025) highlights the ongoing pressures facing NHS staff.

[National data](#) suggests that mental health conditions account for around 8.9 per cent of sickness absence across the broader workforce. This indicates mental health related absence is proportionately much more prevalent within the NHS workforce, reflecting the unique pressures associated with delivering healthcare services.

Employers continue to emphasise the importance of targeted wellbeing interventions, effective workforce support and retention measures to help address these challenges and improve workforce resilience.

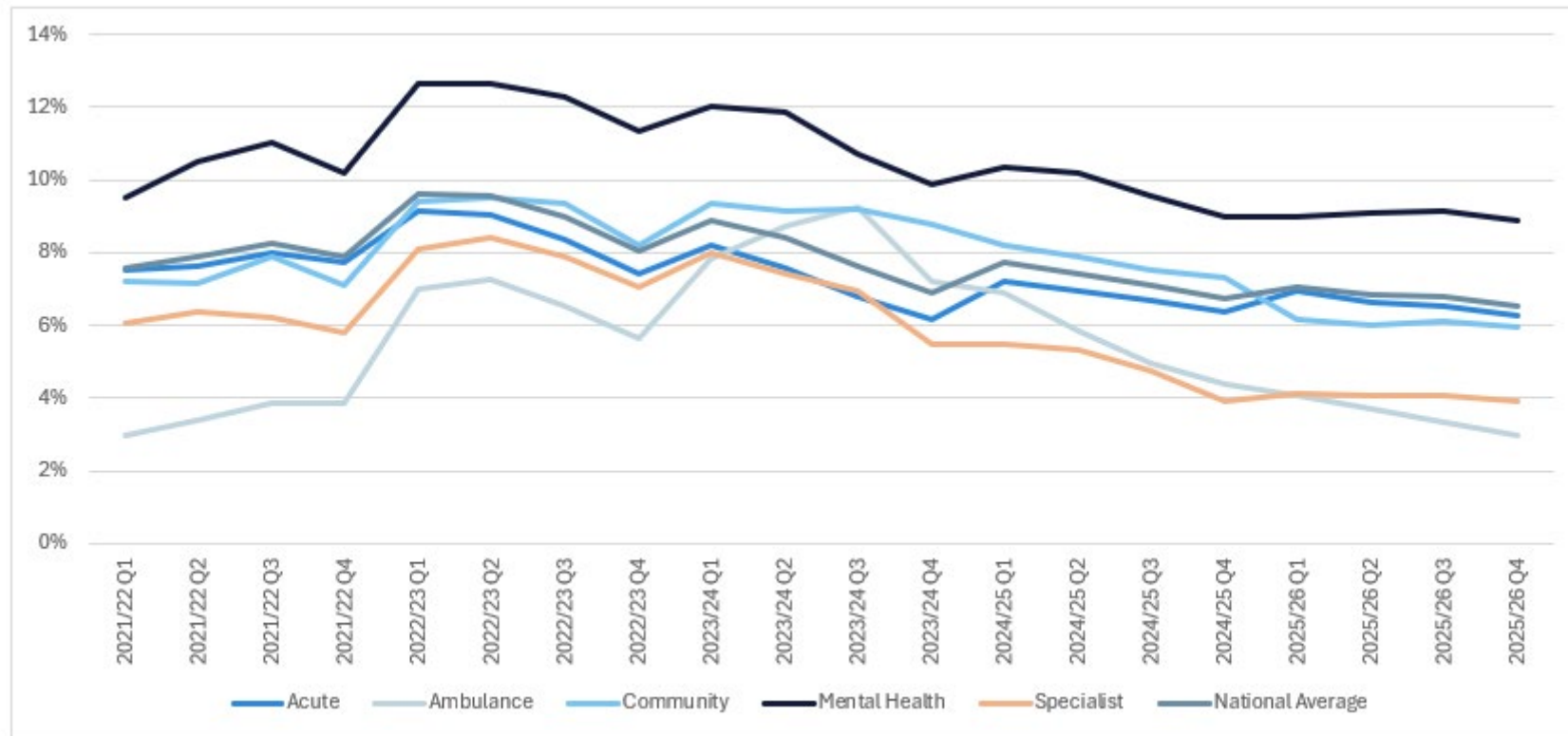
Vacancy rates

[Recent ONS data](#) shows between April and June 2026, the number of vacancies across the UK has continued to decrease by 7,000 (0.9 per cent) taking the total to 712,000 - the lowest level since February to April 2021. The unemployment to vacancy ratio has remained at 2.5 since July 2025, with around 2.5 unemployed people for every vacancy. This indicates the wider labour market has cooled, with fewer vacancies and a larger pool of potential applicants for each role.

For the NHS, the total number of vacancies (as of March 2026) was 97,475 (6.5 per cent vacancy rate). The number of vacancies has decreased by 0.2 per cent from the same period the previous year.

Figures 1 (see pages 25-27) shows the change in NHS vacancy rate by sector across over the last four years.

Figure 1 – Vacancy rate (by sector) since 2020/21



Quarter	Acute	Ambulance	Community	Mental Health	Specialist	National Average
2021/22 Q1	7.5%	3.0%	7.2%	9.5%	6.1%	7.6%
2021/22 Q2	7.6%	3.4%	7.2%	10.5%	6.4%	7.9%
2021/22 Q3	8.0%	3.9%	7.9%	11.0%	6.2%	8.3%
2021/22 Q4	7.7%	3.9%	7.1%	10.2%	5.8%	7.9%
2022/23 Q1	9.1%	7.0%	9.4%	12.7%	8.1%	9.6%
2022/23 Q2	9.0%	7.3%	9.5%	12.6%	8.4%	9.6%
2022/23 Q3	8.4%	6.5%	9.4%	12.3%	7.9%	9.0%
2022/23 Q4	7.4%	5.6%	8.2%	11.3%	7.1%	8.0%
2023/24 Q1	8.2%	7.8%	9.3%	12.0%	8.0%	8.9%
2023/24 Q2	7.6%	8.7%	9.2%	11.9%	7.4%	8.4%
2023/24 Q3	6.8%	9.2%	9.2%	10.7%	6.9%	7.7%
2023/24 Q4	6.2%	7.2%	8.8%	9.9%	5.5%	6.9%
2024/25 Q1	7.2%	6.9%	8.2%	10.3%	5.5%	7.7%
2024/25 Q2	6.9%	5.9%	7.9%	10.2%	5.3%	7.4%

2024/25 Q3	6.7%	5.0%	7.5%	9.6%	4.8%	7.1%
2024/25 Q4	6.4%	4.4%	7.3%	9.0%	3.9%	6.7%
2025/26 Q1	6.9%	4.1%	6.2%	9.0%	4.1%	7.1%
2025/26 Q2	6.6%	3.7%	6.0%	9.1%	4.1%	6.9%
2025/26 Q3	6.5%	3.3%	6.1%	9.1%	4.0%	6.8%
2025/26 Q4	6.3%	3.0%	6.0%	8.9%	3.9%	6.5%

Q = Quarter: Q1 = April to June / Q2 = July to September / Q3 - October to December / Q4 - January to March

Source: [NHS Vacancy Statistics England](#)

The vacancy rate has fallen to its lowest level in four years, aligning with employer feedback that many organisations have introduced vacancy controls and recruitment freezes to stay within tight financial plans. While vacancies have reduced across all sectors over the past four year, vacancies in mental health trusts remain stubbornly high.

NHS financial position

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 departments, it remains below long-term historical growth and is widely considered 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 the financial challenge is expected to be at least as severe as, if not more severe than, the previous year, and further prioritisation decisions may be required to remain within budget.

On capital, the Spending Review provided 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 workforce costs account for the largest share of overall expenditure. While funding settlements include provision for pay, there are ongoing challenges in ensuring allocations fully reflect the total and recurrent cost of pay awards, including associated on costs. 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.

In this context, pay awards above the level assumed in financial planning present an 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.

As part of our engagement with employers, we asked what impact implementing pay awards above the stated level of affordability have on their organisations financial position and plans to improve staff experience and working conditions. The responses show that financial pressure and staff experience are closely connected. Many employers reporting a significant or moderate financial impact also said a higher than planned pay award would affect their ability to improve staff experience and working conditions.

“From a service delivery perspective, the need to absorb additional cost pressures is likely to drive difficult trade-offs. This may include constraints on recruitment, vacancy management or delayed investment in workforce development and service improvement.

“In an operationally pressured environment, this creates a risk to performance, quality of care and the ability to sustain safe staffing levels over time”.

Deputy Chief People Officer, Ambulance sector, South region.

Employers continue to 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.

There are also specific funding risks for NHS services commissioned or funded through local government routes, including some public health and community services. Where NHS organisations employ staff on AfC terms and conditions, but contract income is received through local authority or other locally commissioned arrangements, national pay award funding may not automatically flow through in the same way as NHS-funded activity. If contract values do not fully reflect the recurrent cost of pay awards, employers may be required to absorb these pressures locally or manage them through service-level savings. This may place additional pressure on services already operating within constrained local funding arrangements and could affect their ability to sustain delivery, retain staff and implement pay awards consistently.

Changes to the NHS Payment Scheme

The [NHS Payment Scheme \(NHSPS\)](#) is the national framework that governs financial transactions between commissioners and providers of NHS-funded secondary healthcare services, including the rules and prices used to determine provider payments.

From 1 April 2026, the main change is that pay awards are no longer fully assumed and funded within the initial NHS Payment Scheme prices at the start of the financial year. Instead, NHS England is now publishing the NHSPS using provisional pay assumptions and then revising the cost uplift factor (CUF) and provider payment rates once the actual national pay award is agreed, with the changes backdated to the start of the year.

This approach reduces the risk that employers will be required to absorb the full cost of nationally agreed pay awards from existing resources and provides greater confidence that future pay settlements can be supported through the NHS funding framework. However, the extent to which funding fully matches the actual cost impact for individual organisations remains dependent on national funding assumptions.

As part of our engagement with employers, we asked them to what extent they expect changes to the NHS Payment Scheme to affect how pay awards are funded at trust level in England; 30 per cent of employers said it would have a significant or moderate impact and 20 per cent were unsure about the effects it would have, which signals that half of employers did not yet have enough clarity to judge the effect.

Employers consistently highlighted concerns that changes to the NHS Payment Scheme may not fully offset the cost of future pay awards, particularly where funding is not provided on a timely, recurrent basis or does not reflect the full cost of implementation, including on-costs. Several employers noted that pay awards are often agreed after planning assumptions and NHS Payment Scheme

prices have been set, creating a risk of in-year financial pressures and uncertainty in budget planning.

While some acknowledged that the impact would be limited if funding remained aligned to pay assumptions, the general view was that there is insufficient assurance that future pay awards will be fully funded.

These concerns were intensified by the current financial environment. Many organisations reported they are already operating under significant financial constraints, with requirements to deliver balanced budgets, reduce workforce expenditure and achieve sizeable cost improvement programmes (CIPs).

Specific concerns were also raised about the potential cumulative impact of wider workforce policy developments. Some employers highlighted the ongoing review of band 5 roles and the possibility that some roles may be re-banded to a higher pay band. Funding has been allocated to trusts to cover the cost of re-bandings and implementation costs such as the need for additional job evaluation evaluators to be trained. However, employers are concerned that any expansion of higher banding outcomes would create financial pressure in excess of the additional funding provided, requiring organisations to identify further funding or savings to meet the increased pay bill.

A small number of employers commented on the complexity of the NHS Payment Scheme itself. Despite differing levels of familiarity with the system, there was broad agreement that the key risk relates to whether funding is sufficient, recurrent and aligned to the true cost of pay awards at organisational level.

Industrial action

Dissatisfaction with the 2026/27 pay award of 3.3 per cent remains significant across the AfC trade union landscape. [Many unions](#) argue that the increase falls short of delivering meaningful pay restoration

after years of below-inflation settlements and does little to address ongoing recruitment and retention challenges. In March 2026, 14 trade unions submitted a joint letter to the Secretary of State for Health and Social Care, signed by 78,000 staff, expressing concerns that the 3.3 per cent pay award failed to address the longstanding disparity between AfC staff and other staff groups who have received higher pay awards in recent years.

Several unions, including Unite, the Royal College of Nursing (RCN), Chartered Society of Physiotherapy (CSP) and the GMB, have previously withdrawn from the PRB process and called for direct negotiations with government on both annual pay awards and wider AfC pay reform.

There is a sense that, for some trade unions, expectations around the AfC structural reform negotiations have become more closely linked to the overall assessment of the acceptability of the 2026/27 pay settlement, given that the headline award fell below what they had hoped for. This creates a risk that, if the reform process does not deliver meaningful or visible progress, dissatisfaction with the overall pay settlement could intensify and increase employee relations pressures.

Doctors' industrial action has had a significant and sustained impact on NHS organisations, extending beyond the immediate disruption caused by strike days. Employers have had to manage substantial operational pressures, including increased workloads for non-striking staff, service disruption, delayed activity and ongoing recovery efforts to address treatment backlogs. Repeated periods of industrial action over several years have placed additional strain on workforce capacity, staff wellbeing and employee relations, with many staff groups being required to provide flexibility to maintain essential services.

While the resident doctors' pay deal was accepted on 29 June 2026, bringing an end to that dispute and reducing the immediate risk of further strike action, industrial relations pressures remain. The British Medical Association (BMA) subsequently balloted consultant and

specialty, associate specialist and specialist (SAS) doctors in England on potential industrial action. The ballot, which opened on 11 May 2026 and closed on 6 July 2026, resulted in consultants voting in favour of industrial action, although no strike action has been announced. SAS doctors also voted in favour of industrial action but did not meet the statutory threshold required to take it.

AfC trade unions have expressed significant concern about the differential between medical and AfC pay awards, contributing to dissatisfaction with the 2026/27 AfC pay uplift and reinforcing perceptions of inequity between workforce groups. This presents a material risk to staff morale, engagement and retention, particularly in the context of ongoing workforce shortages, increasing sickness absence and sustained operational pressures. Employers will need to carefully manage these perceptions and maintain constructive employee relations to minimise the risk of further workforce dissatisfaction and potential disruption to service delivery.

The divergence in pay outcomes between staff groups risks undermining confidence in the perceived fairness of NHS reward arrangements, at a time when employers are seeking to improve retention, reduce absence, support productivity and maintain workforce engagement.

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. The [2025 WRES data](#) highlights ongoing ethnic disparities in relation to these areas. While BME staff represent 30.7 per cent of the NHS workforce overall, they account for only 14.1 percent of staff in bands 8c-VSM roles, compared with 82.9 percent of white staff. Similar patterns are seen across both clinical and non-clinical workforces, with BME representation reducing as pay band increases. White applicants were 1.77 times more likely to be appointed from shortlisting than BME applicants, while 49.6 percent of BME staff believed their organisation provides equal opportunities for career progression, compared with 59.1 percent of white staff.

The [2025 WDES data](#) highlights continuing inequalities in career progression and workplace experience for disabled staff. Disabled colleagues represent 6.7 per cent of the NHS workforce, compared with 81.4 percent of staff who identify as non-disabled. Representation reduces at senior bands, with disabled staff accounting for 8 per cent of non-clinical staff in bands 1 to 4 but only 6.1 percent in bands 8c to VSM roles. A similar pattern is seen in the clinical workforce, where representation falls from 6.9 percent in bands 1 to 4 to 4.8 percent in bands 8c to VSM. This suggests disabled staff remain underrepresented within higher-paid and senior leadership positions. Perceptions of career progression also reflect these trends, with 51.8 percent of disabled staff believing their organisation provides equal opportunities for career progression or promotion, compared with 57.9 percent of non-disabled staff. Similarly, 36.7 percent of disabled staff felt their organisation values their work, compared with 47.7 percent of non-disabled staff.

Addressing these inequalities is important not only from an equality perspective but also to improve workforce engagement, retention, productivity and the NHS's ability to attract and retain talent.

Alongside these programmes, there has been increasing focus on ensuring equitable access to development opportunities, reducing discrimination and improving progression pathways for

underrepresented groups, including through recommendations arising from nursing career progression work.

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, 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. It 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 Office for Equality and Opportunity 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.

Digital and artificial intelligence (AI)

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 have highlighted the need to address system barriers and digital constraints that currently limit staff's ability to operate flexibly across organisations and care settings. Issues with interoperability and variation in digital systems hinder joined-up working at the neighbourhood and system level. An NHS Alliance report from December 2025 [‘Beyond the hospital: How boards can lead the digital shift to neighbourhood working’](#) states many organisations continue to rely on legacy technology and infrastructure that are not designed to support mobile and neighbourhood-based models of care, limiting opportunities for workforce flexibility and cross-organisational working.

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 emphasise 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.

The growing adoption of AI is set to fundamentally reshape how NHS services are delivered. AI is often associated with improving productivity and reducing administrative workload, with concerns raised that it would 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 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. 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 to adopt the use of 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 simplify process and support workforce supply.

Corporate cost reduction

NHS organisations continue to put in several measures to meet the national [objective](#) of reducing corporate costs, including recruitment freezes, removing posts and restructuring teams.

Employers are concerned that reducing resources, in the absence of the long-term workforce plan, creates an unknown in terms of what roles are needed to deliver on the objectives within the plan. If reducing the workforce is part of cost efficiency measures rather than through the strategic design of services, this is a reactive approach

and one that will have a profound impact on the delivery of services 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 the capacity of organisations to maintain service delivery.

Another risk is the impact on staff morale. In the survey, [93 per cent of trust and ICB respondents](#) reported declining staff morale as a key concern. 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.

Cost reduction and control and the impact on recruitment

Almost half of employers responding to our PRB engagement survey reported that budgetary pressures are having a significant or moderate impact on recruitment decisions within their organisations. Employers described a shift away from routine vacancy filling towards more tightly controlled recruitment, with decisions increasingly driven by affordability, workforce prioritisation and the need to protect only the most business-critical roles.

Employers reported the introduction or extension of organisation-wide vacancy control processes, including periods of full recruitment freeze across most roles. Under these arrangements, recruitment is no longer treated as business as usual. Posts are only approved

where they meet strict criteria, such as being essential for patient safety, statutory compliance or critical operational delivery. This has reduced recruitment activity overall and resulted in delays or cancellations for non-critical roles, even where there is a recognised operational need.

Recruitment requests are also subject to greater scrutiny through formal governance arrangements, including vacancy control panels and multi-stage approval processes. Managers are required to demonstrate affordability, consider alternatives such as redeployment or role redesign, and provide clear justification before posts can proceed. Employers report that this has lengthened recruitment timelines, constrained local decision-making and led to some roles being deferred, redesigned or not approved.

These measures reflect a move from reactive or demand-led recruitment to a highly controlled model focused on financial sustainability. While necessary to manage cost pressures, this approach can create operational challenges, including delays to filling vacancies, increased workload for existing staff and reduced capacity to invest in longer-term workforce planning or development.

Transforming people services

[The transforming people services programme](#) aims to redesign how people services are organised and delivered across the NHS, enabling HR and organisational development (OD) teams to focus on more strategic workforce priorities such as workforce planning, organisational development and talent management. Over the next few years, the programme will largely be focussed 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). A number of early adopter sites 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 individuals working in HR and OD teams across the NHS, the programme is likely to create additional pressures in the short to medium term as organisations balance transformation activity with ongoing operational demands.

Pay disparity between AfC and medical and dental staff

Over the last decade, the AfC pay structure has seen variation in the level of investment in headline pay award uplifts. Headline pay increases have been higher for medical and dental staff than for AfC staff for a number of years.

Figure 2 (see page 42) shows the last decade of headline increase for the AfC workforce.

Figure 2 - NHS pay awards over the last decade

Year	Headline increase	Comment
2015/16	1.0%	Cross-government public sector pay policy limited pay awards to an average of 1% between 2013 and 2017
2016/17	1.0%	
2017/18	1.0%	
2018/19	3.0%	Multi-year pay deal
2019/20	1.7%	
2020/21	1.6%	
2021/22	3.0%	Uniform 3% consolidated pay award to all staff.
2022/23	5.0%	£1400 consolidated award from review body. Plus revised government offer including a non-con payment (2%+ £1250 to £1650 depending on band).
2023/24	5.0%	5% consolidated award agreed as part of government's 2023 offer. Increase in NHS entry pay to £11.45 per hour and move band 2 to be a spot salary.
2024/25	5.5%	Uniform 5.5% consolidated pay award to all staff plus introduction of intermediate pay points to bands 8a, 8b, 8c, 8d and 9.
2025/26	3.6%	Uniform 3.6% consolidated pay award to all staff.
2026/27	3.3%	Uniform 3.3% consolidated pay award to all staff.

Source: [Agenda for Change pay advisory notices](#)

The 2026/27 pay round has continued to highlight differences in pay outcomes between AfC staff and those on medical and dental arrangements. Staff on AfC terms and conditions received a 3.3 per cent consolidated uplift. In comparison, the government accepted the Doctors' and Dentists' Review Body (DDRB) recommendations of a 3.5 per cent increase to pay for resident doctors, consultants, specialty, specialist and associate specialist (SAS) doctors, and salaried GPs, alongside a 3.75 per cent increase for salaried dentists working in community dental services.

Pay for AfC and medical and dental staff is determined through separate arrangements. However, staff work together in multidisciplinary teams across a wide range of health and care settings. Employers report these differences can create challenges in communicating pay decisions clearly and consistently, particularly when staff compare pay across roles and professions within the same organisation.

Of the employers surveyed via the NHS Employers Terms and Conditions of Service (TCS) Network, 40 per cent said that differential pay awards had somewhat negatively impacted staff morale and motivation in their organisations. Employer feedback reflected that the impact had increased perceptions of inequity, lowered morale and created additional employee relations pressures among AfC staff.

However, the discussion also indicated that concerns are not primarily rooted in resentment towards medical and dental staff receiving a higher uplift, but rather in broader dissatisfaction with the AfC pay and banding framework. In this context, the differential award appears to have reinforced existing concerns about fairness and pay determination for some staff groups, rather than acting as a standalone driver of poor relations or morale.

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 in lower-paid roles, can feel

undervalued compared with others, especially amid cost-of-living pressures and external labour market competition.

Maintaining staff morale and trust remains an important consideration. Survey feedback highlights that perceptions of feeling valued, recognition and financial wellbeing are closely linked to engagement and retention. As the NHS continues to manage workforce and service pressures, ensuring that staff feel recognised for their contributions will be important for supporting morale, effective multidisciplinary working and longer-term workforce stability.

Pay award timetable

Maintaining an April implementation timetable is important not only for the effective operation of the pay review process, but also for staff confidence in the system. A timely pay award reduces the need for interim measures to ensure compliance with statutory wage requirements and provides greater clarity for employers and staff at the start of the financial year. This is particularly important for lower-paid staff, where statutory uplifts are applied in advance of the NHS pay award but the subsequent award provides little additional improvement. This can reinforce perceptions among the lowest-paid staff that their contribution is not sufficiently recognised or valued. Ensuring the 2027/28 pay round remains on track for April implementation would help avoid this issue, support clearer communication with staff and strengthen confidence in the fairness and timeliness of the pay-setting process.

Employers welcomed the 2026/27 pay setting process returning to an April implementation date, as this represents an important step towards a timelier and more effective pay round. We understand that, to ensure April implementation for the 2027/28 round, the window of engagement with employers remains shorter. Therefore, our evidence provides an updated contextual position on the AfC workforce, covering a number of specific areas of information that the NHS PRB has specifically requested.

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

NHS terms and conditions (NHS TCS) apply to around 1.2 million full-time equivalent (FTE) staff employed in the NHS in England.

Figure 3 (see page 46) shows the distribution of the AfC workforce across all pay bands. The data shows how FTE levels in each pay band have changed from March 2024 to March 2026. The largest variation can be seen at band 2 where there are almost 58,000 less staff (FTE) in 2026 than two years previous, however there are an additional 45,114 band 3 (FTE) when compared to the same period. This is largely driven by the re-banding of healthcare support worker (HCSW) roles from band 2 to band 3 and the reduction in headcounts being undertaken by employers.

Sources for figure 3:

[NHS Workforce Statistics - March 2024](#)

[NHS Workforce Statistics - March 2025](#)

[NHS workforce statistics - March 2026](#)

Figure 3 – Distribution of NHS Terms and Conditions of Service (TCS) staff by band between March 2024 and March 2026

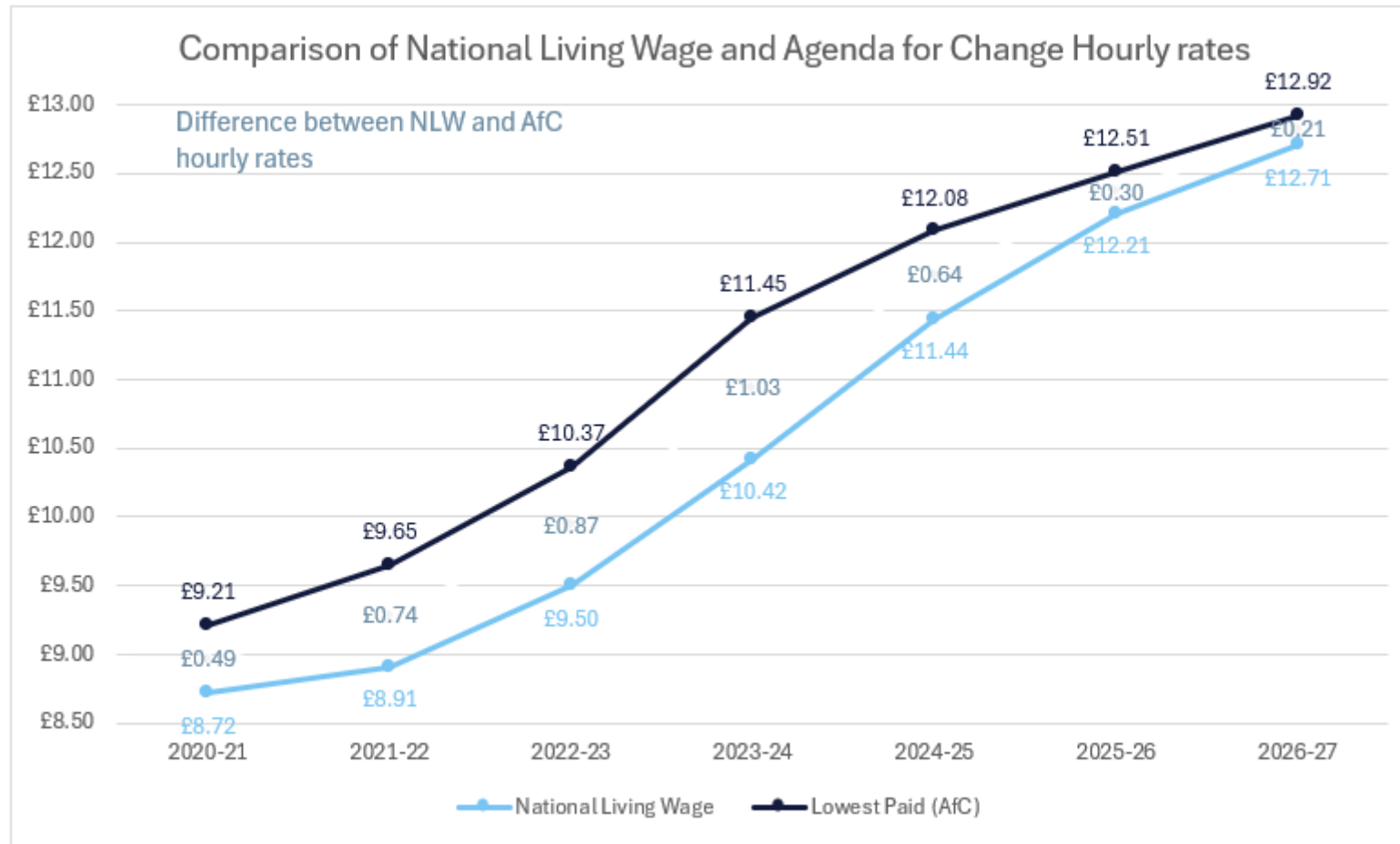
	March 24		March 25		March 26		March 24 to March 26	
Band	FTE	% of NHSTCS workforce	FTE	% of NHSTCS workforce	FTE	% of NHSTCS workforce	FTE	% change
Band 1	1,606	0.1%	1,358	0.1%	1,143	0.1%	-463	-28.8%
Band 2	169,954	14.3%	136,873	11.2%	112,263	9.2%	-57,691	-33.9%
Band 3	180,958	15.2%	211,216	17.4%	226,072	18.6%	45,114	24.9%
Band 4	121,507	10.2%	122,345	10.1%	119,500	9.8%	-2,007	-1.7%
Band 5	247,528	20.8%	257,349	21.1%	257,314	21.2%	9,786	4.0%
Band 6	221,375	18.6%	231,005	19.0%	237,304	19.5%	15,929	7.2%
Band 7	148,214	12.4%	153,163	12.6%	155,459	12.8%	7,245	4.9%
Band 8a	57,217	4.8%	60,151	4.9%	61,081	5.0%	3,864	6.8%
Band 8b	22,398	1.9%	23,044	1.9%	23,093	1.9%	695	3.1%
Band 8c	11,428	1.0%	11,806	1.0%	11,877	1.0%	449	3.9%
Band 8d	5,496	0.5%	5,611	0.5%	5,648	0.5%	152	2.8%
Band 9	3,003	0.3%	3,179	0.3%	3,130	0.3%	127	4.2%
Total	1,190,684	100.0%	1,217,099	100.0%	1,213,884	100.0%	23,199	1.9%

Entry-level pay and the National Living Wage

The interaction between the National Living Wage (NLW) and entry level pay in the NHS has dominated our evidence for many years. Due to the proximity to the NLW of the lower bands in the NHS, as the NLW increases it is necessary to adjust NHS pay accordingly to ensure the NHS remains both legally compliant and competitive.

From 1 April 2026 the NLW increased to £12.71 per hour for workers aged 21 and over, a 4.1 per cent uplift designed to maintain the policy target of around two-thirds of median earnings. Over the same period, the bottom of the NHS AfC pay structure (band 1 (closed) and band 2) sits at £12.92 per hour (from April 2026), providing a 21 pence per hour premium above NLW. As the NLW has repeatedly grown more quickly than NHS pay awards, this has led to erosion of differentials between pay points.

Figure 4 – Comparison of NLW and AfC hourly rates



Source: [Living Wage Foundation - Past Living Wage rates](#)

Figure 4 shows a comparison of the NMW and AfC hourly rates of pay. This year's pay uplift has resulted in the smallest gap between the bottom of the pay structure and NLW since the introduction of AfC in 2004/05. The chart also shows that due to delayed pay awards, there were three occasions an interim top up was required to ensure that NHS pay scales maintained compliance with the NLW. For example, on 31 March 2022 the lowest paid in the NHS earned £9.48 an hour. On 1 April 2022, the NLW was increased to £9.50. Without the interim top up to NHS rates to £9.65, the NHS would not have been compliant with the NLW.

Looking ahead, the [Low Pay Commission's](#) central projection suggests the NLW could rise to around £13.18 per hour from April 2027 (with an indicative range of £13.02–£13.34), implying a further increase to the NLW of between 2.4 per cent to 5 per cent. If realised without an adequate uplift in the lower NHS pay bands, this would further erode the gap between the NLW and the bottom of the NHS pay scale. Unless the 2027/28 NHS pay award is implemented for 1 April 2027, interim measures like those applied in previous years, will be required. Depending on what the NLW increases to, it is highly likely the impact will span further than band 1 (closed) and band 2, into the bottom of band 3 which currently sits at £13.17 per hour.

Compression of the pay scale creates additional challenges for employers. It reduces the ability of the AfC pay structure to maintain clear differentials between roles, which can weaken incentives for staff to take on additional responsibility, progress into higher bands or move into roles requiring different skills, training and accountability. Any increases in the statutory wage floor can quickly absorb the available headroom at the bottom of the structure, which limits employers' scope to retain a competitive advantage when recruiting in local labour markets.

Staff who are paid at rates at the bottom of the pay structure continue to face challenges in terms of accessing salary sacrifice schemes, a large component of the NHS total reward offer. We evidence this in more detail in [section 5](#) of our report.

In previous submissions, we have highlighted difficulties in recruiting and retaining staff at the lower end of the pay structure, driven by competition from other sectors, cost-of-living pressures and the relative competitiveness of NHS pay at lower bands, which is impacting applicant volumes and conversion rates. This is further influenced by organisational approaches to workforce management, including the use of apprenticeship routes for entry-level roles and increased reliance on fixed-term appointments within administration and clerical roles due to workforce change associated with the digital agenda. These factors, alongside ongoing transformation and workforce redesign, have affected both recruitment flexibility and the attractiveness of substantive roles for candidates.

While vacancy rates and turnover have fallen in recent years in the NHS, this should be viewed in the context of tighter vacancy controls, headcount reductions and wider financial pressures across NHS organisations, rather than as evidence that recruitment and retention challenges have been resolved.

Employers continue to report recruitment and retention difficulties in specific clinical and non-clinical roles where external labour market competition remains significant, reflecting targeted workforce pressures in specific roles rather than a universal challenge across the NHS workforce.

Employer feedback identified difficulties recruiting to a range of specialist administrative functions that remain essential to service delivery. Examples included clinical records, library services, medical records data input and some medical secretary roles. These posts are often in lower pay bands, and require organisational knowledge, accuracy and familiarity with clinical systems and processes. Feedback suggested that the current pay rates are not sufficiently attractive to the available workforce, contributing to persistent turnover leading to a constant need to recruit. This is costly to the employer and negatively impacts workforce stability and continuity.

Feedback from ambulance sector employers highlighted that workforce challenges are concentrated in specific lower-band roles

rather than across the wider workforce. Emergency operations centre call handlers and band 2 and band 3 patient transport service roles experience high turnover and retention difficulties, largely due to the pressure and demands of the work and pay. This issue is reported to be consistent nationally.

Some employers reported substantial vacancy levels and high turnover among band 2 staff. One employer indicated they have around 150 vacancies for healthcare assistants (HCAs) and continue to struggle to recruit at the scale required. They reported difficulties encouraging band 2 staff to undertake further development and training to progress into band 3 roles.

External labour market evidence supports the feedback we received from employers. Published comparisons of 2026 supermarket pay rates show several major retailers offering entry-level hourly rates above the current bottom of the AfC pay structure. For example, as of March 2026, [reported national rates](#) include the supermarket Aldi at £13.50 per hour, Lidl at £13.45, Marks and Spencer at £13.41, Tesco at £13.28 and Sainsbury's at £13.23. Most recently, [Asda confirmed](#) from 5 July they increased the hourly pay of store-based workers to £13.10; the second pay increase for staff in 2026. This is compared with £13.17 per hour for the top of band 3 and £12.92 per hour for band 1 (closed) and band 2 in the NHS. This means some workers can access higher basic hourly pay in retail roles that may be perceived as less complex, less pressured or less emotionally demanding than lower-banded NHS roles.

Employers highlighted that band 2 pay rates compare unfavourably with local living costs, particularly in high-cost areas such as London and Oxford. Employers reported that candidates are often discouraged by the combination of relatively low pay, shift working requirements, physical demands and the emotional pressures associated with patient-facing roles. Several organisations noted that the NHS is no longer viewed as a stand-out employer at this level, with the NHS Pension Scheme offering less attraction to prospective employees who are more focused on immediate take-home pay.

This has been a consistent theme in our evidence submissions, and we continue to draw these comparisons to underline a structural challenge for the NHS. While organisations in the private sector can adjust pay quickly and flexibly to remain competitive within the labour market, the NHS faces greater constraints. As a result, increases to pay at the lower end of the AfC pay structure tend to be more limited and incremental, making it difficult to maintain a meaningful differential and remain competitive for entry-level roles.

Real Living Wage (RLW)

The RLW, set independently by the [Living Wage Foundation](#) is currently £13.45 per hour across the UK and £14.80 per hour in London. All trusts across inner and outer London meet the RLW due to being able to include high-cost area supplements (HCAS) payments. Following the 2026/27 pay award, band 1 (closed) and band 2 exceeds the current RLW figure by £1.09 per hour in inner London and 60 pence per hour in outer London.

There are a number of trusts who are real living wage accredited that have sites that sit across two HCAS zones. For trusts who have sites in inner and outer London HCAS zones, trusts receive funding for this that meets the London RLW rate of pay.

As HCAS in the fringe area is £1.16 per hour less than the London RLW, those employers who have chosen to become RLW accredited, need to fund the difference using money from their internal budget. This also applies to the nine NHS organisations (seven trusts and two ICBs) outside of London who have chosen to be accredited RLW employers, who do not receive additional funding for this.

Paying RLW outside London would require employers to give a 4.1 per cent pay rise to all their band 1 and 2 staff, and a 2.1 per cent rise for their band 3 entry staff. Without further action, this would lead to bands 1, 2 and 3 all having identical pay values, requiring further pay increases to band 3 to retain appropriate promotional incentives.

Many employers would prefer to see a coordinated national approach to this issue rather than develop local solutions.

Employers report that the decision to pay the RLW is often driven by the need to support recruitment and retention in lower-banded roles. RLW accreditation can help trusts remain competitive with sectors such as retail and hospitality, where pay may be similar or higher for work perceived as less demanding. Paying a more competitive salary helps NHS organisations to attract candidates who might otherwise seek employment elsewhere. Recruiting and retaining band 2 roles, that are prone to high turnover, is critical to service delivery.

Meeting the RLW creates a recurring cost pressure for accredited NHS organisations, particularly where additional funding is not provided through HCAS or other national mechanisms. While employers recognise the importance of maintaining fair and competitive pay at the lowest bands, the additional cost of doing so locally must be absorbed within already constrained budgets, which means difficult trade-offs between pay, workforce stability and service delivery. We know some employers in the NHS have stepped away from accreditation in recent years due to the financial pressures surrounding this.

We engaged with our reward and recognition network in November 2025 to understand what the associated financial and operational challenges were with official RLW accreditation. Key feedback shows:

- One trust reported a £38,000 cost pressure funded from reserves to meet the new RLW rate. Despite this, the trust remains committed to RLW accreditation for the foreseeable future.
- Another trust identified financing as the main barrier to pursuing accreditation, emphasising the need for central funding to offset annual cost pressures and concerns over bank pay compression and contractor pay increases.

- Organisations also face challenges managing contractual pay adjustments for staff on different contracts, requiring phased implementation timelines.

Adjacent labour market challenges

This year, we have focussed part of our evidence on the NHS PRB's request for information on adjacent labour markets and the extent to which they have caused recruitment and retention difficulties for NHS organisations. Employers continue to report that competition from other sectors is placing growing pressure on the NHS, and this is not limited to roles traditionally considered at the lower end of the pay scale. Increasingly, pressures are being felt across a broader range of roles, reflecting the competitiveness of external labour markets.

We surveyed our TCS network, where 63 per cent of respondents said that recruitment and retention pressures were not limited to a single staff group; they were being experienced across a range of clinical and non-clinical roles.

In terms of clinical roles, employers from trusts in Yorkshire and Oxford said they were experiencing specific challenges with sonographers, perfusionists and radiographers; competing with private health care providers which is causing them significant recruitment and retention issues. One trust has locally agreed recruitment and retention premia (RRPs) in place for a number of band 7 sonographers and band 6 and 7 radiographers to mitigate this issue. The trust plans to continue to reduce these RRP's down and withdraw them by the end of 2027; the decision regarding this will be driven by turnover and workforce data. Another employer told us they have 16 sonography vacancies across the trust, with 30 in post against a budget of 46, and for perfusionists there are currently four vacancies (9.5 WTE in post against a planned workforce of 13.5).

For non-clinical roles, employers highlighted that IT/digital positions face the most significant competition from the private sector, largely

driven by the higher salaries those organisations can offer compared to the NHS. [ONS data](#) shows that median annual gross earnings for an IT technician in 2025 was £35,128. A senior IT engineer in the NHS starting on a band 5 earns £3,000 less, with significantly less salary progression than in the private sector.

An employer from a trust in the north-west of England reported retention challenges amongst domestic staff, reflecting a broader issue we have picked up across the NHS. In addition, catering roles were identified as facing acute pressures, with many staff opting to leave for agency work where hourly pay can be significantly higher; often double or even triple NHS rates. This has contributed to a revolving door effect, with persistent vacancies and ongoing recruitment activity for catering assistants and supervisors, often on a weekly basis, yet with insufficient staff to cover existing shifts.

Competition from the private sector continues to be a key pressure, particularly for newly qualified graduates and professional services staff. Employers continue to highlight that private sector employers often offer higher starting salaries and faster pay progression, with early-career employees increasingly willing to move for relatively small salary increases. HR, finance, digital, procurement and estates roles were highlighted as areas experiencing growing competition.

Despite these challenges, several organisations reported that vacancy freezes, workforce reductions and financial constraints across the NHS have reduced staff movement and turnover in the short term. Some employers indicated that application numbers have increased recently and vacancy rates have fallen in areas such as nursing, suggesting that labour market pressures may have eased compared with recent years.

The market value for some NHS roles is often higher than in the private sector. In previous evidence submissions we have continued to outline the case that some staff benefit from additional earnings, such as unsocial hours and overtime, which can significantly boost base pay.

The NHS relies heavily on the wider NHS employment offer, such as generous annual leave and pension provision, to remain competitive with the wider labour market. With changes in workforce demographics and expectations, the PRB need to consider whether these benefits continue to hold the same level of appeal for all groups of staff, and whether the total employment offer is keeping up pace with the changing needs and expectations of the future workforce. We consider this further in the total reward section of our evidence.

Impact of fair pay agreements

[Fair pay agreements \(FPAs\)](#) are a proposed mechanism for establishing sector-wide minimum pay and employment standards across adult social care in England. The reforms, expected to come into force in 2028, would introduce an adult social care negotiating body, bringing together employer representatives, trade unions and other stakeholders to negotiate legally enforceable agreements covering pay, terms and conditions, working hours, training and other workforce-related matters. The policy aims to address longstanding recruitment and retention challenges within the sector by providing a structured framework for collective bargaining and improving the consistency of employment standards across providers.

Employer feedback suggests it is too early to fully assess the impact of FPAs on NHS workforce supply, including recruitment, retention and movement between the NHS and social care sectors, given there has been limited progress in this area.

Initial employer feedback highlights that from a positive perspective, improving pay and conditions in social care should help stabilise this workforce, reducing turnover and vacancy rates. The sector currently faces challenges with recruitment and retention, driven in part by low pay and limited career progression. By addressing these issues, FPAs are expected to make social care a more attractive long-term career, improving domestic recruitment and retention. This has a potential indirect benefit for the NHS. A more stable social care

workforce can support improved patient flow, reduce delayed discharge, and ease pressure on NHS services, positively contributing to overall system capacity and workforce sustainability.

The NHS and social care sectors draw from overlapping labour pools, particularly in lower-paid and less specialised roles. Pay differentials between sectors influence staff decisions, with workers more likely to leave or not join one sector if alternative roles offer higher pay or better conditions.

Social care roles have typically been lower paid than comparable NHS roles, which has historically reduced competition for staff. If FPAs narrow this pay gap, there may be increased movement of staff between the sectors, particularly in entry-level or support roles where skills are transferable. This could intensify greater competition for new entrants to the workforce, especially in local labour markets where social care employers may be able to offer more flexible working patterns or comparable rates of pay.

The extent of the impact of FPAs will depend on a range of factors, including the extent of pay alignment, funding levels, and whether improvements in social care are matched by continued investment in NHS pay and workforce conditions.

At an organisational level, maintaining the overall competitiveness of NHS roles will be critical. This includes ensuring that NHS pay remains attractive relative to social care, particularly for lower-banded and non-registered roles where competition is likely to increase. Financial reward alone is unlikely to be sufficient, so organisations will need to focus on strengthening the wider employee value proposition. This includes improving working conditions, flexible working arrangements, career development opportunities, access to training and progression and ensuring the total reward package is more accessible to lower banded roles, all of which can support retention and engagement.

Pay for apprentice roles

The government's [post-16 education and skills white paper](#) places apprenticeships at the heart of its strategy to build a high-skilled, employer-led workforce. It sets a target for 10 per cent of young people to be in higher technical education or apprenticeships by age 25 by 2040, nearly doubling current participation. This provides employers in the NHS with an opportunity, as health and social care is identified in the white paper as a growth driving sector. This means that skills investment, including apprenticeships, will increasingly be directed towards workforce shortages in areas like the NHS.

In our [2025/26 evidence submission](#) to the NHS PRB we highlighted substantial variation in how apprentices are remunerated across NHS trusts. Approaches ranged from the use of [annex 21](#) of the NHS TCS Handbook to locally determined arrangements aligned to role-based pay bands or national guidance. This lack of consistency has created challenges in establishing a coherent approach. Employers continue to support the development of a nationally agreed apprenticeship pay framework to provide greater clarity and standardisation.

The [apprenticeships section](#) in our evidence submission provides further detail on recent apprenticeship trends, employer use of the levy and the financial and operational barriers limiting apprenticeship expansion, including backfill, supervision capacity, vacancy controls and consistency of apprentice pay.

Pay incentives for promotion – gaps between NHS pay bands

It is important that the NHS pay structure can offer appropriate pay incentives following a promotion that better recognise the additional responsibilities that are being taken on by staff when they move into a higher-banded role. Figure 5 shows the current gaps between the AfC pay bands in pounds and as a percentage.

Figure 5 – Gaps between bands – 2026/27

Gap between	Gap £	Gap %
Band 2 -> Band 3	£488	1.9%
Band 3 -> Band 4	£916	3.3%
Band 4 -> Band 5	£916	2.9%
Band 5 -> Band 6	£916	2.3%
Band 6 -> Band 7	£1,270	2.6%
Band 7 -> Band 8a	£1,013	1.8%
Band 8a -> Band 8b	£1,832	2.8%
Band 8b -> Band 8c	£2,136	2.8%
Band 8c -> Band 8d	£2,747	3.0%
Band 8d -> Band 9	£3,968	3.6%

Source: [NHS TCS Handbook](#)

Investment in increasing the gaps between bands remains an employer priority, which we provided technical commentary on in our [2025/26 evidence submission \(page 34-35\)](#). As part of the 2018 pay deal, employers and trade unions recognised that these pay gaps would need to be widened in the future and supported by further investment to ensure a pay system that rewards staff for being promoted into more senior roles.

Recognising the level of investment required to achieve widening the gaps between bands across the AfC pay structure, our view remains that immediate action is required for the gaps between bands 2 and 3, bands 6 and 7 and bands 7 and 8a.

Bands 2 and 3

Trusts continue to experience significant issues with the way unsocial hours are structured, particularly between bands 2 and 3 where the basic pay increase doesn't always compensate for the reduction in unsocial hours payments. We highlighted this issue in detail in our [2024/25 evidence submission](#) to the NHS PRB.

Figure 6 below shows the hourly rate payable at each pay point when unsocial hours or overtime are worked.

Figure 6 - Basic, unsocial hours and overtime hourly rates by pay point (2026/27)

Band Step	Basic pay		Unsocial Hours Payment Saturdays & weekdays 8pm-6am		Unsocial Hours Payment Sundays & Public Holidays		Overtime	
	Annual (£)	Hourly rate (£)	Time + premium rate (%)	Hourly rate (£)	Time + premium rate	Hourly rate (£)	Time + premium rate	Hourly rate (£)
1 Entry	25,272	12.92	47%	18.99	94%	25.06	Time Plus 50%	19.38
2 Entry	25,272	12.92	41%	18.22	83%	23.64		19.38
2 Top	25,272	12.92		18.22		23.64		19.38
3 Entry	25,760	13.17	35%	17.78	69%	22.26		19.76
3 Top	27,476	14.05		18.97		23.74		21.08
4 Entry	28,392	14.52	30%	18.88	60%	23.23		21.78
4 Top	31,157	15.93		20.71		25.49		23.90
5 Entry	32,073	16.40		21.32		26.24		24.60
5 Intermediate	34,592	17.69		23.00		28.30		26.54
5 Top	39,043	19.97		25.96		31.95		29.96
6 Entry	39,959	20.44		26.57		32.70		30.66
6 Intermediate	42,170	21.57		28.04		34.51		32.36
6 Top	48,117	24.61		31.99		39.38		36.92
7 Entry	49,387	25.26		32.84		40.42		37.89
7 Intermediate	51,932	26.56		34.53		42.50		39.84
7 Top	56,515	28.90		37.57		46.24		43.35
8a Entry	57,528	29.42		38.25		47.07		29.42

8a Intermediate	60,417	30.90		40.17		49.44	No additional payment	30.90
8a Top	64,750	33.11		43.04		52.98		33.11
8b Entry	66,582	34.05		44.27		54.48		34.05
8b Intermediate	70,896	36.26		47.14		58.02		36.26
8b Top	77,368	39.57		51.44		63.31		39.57
8c Entry	79,504	40.66		52.86		65.06		40.66
8c Intermediate	84,346	43.14		56.08		69.02		43.14
8c Top	91,609	46.85		60.91		74.96		46.85
8d Entry	94,356	48.26		62.74		77.22		48.26
8d Intermediate	100,140	51.21		66.57		81.94		51.21
8d Top	108,814	55.65		72.35		89.04		55.65
9 Entry	112,782	57.68		74.98		92.29		57.68
9 Intermediate	119,583	61.16		79.51		97.86		61.16
9 Top	129,783	66.37		86.28		106.19		66.37

Source: [NHS TCS Handbook](#)

The problem of narrow gaps between pay bands reducing the incentive to seek promotion is made worse by differences in unsocial hours rates. For staff who work unsocial hours, the increase in pay on promotion can be even smaller than the basic pay band gap alone would suggest.

Figure 7 - Gross change in annual earnings on promotion (assuming like-for-like working patterns)

	Gross change in annual earnings on promotion						
Promotion	Change in basic pay £	Change in unsocial hours hourly rate £	Change in total earnings by number of unsocial hours worked per week				
			0	5	10	15	20
Band 1 (closed) -> Band 2 Entry	£0	-£0.77	£0	-£201	-£402	-£602	-£803
Band 2 Top -> Band 3 Entry	£488	-£0.44	£488	£373	£259	£144	£29
Band 3 Top -> Band 4 Entry	£916	-£0.09	£916	£893	£869	£846	£822

Figure 7 shows that for bands 1, 2 and 3, the more unsocial hours worked, the less the financial incentive on promotion.

This issue is most pronounced between bands 1 and 2, where anyone working any number of unsocial hours would see their pay fall on promotion. As basic pay is identical in bands 1 and 2, there is no uplift in basic salary to offset the drop in the hourly unsocial hours rate.

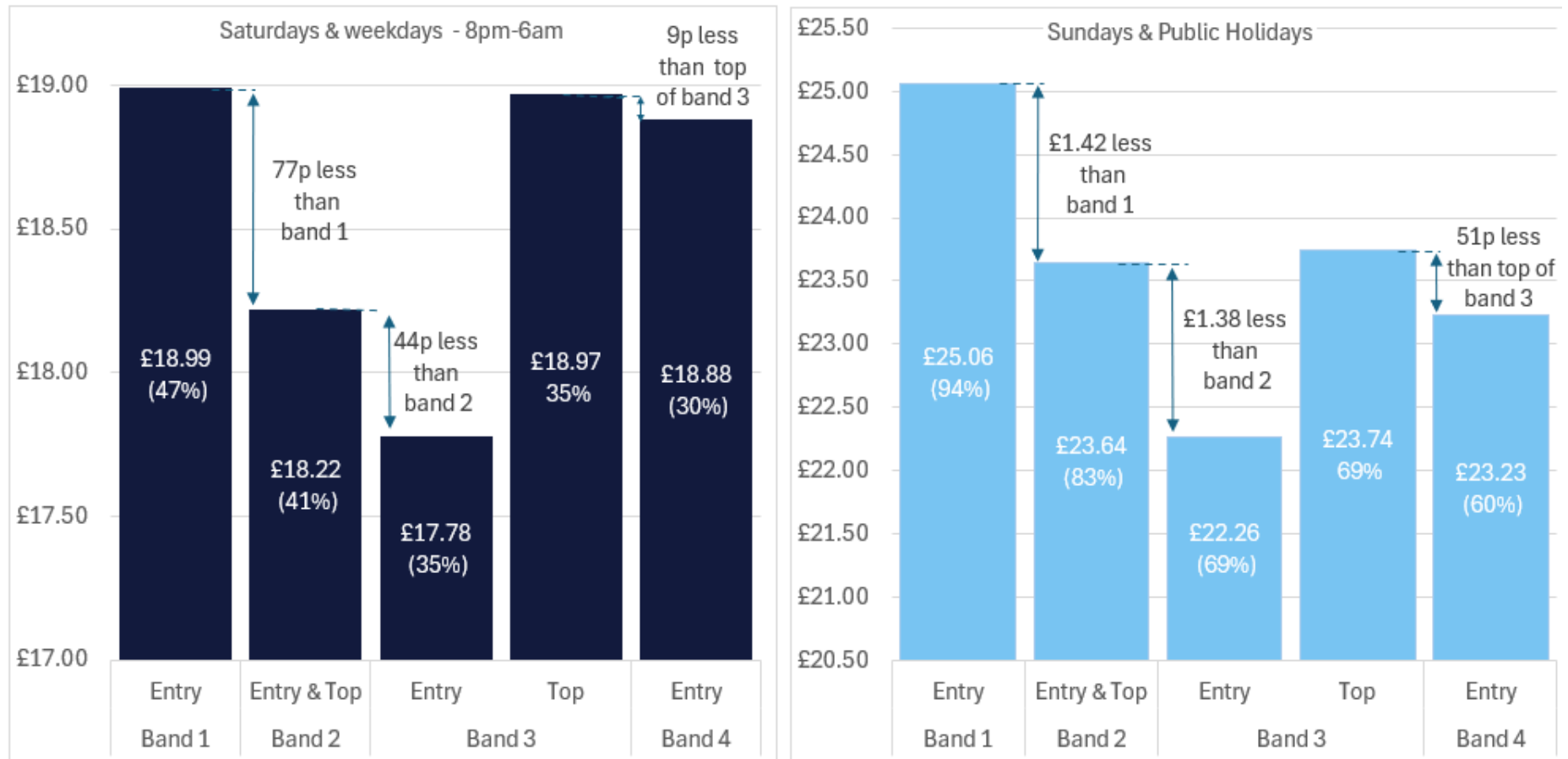
Promotion from band 2 to band 3 would only result in a reduction in gross pay for staff working more than 21 unsocial hours per week. In practice, only a very small proportion of band 2 and band 3 staff have working patterns with such a high share of unsocial hours.

Despite this, the financial incentive to move from band 2 is very limited for staff who work unsocial hours. The table reflects gross annual earnings, but once income tax, national insurance, and pension contributions are applied, the increase in take-home pay becomes negligible.

Given the small reduction in the unsocial hours rate between band 3 top and band 4 entry of nine pence, and the much larger increase in basic pay of £916, the impact of the unsocial hours rate change on promotion is relatively limited. Employers are keen to ensure that the gap between bands 3 and 4 is at least maintained in future so that this position does not worsen.

Band 1 (closed) staff earn the highest unsocial hours premium (as a percentage) across the entire AfC pay structure. Since the 2023/34 pay award, band 2 has the same value as band 1 (closed), resulting in no difference in basic pay across these bands. With higher unsocial hours premium, band 1 have the potential to earn more than band 2, when unsocial hours payments are factored in. This issue continues to impact further up the pay bands, with the entry point of band 3 earning 44 pence per hour less than a band 2 and the entry point of band 4 earning nine pence per hour than a band 3 on Saturdays and weekdays between 8pm and 6am. Figure 8 below shows the differences in hourly unsocial hours pay across bands 1 to 4. Differences in rates paid on Sundays and public holidays are even greater.

Figure 8 – Difference in unsocial hours rates across bands 1 to 4



This creates inequity among groups of staff who receive less pay for a job with a higher level of skill and responsibility. For staff in higher bands, morale can be affected when they see colleagues in lower bands earning similar or higher take-home pay due to unsocial hours enhancements, despite having fewer responsibilities, lower levels of accountability or less demanding leadership requirements. This can create a perception that additional responsibility is not being adequately rewarded and can reduce the incentive to seek promotion.

One employer shared a concern of band 2 nursing assistants receiving higher pay during unsocial periods than band 3 senior nursing assistants. The trust had previously undertaken extensive work to develop key distinctions between band 2 and band 3 roles following previous local disputes. As a result, there is now a clearly defined difference in the responsibilities, skills and additional requirements associated with progression into band 3. However, depending on working patterns and the level of unsocial hours undertaken, the band 3 senior nursing assistants are receiving lower overall earnings than the band 2 nursing assistants.

A review of ward clerk roles was undertaken following the introduction of the Electronic Patient Record (EPR) system. Through staff engagement and the development of an updated job description, the trust confirmed that the role had evolved and, following job evaluation, most ward clerk posts moved from band 2 to band 3. However, six staff working in urgent assessment units were adversely affected. While the review confirmed that they were undertaking the same ward clerk role and that band 3 was the appropriate pay band, their work in a 24/7 service meant they received unsocial hours payments. As a result, despite the increase in basic pay, the move to band 3 led to a reduction in take-home pay for these staff. Although a further review confirmed the role remains consistent with the ward clerk job description, the issue of reduced earnings for the affected employees has not been fully resolved.

There are other examples of organisations facing difficult situations due to the unintended consequences of moving staff from a band 2

to band 3, and the decrease in unsocial hours payments they would receive. One organisation reported that following their merger, a group of band 2 ward clerks thought their role had changed. Following an engagement process and job evaluation, the role came out as a band 3. Another group of staff, working within the urgent assessment units, felt they undertook the same work as a ward clerk. A further review confirmed they were undertaking the same ward clerk work and band 3 was the appropriate pay band, but because they worked in a 24/7 service (unlike the traditional ward clerks) they would be in receipt of unsocial hours payments. As a result, despite the increase in basic pay, the move to band 3 meant a reduction in take-home pay for these staff and a negative impact on these colleagues.

These examples demonstrate that the gap between band 2 and band 3 is so small, the increase in pay doesn't offset the reduction in unsocial hours received for those staff that work during these periods, of which 50 per cent of band 3 staff receive some form of unsocial hours payment across the NHS. Figures 9 and 10 below highlights this further across all pay bands, as well as by staff group at band 3.

Figure 9 – Percentage of staff receiving unsocial hours payments by band

Band	Mean monthly sample size of those who received this pay	Mean monthly sample size of all staff	% of staff receiving an unsocial hours payment
Band 1	1,418	2,089	68%
Band 2	78,877	152,026	52%
Band 3	128,458	256,435	50%
Band 4	31,604	134,004	24%
Band 5	168,755	279,341	60%
Band 6	119,159	264,243	45%
Band 7	42,493	173,217	25%
Band 8a	11,611	66,947	17%
Band 8b	2,246	25,239	9%
Band 8c	703	12,668	6%
Band 8d	248	5,815	4%
Band 9	104	3,253	3%
Non AfC band	3,038	15,044	20%
	588,713	1,390,322	42.3%

Figure 10 – Percentage of band 3 staff receiving unsocial hours payment (by staff group)

Staff Group	Band	Mean monthly sample size of those who received this pay	Mean monthly sample size of all staff	% of staff receiving an unsocial hours payment
Ambulance staff	Band 3	-	-	0%
Central functions	Band 3	1,829	20,620	9%
Hotel, property & estates	Band 3	5,492	10,284	53%
Managers	Band 3	-	14	0%
Midwives	Band 3	-	-	0%
Nurses & health visitors	Band 3	-	-	0%
Scientific, therapeutic & technical staff	Band 3	-	-	0%
Senior managers	Band 3	-	-	0%
Support to ambulance staff	Band 3	7,481	9,706	77%

Support to doctors, nurses & midwives	Band 3	101,391	180,185	56%
Support to ST&T staff	Band 3	12,216	35,475	34%
Unknown classification	Band 3	49	152	32%
		128,458	256,435	50%

Note: Headcount totals may differ slightly from the sum of components in the published data due to some staff working in more than one role across different staff groups/bands.

Source: [NHS England Digital](#)

Bands 7 and 8a

We have heard of longstanding challenges in supporting progression from band 7 to band 8a. Feedback has indicated that some staff at the top of band 7 have been reluctant to move into band 8a roles because the financial uplift is not seen as sufficient when set against the increased level of responsibility. Employers noted this transition often represents a significant shift from a more operational role into one with greater strategic expectations, leadership accountability and organisational responsibility. The consequence of this has been a reduction in opportunities for staff to progress in their careers. Where experienced band 7 staff choose to remain at the top of their band, fewer band 7 posts become available for staff in lower bands to progress into. This has contributed to retention and workforce planning challenges, with limited movement at key points in the structure and reduced incentives for staff to take on more senior roles.

One employer highlighted that the transition from band 7 to band 8a can be further compounded by the loss of overtime opportunities. In some cases, staff moving into band 8a roles experience only a limited increase in basic pay while also losing access to additional earnings available at band 7. To support progression and reduce the financial disincentive associated with moving into more senior roles, one employer reported introducing a local arrangement to pay overtime to band 8a staff undertaking clinical overtime. In the interests of consistency and fairness, employers would support a national solution to this issue.

Graduate entrants and trajectory pay

Our [evidence submission across the last three years](#) has reflected the need for the NHS to remain competitive, both in the short term (starting salary) and longer term (future earnings potential) when it comes to recruiting and retaining graduates.

When benchmarking the NHS graduate starting salary (band 5) it is important to note that salary benchmarks for graduate roles vary considerably depending on the source and population being measured. Comparisons should also be treated with caution, as it can be difficult to make true like-for-like comparisons between NHS and non-NHS graduate roles given differences in working patterns, career pathways and promotion opportunities, as well as the wider reward package, including pension provision and other benefits. The [Graduate Market in 2026](#) report gives a median starting salary of £35,000 amongst the UK's leading graduate employers, while the [Higher Education Statistics Agency \(HESA\)](#) reports the median salary of graduates in full-time employment 15 months after graduation is £30,000. Therefore, the most relevant consideration is not necessarily the standalone salary level, but the direction and pace of salary growth over time. In the NHS, band 5 starting pay has increased from £25,655 in 2021/22 to £32,073 in 2026/27, representing growth of approximately 25 per cent. [Graduate starting salaries amongst the UK's leading employers, referenced in the High Fliers report](#), have increased from £32,000 in 2021/22 to £35,000 in 2026, representing growth of 16.7 per cent.

In our [evidence submission last year \(page 54-57\)](#) we provided in depth analysis into graduate teacher pay and how that compared with graduate pay in the NHS. In July 2026, the government accepted the recommendations of the School Teachers' Review Body (STRB) for a multi-year teacher pay award. From 1 September 2026, teachers in England [received a 3.5 per cent pay increase](#), followed by a further 3 per cent increase from September 2027, which represents cumulative pay growth of 6.5 per cent over a two-year period. [Updated pay scales](#) confirm the current starting salary for a teacher has risen to £34,068 and will rise to £35,090 in 2027. This places the starting salary for a newly qualified teacher around £2,000 above entry point of a band 5 (£32,073) in 2026/27, widening the gap between NHS graduate-entry pay and teacher starting salaries. This also places graduate teachers closer to the median graduate earnings figures more broadly across the wider economy.

Applications to graduate healthcare courses

Applicant numbers provide an indication of the strength of the future workforce pipeline and are therefore an important consideration when assessing graduate pay competitiveness. Band 5 roles account for 21.2 per cent of the NHS workforce and represent the main entry point for registered healthcare professionals. The concentration of staff within bands 5 and 6 reflects the NHS's reliance on large numbers of clinically qualified professionals, meaning the ability to attract graduates into these roles is critical to future workforce supply.

[Recent UCAS data](#) suggests that demand for nursing courses may have stabilised following several years of decline, although application volumes remain substantially below the peak seen during the COVID 19 pandemic. By the June 2025 application deadline, the number of applicants to UK undergraduate nursing courses had increased slightly from 41,520 in 2024 to 41,890 in 2025, representing growth of 0.9 per cent. However, applicant numbers remain well below 2021 levels, meaning the nursing applicant pool is still approximately 33 per cent lower than five years ago. More recent [UCAS applicant data for the January 2026 equal consideration deadline](#) indicates that the recovery remains fragile. Applications to UK undergraduate nursing courses decreased slightly by 0.7 per cent, from 30,550 in January 2025 to 30,350 in January 2026.

A notable trend is the changing profile of applicants for nursing courses. Growth is increasingly concentrated amongst younger age groups, whilst mature applicant numbers continue to decline. By June 2025, applications from 18-year-olds increased by 9 per cent, whereas applications from individuals aged 30–34 fell by 11 per cent and those aged 35 and over fell by 9 per cent. This trend continued into the 2026 cycle, where applications from 18-year-olds increased by 7.1 per cent, compared with decreases of 5.3 per cent among those aged 25–29, 9.1 per cent among those aged 30–34 and 15.8 per cent among those aged 35 and over.

The applicant trends described above provide important context when considering the competitiveness of graduate pay. Mature applicants may be more sensitive to the financial implications of training, student debt, earnings potential and cost-of-living pressures. The continued reduction in applications from older age groups may indicate that nursing is becoming less financially attractive relative to competing occupations.

The position on graduate recruitment should also be considered alongside wider changes to international recruitment and student migration. In some parts of the country, employers report that international students make up a significant proportion of the local pool of potential graduate recruits. This can provide an important source of workforce supply, but it also creates uncertainty where future volumes may be affected by changes to visa rules, post-study work entitlements and wider immigration policy. We cover this in the [international recruitment section](#) of our evidence.

[Data shows](#) that midwifery applicant numbers remain broadly stable but continue to be significantly below historic levels. Applications decreased marginally from 8,760 in 2024 to 8,740 in 2025 (-0.2 per cent), compared with a peak of approximately 15,150 applicants in 2021. This represents a reduction of around 42 per cent over the last four years. Similar to nursing, growth is concentrated among younger applicants, whilst applications from mature age groups continue to decline.

In response to the investigation into maternity and neonatal services, the DHSC announced over £10 million of funding to create 1,000 temporary roles for newly qualified midwives in England. [The initiative aims](#) to support graduates into NHS employment and help address concerns that around one-third of student midwives may otherwise leave the profession.

Graduate leavers

Graduate leaver trends are an important indicator of whether NHS graduate-entry pay remains competitive beyond the point of recruitment. While starting salary influences initial career choice, retention is also shaped by earnings progression, workload, career development and alternative opportunities in the wider labour market. If graduate-qualified staff are leaving the NHS early in their careers, particularly for roles outside healthcare, this may suggest that the overall employment offer is not sufficiently competitive or sustainable when compared with other graduate pathways. Understanding both the number of graduate leavers and where they go provides important evidence on whether pay and reward are supporting long-term workforce supply, not just initial attraction.

We surveyed employers to understand if there were any key trends relating to why graduates leave the NHS. The survey suggests that many NHS organisations have limited intelligence on the destinations of graduates who leave employment. ‘Not known’ was the most frequently selected response, indicating a substantial proportion of employers do not systematically track where graduates go after leaving. Where destinations are known, the most common pattern is movement to other NHS organisations rather than exit the sector altogether. Smaller numbers reported graduates moving to private sector employers, private healthcare organisations or pursuing further study. Overall, the findings indicate that evidence on graduate destinations remains incomplete, limiting employers' ability to fully understand whether graduates are leaving the NHS workforce entirely or simply moving between NHS organisations.

Anecdotally, employers have told us that pay remains a reason for graduates leaving NHS roles, however there are a number of wider issues that may affect their choices. [Analysis of Nursing and Midwifery Council \(NMC\) registration data](#) undertaken by the RCN found that the number of UK-educated nurses leaving the profession within their first five years of registration increased by 67 per cent (697 to 1,166) between 2021 and 2024. [NMC analysis of leavers in 2024/25](#) suggests early-career professionals are more likely than

other groups to cite burnout, workload pressures and poor mental health as factors contributing to their decision to leave, indicating that retention challenges remain particularly acute among newer entrants to the profession. These reasons are consistent with what employers have told us:

- Pay and immediate financial pressures - wider cost-of-living pressures mean graduates may prioritise roles that offer higher starting salaries or better short-term earnings than the NHS.
- Work-life balance and stress - some graduates are attracted to jobs outside the NHS that offer less stress, no shift work and more predictable working patterns.
- Career progression - graduates may perceive faster promotion, clearer progression and quicker movement up pay scales in other sectors or larger NHS organisations.
- Location, opportunity and job security - graduates may move closer to family, return to larger teaching trusts with broader development and research opportunities, or leave where recruitment freezes, fixed-term roles or limited opportunities affect confidence in their future career path.

Band 5 is the main graduate-entry point for many registered professions and accounts for a substantial share of the AfC workforce. If band 5 becomes less attractive relative to other graduate pathways, the NHS risks weakening the pipeline into higher bands including future specialist and leadership roles.

Graduate pay growth

Pay growth is an important element of attracting, engaging and retaining graduate talent. While starting salary is an important consideration for graduates, opportunities for career development, progression and future earning potential can also influence career choices and retention.

Evidence from the [IDR \(Incomes Data Research\) analysis of earnings for teachers and other graduate careers](#) indicates that graduate attraction is influenced by pay progression as well as starting salary. The analysis looked at how teachers' pay growth compared to private sector graduate schemes. While teacher and graduate starting salaries were both £30,000, graduates participating in private-sector graduate schemes typically progressed to median salaries of £36,000 on completion of their training programmes.

In [our evidence to the PRB last year \(page 51\)](#) we provided a comparison between the pay growth of band 5 NHS staff and teachers to highlight the differences between the professions. Although teacher pay progression over the first five years marginally exceeds that of band 5 graduates, private-sector graduate schemes remain a significant competitor. This is not necessarily because of higher starting salaries, but because private-sector employers have greater flexibility to offer faster salary progression, market supplements and performance-based rewards. Graduates are often attracted by the higher long-term earning potential available outside nationally determined pay structures.

While the NHS is unlikely to match the long-term earning potential available in some private-sector graduate careers, employers are keen to strengthen their graduate offer through clearer and more transparent career pathways. This includes progression routes from band 5 to band 6, structured development programmes and defined career milestones. These approaches would provide graduates across a number of professions, with greater visibility of future career opportunities and earnings progression and help to improve attraction and retention of such a large proportion of the NHS workforce.

VSM pay and interaction with AfC

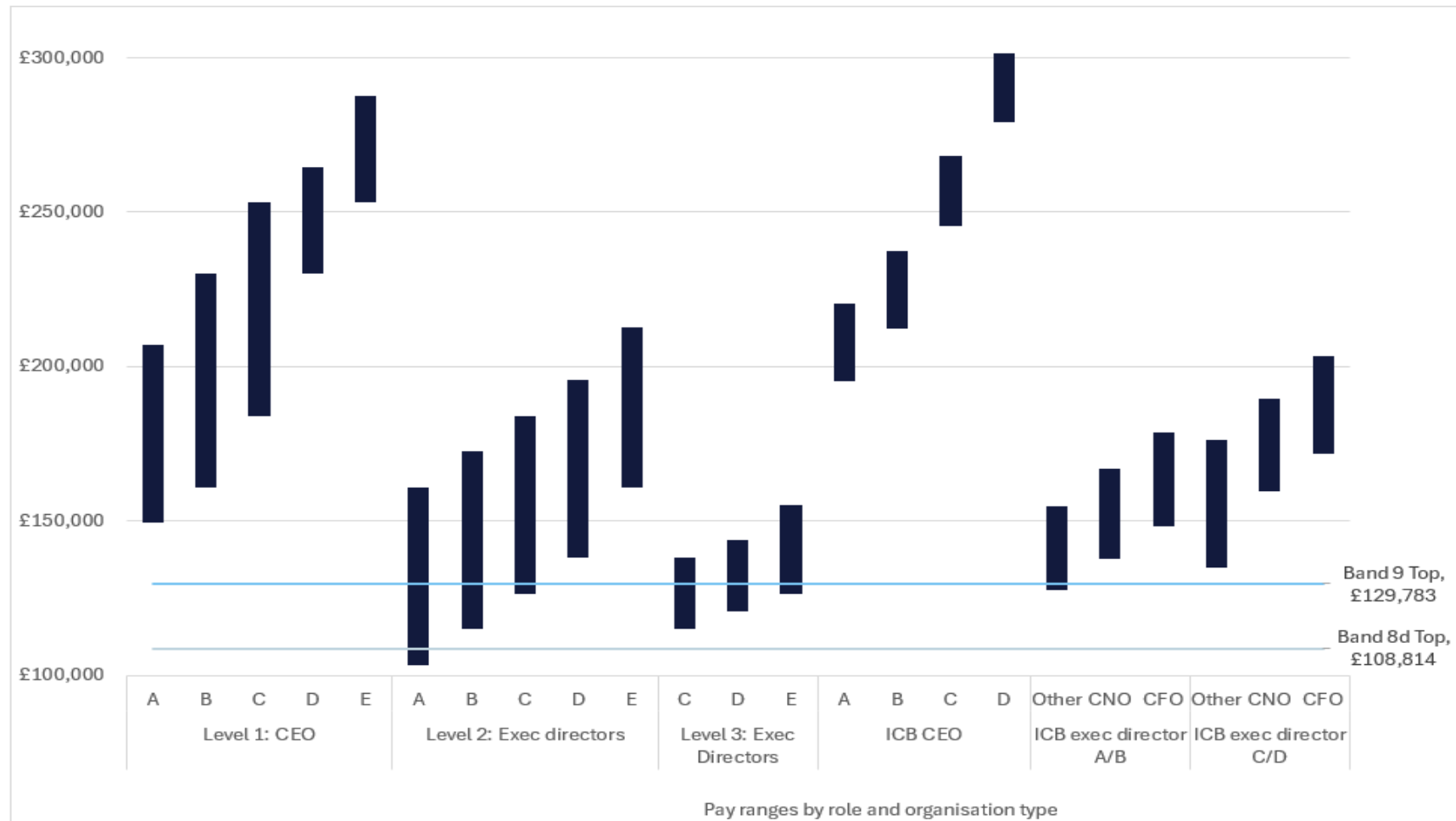
Over the last decade there has been a number of uplifts to pay across the AfC pay structure. A consequence of this is that there is now a significant overlap between the top of the AfC pay structure

(bands 8d and 9) into the very senior manager (VSM) pay structure. Organisations needing to recruit to senior roles find that it is sometimes easier to recruit to AfC band 8d and band 9 roles than to a VSM post. This is a long-standing issue and the retained view of employers is that the anomalies need to be worked through and considered further in light of the VSM pay framework.

The minimum salary on the [VSM pay framework](#) (band A) is £103,514. The lowest point on the AfC pay scale where it crosses over with VSM pay is the top of band 8d, meaning that all staff employed on band 9 are paid above the minimum VSM salary range.

The [VSM pay framework](#) sets minimum pay levels for very senior managers, with separate minima for chief executive officers, board directors and executive directors. These minima vary between trusts and ICBs and are further adjusted according to each organisation's turnover or weighted population. Staff at the top of band 9 on AfC earn £129,783. The minimum salary for provider trust level 2 directors in organisations with turnover below £750 million, all provider trust level 3 directors, and ICB 'other board executives' falls below this level. While some VSMs may earn less than £129,783 when paid at the minimum, their actual salary may be higher depending on role, organisational size and local arrangements. Figure 11 below shows the overlap between AfC (top of band 8d and band 9) and VSM grades.

Figure 11 - Comparison of basic pay between the top of AfC and the very senior manager pay framework pay ranges



Source: [VSM pay framework pay ranges](#)

Through our engagement survey, 34 per cent of employers said the pay overlap is having a moderate or significant impact in terms of the ability for organisations recruitment to and progression into more senior roles.

Employers report the overlap between the top of the AfC pay structure and lower end of VSM pay is creating growing challenges for recruitment, progression and retention. The limited financial differential is reducing the incentive for senior AfC staff to move into VSM roles, where the increase in accountability, complexity and exposure is not always matched by a sufficiently attractive increase in reward.

Several employers described reduced interest in VSM roles, fewer applications and reluctance among band 9 deputies or senior leaders to progress into executive-level posts. This is also affecting leadership development pipelines, with some organisations seeing lower interest in programmes such as Nye Bevan because the potential pay uplift on appointment to a VSM role is viewed as unattractive.

Employers also highlighted internal pay management issues. In some cases, organisations are having to increase VSM salaries to maintain a clear differential from top of band 9 roles, particularly where additional allowances such as London HCAS apply. This creates local pressure and can lead to dissatisfaction among existing VSMs and sub-board leaders, especially where AfC roles retain more favourable terms and conditions.

Overall, employers are seeing a risk that the current overlap weakens the attractiveness of VSM roles, makes succession planning more difficult and may increase turnover risk among executive director and senior sub-board roles. While not all organisations have yet seen a direct impact on applications, many expect this to become more significant as VSM vacancies arise and salaries need to be agreed.

In terms of national solutions, employers' responses were highly consistent and centred on preserving a meaningful financial and career distinction between AfC band 9 and VSM roles.

The most frequently raised theme was the need for a clear and visible pay differential between the top of band 9 and the entry point of VSM roles. Many employers felt that pay compression has reduced the financial incentive to progress into more senior positions and that the gap should be restored and protected over time.

Several employers called for a national review of VSM pay arrangements, particularly the lower end of the VSM framework. Suggestions included increasing VSM pay ranges, introducing greater flexibility in VSM pay setting and conducting more regular reviews to prevent further overlap with AfC salaries.

A number of employers suggested reviewing or potentially capping band 9 pay progression to reduce further overlap from occurring. There were also calls for stronger national consistency and assurance around the allocation of band 9 roles, including potential NHS England oversight or sign-off.

Employers also highlighted comparisons between senior AfC and VSM roles are affected by differences in contractual arrangements, as some senior AfC staff may receive additional on-call payments on top of basic salary, whereas for VSM roles such responsibilities are generally reflected within base salary.

Beyond pay, employers emphasised the importance of making VSM careers more attractive through clear career pathways, leadership development programmes, rotational assignments and stretch opportunities and broader leadership exposure. This was seen as important for maintaining a strong leadership pipeline and encouraging talented staff to progress into VSM positions.

Section 3 – Non-pay elements of the AfC deal

Delivering on pay deal recommendations

Following the work undertaken by the NHS Staff Council, NHS Employers, NHS England and DHSC as part of the 2023/24 pay deal agreement, the NHS Staff Council continues to work collaboratively with all stakeholders on a number of key priorities.

As part of this programme of work and in line with the NHS Staff Council's responsibility for maintaining the NHS terms and conditions of service (TCS), a comprehensive review of the [NHS TCS Handbook](#) is underway. This has included a review of section 12 (contractual continuity of service), which has led to the development of [guidance](#) on the recognition of experience gained outside of the NHS, both within the UK and internationally.

The development of this guidance has been informed by the nursing career progression group, established as part of the 2023 non-pay deal commitments workstream. The guidance supports greater consistency and fairness in the recognition of prior experience and helps to address concerns regarding potential unfair or discriminatory treatment of staff.

Additionally, the NHS TCS Handbook steering group reviewed and updated annex 20 to meet the requirements of the nursing career

progression non-pay recommendations. This clarified that the provisions do not exclude nursing staff and was published in January 2026.

As part of the reducing agency workstream, a recommendation was made to review annex 7 – good practice guidance on managing working patterns. This review has now been completed and recommendations have been developed and presented to both the steering group and the NHS Staff Council for consideration.

These updates demonstrate continued progress in delivering the non-pay commitments by improving clarity, consistency and fairness in the application of AfC TCS.

AfC 2023 pay deal job evaluation recommendation delivery update and impact

Work to improve the application of the Job Evaluation Scheme (JES) in NHS provider organisations, mandated by the Secretary of State in April 2025 has progressed well at national level. As a reminder, the intention behind the work programme is to ‘build capacity, restore confidence and invest to modernise’ the NHS JES.

October 2025 saw the first of a quarterly mandatory data-collection exercise across provider organisations, requiring them to provide data on steps demonstrating that board-assurance measures are in place and to capture data on nursing and midwifery job-description reviews. This quarterly collection was supplemented in April 2026 with an audit of job evaluation practice more generally, with providers asked to RAG rate their job evaluation work against a set of questions/statements based on agreed best practice standards.

A new enabling agreement on job evaluation was incorporated into the NHS TCS Handbook as annex 31 in April 2026. This is a significant step for the NHS Staff Council partners, and the principles

and requirements outlined in it should now inform all work across the service – nationally, regionally and locally.

The procurement of a digital recording system for job evaluation in England has encountered delays going through approval processes within NHS England. It is anticipated that roll out will commence in April 2027 and employers are keen to take advantage of the benefits it will bring.

While the work to deliver the recommendations on job evaluation has, overall, been a positive example of robust partnership working, there is a nervousness among employers that it will lead to an unmanageable demand for job evaluation reviews and a need to manage expectations locally about ability to respond. Ensuring resources to undertake and oversee job evaluation at all levels will be vital to the success of efforts to improve job evaluation performance and consistency as intended, and address staff side concerns about governance and assurance matters. We are supporting the NHS Staff Council to consider the findings of the first annual audit of job evaluation practice to help determine future work needed to continue capacity and confidence building.

Band 5 nursing role review

[We reported last year](#), following the publication of updated job matching profiles for nursing and midwifery, that employers anticipated banding change would come from job description updates rather than changes made within the profiles themselves. The work on job description updating advised by the NHS Staff Council has now been superseded by the government's commitment to '[a fairer deal for nurses](#)' which requires all band 5 nursing roles to be reviewed by October 2028.

While many employers have reported making progress in partnership with local trade unions, many are struggling to manage the expectations of staff which have been raised by [RCN communications](#) indicating they expect most nurses currently paid at

band 5 to see a significant uplift in pay. Employers acknowledge the need for staff to be paid correctly for the work they are required to do but need to retain the ability to manage and set those requirements according to their service operating plans and financial situation. They have also expressed concern about the pressure they are under from nursing unions to progress this work at a pace they do not have the capacity for.

Nurse career progression

A lack of career progression opportunities poses challenge to nursing morale, motivation, retention and attraction. There is particular concern that career progression is more limited for staff from a BAME background. Alongside reforming the AfC pay structure, the Secretary of State for Health and Social Care committed to improving nursing career progression outcomes and in April 2025 agreed ten recommendations from a stream of work arising from the 2023 AfC pay deal (non-pay commitments).

The recommendations were developed by a task and finish group of employer and staff side colleagues led by DHSC and NHS England. They are grounded in insight from nurses, evidence from NHS data and expertise from NHS employer, professional body and trade union organisations. For example, data reveals nurses move more slowly to band 6 and above compared to other professions. The recommendations aim to improve career progression opportunities for nurses, particularly those who are BAME and internationally educated, as evidence demonstrates they face additional barriers to develop and progress. Recent NHS Staff Survey results indicate BAME nurses are half as likely to progress from band 5 into band 6 roles compared to white nurses.

In December 2025, we were asked by DHSC to lead delivery for seven out of ten recommendations. Delivery of this work started in February 2026 and will conclude by August 2027. We have convened a new task and finish group to take forward the work and offer its constructive and expert advice to inform outputs. The task

and finish group has representatives from staff side (RCN, Unison and Unite), management side (chief people officers) and national partners (NHS England's chief nursing officer (CNO) team, Workforce Training and Education team and the CNO and chief midwifery officers' (CMO) Black and Minority Ethnic Strategic Advisory Group).

To support senior leaders with implementing the recommendations, we are highlighting practical and tangible actions employers can take to support good and fair employment practice around career progression for nurses, which is free from racism and other forms of discrimination.

Mileage negotiations

In June 2024, the NHS Staff Council was issued with a mandate to renegotiate the mechanism used to calculate mileage reimbursement. The intent of these negotiations was to create a new, fair and sustainable system for reimbursing NHS staff who use their own vehicles for work, replacing an outdated mechanism that no longer reflected the true cost of motoring.

The negotiations focused on accurately reimbursing staff, particularly those travelling high mileage, while introducing a system that can respond to inflation and changes in motoring costs over time. It also aimed to support workforce and service delivery needs to support recruitment, retention and productivity, particularly as the NHS shifts towards delivering more care in community settings where travel is essential.

The [new mechanism](#) was implemented on 1 June 2026, so it is too early to assess its impact. We intend to review this at a later date.

In the autumn, the group will begin to explore part 2 of the mandate; to provide recommendations on longer term revisions needed for sections of the NHS TCS relevant to NHS mileage and travel, including section 17 and related annexes, in light of NHS carbon

reduction plans, service needs and the requirement to provide a fair framework for reimbursement of work-related travel costs.

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

Job evaluation

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

While this year has not seen any significant equal pay legal cases in the NHS, the case of [Anne v Great Ormond Street Hospital for Children NHS Foundation Trust](#) serves as a cautionary example, whereby not harmonising the pay of insourced staff was deemed to be indirect race discrimination. Equal pay auditing would have picked up such an issue, but this is rarely undertaken by employers. Gender pay gap reporting does not replace the need for equal pay auditing and we remain concerned that the level of risk is not being appropriately captured due to the absence of such audits. These risks can be inferred from the early analysis of job evaluation practice audit returns (referenced above) showing a lack of board reporting in this area.

Concerns regarding inequality between collective bargaining groups in the NHS (in particular medical and AfC) persists and we are aware of the position in local government where allowances paid to one

collective bargaining group but not others have led to legal challenges.

Some local, long-standing disputes relating to job evaluation have now been resolved or in some cases impasse situations have been raised, often as a result of national intervention. However, disputes are still common and, in many cases, become intractable quickly with threat to industrial relations more generally. Such disputes often hang on definition and interpretation of words or values within the scheme criteria. We have supported the NHS Staff Council Job Evaluation Group (JEG) to respond to an increase in requests for support and advice in such cases. However, some can be seen as evidence of the JES being out of date with modern working practices.

Job Evaluation Scheme for the future NHS workforce

The continued and increasing attention to job evaluation is exposing deficits in the scheme architecture itself as well as in its application. The scheme was designed and defined in the early 2000s and neither its weightings, factors nor processes have been reviewed since. The NHS workforce has changed dramatically in that time and the disconnect between workforce reality and the scheme definitions is increasingly apparent. A simple example relates to a financial responsibility factor level defined in the handbook as being “over £1,000”. £1,000 in 2004 was a much higher sum in real terms than it is today yet there has been no adjustment to the scheme requirements.

Another example is changes to qualification levels in certain occupational groups. [We reported last year](#) about the increase in educational standards for public health nursing (also including health visitors, occupational health and school nurses). This increase in education requirements is also now being seen in other professions such as optometry and some radiology roles. Not only does this lead to compression in pay banding for some clinical/technical roles that may be perceived as iniquitous by other occupational groups, it also leaves employers facing increases to their pay bill (plus possible large sums in backdating) regardless of whether there is a change in

job requirements. When the scheme was designed, very few roles required high qualification levels that are now commonplace.

We have supported the joint chairs of the NHS Staff Council to raise the need to address the continued and future use of the JES with government, noting its intention indicated in [plans for the future of the NHS](#) for “sustained partnership working to undertake significant contractual change that provides modern incentives and rewards for accessible high quality and productive care”.

Our view is this must consider and address the need to modernise the scheme for the current and future workforce and be an opportunity to consider how technology can enhance the application of the scheme. This could bring both productivity and consistency gains for employers and staff.

Section 5 – Pensions and total reward

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 in the service 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 [evidenced last year](#) (page 65) 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](#) (page 65) and comment as follows:

- Opt out by pay band – generally, lower paid staff (bands 1 (closed) to 4) and graduate entry (band 5) are less likely to join the scheme than higher paid staff. Cost of living pressures, financial priorities and generational behaviour may be a contributing factor.
- Opt out of international employees – opt outs for international recruits are higher than 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. 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](#) (page 67) 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. Our section on scheme flexibilities (below) gives our view on how the introduction of flexibilities in the future may help to reduce opt outs for affordability reasons, support members to save for their retirement and retain important scheme benefits.

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, including: [the value of the NHS pension scheme posters](#) and [communicating the benefits of the NHS pension scheme videos](#).

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, while maintaining member access to valuable scheme benefits such as life assurance for example. 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. We see the introduction of scheme flexibilities as a medium-term goal because successful implementation requires digital sophistication both centrally and locally that current systems cannot offer. It is realistic that the introduction of scheme flexibilities follows the planned transformation and digitisation of the scheme.

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 results were published](#) in June 2026. The valuation assesses the financial position of the scheme and sets the employer contribution rate required to meet expected future benefit costs. The 2024 valuation results show that the required employer contribution rate has fallen significantly from 23.7 per cent to 15.5 per cent of salaries (a reduction of 8.2 per cent, equivalent to approximately £5.4bn per year). The new employer contribution rate will be in place from 1 April 2027 to 31 March 2031.

The NHS Pension Scheme is a defined benefit pension scheme, where a member's pension is calculated based on their pay and length of scheme membership. In this type of scheme, the employer contribution rate does not have any influence on the value of a member's pension. However, for scheme members, the generous contribution paid by their employer is seen as part of their reward offer, particularly when compared with lower contribution rates paid by employers in other sectors and industries. Without a clear understanding of how the scheme works, there is a danger that staff may view the fall in the employer contribution rate as a reduction in the value of their overall remuneration.

Employers play an important role in promoting the value of scheme membership and that it is a key part of the overall reward offer for working in the NHS. We are proactively reviewing and updating our resources to support employer communications to staff that their pension remains unchanged. We will support employers to continue to highlight the value of scheme membership and the range of valuable benefits it offers.

Member contribution rates are set separately and these results do not affect the cost of membership for staff.

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.

Because the AfC pay award for England was implemented from 1 April 2026, there was no need for a further assessment of member contribution tier thresholds later in 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 of indexation has improved considerably and the implementation of an April pay award has supported this. Figure 12 highlights the NHSPS member contributions rates for 2026/27.

Figure 12 – NHS Pension Scheme member contribution rates – 2026/27

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 Employers website](#)

McCloud remedy implementation

A [revised ministerial statement](#) from 21 May 2026 includes the independent review findings that NHSBSA 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 this implementation requires a minimum six-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 and McCloud

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 a remediable pension savings statement (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 web page](#)
- [Annual allowance](#)
- [Assessing annual allowance - ready reckoner tool and demonstration](#)

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](#) (page 68) about the uptake of partial retirement. We are seeing a slight reduction in partial retirements in 2026, the reasons for this reduction can't be monitored by the scheme.

Partial retirement was introduced in October 2023 for members of the 1995 Section. Members take between 20 and 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 we have received has reduced. We have updated our [partial retirement employment guidance](#) to include legal clarification from DHSC.

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](#) (page 68), 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](#)

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 evidence submission](#) (page 74), we noted that the NHSPS Scheme Advisory Board (SAB) workplan for 2025/26 included exploration of a prototype real-time re-banding solution for all payroll providers. This work was delayed, but we are pleased it is included in the SAB workplan for 2026/27. Beginning this work in March 2027 means this is not a short-term priority for the scheme and we may be looking at implementation from 1 April 2028 at the earliest. We are happy to support this SAB workstream with preliminary work.

Gender pension gap

We are aware through our work with the SAB 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 a SAB discussion 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 has shared its work on the gender pensions gap with the NHS Staff Council to ensure they can take this into account when considering future reform of pay and terms and conditions.

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 recommend the introduction of automated processes such as real-time re-banding and an overhaul

of the systems and interfaces that manage the NHS Pension Scheme as a way of alleviating some pressures on local pension administration.

We are pleased to hear that NHS Business Services Authority (NHS BSA) is embarking on a transformation project and hope that this will help streamline and modernise scheme administration. It is vital 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.

Looking to the future

We continue to support the NHSPS to remain an attractive scheme for the benefit of all members, so 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 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.

Total reward

The NHS total reward offer encompasses the nationally agreed provisions through the NHS TCS Handbook, alongside locally agreed initiatives and benefits that vary from one organisation to another.

Total reward can play a significant role in helping NHS organisations attract, retain and engage their workforce when it is understood, communicated and applied effectively. Done well, it brings together pay, pensions, annual leave, flexible working, health and wellbeing support, learning and development, recognition and wider staff

benefits into a clear and compelling [employee value proposition](#). This can strengthen the NHS's position in a competitive labour market, support staff to feel valued and improve morale and engagement. A strategic approach to total reward also enables employers to make better use of the full employment package, supporting recruitment and retention and the delivery of high-quality patient care.

[NHS Employers Reward and Recognition Network](#) is made up of 371 members, representing 179 NHS organisations. The network brings colleagues responsible for reward and recognition together to share good practice, challenges and provide peer support. Through our network meeting feedback and surveys, employers report on a number of key issues to bring to the NHS PRB's attention.

Resource constraints

Employers repeatedly highlighted a lack of funding and administrative resource as primary reasons for why new or existing reward initiatives can't be progressed or enhanced. NHS organisations do not have a consistent budget for reward which prevents them from being able to invest in a wider range of local initiatives. Some organisations reported being able to access charitable funds to support some recognition initiatives, however this is not recurrent funding and is not available to all organisations. Employers fed back they would like to expand their reward and recognition schemes, but the work involved in governance, payroll/finance processing, eligibility checks, system setup, communications and evaluation is limiting what they can realistically implement.

Recognition

Recognition schemes remain a priority area for network members. When asked about low-cost high impact initiatives, network members cited recognition-based activity such as long service recognition, milestone cards, peer to peer recognition, staff awards and

celebration events and staff networks. Many NHS organisations recognise long service, however current approaches vary. Some organisations offer monetary rewards for different milestones, others offer certificates and badges. The same can be seen for recognising NHS service or trust service, which also varies locally. We hear through our network about the administrative issues that can occur with administering long service schemes. The inconsistency of data in ESR can make it difficult to prove when an individual's service started, which places a large administrative burden on the employer. Feedback from members suggests a national approach to recognising all NHS service, rather than service with an individual trust, would enable more staff to be acknowledged for their contribution, commitment and dedication to the NHS. This would also support greater consistency and fairness across organisations. We have received a number of queries from individuals who are unclear why they are unable to access long service awards, highlighting the need for clearer and more consistent arrangements.

Evaluating reward

Survey feedback highlighted that for those employers that evaluate their reward offering, they look at each individual part of the offering separately, for example, tracking uptake and engagement through payroll and provider data and scheme participation rates. However, as there are so many components that make up the total package, it is difficult to attribute each one to having demonstrable impact on recruitment, retention and motivation. 40 per cent of employers surveyed said that in terms of an overarching evaluation method, they use the NHS staff survey 'we are rewarded and recognised' questions, monitoring key themes and trends year on year. Although staff survey results provide a strong overview, employers report difficulties in terms of being able to demonstrate a clear correlation with the reward and recognition offer.

Some employers have been looking at alternative methods to measure impact including:

- standalone surveys on financial wellbeing, later integrating related questions into their annual staff survey to track changes over time
- highlighting the value of cost savings and income generated from staff accessing reward schemes
- using personalised questions in quarterly pulse surveys to tailor initiatives like pensions workshops, helping to better assess relevance and effectiveness
- one trust is exploring if there is any correlation between staff benefit take up (in certain workforce areas) and metrics such as staff turnover and staff absence to see if they can demonstrate the impact of their staff benefits.

Salary sacrifice schemes

In our previous evidence submissions to the NHS PRB we have continued to reference the issues NHS organisations face in terms of salary sacrifice (and net deduction) schemes and NMW compliance, with a large proportion of the lower banded workforce still unable to access them.

Our [2026/27 evidence \(page 79\)](#) provided analysis of different salary levels and the maximum amount of salary sacrifice that could be taken without falling below NMW.

Figure 13 below provides a comparison between 2025/26 and 2026/27, demonstrating that the estimated maximum salary sacrifice levels have reduced across bands 1 (closed) to the entry point of band 4. This indicates the issue has become more acute for both employers and staff over the past year, with even less headroom available for salary sacrifice arrangements and a growing proportion of lower-paid staff effectively excluded from accessing parts of the wider reward offer.

To ensure employees' pay does not fall below the NMW after salary sacrifice deductions, employers must carefully assess the applications they approve. As salary sacrifice repayments are spread over many months, it is difficult for employers to determine the maximum amount that can be sacrificed without knowing future pay awards in advance. This necessitates a cautious approach. Figure 13 shows the estimated theoretical salary which might be sacrificed. In practice, limits in place may be lower than those shown, as there will be variation between organisations on how this risk is managed.

Figure 13 – Estimated theoretical maximum salary sacrifice

Year	NMW (21 and over)	Weekly Hours	Weeks in a year	Annual Hours	Annual NMW Salary
25/26	£12.21	37.5	52.1429	1955.3588	£23,875
26/27	£12.71	37.5	52.1429	1955.3588	£24,853
Band Step	Full time Basic Pay (25/26)	Estimated Maximum Salary Sacrifice	Full time Basic Pay (26/27)	Estimated Maximum Salary Sacrifice	Change
1 Entry	£24,465	£590	£25,272	£419	-£171
2 Entry	£24,465	£590	£25,272	£419	-£171
2 Top	£24,465	£590	£25,272	£419	-£171
3 Entry	£24,937	£1,062	£25,760	£907	-£155
3 Top	£26,598	£2,723	£27,476	£2,623	-£100
4 Entry	£27,485	£3,610	£28,392	£3,539	-£71
4 Top	£30,162	£6,287	£31,157	£6,304	£17
5 Entry	£31,049	£7,174	£32,073	£7,220	£46

Source: Salary sacrifice for employers

Calculation: $\text{NMW} \times 37.5 \text{ hrs} \times 52.1429 \text{ weeks} = \text{Annual Salary at NMW}$ and $\text{Actual Salary} - \text{Annual Salary at NMW} = \text{Maximum Salary Sacrifice Amount}$

As outlined in section two, organisations are experiencing increasing difficulty recruiting and retaining staff in lower-banded roles due to competition from external labour markets. However, a significant element of the overall reward package, like salary sacrifice schemes, remains inaccessible to many of these staff groups.

Employers offer a wide range of salary sacrifice schemes as part of their overall reward package, extending beyond traditional benefits such as lease cars and household goods, including options such as purchasing additional annual leave. Employers have told us that staff assume that certain benefits, particularly annual leave purchase schemes, are universally available, especially where they are not explicitly presented as salary sacrifice arrangements. Access can be restricted for employees in lower pay bands where participation would reduce earnings below the NMW threshold.

This highlights that a number of elements of the total reward offer are less accessible to those on lower pay, creating an imbalance whereby benefits designed to enhance the overall employment package are more readily available to staff in higher-paid roles with greater financial flexibility.

Trusts report using invoicing mechanisms to enable access to benefits (for example, where staff can choose to pay via direct debit or invoice for car parking permit schemes). This is particularly relevant for lower-paid staff, where salary sacrifice or net deduction arrangements could reduce earnings below the NMW threshold and therefore prevent participation. These approaches are often resource-intensive and create a substantial administrative burden, reducing efficiency and consistency across organisations.

Future proofing the total reward offer

The NHS relies heavily on the total employment offer to remain competitive when the market value of some roles is higher in the private sector and sectors such as retail have the ability to be more agile and reactive with pay rises. However, with changes in workforce

demographics and expectations, employers need to consider whether these benefits continue to hold the same level of appeal for the changing needs of the future workforce.

To be able to offer a reward package that is meaningful, cost effective and has long-term impact, benefits need to be diverse, inclusive and adaptable. Every individual will look for rewards that resonate with them and that they feel connected to. This can be challenging when a large part of the reward offer is nationally agreed and inflexible for organisations to adapt or change or is constrained by legal compliance measures for example NMW. Other sectors are increasingly offering more innovative, personalised and flexible benefits packages designed to meet changing workforce expectations.

The NHS would benefit from having the ability to provide flexibility to other parts of the employment package, to ensure it remains competitive and is seen as an employer of choice for the future generations. Our case study looks at [rewarding and recognising a multi-generational workforce](#) and what organisations can do differently when thinking about designing an age inclusive reward offer.

“For some staff there may be a greater preference for higher immediate earnings, even if that came with a reduction in annual leave entitlement or pension contributions. Gone are the days of wanting to work for the NHS because it matters to me. This may not be the same reason why the newer workforce demographic join the workforce, particularly given the negative media portrayal of the NHS recently.

While the NHS continues to provide valuable benefits, the relative attractiveness of the NHS offer may diminish over time if it does not continue to evolve, potentially impacting recruitment, retention and

employee engagement in an increasingly competitive labour market”.

Head of People Services, Acute Trust, Yorkshire Region.

Section 6 – Staff experience

[Recent NHS England performance data](#) highlights that pressure on services is no longer confined to winter. Data shows that in June 2026 the highest average daily attendances for urgent and emergency care in NHS history were recorded and ambulance incidents were up by more than 7 per cent compared with the previous year. This level of sustained, year-round pressure has direct implications for staff experience, with higher demand, persistent flow challenges and the continued use of corridor care increase workload intensity, reduce recovery time between peaks of pressure and risk worsening stress, burnout and morale at a time when staff survey results already show concerning trends in health and wellbeing.

NHS Staff Survey 2025

The [NHS Staff Survey 2025](#) showed relatively little movement in overall theme scores with morale and motivation indicators remaining stable.

There were however falls in some key question areas that relate to staff experience. This was reflected in the fall in willingness of staff to recommend the NHS as a place to work.

In particular, many of the measures for health and wellbeing worsened. Indicators of stress, burnout and pressure remained

unacceptably high. In addition, there was a fall in staff believing their employer takes positive action on health and wellbeing, down from 57 per cent to 54 per cent. Staff had a more favourable view of support from their own line manager, with this remaining stable at 71 per cent.

As noted by the NHS PRB, absence levels have remained high. The [most recent national statistics](#) showed that national absence rates increased from 4.7 per cent in May 2025 to 5 per cent in May 2026. A lower sickness absence rate generally means more staff available to deliver services, which can positively impact on staff experience, productivity and patient care. This is particularly important given that reducing sickness absence is a key national workforce driver, with sickness absence rates included in the NHS Oversight Framework as a measure of organisational performance.

We have developed a range of [resources](#) to support employers with a focus on action on mental health, stress and burnout. This includes a [guide to key actions](#) and a webinar where organisations shared ongoing initiatives.

We recommend an organisation-based prevention focused approach. Individual intervention techniques can be helpful but are most effective within a comprehensive framework. We are also involved through the [Health, Safety and Wellbeing Group \(HSWG\)](#) with wider research work on the issue of fatigue and work on definitions and support will be published in due course.

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

Satisfaction with pay

Following a significant increase between 2022 and 2023, NHS staff satisfaction with pay has remained steady over the past three years. This year's results showed that 32.13 per cent of staff said they are satisfied with their level of pay.

Negative staff experiences

There continues to be high levels of violence, bullying and harassment against NHS staff which have an adverse impact on staff experience. On these measures, there continue to be very marked inequities in staff experience. There has been limited progress in reducing these inequalities in recent years. In 2025, overall levels were stable, though measures of harassment by managers has reduced and rates of reporting increased.

We have supported work via the Social Partnership Forum to address these issues including most recently with [guidance on post-incident support](#).

NHS Staff Standards

The [NHS staff standards](#), published on 7 July 2026, provide a framework to improve staff experience in the NHS. The standards were developed by DHSC and NHS England with engagement from the national Social Partnership Forum.

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 and tackling racism and promoting flexible working. Their inclusion in the [NHS Oversight Framework](#) means trusts will be assessed, supported and monitored 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 the development of the standards and will be supporting employers to implement them effectively. We have recently launched a [staff standards hub](#) that brings together practical guidance, tools and resources across all six standards to support employers with implementation.

Section 7 – Workforce supply, employment practice and regulation

Impact of government policy priorities

A number of government policies including immigration changes, apprenticeship reforms and competing NHS England requirements to reduce costs and improve productivity are having a negative impact on the recruitment and retention of the NHS workforce. Trusts need to be able to recruit to a range of roles and from a range of diverse pipelines, as well as retaining their experienced current employees, to ensure we have a fit for the future workforce.

Entry level roles

As one of the largest employers in many local areas, the NHS has an important role to play as an anchor institution, supporting local employment, skills development and inclusive economic growth. Recent government reports, including [Get Britain Working](#) and [Young people and work](#), emphasise the importance of helping young people access employment and training opportunities, recognising the benefits this brings not only to individuals' health, wellbeing and

future prospects, but also to the wider economy. This is a key government priority.

The [2025 Spending Review settlement](#) for the NHS required annual improvements in productivity of 2 per cent, which has led to trusts either holding vacancies or removing posts entirely. This appears to have had an impact on recruitment to entry level roles and the figure 14 below highlights that between March 2024 and March 2026, the band 2 and band 3 workforce reduced by 3.58 per cent (12,577 jobs).

Figure 14 – Number (FTE) of band 2 and band 3 between March 2024 and March 2026

	FTE			Mar-24 to Mar-26	
Band	Mar-24	Mar-25	Mar-26	Total FTE	% change
Band 2	169,954	136,873	112,263	-57,691	-33.95%
Band 3	180,958	211,216	226,072	45,114	24.9%
Total	350,912	348,089	338,335	-12,577	-3.58%

Source: [NHS Workforce Statistics](#)

These roles are crucial for career progression into further clinical support roles such as nursing associates and other registered healthcare positions. Entry roles in other sectors are seen as less stressful and more attainable for young people. To compete with this perception, NHS entry level role salaries must be able to attract young people and be seen as a worthwhile career to follow. We report on this further in [section 2](#) of our evidence.

Employers continue to highlight that opportunities for new entrants are becoming more limited, with a growing reliance on internal recruitment to fill roles. This is identified as a potential risk to widening participation activity and the government's plan to recruit to entry level roles, particularly for young people. Looking ahead, we anticipate that the greater adoption of AI and robotic process

automation (RPA) may further reduce the volume of some entry-level roles, increasing competition for available opportunities and potentially accelerating the longer-term decline in traditional entry routes into the NHS workforce.

Even though employers are dealing with these barriers and stricter vacancy control measures to manage their budgets and workforce growth, there are still areas of good practice supporting young, NEETS and disadvantaged people into work which support the government agenda:

- The ten initial [widening access demonstrator](#) (WAD) sites have illustrated how a small investment can provide those from under-represented and/or deprived communities into employment. In year one, the WAD sites supported more than 1,800 individuals into employment or other positive destinations, for example education or training, exceeding the substantive employment target by 90 per cent. This demonstrates that reasonable financial input can support the government targets.
- The initial WAD programme has been extended for a further year and will include four more sites.
- The [DHSC's commission with The King's Trust](#) continues to support young people into NHS and social care employment, as well as supporting them to progress once in work.
- Employers have also found T Level placements can be a successful approach in introducing young people to careers within the NHS they may not have considered, such as [estates and facilities](#). In addition, a recent report commissioned by the [Gatsby Foundation](#) has demonstrated that every £1 spent on T Level placements brings a benefit of £1.81 to the organisation.

We will continue to work with employers to share and promote these areas of good practice and support others to think creatively about how they can support this agenda within their current resources.

Newly qualified registered professionals

The same financial pressures on employers, as well as the reduction in turnover rates, are affecting the recruitment of newly qualified healthcare professionals including nurses, midwives, paramedics and physiotherapists. In 2025/26, NHS England recommended a [graduate guarantee scheme](#) for trusts, but this appears to have compounded the problem in 2026/27. Many opportunities offered under the scheme in 2025/26 were fixed-term posts, meaning employers are now having to manage the transition of graduates into ongoing roles while simultaneously finding employment opportunities for newly qualified graduates in 2026/27. Employers have reported regional differences for some professionals, with some reporting there are only enough vacancies in their area for a third of the newly qualified nurses. In comparison, the South West region continues to have a range of vacancies available for nurses and other healthcare professionals.

A blanket narrative that there are no jobs for newly qualified individuals has emerged, which is unhelpful. We have heard anecdotally that careers advisors in schools and colleges are not recommending healthcare as a potential career route due to this perceived lack of vacancies and recruitment restrictions.

Apprenticeships

Figure 15 shows a continuing decline in health, public services and care apprenticeship starts from 2021/22 to 2025/26. The data illustrates that the number of achievements (completion of apprenticeships) continues to steadily increase even though the starts are fewer.

Figure 15 – healthcare and public services apprenticeship starts from 2021/22 to 2025/26	2021/22	2022/23	2023/24	2024/25	2025/26
Starts: Health, public services and care	79,490	78,180	75,480	75,330	64,940
Achievements (completion of apprenticeships): Health, public services and care	25.50%	27.00%	27.10%	28.50%	28.9%

Source: [Academic year 2025/6 Apprenticeships](#)

We recently surveyed employers to understand the use of the apprenticeship levy and the barriers they face in fully utilising available resources. A total of 140 NHS organisations responded to the survey. The findings indicated the following:

- Apprenticeships remain widely used across clinical and non-clinical roles but are primarily supporting existing staff – 91 per cent of organisations used their levy in 2025/26, with 83 per cent using it mainly to upskill existing employees rather than recruit new entrants.
- Policy changes and defunding of standards are the most significant concerns - defunding of standards (97 per cent) and policy changes (94 per cent) are the highest-ranked issues, with particular concern about the impact on levy utilisation, leadership development and progression pathways.
- Lack of backfill funding continues to be the biggest practical barrier to delivery - alongside workforce capacity, supervision constraints and vacancy controls. This significantly limits organisations' ability to release staff and expand apprenticeship activity.
- Apprenticeships are not yet being used at scale for under-25 recruitment – most organisations report between 1 to 24 per cent of levy spend is on under 25s, reflecting structural barriers

including lack of entry-level roles, funding constraints and supervisor capacity.

- Levy rules are seen as too inflexible for workforce planning - employers consistently highlight limitations on using funds for backfill, salaries and wider training costs, reducing the ability to align apprenticeships with service needs.
- Mismatch between national policy ambitions and employer experience – while apprenticeships are seen as a key route into the NHS, particularly for younger people, structural constraints, especially funding, vacancies and supervisor capacity are limiting their use in practice.
- Future levy use is becoming more uncertain – many organisations expect reduced spend, increased levy expiry and a shift in delivery due to policy reform, financial pressures and workforce constraints.
- We do not have access to national data on apprenticeship retention rates but understand there are low attrition rates from the programmes, as reported in our 2025/26 evidence.
- NHS England recently released the first 500 nurse degree apprenticeships from the 2,000 described in the 10 Year Plan. Employers were asked to bid for these opportunities and we understand these roles were oversubscribed, demonstrating the continuing support that NHS trusts have for this route into nursing.

Pay and consistency

The issue of apprentice pay continues to be raised by employers, with examples from organisations paying new entrants [national apprenticeship pay rates](#), in contrast with those who were already in the NHS being protected under the AfC terms and conditions - meaning they are not paid any less than their previous NHS pay

rates. It is noted this lack of consistency may act as a barrier to participation, particularly for those from lower-income backgrounds.

International recruitment

While the government's ambition to reduce reliance on international recruitment is understandable, this shift will only be sustainable if the NHS domestic workforce supply and retention rates are strengthened at the same pace. Immigration policy changes have already contributed to a significant reduction in international recruitment. The most recent immigration figures show there were only 1,507 health and social care visas applied for in [Q1 of 2026](#), compared to 38,127 in [Q1 of 2023](#), prior to the announcement of immigration changes.

While some parts of the NHS are currently experiencing an oversupply of applicants, including newly qualified graduates seeking employment, this position may prove temporary. The reduction in international recruitment will have a cumulative impact over time and, unless domestic workforce supply and retention are strengthened sufficiently, risks contributing to workforce shortages in the medium to long term.

In November 2025, the government launched a [consultation on earned settlement proposals](#). These proposals would make the UK a less attractive destination for international recruits and would dampen retention of the UK's current employees, as they would be competing with countries with shorter and/or clearer settlement pathways. A recent [report by The Health Foundation](#) states "the latest target to reduce international recruitment is not realistic and risks worsening workforce shortages". With 32 per cent of staff in London reporting a non-UK nationality, changes to immigration and settlement policy could have a disproportionate impact in some regions. A more attractive and sustainable domestic workforce offer is needed, alongside clear policy measures to support the retention of internationally educated staff who are already working in the NHS.

In the short to medium term, these immigration policy changes are expected to increase pressure on employers, particularly in recruiting to hard-to-fill roles and services where domestic pipelines are not yet sufficient.

Chief People Officer, Acute trust, South East Region:

One NHS employer reported that, following a period of significant international nurse recruitment over around three years, it paused overseas recruitment in 2023 once vacancy levels became more sustainable. The organisation is concerned that without action to strengthen nurse supply pipelines now, it may face similar vacancy pressures again within the next two to three years as natural workforce turnover continues.

Its main university partner expects a cohort of around 60 nursing students to graduate in 2027, but the cohort is made up almost entirely of international students because the university was unable to fill places with UK applicants. This means that, on graduation, the students will be classed as international recruits and their ability to work in the UK will depend on the visa rules in place at the time.

The organisation also highlighted risks arising from the removal of sponsorship routes for healthcare support workers from December 2026. As a high-cost area without access to high-cost area supplements, it struggles to attract domestic candidates into these roles. It is developing 'new to care' and 'employability' programmes for local residents, but this remains a fragile route into registered nursing, particularly given financial constraints affecting apprenticeship pathways.

Similar concerns were raised in other professional groups. For example, the employer can sponsor band 2 medical laboratory assistant roles and support staff to progress towards biomedical scientist roles. However, once qualified, a band 5 biomedical scientist salary may not meet sponsorship thresholds, meaning staff may need to remain in assistant roles until they can progress to a band 6. This creates a disconnect between workforce development pathways and immigration salary requirements, with potential consequences for retention, career progression and service capacity.

A coordinated government approach is needed to balance immigration and workforce policies, supporting both domestic workforce growth and the retention of internationally educated staff to maintain NHS recruitment and service sustainability.

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