NHS Pay Review Body

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THIRTY-EIGHTH REPORT 2025

Chair: Stephen Boyle

CP 1322

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Presented to Parliament by
the Prime Minister and Secretary of State for Health and Social Care
by Command of His Majesty

Presented to the Welsh Parliament by
the Cabinet Secretary for Health and Social Care

Presented to the Northern Ireland Assembly by the Minister of Health

CP 1322

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NHS Pay Review Body terms of reference

The NHS Pay Review Body (NHSPRB) is independent. Its role is to make recommendations to the Prime Minister, the Secretary of State for Health and Social Care, the First Minister and the Cabinet Secretary for Health and Social Care in Wales and the First Minister, Deputy First Minister and Minister for Health in Northern Ireland, on the remuneration of all staff paid under Agenda for Change and employed in the National Health Service (NHS).

In reaching its recommendations, the Review Body is to have regard to the following considerations:

- the need to recruit, retain and motivate suitably able and qualified staff;
- regional/local variations in labour markets and their effects on the recruitment and retention of staff;
- the funds available to the Health Departments, as set out in the Government's Departmental Expenditure Limits;
- the Government's inflation target;
- the principle of equal pay for work of equal value in the NHS;
- the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

The Review Body may also be asked to consider other specific issues.

The Review Body is also required to take careful account of the economic and other evidence submitted by the Government, Trades Unions, representatives of NHS employers and others.

The Review Body should take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief, and disability.

Reports and recommendations should be submitted jointly to the Prime Minister, the Secretary of State for Health and Social Care, the First Minister and the Cabinet Secretary for Health and Social Care in Wales and the First Minister, Deputy First Minister and Minister for Health in Northern Ireland.

Members of the Review Body are:

Stephen Boyle (Chair)
Professor Stephen Bach
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Stephanie Marston
Professor Karen Mumford CBE
Mark Pennifold

The secretariat is provided by the Office for the Pay Review Bodies.

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Executive Summary

1. The Secretary of State for Health and Social Care, the Health Minister in Northern Ireland and the Cabinet Secretary for Health and Social Care in Wales asked us in their respective remit letters to make a recommendation for a pay award for Agenda for Change (AfC) staff for 2025/26. Our report and recommendations have regard to our standing terms of reference.

2. Five years on from the onset of the COVID-19 pandemic, there are some early signs of stabilisation in the NHS. However, it remains under strain and Lord Darzi's report described a health service in England struggling in the face of rising demand and immense pressure.

3. After a period of rapid workforce expansion, recruitment is now slowing. This is partly due to the extremely strained financial position of NHS organisations. Retention has improved. However, staff have told us they do not feel the pressure on them has eased, with some saying pressure and demand are higher than ever. The latest Staff Survey shows staff are less enthusiastic about their jobs and less likely to say they look forward to going to work.

4. The UK Government and the Department of Health Northern Ireland told us 2.8% was in budget for a pay award. The Welsh Government did not confirm their budget allocation for pay, although in written evidence, supplied before the budget had been finalised, they indicated that the resource budget in 2025/26 would be 3% higher than in 2024/25. HMT have said departments will not be given additional funding for pay awards in 2025/26, should Pay Review Body recommendations exceed stated affordability. Since parties gave evidence to us, the wider fiscal context has only become more challenging.

5. The latest Consumer Price Index (CPI) inflation rate at the time of submitting this report is 2.8% for February 2025, although Office for Budget Responsibility (OBR) have forecasted CPI inflation will rise to 3.2% across 2025. Median pay settlements are reported to be between 3.0% and 3.4% for the three months to February 2025.

6. **Reflecting the evidence presented to us and the data available to us we recommend a 3.6% consolidated pay award for 2025/26 across all AfC pay points from 1 April 2025.**

7. In addition, DHSC requested in their written evidence 'a view on the relative priorities of investing in headline pay and structural reform this year, within an affordable pay settlement'. The Department of Health Northern Ireland made the same request. We considered the need for structural reform to Agenda for Change sufficiently important a year ago to recommend that governments provide a funded mandate for reform. We are disappointed that, following acceptance, this recommendation has not been implemented.

8. We have considered that request carefully, including by inviting parties to submit additional evidence. Our judgement is that, between investing in headline pay and investing in structural reform in this year's constrained fiscal environment, the greater priority is headline pay.

9. We therefore conclude that no resources from the envelope for a pay award should be allocated to structural reform in 2025/26. This position reflects our assessment of the original and additional evidence received, alongside the context of the pending 10 Year Health Plan and associated workforce plan, the forthcoming Spending Review, and the fact that discussions on reform priorities among governments, the NHS Staff Council and social partners have not yet started. However, we remain persuaded of the case for reform. We again **recommend the UK Government provides the NHS Staff Council with a funded mandate to resolve outstanding concerns with the AfC pay structure.**

10. Maintaining the integrity of the AfC contract across England, Northern Ireland and Wales will require all three administrations to be engaged in such a process. For that reason, we also recommend to the Northern Ireland Executive and the Welsh Government that they support the issuance of a funded mandate to the NHS Staff Council and that they work with the NHS Staff Council, their social partners and with the UK Government on this matter.

11. If the governments choose to accept this recommendation, we expect them, as an indication of the seriousness of their intent, to make material progress towards agreeing with the NHS Staff Council a plan for the implementation of structural reform before the 2026/27 pay round begins. At the beginning of that round, we will invite parties to set out their assessment of the progress that has been made.

CHAPTER 1 Introduction

1.1 The NHS Pay Review Body (NHSPRB) received remits from the UK Government, the Department of Health for Northern Ireland and the Welsh Government for the 2025/26 pay round. This report presents our pay and other recommendations for 2025/26 for staff paid under AfC contracts in the NHS and the reasons for these recommendations.

The Review Body Process

1.2 The NHSPRB is an advisory non-departmental public body whose members are appointed through the public appointments process.

1.3 The annual PRB process is initiated by remit letters from the three governments. Our standing terms of reference provide overall direction to the NHSPRB. Following receipt of the remit letters, the PRB formally requests parties, such as trade unions, employers and governments, to submit written evidence. Evidence received from the parties is supplemented by statistical information and research published by independent analysts.

1.4 Our remit letter from the Department of Health and Social Care (DHSC) was received earlier than in previous years, on 30 September 2024. As we have laid out in previous reports, we know the importance of a timely review body process and the receipt of an earlier remit letter means we are able to deliver our report to governments sooner than in previous years. We hope that further progress next year from governments in issuing the remit letters and preparing evidence will mean we will be able to submit our report sufficiently far in advance of the 2026/27 financial year, meaning that it would be possible for AfC staff to receive payment in a timely way.

Our 2024 report

1.5 The NHSPRB received remit letters from the UK Government, the Department of Health Northern Ireland and the Welsh Government in December 2023 seeking a recommendation about pay for 2024/25.

1.6 We submitted our 2024 report on 7 June 2024 which recommended a 5.5% consolidated uplift for all AfC staff, intermediate pay points to be added to Band 8a and above, and for the UK Government to issue the NHS Staff Council with a funded mandate to begin to resolve outstanding concerns within the AfC pay structure. We also recommended the Northern Ireland Executive, and the Welsh Government support the issuance of a funded mandate and work with the UK Government on this matter.

1.7 On 29 July 2024, the UK Government accepted the recommendations in full. On 10 September 2024, the Welsh Government accepted the recommendations in full. The Department of Health Northern Ireland confirmed at oral evidence on 11 February 2025 that they were also accepting the recommendations in full.

1.8 The first two recommendations have been implemented in England and Wales with payments being made to staff, and the recommendation will be implemented fully in Northern Ireland, backdated to April 2024, this spring.

1.9 Although accepted, the recommendation to provide the NHS Staff Council with a funded mandate for structural reform has not been implemented.

Remits for 2025/26

1.10 The Secretary of State for Health and Social Care, the Cabinet Secretary for Health and Social Care in Wales and the Minister for Health in Northern Ireland wrote to us on 30 September, 30 October and 25 November 2024, respectively, requesting a pay recommendation for 2025/26.

1.11 In their written evidence received on 10 December 2024, the DHSC further asked for a view on the relative priorities of investing in headline pay and investing in the pay structure mandate this year following our recommendation for 2024/25. Subsequently, the Department of Health Northern Ireland requested the same view.

Our overall approach to the pay review process

1.12 When considering the evidence, we are required to have regard for the following factors, as set out in the NHSPRB terms of reference:

- the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved;
- the need to recruit, retain and motivate suitably able and qualified staff;
- regional/local variations in labour markets and their effects on the recruitment and retention of staff;
- the funds available to the Health Departments as set out in the Government's Departmental Expenditure Limits;
- the Government's inflation target;
- the principle of equal pay for work of equal value in the NHS; and
- the Review Body may also be asked to consider other specific issues.

Evidence submissions and visits

1.13 Between November 2024 and February 2025, we received written and oral evidence, and the majority of the parties published their evidence on their websites. Those who submitted evidence were as follows:

Government Departments

- Department of Health and Social Care
- Department of Health, Northern Ireland
- HM Treasury
- Welsh Government

NHS Organisations

- NHS England

Trade unions representing NHS staff

- British Dietetic Association
- Chartered Society of Physiotherapy
- GMB
- Royal College of Midwives
- Royal College of Podiatry
- Society of Radiographers

Employer bodies

- NHS Employers
- NHS Providers

1.14 The NHS Staff Side chose not to submit evidence to the NHSPRB this year. Evidence was received from some but not all of its constituent trade unions. The NHSPRB process benefits considerably from the considered engagement of all parties. We highly value input from the employee and employer sides of the NHS Staff Council, and hope that both will choose to submit evidence next year.

Our visits

1.15 We conducted visits to NHS trusts in England, a health and social care trust in Northern Ireland, and a Welsh health board between October and December 2024. We also visited the University of Plymouth which trains people in healthcare disciplines. These visits helped us to understand the experience of staff and managers and the pressures they face. At the University, we met with students, teachers and managers. The visits were particularly useful in hearing first-hand views on pay arrangements and the way in which they relate to recruitment, retention and motivation. We are grateful to the management, staff representatives, and AfC staff who participated in these visits, and particularly those involved in their organisation. We visited the following organisations:

- Alder Hey Children's NHS Foundation Trust
- Belfast Health and Care Trust
- Croydon Health Services NHS Trust
- Milton Keynes University Hospital NHS Foundation Trust
- South London and Maudsley NHS Foundation Trust
- University Hospitals Plymouth NHS Foundation Trust
- University of Plymouth
- Welsh Ambulance Service

- Wirral Community Health and Care NHS Foundation Trust

1.16 The NHSPRB's role is to evaluate independently the AfC workforce, separate from other NHS workforce groups. However, we acknowledge that, in practice, AfC staff collaborate closely with medical and dental staff and senior management as a unified team. During our visits, we hear that recommendations from the DDRB and SSRB, along with related Government decisions, can affect the morale of staff under the AfC contract.

1.17 Our report provides recommendations on AfC pay in the NHS for 2025/26. We have made our independent recommendations in the context of our terms of reference and remit letters and have assessed the evidence, data, and information as they relate to the standing terms of reference. In Chapter 3, we discuss and provide commentary on the data and other evidence available to us.

1.18 Our report sets out the context of NHS developments relevant to our considerations of the AfC workforce (in Chapter 2), followed by our analysis (in Chapter 3) and our conclusion and recommendations (in Chapter 4). Appendices A-E set out the workforce data we considered, structural reform costings and remit letters received from governments.

CHAPTER 2 NHS Context

2.1 We set out in this chapter the developments in the NHS and the broader context in which it is currently operating, which relate to our consideration of the AfC workforce. The chapter covers published data and reports by external commentators. The developments in the NHS and the wider context feed into our analysis in Chapter 3 of this report.

2.2 The NHS remains under enormous pressure. In July 2024, the then new Health Secretary set out that the policy of the DHSC was that the NHS is 'broken'[1] and asked Lord Darzi to undertake a rapid investigation into the state of the NHS.

2.3 Reporting in September 2024, Lord Darzi said that the NHS was in 'serious trouble'[2] and the NHS has not been able to meet the most important promises made to the people since 2015.

2.4 Lord Darzi further added that the NHS budget is not being spent where it should be; too great a share is being spent in hospitals, too little in the community, and productivity is too low. He said the key reason for productivity being too low is that patients no longer flow through hospitals as they should, and a desperate shortage of capital prevents hospitals being productive. He further noted that it needs to be stressed that falling productivity does not reduce the workload for staff. Rather, 'it crushes their enjoyment of work'.

2.5 The 2024 CQC State of Care report also notes, as they did in 2023, that high demand for services and ongoing pressure in all parts of the system mean that many people, including children, are not getting the care they need when they need it[3].

2.6 To reform the NHS and improve its performance, the UK Government has set out new policies on the NHS which are characterised by three main shifts: analogue to digital, hospital to community, and treatment to prevention. These have been identified as guiding principles for a new NHS 10-Year Health Plan expected in Spring 2025, following which the Government is also expected to refresh the Long-Term Workforce Plan. How these policies will impact on the future skill mix and composition of the workforce is yet to be seen.

NHS Demand

2.7 Pressure and demand on the NHS have increased in recent years, which is reflected in NHS performance statistics. In England, Northern Ireland and Wales, the latest statistics show elective waiting lists are 63%[4], 54%[5] and 73%[6] higher, respectively, than they were prior to the COVID-19 pandemic. Whilst the COVID-19 pandemic had a significant and long-lasting impact on the NHS, there are a number of other factors impacting demand for care.

2.8 An aging population is thought to be one of the most significant drivers of demand. Life expectancy for both men and women in the UK has increased, a trend expected to continue;

[1] The NHS is broken: Health and Social Care Secretary statement - GOV.UK
[2] Summary letter from Lord Darzi to the Secretary of State for Health and Social Care - GOV.UK
[3] State of Care - Care Quality Commission
[4] Statistics » Consultant-led Referral to Treatment Waiting Times Data 2024-25
[5] Hospital waiting times statistics | Department of Health
[6] NHS hospital waiting times

however, healthy life expectancy has fallen[7,8]. This means that as the UK population grows and ages, there is and will continue to be rising demand for treatment, care and support.

2.9 Older people are also more likely to have multiple health conditions. In 2015, 54% of people aged over 65 had two or more health conditions. By 2035, researchers estimate that figure could rise to 68%. Living with multiple conditions has been shown to lead to greater complexity in care, a higher risk of hospital admissions and re-admissions, longer hospital stays and delayed discharge[7].

2.10 Analysis commissioned for Lord Darzi's report found that whilst NHS activity has increased, complexity has risen, with the proportion of NHS patients with disabilities notably increasing at more than nine per cent a year between 2017 and 2023; and that spending on specialised services has increased at a much faster rate than routine care[8].

2.11 Capacity constraints in social care also place an increasingly large burden on the NHS. The challenges in social care mean patients are staying in hospital for longer than their medical needs require them to be there as they cannot be safely discharged to social care services. This places increasing pressure on the capacity in hospitals[8].

2.12 Demand on emergency care has also increased. In England, in December 2024, there were more than 2.3 million A&E attendances[9]. This is 7.4% higher than December 2023. Calls to 999 were up 4.2% over the same period[10]. In Northern Ireland, in September 2024, A&E attendances were 1.1% higher than September 2023[11]. In Wales, in December 2024, A&E attendances were 4.6% higher than December 2023[12].

2.13 The increased demand on emergency care has partly been driven by a decrease in the accessibility of GP services[13]. Analysis has shown that people are turning to emergency care services when they are unable to access primary care[14].

2.14 Although, over the past five years, A&E attendances have increased at a slower rate than workforce growth and funding, patients are spending longer waiting for care in emergency departments. January 2025 saw a new high of 61,529 patients waiting over 12 hours in A&E in England before being admitted to a hospital bed, the most since current records began in 2010[15]. The reasons for this are complex; however, significant drivers are thought to be fewer hospitals beds caused by delayed discharge, increased demand on other clinical services, and sustained staffing pressures[16].

2.15 The combination of these factors, as well as a number of others, including the residual impact of the COVID-19 pandemic, means NHS staff are coming under increasing pressure across the service which in turn impacts on their morale, and engagement and leads to increased burnout[17].

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[7] Healthy ageing and care for older populations - POST
[8] Independent Investigation of the National Health Service in England
[9] Statistics » A&E Attendances and Emergency Admissions 2024-25
[10] NHS England » Monthly Operational Statistics – December 2024, NHS England » Monthly operational statistics – December 2023
[11] Emergency Care Waiting Time Statistics (July – September 2024) | Department of Health
[12] Emergency department
[13] Patients' overall experience of NHS and social care services | Nuffield Trust
[14] Are A&E waiting times bad because too many people are going there who don't need to? | NHS Confederation
[15] Urgent and emergency care pressures persist
[16] What's Going On With A&E Waiting Times? | The King's Fund
[17] 10 Actions The Government Can Take To Improve NHS Working Conditions | The King's Fund

NHS Workforce

2.16 In the year to September 2024, the AfC workforce grew in all three nations, but less strongly than in 2023. Between September 2023 and September 2024, workforce growth was strongest in England, as the number of FTE staff grew by 3.7%, following growth of 5.6% in the previous year. Over the year to September 2024, FTE staff numbers in Wales grew by 2.4% (down from 4.3% in 2023), while workforce growth in Northern Ireland was weaker, at 1.4% (down from 1.6% in 2023).

2.17 The latest data on vacancies also show signs of improvement. In England, in the third quarter of 2024/25 the nursing and midwifery vacancy rate was 6.4%, down from 7.5% in the previous quarter, down from 8.3% in the same quarter a year earlier, and the lowest rate for at least seven years. The vacancy rate for non-nursing and midwifery AfC staff groups was 7.9%, up from 7.8% in the previous quarter, and up from 7.7% in the same quarter a year earlier.

2.18 For Northern Ireland, the most recent data shows that at the end of December 2024 there was an overall vacancy rate (including medical and dental staff) of 6.8%, up from 6.4% in the previous quarter, but down from 7.0 % a year earlier.

2.19 For Wales, the most recent data shows that at the end of September 2024 there was an overall vacancy rate (including medical and dental staff) of 5.9%, up from 5.8% in the previous quarter, but down from 6.2% a year earlier. NHS workforce data is discussed in further detail in Chapter 3 and Appendix A.

Industrial relations

2.20 Whilst there has been no national industrial action over the past twelve months, industrial relations have been described as fragile. Many trade unions ran pay consultations following the 2024/25 recommendations, with most trade union members accepting the recommendations. However, in the consultations run by the Royal College of Nursing (RCN), 64%[18] of respondents working in the NHS in England and 72%[19] of respondents working in the NHS in Wales rejected the recommendation of a 5.5% pay award. In contrast, 73% of respondents working in health and social care in Northern Ireland accepted the recommendation[20].

2.21 As discussed in Chapter 1, the governments have not implemented one of the recommendations from our 37th report, where we recommended a funded mandate should be given to the NHS Staff Council for structural reform to the AfC pay scale. DHSC asked us in their written evidence for a view on the relative priorities of investing in headline pay and investing in the pay structure mandate this year. The Department of Health Northern Ireland made the same request. AfC trade unions have publicly stated their discontent at this ask. For example, the Chartered Society of Physiotherapy (CSP) have said it is 'simply implausible' to make much-needed reforms to Agenda for Change within a cost envelope also intended to deliver a pay rise for NHS staff[21].

NHS Productivity

2.22 In his report, Lord Darzi concluded productivity in the NHS was 'too low' and 'there is an urgent need to boost it'. This is a view supported by data from the Office for National

[18] RCN members reject NHS England pay award | News | Royal College of Nursing
[19] NHS pay consultation in Wales: RCN members vote reject | News | Royal College of Nursing
[20] Result of RCN Northern Ireland consultation on HSC pay offer | News | Royal College of Nursing
[21] Government risking below-inflation pay rise for NHS staff in England, CSP warns | The Chartered Society of Physiotherapy

Statistics (ONS), where analysis found healthcare productivity was estimated to be 2.4% lower in Q3 2024, compared with Q3 2023[22].

2.23 Despite ongoing concerns regarding productivity in the NHS, analysis by the Institute for Fiscal Studies has found from January to July 2024, there was a considerable increase in patients being treated in the acute sector, with elective admissions up by 10.3%. This increase in activity is greater than the increase in clinical staffing over the same period suggesting productivity improvements[23]. The Darzi Report identified flow through hospitals as the main reason for low productivity in the NHS. Resolving this situation would require increased capacity in primary and social care, as identified in the previous section.

2.24 In response to the productivity challenge, the Health Foundation have set-up a productivity commission which aims to provide evidence and solutions to boost NHS productivity over the next decade. This will be particularly important as the Chancellor has said she expects the NHS to deliver higher productivity in return for extra investment[24].

NHS Finance

2.25 The financial position across NHS organisations is extremely tight. Integrated Care Systems had recorded a deficit position of £1.3bn (nearly £700m more than planned) by the middle of 2024/25. Government changes to the fiscal rules prohibit capital-to-revenue swaps to cover revenue overspends[25,26].

2.26 The NHS operational planning guidance for 2025/26 sets out the reality of the financial situation. Reaching the improved financial position required means stretching productivity requirements: NHS organisations will need to reduce their cost base by at least 1% and achieve a 4% improvement in productivity, double the requirement in last year's guidance. The King's Fund say this means budgets are more stretched than ever before[27] and it is likely that local areas will be forced to make difficult decisions about deprioritising the services that will cause least harm.

2.27 Following the publication of the NHS operational planning guidance, NHS England wrote to Integrated Care Boards (ICBs) and NHS trusts on 6 March forecasting a very significant financial deficit for 2025/26 (£6.6 billion when deficit support is stripped out) and limited confidence of delivery of operational expectations[28].

2.28 The Government subsequently announced NHSE will be brought back into the DHSC which it has been reported could release around £500 million[29]. It has also been reported ICBs have been asked to cut costs by 50%[30].

Conclusion

2.29 Record demand across the NHS has led to significant pressure on the NHS and its staff. Looking forward into 2025/26, NHS budgets will be significantly stretched, and some local organisations may face difficult decisions on deprioritising services. Productivity has fallen

[22] Public service productivity, quarterly, UK - Office for National Statistics
[23] NHS hospital productivity: some positive news | Institute for Fiscal Studies
[24] How improvement can help NHS productivity - The Health Foundation
[25] Autumn Budget 2024 - GOV.UK
[26] New planning guidance signals the major task ahead for the NHS - The Health Foundation
[27] NHS Priorities For 2025/26: Our Insights | The King's Fund
[28] NHS England » Update on 2025/26 planning round
[29] Abolishing NHS England: what you need to know | NHS Confederation
[30] NHS Confederation responds to reports of ICB and provider cost cutting orders | NHS Confederation

in recent years and requires medium term solutions such as capital investment and improved patient flows throughout the health system. The NHS is also facing the challenge of an aging population with increasingly complex medical and social needs. Within this context, we have received evidence from the parties listed in Chapter 1. Chapter 3 presents our independent analysis and Chapter 4 our conclusions and recommendations, based on the evidence received, considering the NHS context described above.

CHAPTER 3 Analysis

3.1 Our analysis in this chapter gives regard to the written and oral evidence we have received. Copies of written evidence are available on request from the NHSPRB secretariat. The evidence relates to our terms of reference and matters remitted to us this year. Our analysis covers:

- the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved;
- workforce, recruitment, and retention;
- morale and motivation;
- national, regional and local variations in the labour market;
- affordability;
- economic outlook and the Government's inflation target;
- equal pay for work of equal value;
- earnings;
- total reward; and
- the AfC pay structure.

Overall NHS strategy with patients at its heart

3.2 The strategy for the NHS in England is currently being revised to reflect the priorities of the new government. As noted in Chapter 2, in July 2024, the new Health Secretary set out that the NHS was 'broken' and subsequently asked Lord Darzi to carry out a review on the state of the NHS. Following this, in January 2025, the Health Secretary set out a new mandate for reform of the NHS reflecting patients' priorities: cutting waiting times, improving access to primary care and improving urgent and emergency care[31].

3.3 DHSC are also expected to publish a 10 Year Health Plan in the spring, which aims to deliver the three big shifts they say the NHS needs to be fit for the future: from hospital to community, from analogue to digital and from treatment to prevention[32].

3.4 On 10 December 2024, the Department of Health Northern Ireland published a three-year plan for health and social care in Northern Ireland. They say the plan sets out a series of initiatives to improve healthy living, primary care, hospital care, social care, productivity and patient safety, while tackling health inequalities[33].

3.5 On 1 February 2023, the Welsh Government published their National Workforce Implementation plan in response to the additional demands on the NHS workforce since the COVID-19 pandemic.

Demand, performance and public satisfaction

3.6 The NHS has struggled to cope with demand since the onset of the COVID-19 pandemic. Whilst we are now seeing elective waiting lists fall from the peak of 7.77 million[34] in September 2023, the overall backlog in England still stands at 7.4 million. This is compared

[31] Road to recovery: the government's 2025 mandate to NHS England - GOV.UK
[32] Project: The three shifts | Change NHS
[33] Nesbitt launches major three-year plan | Department of Health
[34] NHS key statistics: England - House of Commons Library

to 4.60 million in January 2020. As discussed in Chapter 2, waiting lists in Northern Ireland and Wales also remain significantly higher than prior to the COVID-19 pandemic.

3.7 In England, the number of A&E attendances has now returned to pre-pandemic levels but performance against the four-hour target has worsened. In the three months to February 2025 there were 6.6 million A&E attendances, 1.1% more than in the three months to February 2024, and 6.1% more than in the three months to February 2020. Waiting time performance worsened for all types of A&E attendances: 57.1% of patients attending type 1 departments were admitted, transferred, or discharged within four hours, and for patients attending type 2 and 3 departments the proportion was 96.8%[35].

3.8 Attendance at A&E in Wales has remained relatively stable. However, performance against both four-hour and twelve-hour targets has worsened[36]. In Northern Ireland, attendances increased 7.6% in December 2024 compared to December 2023, and only 31.9% of patients were seen within the four-hour target, the worst on record[37].

3.9 As a consequence of longer waiting times and people feeling unable to get the right care when they need it, public satisfaction with the NHS has fallen. In the most recent British Social Attitudes Survey, conducted in 2024 and published in April 2025, just one in five British adults (21%) were 'very' or 'quite' satisfied with the way in which the NHS runs. This is the lowest level of satisfaction recorded since the survey began in 1983, it applies within all demographic and socio-economic groups and shows a steep decline of 39 percentage points since 2019[38].

Lord Darzi's Report

3.10 In September 2024, Lord Darzi published his review into the NHS in England. The report describes an NHS in 'serious trouble'. Public trust and confidence have been damaged by the inability of the NHS to meet the promises of the NHS constitution and consequently, public satisfaction is at its lowest level ever recorded.

3.11 Lord Darzi further notes that A&E is in an 'awful state' and waiting times for hospital procedures have 'ballooned'. In 2010, 94 percent of people attending type 1 or type 2 A&E were seen within four hours; by May 2024 that figure had dropped to just over 60 percent. In June 2024, compared to March 2010, fifteen times as many people were waiting over a year for treatment.

3.12 The report also notes that the NHS budget is not being spent where it should be; too great a share is being spent in hospitals, too little in the community and productivity in hospitals is too low. The report goes on to say that the 'dire state' of social care means 13 per cent of NHS beds are occupied by people waiting for social care support or care in more appropriate settings. The result is there are seven per cent fewer daily outpatient appointments for each consultant, 12 per cent less surgical activity for each surgeon, and 18 per cent less activity for each clinician working in emergency medicine.

3.13 Lord Darzi concludes there are four heavily inter-related factors that have contributed to the current dire state of the NHS: austerity and capital starvation; the impact of the COVID-19

[35] Statistics » A&E Attendances and Emergency Admissions
[36] Emergency department
[37] 'Worst' A&E data on record must galvanise NI government to act | RCEM
[38] Public Satisfaction With The NHS And Social Care In 2024 | BSA | The King's Fund

pandemic; lack of patient voice and staff engagement; and management structures and systems.

Mandate to reform the NHS

3.14 Following Lord Darzi's investigation, the UK Government say they are committed to ensuring that every individual receives timely, high-quality care. The mandate for 2025 (which sets out the operational guidance for the year ahead for the NHS in England) lays the foundation for longer-term reform as part of the Government's health mission focused on the three strategic shifts noted above.

3.15 The mandate sets out five objectives for the NHS in England:

- Reform to cut waiting times: the government say they will prioritise reducing waiting times for elective care and improving the experience of care by empowering patients with greater choice and autonomy over their treatment
- Reform to improve primary care access: Improving primary care access is essential to support a move to a neighbourhood health service, with more care delivered in local communities to identify and manage problems earlier
- Reform to improve urgent and emergency care: Ambulance response times and waiting times in A&E are unacceptable. The government say it will take time and transformation for these services to be fit for the future, but a start must be made
- Reform to the operating model: The government say that over time ICBs and trusts will have greater freedom and flexibility, where patients have more choice and control
- Reform to drive efficiency and productivity: The NHS will need to revisit how they can further improve efficiency and productivity.

3.16 This mandate has applied since January 2025 and more details and further plans about how the NHS will be reformed will follow in the 10 Year Health Plan expected to be published in the spring.

3.17 The previous government published a widely welcomed Long Term Workforce Plan in June 2023 with ambitious targets for very substantial workforce growth by 2036 to support the changing and growing demands placed on the NHS. In evidence, we heard that the three shifts that will underpin the 10 Year Health Plan may point to a different workforce shape in future. We were told there will be an important update to the Long Term Workforce Plan following the publication of the 10 Year Health Plan which will provide more detail on the Government's strategy for the NHS workforce.

Northern Ireland Executive: Three year plan

3.18 In December 2024, the Northern Ireland Executive published their three-year plan for health and social care. The three-year plan sets out a range of actions to address the challenges facing the health and social care system. These actions are organised across three domains: stabilisation, reform and delivery.

3.19 The priority for the stabilisation domain is to stabilise the existing system and critical services within that system, particularly those that face challenges in terms of demand, workforce and funding.

3.20 The priority for the reform domain is long-term improvement and increasing capacity to better meet the needs of the population.

3.21 The priority for the delivery domain is to ensure the overall system operates as effectively, and efficiently as it can.

Welsh Government: National Workforce Implementation Plan

3.22 On 1 February 2023, the Welsh Government published their National Workforce Implementation plan in response to the additional demands on the NHS workforce since the COVID-19 pandemic. The plan includes immediate actions to address the current pressures, such as recruiting more nurses from overseas and creating an 'All Wales Collaborative Bank' to enable the NHS to address short term staffing issues.

Our assessment of overall NHS Strategy

3.23 Five years on from the onset of the COVID-19 pandemic, there are some early signs of stabilisation in the NHS. However, Lord Darzi's report described a health service struggling in the face of rising demand and immense pressure. The COVID-19 pandemic has left a lasting impact on patient care and workforce morale, creating significant challenges in delivering timely and high-quality care.

3.24 Investment in pay is important for retaining staff but, in the past, it has often come at the cost of other priorities. Balancing these competing needs has always been a challenge. With the revised fiscal rules, one option pursued in the past to fund pay awards - to switch resources away from capital - is no longer available.

3.25 Looking forward, new plans and strategies are in progress in England with a 10 Year Health Plan, and an associated workforce plan, expected later this year. Until these are completed the Long Term Workforce Plan published in June 2023 is in abeyance.

3.26 The Long Term Workforce Plan was widely welcomed and recognised as a significant step forward in addressing workforce challenges. Any refreshed workforce plan should build on the insights gained through the development of the Long Term Workforce Plan. However, we acknowledge that the wider strategy for the NHS has evolved since this time, which will have implications for the size and shape of the future workforce.

3.27 The Department of Health Northern Ireland published a new strategic three-year plan for health and social care in Northern Ireland. We are conscious the progress of implementation will be influenced by future budget settlements.

Workforce, recruitment and retention

Workforces

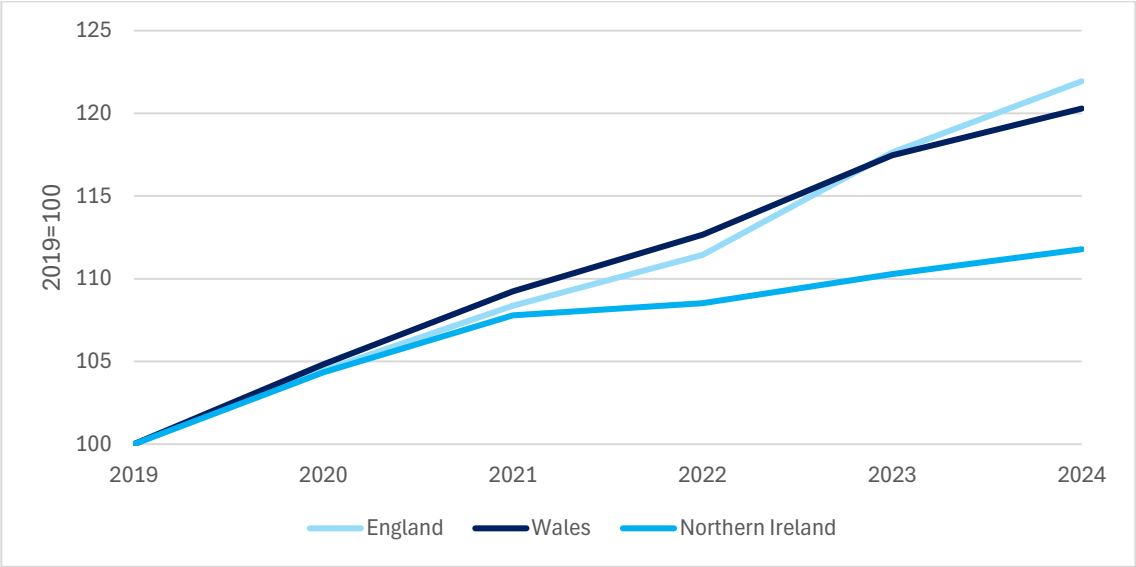
3.28 In this section we consider the data and evidence relating to the recruitment, retention and motivation of staff. Appendix A sets out the full workforce data analysis that underpins our report and recommendations, including workforce data by protected characteristics.

AfC workforce across England, Northern Ireland and Wales

3.29 The AfC workforce has grown very rapidly over the past five years. The workforce continues to grow, and growth remains strong by the standards of the past although the pace of growth is slowing.

3.30 Between September 2019 (prior to COVID-19) and September 2024, the AfC workforce has grown in: England by 22% (an annualised rate of 4.0%); Wales by 20% (3.8% annualised); and Northern Ireland by 12% (2.3% annualised).

Figure 3.1: Growth in the AfC full time equivalent workforce, England, Wales and Northern Ireland, 2019 to 2024



Source: NHS England, Stats Wales, Department of Health, Northern Ireland

3.31 The latest data, for the third quarter of 2024/25, shows a vacancy rate for nursing and midwifery of 6.4% in England, down from 8.3% a year earlier, and the lowest rate recorded since at least the first quarter of 2017/18, when data started to be collected using the current methodology. The vacancy rate for other AfC staff groups, is, at 7.9%, greater than that for nursing and midwifery for the first time.

Recruitment

3.32 Recruitment has decelerated over the past twelve months. Following the achievement of the '50,000 nurses' target in England, international recruitment has slowed, and extremely tight financial circumstances mean some trusts have implemented effective recruitment freezes. NHS Providers told us most trusts have introduced stringent pay controls and vacancy management measures. They said recruitment is only going ahead for the most critical roles.

3.33 The Nursing and Midwifery Council (NMC) register shows that in September 2024, there were 841,367 nurses and midwives registered to work in the UK, an increase of 4.1% from a year earlier.

3.34 The number of joiners in the year to September 2024 was 2% lower than in the previous year at 57,520. 30,093 (52%) of those were nurses and midwives trained in the UK; 26,459 (46%) were trained outside the EU/EEA; and 668 (2%) were trained in the EU/EEA. The NMC note they have seen a fall in internationally educated joiners and an even higher proportional rise in leavers.

3.35 The number of applicants for midwifery courses in 2024 was 8% below applicant numbers in 2019. However, for nursing courses numbers of applicants were 6% higher and for other health degrees 49% higher than in 2019.

3.36 The trend in course acceptances has been similar. In 2024, the number of acceptances for midwifery courses was 11% lower than in 2019, while acceptances for nursing courses increased by 2%.

3.37 Apprenticeships provide an alternative and accessible route to a career in the NHS and can help widen access to clinical training to those from a broader range of backgrounds. The NHS in England set out in the Long Term Workforce Plan that they aim to have 22% of all clinical staff training through apprenticeships by 2031/32, up from the current seven percent[39]. Data has shown that staff who have completed apprenticeships have higher retention rates compared to the rest of the workforce. NHSE told us on-programme attrition rates are as low as four percent.

3.38 Despite the planned growth, NHS Employers told us that several obstacles persist in expanding apprenticeship opportunities. They told us that tight financial constraints and related recruitment freezes have led many trusts to pause apprenticeship onboarding. Additionally, employers have anecdotally reported that the ongoing inflexibility of current apprenticeship levy funding is a significant barrier to expanding and diversifying their apprenticeship programs.

Our assessment of recruitment

3.39 In recent years, recruitment has been at its strongest rate on record, although the pace of workforce expansion is now slowing. This is partly due to extremely tight financial circumstances which mean NHS trusts and organisations are looking at how they can control workforce costs. Neither in the data we have reviewed nor in the submissions of parties is there any evidence of sustained recruitment difficulties concentrated in specific roles.

3.40 We anticipate recruitment will slow further in the coming year. Longer term, it will be important to ensure that there is a stable pipeline for recruitment into the NHS, as well as an ongoing focus on retention. We expect the refreshed workforce plan, expected later this year, along with the 10 Year Health Plan, will outline the NHS's long-term recruitment strategy, addressing how future workforce supply can meet growing healthcare needs.

Retention

3.41 Overall, vacancy rates in the NHS have fallen. In England, in the third quarter of 2024/25 the nursing and midwifery vacancy rate was 6.4%, down from 7.8% in the previous quarter, down from 8.3% in the same quarter a year earlier. The vacancy rate for non-nursing and midwifery AfC staff groups was 7.9%, up from 7.8% in the previous quarter, and up from 7.7% in the same quarter a year earlier.

3.42 For Northern Ireland, the most recent data shows that at the end of December 2024 there was an overall vacancy rate (including medical and dental staff) of 6.8%, up from 6.4% in the previous quarter, but down from 7.0 % a year earlier.

3.43 For Wales, the most recent data shows that at the end of September 2024 there was an overall vacancy rate (including medical and dental staff) of 5.9%, up from 5.8% in the previous quarter, but down from 6.2% a year earlier.

3.44 Turnover has also reduced over the past 12 months. In England, outflow rates have fallen back to 9.7%, in the year to December 2024, the lowest rate since at least 2010 (except for a short period during the COVID-19 pandemic). Voluntary resignation and retirement are the most common reasons for leaving.

3.45 For many of those who were identified as voluntary resignations, some more specific information on the reason for leaving is available. In 2023/24, far more people said they

[39] Apprenticeships in the NHS | NHS Employers

were leaving for a better work life balance (21,900) than for a better reward package (4,900). Some of those who left the direct employment of the NHS may still be providing services for the NHS, for example, through working in primary care organisations. Others may be working in other areas of healthcare such as the private sector or social care. As the NHS is the primary source of trained healthcare staff for these other sectors, there is a symbiotic relationship where they are both dependent on NHS resourcing strategies, and in competition with the NHS for trained staff.

3.46 In Northern Ireland, the leaving rate for all HSC staff in 2023/24 was 7.7%, down from 8.4% in 2022/23 and 8.1% in 2021/22.

Our assessment of retention

3.47 It is encouraging that over the past 12 months the NHS has seen reduced vacancy and turnover rates. NHSE say that NHS staff retention schemes have helped cut the number of workers leaving the health service to one of its lowest levels in over a decade[40]. Despite this, we heard on visits that staff do not feel the pressure placed on them has eased, with some staff members saying pressure and demand is higher than it had ever been.

Temporary staffing

3.48 Strong growth in the permanent workforce in recent years, alongside policies to reduce agency spending, has seen temporary staffing costs decrease. In England, non-medical agency costs made up 3.1% of the total NHS pay bill in 2023/24, down from 4% in 2022/23, representing a cost reduction of approximately £438 million (19%).

3.49 In Northern Ireland, agency costs for nursing and midwifery staff and other non-medical staff had been increasing sharply since 2014/15, from £38 million to £279 million in 2022/23; however they fell back to £241 million in 2023/24. The increase in expenditure on nursing and midwifery staff over that period was particularly large, from £12 million in 2014/15 to £186 million in 2022/23, before falling back to £154 million in 2023/24. In addition, the Department of Health said that spending on staff through banks in 2022/23 was £136 million, of which £91 million was on nursing and midwifery staff.

3.50 In Wales, agency expenditure decreased in 2023/24, compared with 2022/23. Overall agency expenditure on AfC posts was £188 million, a reduction of £54 million (22%) from 2022/23.

Our assessment of temporary staffing

3.51 Reduced temporary staffing costs free up resource to allocate to recruitment of substantive staff and patient care.

3.52 The reduction in agency usage is not necessarily felt by substantive staff. On visits to NHS organisations, staff told us trusts are still relying on agency staff to fill shifts. It is also viewed as the more lucrative option by staff when compared to working in the substantive workforce.

[40] NHS England » Staff leaving the NHS among lowest in over a decade

Morale and motivation

NHS Staff Survey (England)

3.53 The NHS Staff Survey in England is the best indicator of morale and motivation across the NHS. The response rate in 2024 was 50% with 775,000 responses, up from 48% in 2023. Although there was a one percentage point increase in all staff across the NHS saying they were satisfied with their pay, there was a reduction in the percentage of registered nurses and midwives, nursing and healthcare assistants, and the wider healthcare team saying they were satisfied with their pay[41].

3.54 Results relating to job satisfaction and workload were mixed compared with 2023, with a fall in some key indicators. Results remained generally better than in 2022 and 2021.

3.55 In 2024, compared with 2023, staff were less likely to say that:

- they looked forward to going to work;
- they were enthusiastic about their job;
- time passed quickly when they were working;
- they felt valued by their line manager and organisation; and were less likely to recommend their organisation as a place to work.

3.56 However, there were some more positive results, with:

- more staff saying they were better able to meet the demands on their time;
- more staff saying they were able to achieve a good balance between work and home life;
- fewer staff said they were considering leaving the NHS;
- fewer staff said that they had experienced harassment, bullying or abuse from patients, relatives or the public.

NHS Staff Survey (Wales)

3.57 In 2024, NHS Wales conducted a staff survey. The response rate was 22%, up from 21% in 2023. Detailed results have yet to be published, but they say the average staff engagement score fell from 75 in 2020 to 73 in 2023 and further to 72 in 2024.

Staff sickness

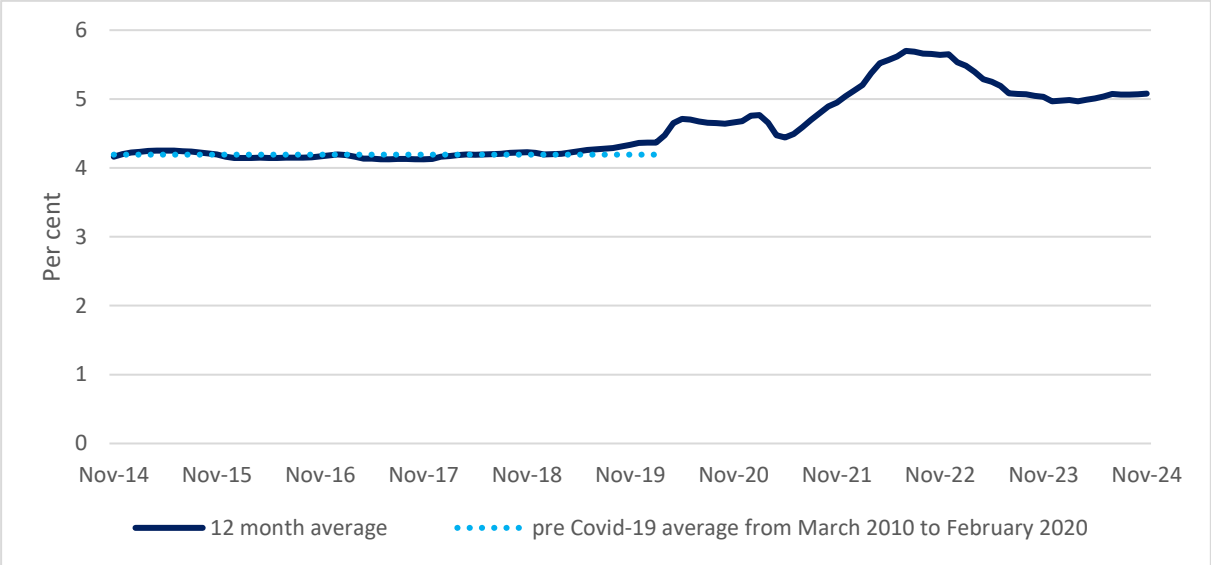
3.58 Sickness absence reduces the number of suitably qualified staff available to work and is an indicator of staff engagement and the wellbeing of the workforce. Data for both England and Wales show that sickness absence rates have lowered over the last year but still remain higher than the rates seen prior to the COVID-19 pandemic. Data for England show increases in the number of days lost to sickness absence for infectious diseases and chest and respiratory problems, which might be directly related to COVID-19, but by far the

[41] Working together to improve NHS staff experiences | NHS Staff Survey

greatest increase was in days lost to anxiety, stress, depression and other psychiatric illnesses.

3.59 In England, sickness rates between 2010 and 2020 averaged 4.2%. This peaked to 5.7% in the second half of 2022. The latest data, for the 12 months to November 2024 shows sickness rates levelling off at 5.1%. Lord Darzi said in his report that current sickness rates in the NHS mean, in hospitals, there are 20 days lost per nurse per year to sickness absence. This rises to 21.5 days per midwife per year, and 24.5 days per healthcare assistant per year[42]. Sickness absence rates for England are displayed below in Figure 3.2.

Figure 3.2: Sickness absence rates in England, all staff, November 2014 to November 2024



Source: NHS England

3.60 The most common reason for sickness absence was 'anxiety, stress, depression and other psychiatric problems', accounting for 27% of all absence. The next most common reasons for sickness were 'cold, cough, flu' (11%), 'other musculoskeletal problems' (9%), 'gastrointestinal problems' (8%).

3.61 In Wales, between 2010 and 2020, monthly sickness absence rates fluctuated between 5% and 6%, with a 12-month average around 5.3%. Sickness absence rates have been more volatile since the onset of the COVID-19 pandemic and in the 12 months to 30 September 2024, the average sickness absence rate was 6.2%.

Industrial relations

3.62 We are acutely aware of the fragility of industrial relations. Whilst HMT told us they were resetting relations with the public sector, it is not a sentiment that is fully shared by all AfC trade unions. In our 2024/25 report, we recommended the UK Government provided the NHS Staff Council with a mandate for structural reform of the AfC pay scale. This recommendation was subsequently accepted but was not implemented within the 2024/25 financial year. Instead, as part of their written evidence in December 2024, the UK Government asked us to give a view on the relative priorities of investing in headline pay and investing in the pay structure mandate this year, within an affordable overall pay settlement for DHSC. This request has been met with considerable disappointment by

[42] Independent Investigation of the National Health Service in England

representatives of staff and employers. They are concerned about the adverse effect it has had and may continue to have on industrial relations. We discuss this request further at 3.158 to 3.175.

3.63 Whilst there has been no industrial action at a national level in the past twelve months, there has been industrial action at a local level which has mostly concerned a campaign to regrade Band 2 Healthcare Support Workers to Band 3. This campaign has achieved significant success, with Band 3 Healthcare Support Worker posts increasing by 75% over the past five years.

Our assessment of motivation

3.64 The NHS Staff Survey in England is the most reliable indicator of morale and motivation across the NHS. Although the results remained generally better than in 2021 and 2022, the 2024 results are mixed, compared with 2023, with some declines in motivation scores among some AfC staff groups. For instance, enthusiasm levels among nursing, midwifery, and ambulance staff have decreased by six and nine percentage points, respectively, since 2020. Reduced motivation can lead to disengagement, which may negatively impact patient care[43].

3.65 The survey offers valuable insights into the experiences of NHS staff. Although NHS Wales has conducted similar surveys in recent years, the low response rate and lack of detailed published data limits the insights gained. Additionally, the absence of a Staff Survey in Northern Ireland means that, apart from our visits to trusts in Northern Ireland, we have no insight into the experience of staff in Northern Ireland.

3.66 We heard from employer organisations that national messaging regarding the NHS being 'broken' has impacted on the morale and motivation of staff. Furthermore, whilst the 2024/25 pay award was broadly viewed positively, many were disheartened by the award when compared with the additional funding the UK Government invested into resident doctors pay.

3.67 Sickness absence rates are an indicator of staff engagement. Sickness absence rates are on average higher across the NHS than they were prior to the COVID-19 pandemic. Lord Darzi described sickness absence rates across the NHS as 'distressingly high'.

3.68 We recognise the industrial relations environment remains fragile. Fragile industrial relations can in turn further impact morale and motivation. Demotivated staff are less likely to provide high-quality care which can affect patient outcomes and satisfaction[44].

National, regional and local variations in the labour market across the NHS

National variations

3.69 AfC pay is higher in Scotland than in England, Northern Ireland and Wales. The percentage difference varies across the bands.

3.70 In 2023, the UK and Welsh Governments negotiated separate deals with their respective social partners. One consequence of those separate deals is that consolidated pay in Wales is 1.5% higher than in England and Northern Ireland. Further to this, the Welsh Government

[43] The impact of medical staff motivation on the quality of practice in healthcare: a systematic review | International Journal Of Community Medicine And Public Health

[44] Reduced discretionary effort by staff is affecting NHS productivity, report finds | The BMJ

currently pay Bands 1-3 the same rate to comply with the Living Wage Foundation Real Living Wage. The Welsh Government told us higher pay in Wales compared to England has no impact on recruitment in Wales.

3.71 In evidence, some parties told us that higher rates of pay in Scotland were causing both staff and students to move to Scotland from other parts of the UK. We also heard from that staff had moved into roles in the Republic of Ireland from Northern Ireland due to higher levels of pay in the Republic of Ireland. However, in neither case has evidence been presented about the scale of any such flows.

3.72 The Department of Health Northern Ireland have commissioned the Government Actuary Department to look at the comparative employment packages between Northern Ireland and the Republic of Ireland, albeit they were clear their policy was to maintain pay parity with England.

Regional and local variation and HCAS

3.73 The High-Cost Area Supplement (HCAS) allowance, also referred to as London Weighting, is a payment made to employees who work in London and the surrounding areas. The allowance is divided into three levels, Inner, Outer and Fringe (set out in Table 3.1).

Table 3.1: HCAS rates

Area	Rate
Inner London	20% of basic salary, subject to a minimum payment of £5,414 and a maximum payment of £8,172
Outer London	15% of basic salary, subject to a minimum payment of £4,551 and a maximum payment of £5,735
Fringe	5% of basic salary, subject to a minimum payment of £1,258 and a maximum payment of £2,122

Source: NHS Employers

3.74 Although there were no specific proposals on changes to HCAS from parties this year, over the past few years we have heard concerns from parties about HCAS and its need to be reformed. Parties have called for HCAS to be applied in other areas of the UK where the cost of living is perceived to be elevated and for the total amount paid to staff to be reviewed.

3.75 We also heard on visits to London-based NHS organisations that HCAS boundaries are impacting where staff choose to work.

3.76 However, the solutions are not clear and DHSC told us that, at the time they gave evidence, they do not have conclusive evidence that there are differences in recruitment and retention indicators that are related to HCAS and could be alleviated if the system were changed.

Our assessment of national, regional and local variations in the labour market across the NHS

3.77 We have not received evidence concerning national, regional or local variations in labour markets to affect our recommendations this year or that shows different rates of pay in place across the UK are driving staff to change where they live and work. This supports wider evidence from parties that issues beyond pay such as wider working conditions and the broader state of the NHS have important influence in staff decisions on the attractiveness of roles.

3.78 Whilst there have been calls for reform to HCAS from parties over the past few years, no evidence was offered on the current HCAS structure. In future years, if parties advocate a full review of HCAS, we would require evidence as listed at Appendix B in our 35th report.

Affordability

3.79 HMT told us borrowing and debt remain high by historic standards. They said public sector net borrowing was forecast to increase to £127.5 billion in 2024/25. This is £40.3 billion higher than the OBR forecast in March 2024, largely reflecting higher debt interest spending and in-year pressures, including as a result of public sector pay awards.

3.80 At the Autumn Budget, HMT introduced new fiscal rules aimed at ensuring the long-term sustainability of public finances. These rules prohibit capital-to-revenue swaps to finance pay awards. HMT further added the spending envelope for the parliament and departmental budgets for 2025/26 have now been fixed, and the government is committed to living within them.

3.81 In light of this context, HMT said departments will not be given additional funding for pay awards in 2025/26, should Pay Review Body recommendations exceed stated affordability levels.

3.82 In their written evidence, DHSC told us there was 2.8% in budget for a pay award in 2025/26. They further told us the fiscal and economic environment has pushed the NHS into an extremely challenging financial position, despite significant additional funding of £25.7bn being agreed for the NHS in the 2024 autumn statement for 2025/26 and 2026/27[45].

3.83 DHSC said that the 2024/25 award was above the funded envelope and so they took a range of difficult decisions, including cancelling Social Care charging reform and reviewing the New Hospitals Programme, to manage the pressures.

3.84 They also note in their evidence that accepting recommendations above what is budgeted for in 2025/26 would mean 'stark trade-offs' against activity and wider budgets or consideration to whether productivity improvements can unlock further funding. This is against a backdrop of already stretching productivity assumptions discussed in Chapter 2.

3.85 At oral evidence, the Department of Health Northern Ireland told us their budget planning position builds in a 2.8% pay award. Anything above this will be challenging to fund. Whilst it is difficult to say what the trade-offs would be, they said that in making efficiency savings in 2024/25, trusts were considering high impact and 'potentially catastrophic' trade-offs which the Minister deemed would be unacceptable for pay award funding.

3.86 The Welsh Government did not confirm their budget allocation for pay, although in its written evidence, supplied before its budget had been finalised, the Welsh Government appeared to indicate that the resource budget in 2025/26 would be 3% higher than in 2024/25. At oral evidence, they told us funding for a pay award was held separately from day-to-day budgets and funding will be allocated from health budgets once the pay award for 25/26 is confirmed by the Cabinet Secretary.

3.87 NHS Employers told us the fiscal context is very challenging with limited financial resources. 2025/26 is presenting the toughest financial outlook in years and the cost improvement programme is bigger than it has ever been. There is no headroom for provider organisations

[45] New funding to fix the NHS: here's how it will be spent - GOV.UK

to add additional funding on top of agreed local budgets for 2025/26. They also told us productivity growth beyond already ambitious plans is 'implausible'.

Our assessment of affordability

3.88 As discussed above, it is evident that the fiscal environment is particularly demanding. HMT has explicitly stated that no additional funding will be provided for pay awards, and the new fiscal rules prohibit capital-to-revenue swaps to finance awards, as has been used to support pay awards above affordability in previous years.

3.89 The settlement for DHSC and, where relevant, for other Whitehall departments, affects the resources available for health and social care in Northern Ireland and Wales through the operation of the Barnett formula.

3.90 We note, in particular, the highly constrained resource environment in which the Department of Health Northern Ireland is operating and the difficult resource allocation decisions it faces.

3.91 The financial situation of NHS organisations is also strained. NHS Providers and NHS Employers told us if any element of pay award was unfunded, they would have to reduce day-to-day spending on other items which will ultimately adversely affect patient care and outcomes.

3.92 Since the time of evidence, the fiscal challenges have only heightened. In their spring forecasts, the OBR downgraded GDP growth predictions for 2025 from 2.0% to 1.0%. On 6 March 2025, NHS England wrote to NHS organisations noting the NHS in England is facing a very significant financial deficit of £6.6 billion. This compounds all of the affordability challenges discussed above.

3.93 It is clear from the evidence NHSPRB received this year that the financial position of the NHS across England, Wales and Northern Ireland is tighter than it has been in many years, and that there will be implications for service delivery and patients if pay awards are in excess of what has been budgeted for.

The Government's inflation target and the economy

Economic growth

3.94 UK gross domestic product (GDP) remains relatively flat. GDP increased 0.1% in Q4 2024 and 1.1% across the whole of 2024. In February 2025, the Bank of England revised down its 2025 GDP forecast to 0.75%, from 1.5% in its previous forecast. The OBR subsequently revised down their 2025 GDP growth forecast to 1.0% in March 2025, from their previous forecast of 2.0%. These revisions highlight growing economic challenge, including weak productivity, which are expected to pressure public finances further.

Consumer prices

3.95 Inflation, as measured CPI was at 2.8% in February 2025. CPI including owner occupiers' housing costs (CPIH) inflation was at 3.7%, and the Retail Price Index (RPI) rate was at 3.4%[46].

3.96 As of February 2025, the Bank of England and the OBR expect CPI to rise to around 3.7% in the third quarter of 2025, and average 3.2% across 2025.

Earnings growth

3.97 Average weekly earnings growth increased 5.8% in the three months to January 2025, according to the latest figures from the ONS, while regular pay (excluding bonuses) increased by 5.9%.

Pay settlements

3.98 For the three months to February 2025, median pay settlements were reported to be 3.0%, 3.2% and 3.4% according to Brightmine, Incomes Data Research (IDR) and Labour Research Department (LRD), respectively. The Bank of England Agents' summary which describes business conditions reported in Q1 2025 that average pay rises for 2025 are expected to be 3.5% to 4%. This is broadly consistent with the results of the Agents' annual pay survey at the start of the year (3.7%)[47]. The OBR expect pay settlements will average between 3.0% and 4.0% throughout 2025.

The labour market

3.99 Pay as you earn real time information data indicates that the number of employees on payrolls in February 2025 was 30.4 million; a small rise of 0.2% or 67,000 employees compared to February 2024.

3.100 The Labour Force Survey (LFS) shows that the overall level of employment was 33.9 million in the three months to January 2025, up 608,000 over the year and 740,000 higher than the peak prior to the COVID-19 pandemic in the three months to February 2020. The number of employees is estimated to have increased by 1.4 million since February 2020, while self-employment is estimated to have fallen by 640,000[48].

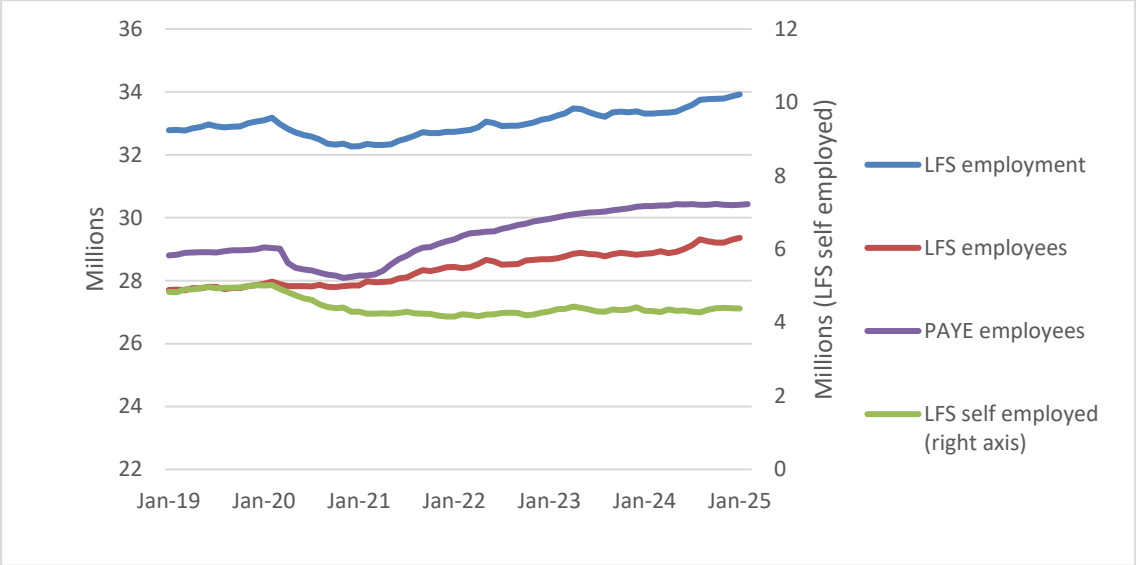
[46] The target set by the Government for the Monetary Policy Committee is to maintain inflation (measured by the Consumer Prices Index, CPI) at 2%. Unlike the Retail Prices Index (RPI), the CPI excludes mortgage interest payments and some other housing components. The two indices also have differences in the coverage of goods and services and are calculated using a different formula. RPI is no longer an official national statistic.

CPIH (H for housing) is based on the CPI measure, plus owner occupiers' housing costs. These are the costs associated with owning, maintaining and living in one's own home and have a weight of 16.5% in the CPIH index. It uses 'rental equivalence', the rent paid for an equivalent house, as a proxy for the cost of housing services. The rental equivalence approach does not capture changes in asset value; rather it measures the change in price of housing services provided. CPIH also includes council tax which is excluded from the CPI, and has a weight of 2.8% in the index.

[47] Agents' summary of business conditions - 2025 Q1 | Bank of England

[48] Labour Force Survey (LFS) estimates have been affected by increased volatility resulting from smaller achieved sample sizes, meaning that estimates of change should be treated with additional caution

Figure 3.3: Employment levels, Labour Force Survey (LFS) and payroll data, 2019 to 2025



Source: ONS (MGRZ, MGRN, MGRQ); PAYE RTI data

3.101 The unemployment rate was 4.4% in the three months to January 2025, 0.3% above estimates of a year ago.

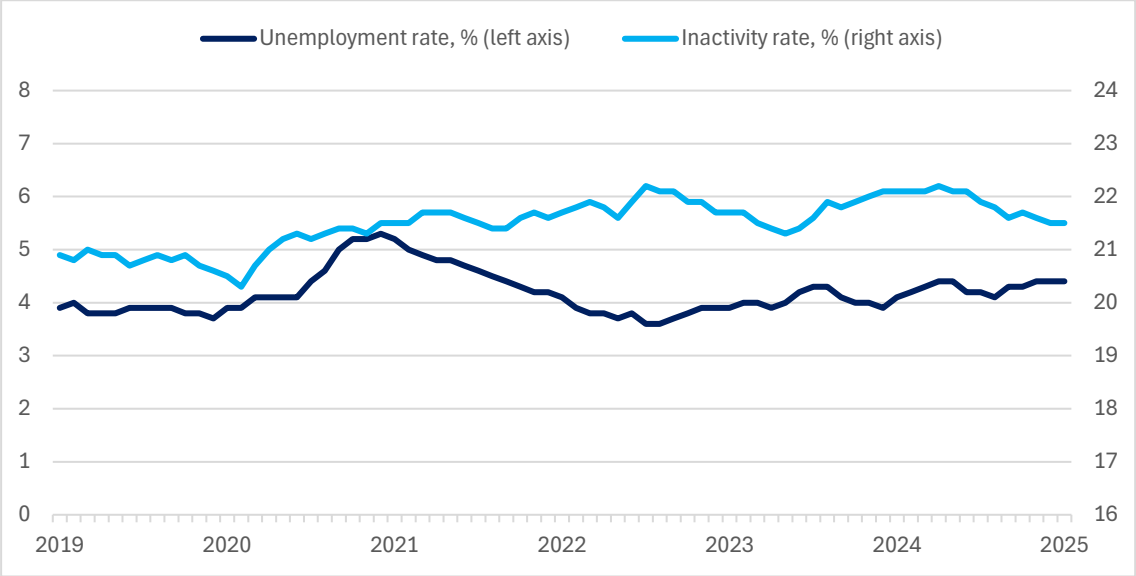
3.102 The UK economic inactivity rate for people aged 16 to 64 years was estimated at 21.5% in November 2024 to January 2025. This is below estimates of a year ago, and down from the latest quarter.

3.103 However, compared to the three months prior to the COVID-19 pandemic, economic inactivity rates have risen in all age groups except ages 35-49. The rise is most marked in 18–24 year-olds where inactivity rates have risen from 29.5% to 32.9%.

3.104 Vacancies across the economy have fallen. In the three months to February 2025, the estimated number of vacancies was 816,000. This represents a fall of 10.5% from a year ago. Since its peak in March to May 2022, vacancies have decreased by approximately 492,000, with declines across most industry sectors[49].

[49] Vacancies and jobs in the UK - Office for National Statistics

Figure 3.4: Unemployment and inactivity rates, 2019 to 2025



Source: ONS, LFS (MGSX, LF2S)

Our assessment of the Government's inflation target and the economy

3.105 As of February 2025, CPI rose by 2.8% compared to the previous year. Inflation remains above the Bank of England's target (2.0%) and is expected to peak in the third quarter of 2025 before returning to target in the medium term.

3.106 Low levels of economic growth in 2024, coupled with downgraded forecasts for 2025, are placing increasing pressure on public finances. This weaker economic outlook reduces government revenues and heightens fiscal constraints, making the affordability context for pay awards more challenging.

3.107 Over the past 12 months, the UK has experienced notable earnings growth. As of January 2025, average weekly earnings rose 5.8% year-on-year. Earnings growth is not currently compatible with the inflation target. We recognise the possibility that a 'high' award for AfC staff could contribute to sustaining inflation above target.

3.108 Pay settlement data shows pay awards coming down compared to those in 2024, and at lower levels than recent earnings growth. The latest data shows median pay awards at 3.0-3.4% for the three months to February 2025. Brightmine said that nearly three-quarters of pay deals were worth less than the award given to the same employee group a year ago.

Equal pay for work of equal value

The NHS Job Evaluation Scheme (JES)

3.109 The NHS JES measures the skills, responsibilities and effort that are required for a job, and allocates it to an AfC pay band. It does this by comparing jobs to national job profiles or evaluating jobs locally, to set the basic pay for staff.

3.110 Over the past couple of years, we have heard a range of views from staff on the effectiveness of the scheme at a local level. Staff at some organisations report having access to a well-publicised and effective job evaluation process, whilst at other organisations, staff believe their local JES is ineffective and does not operate as intended. The latter view is the one more commonly expressed to us. In those places where the JES does not operate as

intended, job evaluation processes are often perceived as taking too long to deal with immediate issues and, in some cases, financial constraints are perceived as holding back appropriate re-gradings.

3.111 As part of the deal the UK Government agreed with trade unions in England for 2023/24, a Job Evaluation Task and Finish Group was formed. We understand the workstream has now concluded and recommendations have been accepted by Ministers. Recommendations include:

- Restoring confidence - by reaffirming contractual entitlements;
- Building capacity – through improving performance and accountability; and
- Investing to modernise – through a digital JE platform.

3.112 As part of their deal, the Welsh Government agreed to review all job descriptions that are more than three years old. We understand this work is ongoing.

3.113 In previous reports, we have commented on the nursing and midwifery profile review, noting the review should be completed as soon as feasibly possible. We are pleased to see the work is progressing and draft profiles are expected for Bands 4-6 in June. We understand any costs associated with re-bandings as a result of the review are expected to be funded locally.

3.114 As discussed earlier in this chapter, AfC trade unions have led successful campaigns locally to regrade Band 2 Healthcare Support Workers to Band 3. The campaign followed updated job profiles in 2021 which clarified Band 2 roles focus on personal care, while Band 3 includes delegated clinical duties.

3.115 Subsequently, trade unions set out a case that Band 2 Healthcare Support workers carried out delegated clinical duties which has led to a significant number of re-bandings across the country and a 75% increase in Band 3 Healthcare Support Worker roles over the past five years.

Our assessment of equal pay for work of equal value

3.116 As discussed in our 36th report, since the inception of the AfC contract in 2004, the nature of healthcare roles has changed and, in general, the complexity of roles has increased. However, in many cases, job banding has not reflected the changing nature of a role.

3.117 We heard from staff on visits that the expectation and responsibilities placed on them is perceived to be more than it used to be; however, this is not reflected in their banding which can be demotivating to staff.

3.118 We have also heard from staff that the JES is not effectively or evenly applied across the system. We hope the recommendations from the JES Task and Finish Group and the associated investment helps strengthen the JES infrastructure across the system.

3.119 Nurses and midwives represent the biggest group of staff in the NHS and, given the variety of roles they undertake, we are clear in our recent reports that the review of nursing and midwifery banding carried out by the NHS Staff Council is important and timely work. We welcome the progress made to date. The review should now be completed promptly, and any resulting job profile reviews should be planned and budgeted for as soon as feasibly possible.

3.120 We note the commitment the Welsh Government made to review job profiles, and we look forward to hearing how implementation progresses.

AfC Earnings

AfC awards

3.121 In our 37th report, we recommended a 5.5% consolidated uplift for all AfC staff, intermediate pay points to be added to Band 8a and above, and for the UK Government to issue the NHS Staff Council with a funded mandate to begin to resolve outstanding concerns within the AfC pay structure. We also recommended the Northern Ireland Executive and the Welsh Government support the issuance of a funded mandate and work with the UK Government on this matter.

3.122 The UK Government, the Welsh Government and most recently, the Department of Health Northern Ireland accepted the recommendations in full. The award has now been paid in England and Wales, and we anticipate the award will be paid in Northern Ireland, backdated to April 2024, this spring. Despite full acceptance, the third recommendation in our 37th report which recommended that the UK Government, supported by the Department of Health Northern Ireland and the Welsh Government, provide the NHS Staff Council with a funded mandate to resolve outstanding concerns within the AfC pay structure has not been implemented.

Earnings growth

3.123 In the 12 months to December 2024, mean annual earnings range between £94,846 for senior managers and £24,122 for hotel, property and estates staff.

3.124 All groups saw an increase in average basic pay of between 4.9% (midwives) and 6.8% (senior managers). All staff groups saw a reduction in non-basic pay, of between 14.4% (ambulance staff) and 48.3% (central functions staff). The fall in non-basic pay in 2024 is a result of the 2023 award, agreed between government and the trade unions, which included additional, non-recurring cash payments.

National Living Wage (NLW)

3.125 The NLW increased from £11.44 to £12.21 an hour on 1 April 2025. Between 2017 and 2024 the NLW increased by 53%, while the Living Wage Foundation Real Living Wage increased by 42%. Over the same period, the lowest hourly rate of pay in the NHS increased by 53%, as the Band 1 rate was increased to match that of the Band 2 minimum as part of the 2018 AfC agreement, and in 2023 the lowest Band 2 pay point was increased to match the value of the highest Band 2 pay point.

3.126 In 2024/25, Band 1 and Band 2 pay in the NHS in England and Northern Ireland was £12.08 an hour and Band 3 pay was £12.31 an hour. In England, to remain legally compliant with the NLW from 1 April 2025, Band 1 and 2 pay rose to £12.36 and, to maintain differentials, to £12.59 for Band 3 staff. Band 1 and 2 pay rose to £12.21 in Northern Ireland to remain legally compliant.

3.127 The Welsh Government are committed to paying the Living Wage Foundation Real Living Wage to staff working in the NHS in Wales, which increased to £12.60 an hour in October 2024, with all Living Wage employers given until 1 May 2025 to implement the rise. In

response, the Welsh Government increased Band 1, 2 and 3 pay to £12.60 an hour on 1 April 2025.

3.128 We were told by NHS Employers that the interaction between NLW and salary sacrifice and net deduction arrangements in operation across the NHS, continues to be challenging for employers. We discuss this further at paragraph 3.151.

Unsocial hours payments

3.129 We have heard differential unsocial hours arrangements at Bands 1-3 means staff are disincentivised to take promotional opportunities as they may see their take-home pay decrease. The difference in unsocial hours premiums is also seen as unfair amongst staff. The table below sets out the unsocial hours rate for at different Bands.

Table 3.2: unsocial hours rates, AfC

Pay band	All time on Saturday (midnight to midnight) and any week day after 8pm and before 6am	All time on Sundays and Public Holidays (midnight to midnight)
1	Time plus 47%	Time plus 94%
2	Time plus 41%	Time plus 83%
3	Time plus 35%	Time plus 69%
4-9	Time plus 30%	Time plus 60%

Graduate entrant pay

3.130 We heard from a couple of parties at evidence that 'graduate entry' pay in the NHS is insufficient and does not attract graduates to join the workforce although we did not receive any evidence about the volume of graduates of health disciplines choosing careers in other sectors or the reasons for any such choices. Data from the Longitudinal Education Outcomes (LEO) data set are published each year by the Department for Education (DfE) and track the employment and earnings outcomes of UK-domiciled first-degree higher education (HE) graduates.

3.131 The data shows that one year after graduation, the median annual gross earnings of nursing and midwifery graduates were 32% higher than the median and ten years after graduation, median earnings of nursing and midwifery graduates are broadly in line with the median.

Alternative employment opportunities

3.132 During visits to NHS organisations, staff at the lower end of the AfC pay scale often tell us about alternative employment opportunities, particularly in retail. They report that these roles offer higher pay and are less stressful compared to their NHS positions.

3.133 Four out of the six largest supermarkets in the UK have announced they will raise pay to at least £12.60 an hour by August 2025, in line with the Living Wage Foundation Real Living Wage. This is compared to the National Living Wage at £12.21. A number of supermarkets have also announced reductions in the number of employees and overall retail employment continues to fall.

3.134 While retail jobs may offer higher hourly pay, they are typically part-time and/or temporary. In contrast, Band 2 and Band 3 jobs are predominantly full-time and permanent, providing greater job security and benefits. Retail jobs often do not offer the same comprehensive

total reward package, suggesting that jobs in the NHS and in retail are not complete substitutes and that headline pay is only one aspect of an employers offer.

3.135 The social care sector is also a large competitor market, although with different types of employers paying different rates. Mean care worker pay overall in the independent sector was £11.23 an hour in 2023/24, whilst care workers who were employed by local authorities had a mean hourly rate of £12.43 in 2023/24. This is compared to £11.45 at AfC band 2 in 2023/24[50]. However, care worker roles often do not offer the same total reward package as the NHS.

Our assessment of AfC earnings

3.136 Across AfC in recent years, we have seen a growing workforce, falling vacancies, rising retention, falling temporary staffing costs, weak morale and fragile industrial relations. We have not heard that the overall level of pay is adversely reflecting recruitment and retention in general. However, a persistent theme of the evidence we have received is that the structure of the AfC pay system contains within it disincentives to seek promotion and that there are concerns about the level of pay at the lowest bands.

3.137 From April 2020 to April 2025, the NLW rose by 40%. Coupled with the targeted pay award in 2023, and taking into account the temporary uplift to Band 2 from 1 April 2025, this has resulted in a 34% increase in Band 2 pay in England; a 20% increase to the entry point at Band 5; and a 17.5% increase to the entry point at Band 8a over the same period.

3.138 In Wales, Band 2 pay has increased by 37% over the same period due to the decision taken by the Welsh Government to implement the Real Living Wage across the NHS. The entry point at Band 5 has increased by 22%, while the entry point at Band 8a has increased by 19%. In both cases, this has clearly caused compression throughout the AfC pay spine reducing incentives for promotion.

3.139 Relative pay plays a crucial role in recruitment and retention, particularly for lower bands in the NHS. The 2025 pay award is being implemented alongside a significant increase in the NLW to £12.21 per hour. Recent high increases to the NLW have created challenges for the AfC pay structure by contributing to reduced differentials at the lower bands.

3.140 We have heard concerns over the past couple of years that pay for graduate professions in the NHS is insufficient. LEO data, discussed above, notes that one year after graduation, the median annual gross earnings of nursing and midwifery graduates are 32% higher than the median and ten years after graduation, median earnings of nursing and midwifery graduates are broadly in line with the median.

3.141 There is not a full understanding of the reasons for the narrowing over the first ten years after graduation of the wage premium earned by nursing and midwifery graduates as compared with graduates as a whole. We would appreciate future evidence and data that explains this trend and the factors influencing it.

[50] Social Care 360: Workforce And Carers | The King's Fund | The King's Fund

Total reward

3.142 The total reward package in the NHS includes a generous holiday allowance, which increases each year on top of public holidays (up to 33 days), sickness absence arrangements of up to 12 months of payment, access to a defined benefit pension scheme with an employer contribution rate of 23.7%, enhanced parental leave, and support for learning, development, and career progression. These benefits are significantly above the statutory minimum and exceed those offered in other sectors. DHSC say comparisons with the wider labour market should not just be limited to pay but include the full reward package.

Pensions

3.143 The NHS Pension Scheme is a core offering of the total reward package and remains one of the most generous in the wider economy. The employer pension contribution is 23.7% for all employees, with a tiered contribution for employees. Research from Nest Insight[51] showed that in 2022 most employers contribute no more than 3% of gross pay for some or all of their employees.

3.144 The DHSC said that in June 2024, 87.9% of non-medical (AfC) staff were members of the NHS pension scheme. Broadly, staff in the higher bands were more likely to be scheme members than those in lower bands.

3.145 Between 2014 and 2024, membership rates increased for those in Bands 1 to 4 but decreased for those in Bands 5 to 9.

3.146 DHSC say that non-British staff are traditionally less likely to be members of the NHS pension scheme than those with British nationality. In June 2024, 90% of Band 5 staff with British nationality were pension scheme members, similar to the share across the NHS as a whole, while just 57% of those with a non UK/EU/EEA nationality were scheme members. The membership rate was lowest amongst Band 5 staff from the Rest of the World with two to four years' experience. 43% of this group were members of the scheme.

3.147 In previous reports we have highlighted the importance of accurately and clearly communicating the value of the total package, including the NHS Pension Scheme, to staff. NHS England's Pension Response Project, developed in 2021, aims to demonstrate the financial benefits of the pension scheme to staff. Since 2021, they have reached 27,800 staff, equating to 2% of the workforce in England. They say staff appreciate and value the opportunity to ask questions and clarify their understanding.

3.148 DHSC said that staff receive a Total Reward Statement which provide personalised information about the value of staff employment packages, including remuneration details and benefits provided locally by their employer. Furthermore, it said that NHS pension scheme members receive an annual benefit statement, which shows the current value of their scheme benefits. Of the approximately three million statements available, only 12% of statements have been viewed.

Flexible working

3.149 The England Staff Survey results for the 'We work flexibly' section showed that improvements recorded in 2023 were built on in 2024. Scores for this section increased from 6.09 in 2022 to 6.28 in 2023 and to 6.31 in 2024. 71.3% of respondents said that they could approach their line manager to talk about flexible working, up from 66.9% in 2021,

[51] https://www.nestinsight.org.uk/wp-content/uploads/2022/10/Employer-pension-contributions-in-the-UK.pdf

while 57.7% of respondents said that they were satisfied with the opportunities for flexible working, up from 54.1% in 2021.

3.150 NHSE told us they continue to target improvements in flexible working for groups where it appears to be less embedded, including ambulance and maternity service staff.

Salary sacrifice

3.151 Salary sacrifice arrangements allow an employee to pay for a non-cash benefit from their gross pay. An effect of making such payments for benefits is to reduce the cash amount of the payment an employee receives. NHS organisations offer a range of salary sacrifice arrangements to employees including, childcare vouchers, car lease schemes and cycle to work schemes[52].

3.152 If a salary sacrifice or net deduction arrangement reduces the cash amount of an individual's pay below the NLW threshold, it can mean that trusts are not compliant with legislation pertaining to the NLW. NHS Employers highlighted that variations over time in the size of the gap between the NLW and bottom of the AfC pay scale, along with temporary top-ups when pay awards are delayed beyond 1 April, have affected the eligibility of some employees to participate in salary sacrifice schemes, disproportionately affecting the lowest-paid staff. These employees often rely heavily on salary sacrifice and net deduction schemes, and those with existing arrangements may find the relevant measure of their pay falling below the NLW when these factors are considered.

3.153 NHS Employers told us bringing implementation of future pay awards back to 1 April would help to mitigate the non-compliance of organisations in terms of the NLW and prevent staff potentially losing out on a valuable part of their total reward package.

Our assessment of total reward

3.154 The total reward package and the NHS Pension Scheme remain more generous than many reward packages in the wider economy. Whilst NHS pension scheme membership has not changed significantly, we note that international recruits are less likely to join the pension scheme. To be able to retain international recruits in the NHS, staff need to be aware of the total reward package available to them.

3.155 We are encouraged by the improvements in pension communication across the NHS and are keen to see the Pension Response Project continue. However, we note that only 12% of annual benefit statements have been accessed. Improving the accessibility of annual benefit statements and promoting them as valuable source of information would increase staff awareness of their benefits.

3.156 We are encouraged by continued improvements in NHS Staff Survey scores regarding flexible working. Flexible working is increasingly recognised as a critical aspect of staff experience, contributing to recruitment, retention, and overall morale. We urge systems to sustain efforts in embedding flexible working practices across the NHS, ensuring they are accessible to all staff from day one of employment.

3.157 It is important staff are able to access all elements of the total reward package, and we note the concerns raised with us by NHS Employers regarding salary sacrifice. As we set out in

[52] Salary sacrifice schemes | NHS Employers

Chapter 1, we are hopeful that next year we will be able to report ahead of the 2026/27 financial year which will go some way in responding to the concerns of NHS Employers.

AfC pay structure

3.158 In our 37th report, we discussed the AfC pay structure and the concerns raised with us by parties concerning disincentives throughout the pay structure. We agreed with the evidence we received last year that there is a case for reform and also agreed with stakeholders that the expertise to complete any review and reform of the AfC pay scale sits with the NHS Staff Council.

3.159 Therefore, in response, we recommended in our report last year that the UK Government issue the NHS Staff Council with a funded mandate to begin to resolve outstanding concerns within the AfC pay structure. We also recommended the Northern Ireland Executive and the Welsh Government support the issuance of a funded mandate and work with the UK Government on this matter. All three Governments accepted this recommendation.

3.160 Subsequently, despite their acceptance of last year's recommendation, in their 2025/26 written evidence, DHSC asked us for a view on the relative priorities of investing in headline pay and investing in the pay structure mandate this year. The Northern Ireland Executive then confirmed they would also welcome a view on the relative priorities. As this request was made in written evidence and not in the remit letter, we decided to delay oral evidence and asked parties to the process for evidence and views on this request.

3.161 Whilst trade unions welcomed the recommendation and its acceptance by governments, they did not support the subsequent requests to us to provide a view on the relative priorities of investing in headline pay and investing in the pay structure mandate this year, within the already tight funding envelope for headline pay. This has contributed to the further fragile industrial relations climate we heard about in evidence.

3.162 DHSC told us they intended to engage with trade unions prior to the publication of our report to establish a timeline for structural reform. At the time of oral evidence, none of the governments had opened discussions either with Staff Side representatives, the NHS Staff Council or with each other about structural reform and the third recommendation of our 37th report.

3.163 There were a range of views on how the NHSPRB should respond to this subsequent request. There was unanimity among all parties that expressed a view that increasing headline pay this year is the greater priority. Among trade unions in particular, there was a unanimous view that funding for headline pay and structural reform should be considered separately. Trade unions also expressed frustration that following acceptance of the recommendation, the Government returned the matter to us.

3.164 Further to this, some trade unions did not believe it was appropriate for us to comment on the funding balance.

3.165 NHS Employers, however, told us they see structural reform as a pressing priority where progress needs to be made in this pay round.

3.166 Consistent with their evidence to us last year, the unanimous view among parties that expressed a view remains firmly that any structural changes should be determined by the NHS Staff Council, the position that we supported in our 37th Report. Without resiling from that position, but in order to inform our response to the additional request from DHSC and

the Department of Health Northern Ireland, we asked parties about their priorities for a programme of structural reform. There was not a clear consensus on what the priorities should be. Suggestions included:

- Differentials between pay points needs to be addressed to ensure there are financial incentives for staff to seek promotional opportunities;
- Pay at the bottom end of the AfC scale needs to be addressed to ensure the NHS is a competitive employer at Bands 1-3. Some parties suggested aligning with the Living Wage Foundation's Real Living Wage could be appropriate;
- Graduate entry pay (Band 5) needs to increase as some say it is currently insufficient to compete in the wider graduate market;
- Differential unsocial hours rates at Bands 1-3 disincentivise promotion, so unsocial hours rates should be standardised to reduce this effect;
- Unsocial hours rates should be paid at Bands 8a and above.

Our assessment of the AfC pay structure

3.167 We remain of the view that there are issues and disincentives within the AfC pay structure that need addressing. It is clear that anomalies that have occurred over a number of years can affect motivation and can act as a disincentive to promotion.

3.168 We also remain of the view that any decisions on how such concerns should be addressed are for the NHS Staff Council.

3.169 We heard on visits this year the disparities in pay both within and between bands is demotivating for staff. In Wales, from 1 April, a temporary increase in pay at the lower end means staff on Bands 1-3 are receiving the same hourly rate. It is unjust that staff at a higher pay band with increased responsibilities are paid the same as those with fewer responsibilities. Moreover, differences in unsocial hours payments result in Band 3 staff in Wales earning less than their colleagues in Bands 1 and 2 if they work the same total and unsocial hours. Similarly, Band 2 staff working the same total and unsocial hours as staff at Band 1 will be paid less than colleagues at Band 1.

3.170 We also heard the compressed differentials between bands discourages staff from taking leadership positions. For example, the differential between Band 7 and 8a is 1.8%. Whilst DHSC told us last year that data did not reflect any difficulties in attracting applicants to promotional opportunities at this level, it was clear on visits that staff are disincentivised from taking promotion which could have long-term implications for leadership development and workforce morale.

3.171 We agree pay at the bottom end of the structure needs to be considered further. Compression over a number of years has led to a spot rate for Bands 1 and 2 and a 1.9% differential with Band 3 in England and Northern Ireland. As discussed above, since 1 April 2025, Band 1, 2 and the entry point at Band 3 are paid the same hourly rate in Wales.

3.172 Some parties have advocated for the Living Wage Foundation's Real Living Wage to be the floor of the AfC pay scale which is currently £12.60 across the UK and £13.85 in London. Over the past five years, targeted pay increases at the lower end of the scale have already led to significant compression between pay bands. Implementing the Real Living Wage without additional measures would exacerbate this issue, potentially reducing incentives for career progression. Although we note that the Real Living Wage is already paid by NHS organisations in Wales and some NHS organisations in England.

3.173 As discussed in last year's report and above, there is no evidence that 'graduate pay' in the NHS is insufficient and that graduates are not joining the NHS on this basis. One year after graduation, the median annual gross earnings of nursing and midwifery graduates are 32% higher than the median for all graduates.

3.174 Differential unsocial hours and compression of the pay scale mean some lower banded staff in Bands 1 and 2 are taking home higher pay than Band 3 staff. This is an issue that has been raised with us by NHS Employers over the last couple of years. This disparity is problematic as it undermines the intended progression and incentive structure within the Agenda for Change pay scale.

3.175 These are a selection of issues and concerns raised with us over the past few years. Parties in evidence this year were in agreement that there is no 'quick-fix' to the concerns expressed with the current structure of the AfC pay scale and they do not seek one, as any piecemeal reforms risk creating unintended consequences across other parts of the pay scale. Rather, the consensus among parties is that a comprehensive plan for reform is needed to ensure that structural changes are both effective and equitable.

CHAPTER 4 Conclusion and recommendations

4.1 The Secretary of State for Health and Social Care, the Minister for Health in the Department of Health Northern Ireland, and the Cabinet Secretary for Health and Social Care in Wales asked us in their respective remit letters to make recommendations for a pay award for AfC staff for 2025/26. In this chapter, we set out our recommendations on AfC pay for 2025/26 in England, Northern Ireland and Wales. We make these recommendations in line with our standing terms of reference, which specify that in reaching its recommendations, the Review Body is to have regard to the following considerations:

- the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved;
- the need to recruit, retain and motivate suitably able and qualified staff;
- regional/local variations in labour markets and their effects on the recruitment and retention of staff;
- the funds available to the Health Departments as set out in the Government's Departmental Expenditure Limits;
- the Government's inflation target;
- the principle of equal pay for work of equal value in the NHS; and
- the Review Body may also be asked to consider other specific issues.

4.2 In addition to the request for a recommendation for a pay award, in their written evidence received on 10 December 2024, the DHSC further requested a view on the relative priorities of investing in headline pay and investing in the pay structure mandate this year, within an affordable settlement for DHSC, following our recommendation for 2024/25. The Department of Health Northern Ireland subsequently confirmed they would welcome a view as well.

Evidence to the NHSPRB on pay awards

4.3 DHSC told us that the autumn budget means NHS England RDEL budgets will rise from £182.8 billion in 2024-25 to £193 billion in 2025-26, a 5.6% increase. They told us 2.8% was in budget for a pay award.

4.4 DHSC further told us that accepting recommendations above what is budgeted for would mean stark trade-offs against activity and wider budgets, or consideration of whether productivity improvements can unlock further funding. However, we have not received evidence this year of any planned productivity improvements that could directly provide extra funding for pay and we have been told the productivity gains in excess of plans are 'implausible'.

4.5 At the Autumn Budget, HMT introduced new fiscal rules aimed at ensuring the long-term sustainability of public finances. These rules prohibit capital-to-revenue swaps to finance pay awards. HMT confirmed the spending envelope for the Parliament and departmental budgets for 2025/26, and that the government is committed to living within them. In light of this context, HMT said departments will not be given additional funding for pay awards in

2025/26, should the Pay Review Body recommendations be higher than the government's stated affordability.

4.6 The Department of Health Northern Ireland told us their budget planning position builds in a 2.8% pay award. Anything above this will be challenging to fund. Whilst it is difficult to say what the trade-offs would be, they stated that in making efficiency savings in 2024/25, trusts were considering high impact and 'potentially catastrophic trade-offs' which the Minister deemed would have been unacceptable.

4.7 The Welsh Government did not confirm their budget allocation for pay, although in its written evidence, supplied before its budget had been finalised, the Welsh Government appeared to indicate that the resource budget in 2025/26 would be 3% higher than in 2024/25. At oral evidence, they told us funding for a pay award was held separately from day-to-day budgets and this allocation will be provided once the pay award for 2025/26 is confirmed by the Cabinet Secretary.

4.8 NHSE told us that fiscal constraints in 2025/26 are more significant than in previous years due to inflation and resource limitations. DHSC set out that the NHSE budget for 2025/26 has been confirmed and there will be no additional funds available to NHSE to support pay increases.

4.9 NHS Employers told us the fiscal context is very challenging, with constrained financial resources. The 2025/26 budget presents the toughest financial outlook in years and the cost improvement programme is bigger than it has ever been. There is no headroom for provider organisations to add additional funding on top of agreed local budgets for 2025/26.

4.10 NHS Providers told us that, in Autumn 2024, 64% of trust HR directors responding to their pay survey said a pay uplift of at least 5% would be needed for 2025/26 to support recruitment, retention and morale for AfC staff. They said any award should be fully funded. However, if existing funding needed to be reallocated to support a pay award, it could harm patient care.

4.11 The British Dietetic Association told us they would be looking for a pay award at least 1% above inflation as a minimum and an extra 1% to address pay restoration. They are keen that structural reform is funded separately from a pay award and do not believe making a recommendation for the appropriate amount of funding to be invested into a mandate for structural reform is in the remit of the NHSPRB.

4.12 The Chartered Society of Physiotherapy told us the 2025/26 pay round must deliver an above inflation pay rise to NHS staff in each nation. They are keen that structural reform is funded separately from a pay award and would not support the NHSPRB giving a recommendation on funding for structural reform.

4.13 GMB told us a pay award should be above inflation, with RPI used as the measure of inflation. They also would like to see a plan for Band 2 to be paid at least £15 an hour and a plan to address the subsequent differentials between AfC pay bands. They further told us funding for structural reform should not be traded off against funding for a headline pay award.

4.14 The Royal College of Midwives told us any pay award should be above inflation, with RPI used as the measure of inflation. They do not think a recommendation for structural reform should be within the NHSPRB's remit.

4.15 The Royal College of Podiatry told us that a pay award above inflation would help recruitment and retention in the podiatry profession and recognise the role their members play in improving the health of the nation.

4.16 The Society of Radiographers told us a pay award should be significantly above inflation. They also do not think pay awards should be traded off against funding for structural reform. They would expect to see structural reform tied in with the 10-Year Health Plan.

Concluding remarks

4.17 Five years on from the onset of the COVID-19 pandemic, there are some early signs of stabilisation in the NHS, but the service continues to face immense pressures. The COVID-19 pandemic has left a lasting impact on patient care and workforce morale, creating significant challenges in delivering timely and high-quality care.

4.18 Waiting lists are starting to come down from peaks of 7.7m, 620,000 and 800,000 in England, Northern Ireland and Wales, respectively. However, they are still 63%, 54% and 73% higher than prior to the onset of the COVID-19 pandemic. As a consequence, patients are not getting the right care at the right time. As Lord Darzi said in his report, this has led to public trust and confidence being damaged by the inability of the NHS to meet the promises of the NHS constitution and, consequently, public satisfaction is at its lowest level ever recorded.

4.19 The AfC workforce has seen rapid growth over the past five years, with staff numbers increasing by more than 20% in England and Wales between September 2019 and September 2024. However, this rapid expansion is now slowing. This is partly due to extremely tight financial circumstances across the NHS, and some NHS organisations are responding by restricting recruitment to critical roles.

4.20 Dedicated national funding for international recruitment has ceased in England. Given 49% of new joiners to the NMC register between March 2022 and March 2024 were internationally educated, it is vitally important the NHS now does what it can to retain this group of staff in the NHS.

4.21 Retention across the NHS has improved over the past 12 months. However, we heard on visits that staff do not feel the pressure placed on them has eased, with some staff members saying pressure and demand is higher than it has ever been. This, in turn, can impact on motivation. Demotivated staff are less likely to provide high-quality care which can affect patient outcomes and satisfaction[53].

4.22 Improved retention has led to a reduction in vacancy rates. In England, in the third quarter of 2024/25 the nursing and midwifery vacancy rate was 6.4%, down significantly from 8.3% a year earlier, although the vacancy rate for non-nursing and midwifery AfC staff groups was 7.9%, up slightly from 7.7% a year earlier. The latest data also shows a fall in the vacancy rate in both Wales (5.9% in September 2024, down from 6.2% a year earlier) and Northern Ireland (6.8% in December 2024, down from 7.0% a year earlier).

4.23 Satisfaction with pay in 2024, compared with 2023, was lower for registered nurses and midwives, nursing and healthcare assistants and the wider healthcare team, but improved for ambulance staff and allied health professionals. However, satisfaction with pay improved significantly for medical and dental staff. This reflects the sentiment we heard on

[53] Reduced discretionary effort by staff is affecting NHS productivity, report finds | The BMJ

visits that whilst the 2024/25 AfC pay award was broadly viewed positively, many were disheartened by the award when compared with the additional funding governments across the UK invested into resident doctors' pay.

4.24 The 2024 NHS Staff Survey results were mixed compared with 2023, with a fall in some key indicators. Staff were less likely to say that they were enthusiastic about their job and that they looked forward to going to work. However, staff were more likely to say that they were able to meet the demands on their time, and that they were able to achieve a good balance between work and home life. Fewer staff said that they were considering leaving the NHS.

4.25 Beyond pay, there are a number of factors which impact an employee's experience of work. Staff have told us it is important their role is appropriately reflected in their AfC banding and so having an effective job evaluation scheme in place is crucial. We understand that national funding for the job evaluation scheme has been approved by Ministers in England, and we hope this will help improve the functionality of the scheme. In previous reports, we have also commented on the nursing and midwifery profile review, noting the review should be completed as soon as feasibly possible. We are pleased to see the work is progressing and draft profiles are expected for Bands 4-6 in June. We understand any costs associated with re-bandings as a result of the review are expected to be funded locally.

4.26 There has been a recent loosening of the labour market across the whole economy which reflects ongoing economic challenges. Job vacancies surged after COVID-19 lockdowns to a peak of 1.3 million in mid-2022 and have now dropped to 816,000 in the three months to February 2025, a 37% reduction. Vacancies are now similar to the level prior to the COVID-19 pandemic[54]. However, the number of unemployed people per vacancy has risen from 1.6 prior to the COVID-19 pandemic to 1.9 now, representing a rise of 15%, and an increase of 24% from 18 months ago.

4.27 Despite this, earnings growth has remained strong. In the three months to January 2025, total pay across the economy (including bonuses) rose by 5.8% year-on-year, while regular pay (excluding bonuses) increased by 5.9%. Earnings growth is expected to moderate throughout 2025 to 4.3%[55].

4.28 The latest CPI inflation rate at the time of submitting this report is 2.8% for February 2025, although the OBR has forecasted CPI will rise to 3.2% across 2025.

4.29 Pay settlements are also expected to fall in 2025. Latest estimates from the Bank of England Agents' survey suggest average pay rises for 2025 of 3.5% to 4%[56] and the OBR expects pay settlements will average between 3.0% and 4.0% throughout 2025. In the three months to February 2025, Brightmine, IDR and LRD data showed median pay settlements at 3.0%, 3.2% and 3.4% respectively. Brightmine have also said that nearly three-quarters of pay deals were worth less than the award given to the same employee group a year ago.

4.30 The NLW increased by 6.7% on 1 April 2025 to £12.21. Many retailers, often viewed as alternative employers for lower banded staff in the NHS, have responded with pay increases of around 5%. However, at least one major supermarket has reduced their unsocial hours payments to fund these pay awards. Vacancies have also fallen in retail. Between the three months to January 2020 and the three months to January 2025 the overall number of

[54] Vacancies and jobs in the UK - Office for National Statistics
[55] EFOs - Office for Budget Responsibility
[56] Agents' summary of business conditions - 2025 Q1 | Bank of England

vacancies across the economy increased by 3,000, while the number of retail vacancies fell by 30,000 over the same period.

4.31 While retail jobs may offer higher hourly pay, they are typically part-time and/or temporary. In contrast, Band 2 and Band 3 jobs are predominantly full-time and permanent, providing greater job security and benefits. The NHS offers a comprehensive total reward package, including a generous pension scheme, which many employees value. The NHS also offers unsocial hours payments in roles across Bands 1-7. Retail vacancies and those in the broader health and social care sector have fallen recently.

4.32 The UK Government and the Department of Health Northern Ireland told us 2.8% was in budget for a pay award. At the point they gave us this evidence, the OBR was forecasting that CPI would average 2.6% for 2025, so a pay award at their affordability level would have constituted an above-inflation award. However, the OBR's CPI forecast for 2025 has since increased to 3.2%.

4.33 The Welsh Government did not confirm their budget allocation for pay, although in its written evidence, supplied before its budget had been finalised, appeared to indicate that the resource budget in 2025/26 would be 3% higher than in 2024/25. HMT have said departments will not be given additional funding for pay awards in 2025/26, should Pay Review Body recommendations exceed the stated affordability. Since evidence was provided to us, the wider fiscal context has only become more challenging.

4.34 The financial situation of NHS organisations is extremely stretched. In 2025/26, trusts in England are required to cut their cost base by at least 1% and enhance productivity by 4%, which is twice the requirement from the previous year. NHS Employers told us productivity growth beyond already ambitious plans is 'implausible' and so if any element of the pay award is unfunded, they would have to reduce day-to-day spending which will ultimately adversely affect patient care and outcomes.

4.35 Taking into account all of the above, our recommendation for a headline pay award is a 3.6% consolidated uplift effective from 1 April 2025 for all AfC pay points.

4.36 Alongside a headline pay award, we were asked by DHSC in their written evidence, and subsequently by the Department of Health Northern Ireland, to give a view on the relative priorities of investing in headline pay and investing in the pay structure mandate this year. Following this additional request from DHSC in December 2024, we called for supplementary evidence from parties.

4.37 We are clear that reform remains vital to ensure sustainability of the AfC pay structure. This was emphasised strongly in our 37th report, where we formally recommended the NHS Staff Council were issued with a funded mandate by governments for such reform.

4.38 While we were encouraged by the acceptance of this recommendation from all three governments, we are disappointed that steps were not taken to implement it in 2024/25. Important elements of that recommendation included:

- The issuance to the NHS Staff Council of a funded mandate to address structural reform. No mandate has been issued;
- That the three governments work with the NHS Staff Council and social partners on structural reform. At the time of receiving oral evidence no formal discussions about

structural reform had taken place between any of the governments and the NHS Staff Council nor had the governments discussed the matter among themselves.

4.39 Failure to act on accepted recommendations undermines both government decision-making and the NHSPRB process, and we were concerned to see this as an outcome of last year's pay round. The failure to implement our recommendation has also meant a delay in progressing reform that is increasingly urgent.

4.40 Instead, DHSC and the Department of Health Northern Ireland asked the NHSPRB to provide a view on the relative priorities of investing in headline pay and structural reform this year, within their affordability envelope of 2.8%. That request has been met with considerable disappointment by representatives of staff and employers. They are concerned about the adverse effect it has had and may continue to have on industrial relations.

4.41 We have considered that request carefully, including by inviting parties to submit additional evidence. Our judgement is that, between investing in headline pay and investing in structural reform in this year's constrained fiscal environment, the greater priority is headline pay. Beyond the matters that our terms of reference direct us to consider in assessing the additional request, three factors have also influenced our decision.

4.42 Firstly, we heard clear evidence from parties on this matter. They told us that funding for headline pay and for structural reform should be treated separately. Trade unions did not support the request to us from governments to provide a view on what the relative priorities should be between headline pay and structural reform, especially within an already tight funding envelope. We were again given clear evidence that, as we recommended in our report last year, the NHS Staff Council should be the body that considers the priorities and make recommendations for reform. We have also heard strong and consistent evidence that addressing structural issues requires comprehensive reform over a number of years rather than piecemeal adjustments, which risk unintended consequences.

4.43 Secondly, while it applies only to England, DHSC will publish the 10 Year Health Plan this spring, followed by a refreshed workforce plan. This will have consequences for the size and shape of the workforce and these may have implications for the appropriate pay structure for AfC staff. It is sensible that structural reform should be informed by and take place in light of that plan.

4.44 Thirdly, since discussions have not yet begun, it appears to us unlikely that any process for agreeing structural reform would conclude much before the beginning of 2026/27. Since the Spending Review that is underway will provide the funding envelope for the NHS for three years from 2026/27 to 2028/29, it seems appropriate that consideration of the resources to be made available for structural reform are identified in that process.

4.45 We received additional evidence from parties involved in the NHSPRB process and the Staff Side copied us into its letter to the Secretary of State that set out its priorities for structural reform discussions. However, we received estimates of the cost of reforms only from NHS Employers. An initial estimate based on the evidence that was supplied indicates that an investment of at least 1% of the paybill would be required to achieve meaningful reform. This estimate reflects the costings NHS Employers provided for priority reforms in their evidence. Appendix B sets out the basis of this initial estimate. We are conscious there are a number of other priorities presented to us that have not been costed. Some priorities are not possible to cost without parties discussing and developing them in more detail. We are

also aware not all members of the NHS Staff Council participated in the NHSPRB process this year, and they may have additional or different priorities for reform.

4.46 We are acutely aware of the affordability envelope provided by the governments and of the strain on trust finances, which limits the flexibility to address competing priorities. Given these constraints, within the context outlined above, we do not believe it would be appropriate to recommend both a headline pay award that we judge to be consistent with the evidence we have received and our terms of reference and allocate adequate funding for meaningful structural reform without significantly impacting the resources available for patient care.

4.47 Therefore, our view is that no resources should be allocated from the envelope for a pay award to structural reform in 2025/26. However, we remain persuaded of the case for reform. We again **recommend the UK Government provides the NHS Staff Council with a funded mandate to resolve outstanding concerns with the AfC pay structure.** Maintaining the integrity of the AfC contract across England, Northern Ireland and Wales will require all three administrations to be engaged in such a process. For that reason, we also recommend to the Northern Ireland Executive and the Welsh Government that they support the issuance of a funded mandate to the NHS Staff Council and that they work with the NHS Staff Council, their social partners and with the UK Government on this matter.

4.48 If the governments choose to accept this recommendation, we expect them, as an indication of the seriousness of their intent, to make material progress towards agreeing with the NHS Staff Council a plan for the implementation of structural reform before the 2026/27 pay round begins. At the beginning of that round, we will invite parties to set out their assessment of the progress that has been made.

4.49 The Spending Review process, which will include setting the resource envelope for three years from 2026/27, is due to conclude on 11 June. It will be important that resource for a funded mandate, and hence for an implementation plan for structural reform, inform the Spending Review.

4.50 If the governments cannot accept this recommendation in full, they should be clear that they have rejected it.

Appendix A Data appendix

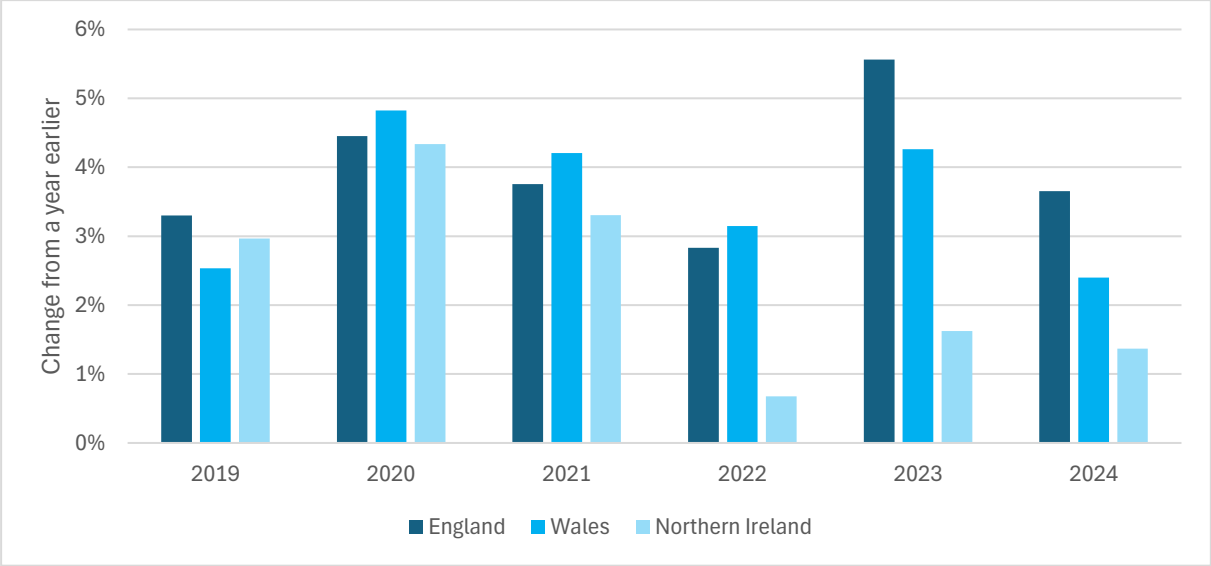
Workforce

AfC workforce across England, Northern Ireland and Wales

1. In the year to September 2024, the AfC workforce grew in all three nations, but less strongly than in 2023. Between September 2023 and September 2024, workforce growth was strongest in England, as the number of FTE staff grew by 3.7%, following growth of 5.6% in the previous year. Over the year to September 2024, FTE staff numbers in Wales grew by 2.4% (down from 4.3% in 2023), while workforce growth in Northern Ireland was weaker, at 1.4% (down from 1.6% in 2023).

2. In September 2024, the most recent date for which data is available for all three countries, there were 1.36 million FTE AfC staff in England, Northern Ireland and Wales, of which approximately 1.21 million were working in England, 61,000 in Northern Ireland and 89,000 in Wales. On a headcount basis there were approximately 1.54 million AfC staff as of September 2024, of which approximately 1.37 million were in England, 69,000 in Northern Ireland and 104,000 in Wales. We also track the trends in the workforce and Figure A.1 shows the change in staffing numbers in each year since 2019.

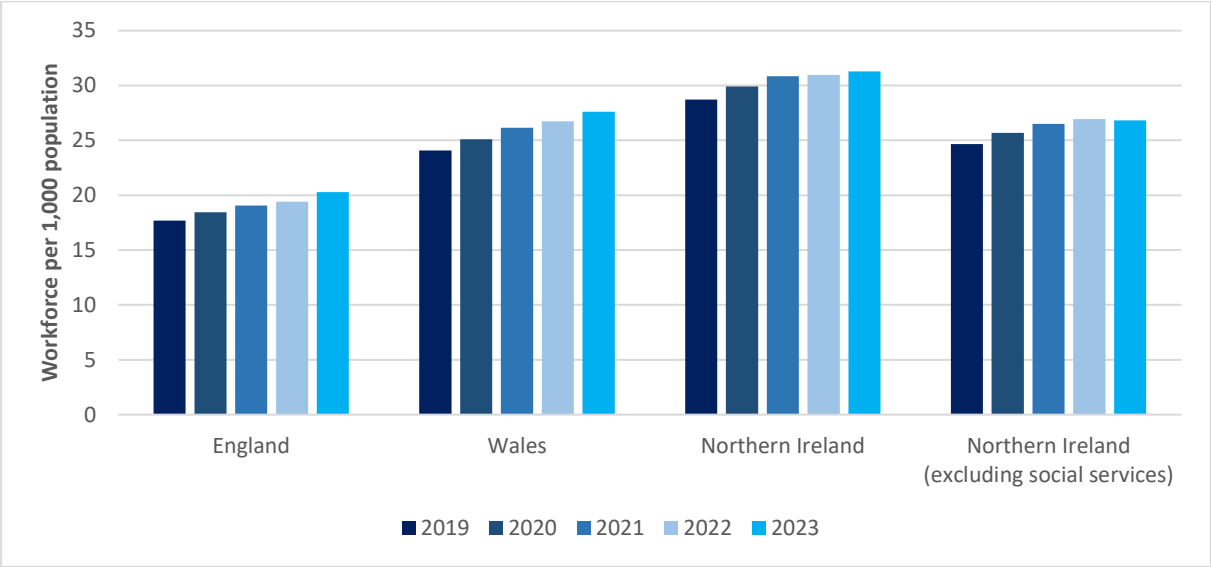
Figure A.1: Changes in AfC full time equivalent workforce, England, Wales and Northern Ireland, 2019 to 2024



Source: NHS England, Stats Wales, Department of Health, Northern Ireland

3. Figure A.2 shows the number of FTE AfC staff per 1,000 population in England, Northern Ireland and Wales. An increase in the height of the bars shows that the number of FTE staff is growing more quickly than the population. The chart also shows that England has the fewest FTE AfC staff per 1,000 population, whereas Northern Ireland has the largest number of FTE AfC staff relative to population size. Unlike England and Wales, the workforce in Northern Ireland includes those working in social services, although even after adjusting for this difference, in 2023 Northern Ireland still had more FTE AfC staff per 1,000 population than England but a smaller amount than in Wales.

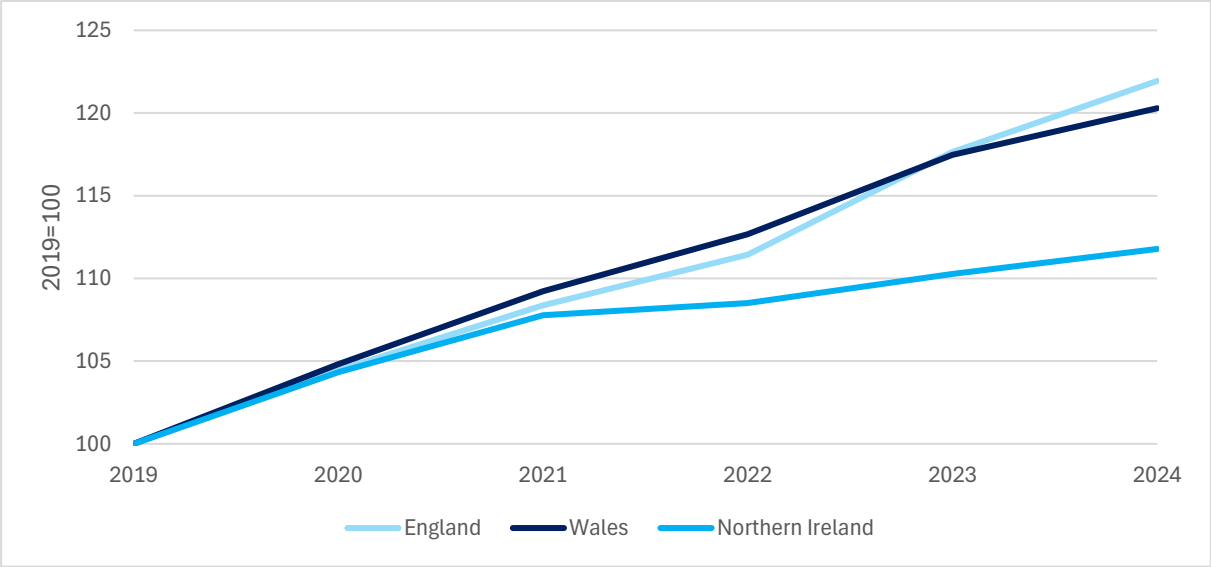
Figure A.2: NHS AfC full time equivalent workforce per 1,000 population, England, Wales and Northern Ireland, 2019 to 2023



Source: OPRB calculations based on data from NHS England, Stats Wales, Department of Health Northern Ireland, ONS

4. Between September 2019 (prior to COVID-19) and September 2024, the AfC workforce has grown in each of the three countries (Figure A3). Over the period as a whole, the AfC workforce grew: in England by 22% (an annualised rate of 4.0%); in Wales by 20% (3.8% annualised); and in Northern Ireland by 12% (2.3% annualised).

Figure A.3: Growth in the AfC full time equivalent workforce, England, Wales and Northern Ireland, 2019 to 2024



Source: OPRB calculations based on data from NHS England, Stats Wales, Department of Health Northern Ireland.

5. Tables A.1 to A.3 show the latest workforce data for each country by staff group.

6. In England, in January 2025, there were 1,226,699 FTE AfC staff, an increase of 28,143, or 2.3% from a year earlier. The overall increase in the number of staff was driven by increases in the number of: ambulance staff (1,886, 9.6%); midwives (1,352, 5.7%); nurses and health visitors (15,801, 4.5%); and scientific, therapeutic, and technical staff (6,870, 4.0%). There was slower growth in the number of infrastructure support staff (1,870, 0.9%), and the number of staff supporting clinical staff (565, 0.1%).

7. Compared with January 2020, prior to the COVID-19 pandemic, FTE AfC staff in January 2025 had grown by 21% overall and at a compound annual growth rate of 3.9%: 29% for ambulance staff; 24% for nurses and health visitors; 22% for scientific, therapeutic and technical staff; 22% for NHS infrastructure support staff; 20% for support to clinical staff; and 13% for midwives.

Table A.1: NHS AfC FTE workforce, England, by staff group, January 2020 to January 2025

	Jan 20	Jan 24	Jan 25	Change 2024-2025		Change 2020-2025	
AfC	1,011,295	1,198,556	1,226,699	28,143	2.3%	215,405	21%
Nurses & health visitors	297,407	352,125	367,926	15,801	4.5%	70,518	24%
Midwives	22,137	23,556	24,908	1,352	5.7%	2,771	13%
Ambulance staff	16,750	19,648	21,534	1,886	9.6%	4,784	29%
Scientific, therapeutic & technical staff	145,661	170,838	177,708	6,870	4.0%	32,047	22%
Support to clinical staff	345,534	412,923	413,488	565	0.1%	67,954	20%
NHS infrastructure support	181,606	218,939	220,809	1,870	0.9%	39,204	22%
Other staff	2,200	527	327	-200	-38.0%	-1,873	-85%

Source: NHS England

8. In Northern Ireland, in December 2024, there were 61,401 FTE AfC Health and Social Care (HSC) staff, an increase of 660, or 1.1%, from a year earlier. The overall increase in the number of AfC staff was driven by an increase in the number of: social services staff of 267 (3.1%); registered nursing and midwifery staff of 352 (2.0%); professional and technical staff of 174 (1.8%); admin and clerical staff of 70 (0.5%); and ambulance staff of 3 (0.3%). There were falls in the number of nurse support staff (201, 4.6%), and support services staff (6, 0.1%).

9. Compared with December 2019, prior to the COVID-19 pandemic, FTE AfC staff in December 2024, had grown by 15% overall; 16% for registered nursing and midwifery staff, 14% for administration and clerical staff, for social services staff, and for professional and technical staff; 8% for estates service staff; 3% for ambulance staff; 1% for support services staff. Over the same period, the number of nurse support staff fell by 5%.

Table A.2: Health and Social Care (HSC) AfC FTE workforce, Northern Ireland, by staff group, December 2019 to December 2024

	Dec 19	Dec 23	Dec 24	Change 23-24		Change 19-24	
All staff (excluding medical and dental)	55,078	60,741	61,401	660	1.1%	6,323	15%
Administration & Clerical	11,586	13,123	13,193	70	0.5%	1,607	14%
Estates Services	753	817	817	0	0.0%	64	8%
Support Services	5,004	5,038	5,031	-6	-0.1%	27	1%
Registered Nursing & Midwifery	15,540	17,651	18,003	352	2.0%	2,463	16%
Nurse Support Staff	4,392	4,380	4,178	-201	-4.6%	-214	-5%
Social Services (excluding Domiciliary Care)	7,770	8,600	8,868	267	3.1%	1,098	14%
Professional & Technical	8,819	9,891	10,065	174	1.8%	1,246	14%
Ambulance	1,214	1,242	1,245	3	0.3%	32	3%

Source: Department of Health, Northern Ireland

10. In Wales, in September 2024, there were 89,437 FTE AfC staff, an increase of 2,095, or 2.4%, from a year earlier. The overall increase in the number of AfC staff was driven by increases in the number of: registered nursing staff (1,203, 5.0%); scientific, therapeutic and technical staff (499, 3.0%); administration and estates staff (246, 1.0%); nursing and midwifery support staff (90, 0.7%); registered midwifery staff (61, 4.5%); health care assistants and other support staff (12, 0.2%). The number of ambulance staff fell by 13 (0.4%).

11. Compared with September 2019, prior to the COVID-19 pandemic, AfC staff in September 2024, had grown by: 20% overall; 28% for administration and estates staff; 24% for ambulance staff; 24% for scientific, therapeutic and technical staff; 19% for nursing and midwifery support staff; 19% for registered nursing staff; and 2% for registered midwifery staff. Over the same period, the number of health care assistants and other support staff fell by 3%.

Table A.3: NHS AfC FTE workforce, Wales, by staff group, September 2019 to September 2024

	Sep 19	Sep 23	Sep 24	Change 23-24		Change 19-24	
All staff (excluding medical and dental)	74,352	87,343	89,437	2,095	2.4%	15,086	20%
Registered nursing staff	21,359	24,145	25,347	1,203	5.0%	3,988	19%
Registered midwifery staff	1,389	1,356	1,417	61	4.5%	28	2%
Nursing and midwifery support staff	10,552	12,462	12,552	90	0.7%	2,000	19%
Administration and estates staff	18,687	23,715	23,961	246	1.0%	5,275	28%
Scientific, therapeutic and technical staff	13,777	16,627	17,127	499	3.0%	3,349	24%
Health care assistants and other support staff	6,071	5,900	5,912	12	0.2%	-159	-3%
Ambulance staff	2,431	3,018	3,005	-13	-0.4%	574	24%
Other non-medical staff	86	119	116	-3	-2.9%	30	35%

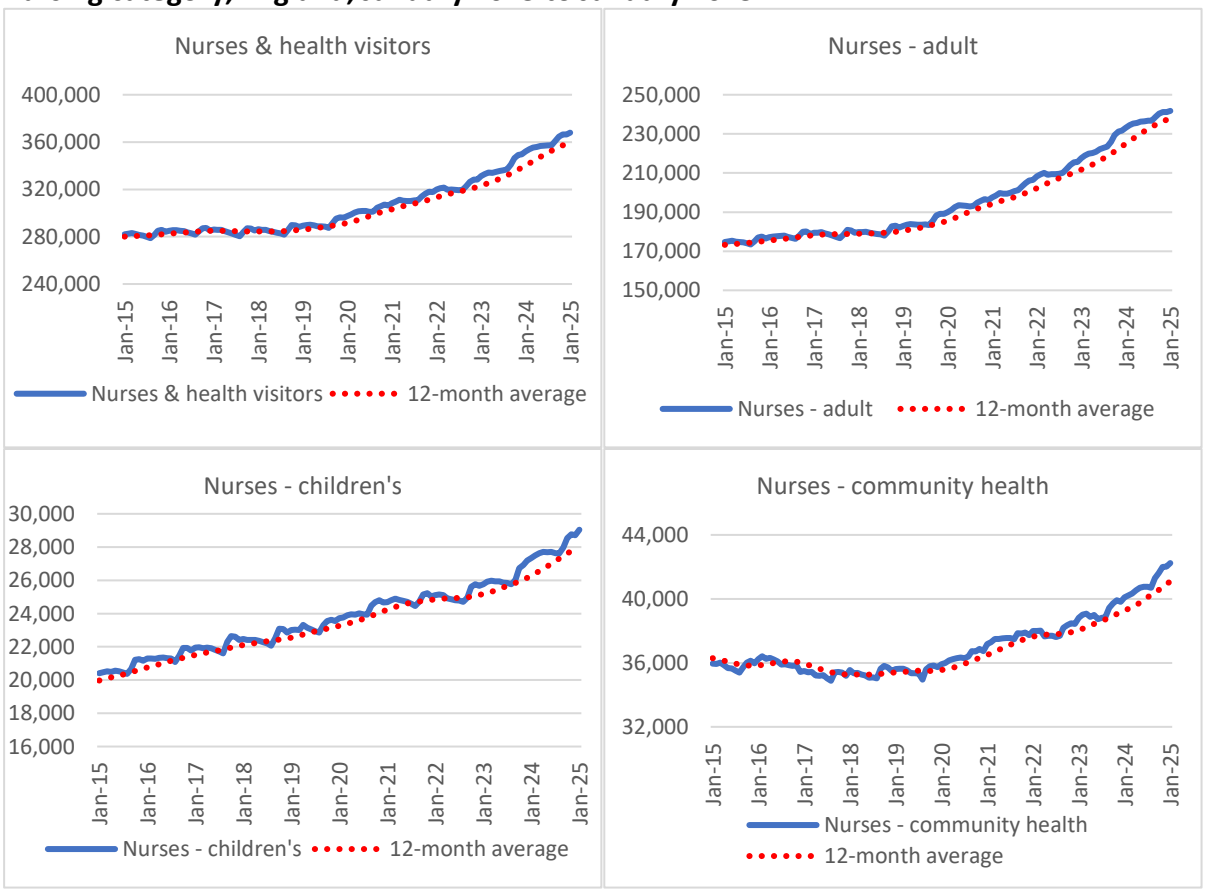
Source: Stats Wales

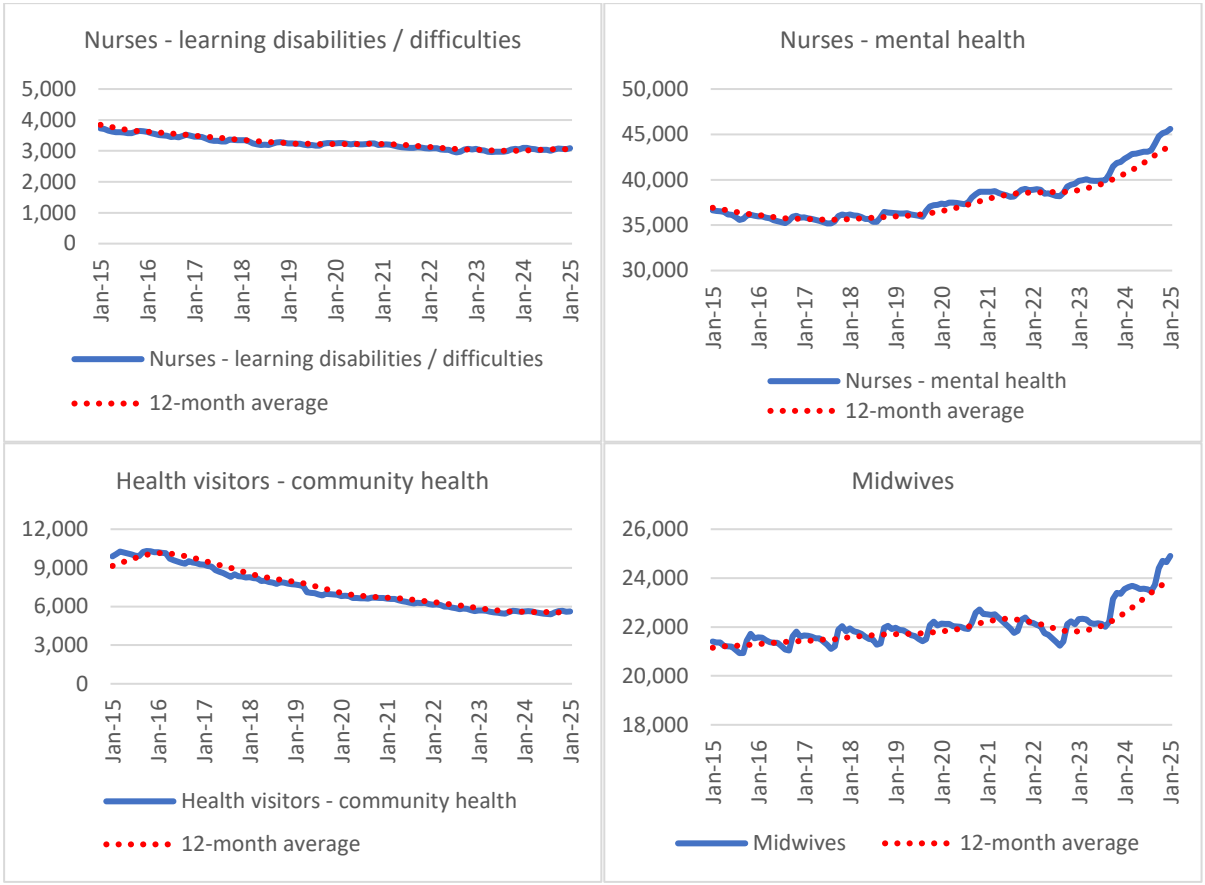
Nursing, health visitor and midwifery workforce in England

12. Figure A.4 shows the FTE number of nurses, health visitors and midwives, in England, working in HCHS, between 2015 and 2025. The data for the three months to January 2025, compared with the same period one year earlier, show an increase in the number of nurses and health visitors of 4.7%. Within that overall total, there were increases in the number of: mental health nurses (7.8%); children's nurses (6.2%); community health nurses (5.4%); adult nurses (4.0%); and learning difficulties/disabilities nurses (0.1%); but a fall in the number of health visitors (-0.1%). Over the same period the number of midwives increased by 5.6%.

13. The data for the three months to January 2025, compared with the same period in 2020 (prior to the COVID-19 pandemic), show an increase in the number of nurses and health visitors of 24%. Within that overall total, there were increases in the number of adult nurses (27%), children's nurses (22%), mental health nurses (22%), and community health nurses (17%) but falls in the number of health visitors (-18%) and learning difficulties/disabilities nurses (-5%). Over the same period the number of midwives increased by 12%.

Figure A.4: Change in the number of nurses, health visitor staff and midwives, FTE, by nursing category, England, January 2015 to January 2025





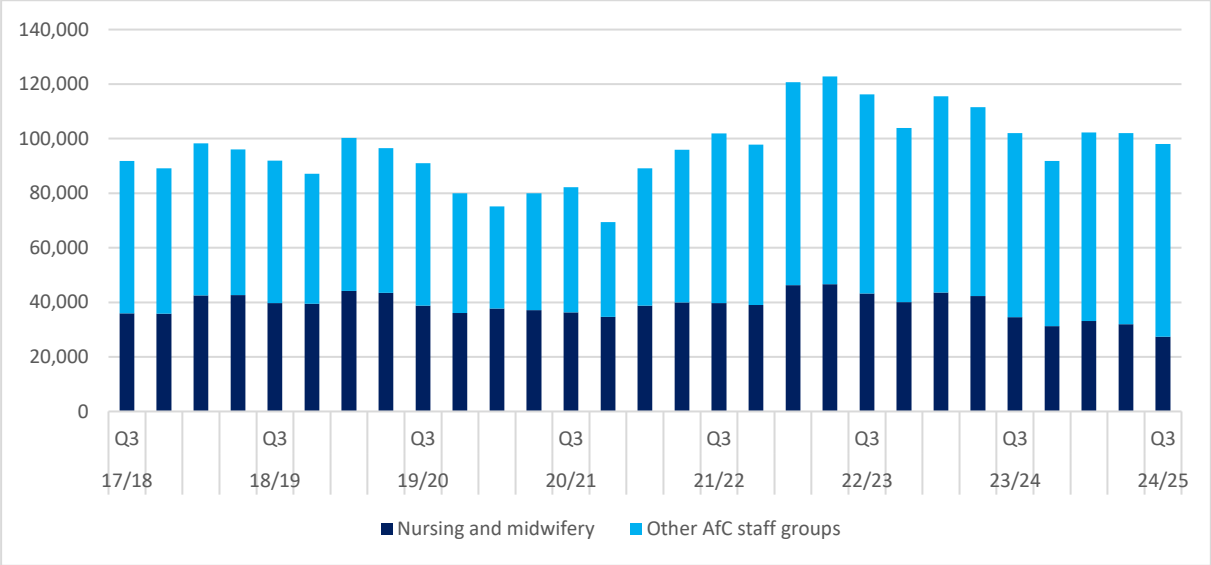
Source: NHS England

Vacancies

14. NHSE publishes quarterly estimates of vacancies across the NHS in **England**[57]. The latest data, for the third quarter of 2024/25, to December 2024, showed that overall, there were 98,102 AfC vacancies in the NHS, of which 27,452 were nursing and midwifery vacancies, and 70,650 were for other AfC roles (Figure A.5).

[57] **A vacancy** in the NHS in England is defined as a post that is unfilled by permanent or fixed-term staff. Some vacant posts may be filled by agency or temporary staff, but these posts are still considered to be vacancies. **The number of vacancies** is the difference between the number of reported full-time equivalent (FTE) permanent or fixed-term staff in post and planned workforce levels (i.e. the total funded or budgeted establishment on an FTE basis). The number of vacancies is on an FTE basis. **The vacancy rate** is a calculation of the FTE number of vacancies as a percentage of planned FTE workforce levels.

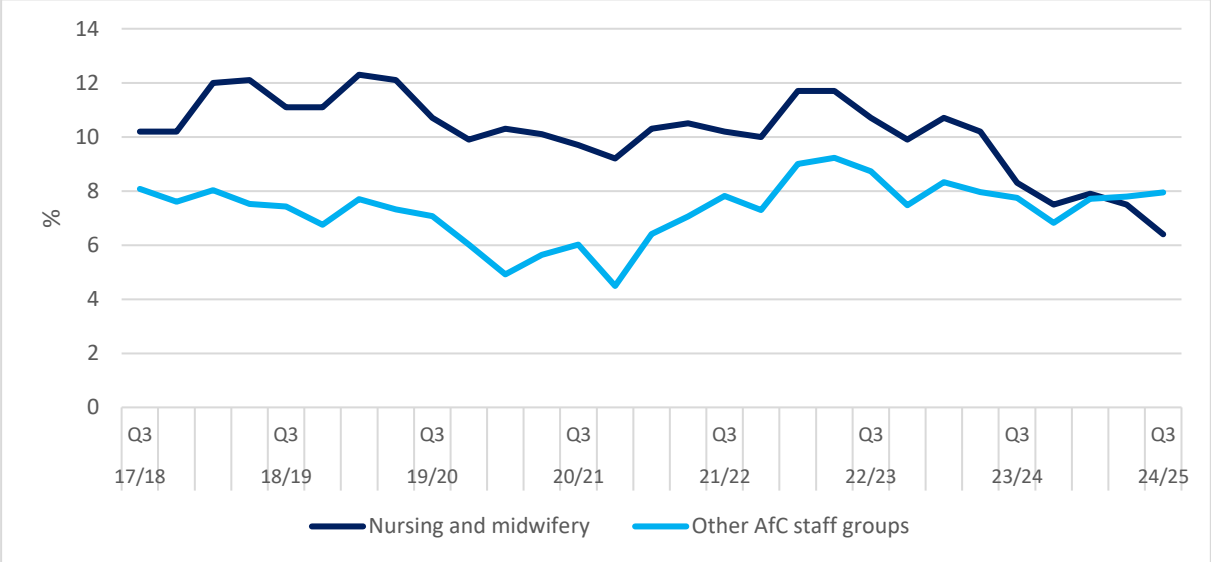
Figure A.5: NHS vacancies, England, 2017/18 quarter 3 to 2024/25 quarter 3



Source: OPRB calculations based on data from NHS England

15. Figure A.6 shows vacancy rates since 2017/18, the earliest date for which there are comparable data. In the third quarter of 2024/25 the nursing and midwifery vacancy rate was 6.4%, down from 7.5% in the previous quarter, down from 8.3% in the same quarter a year earlier, and the lowest rate for at least seven years. The vacancy rate for non-nursing and midwifery AfC staff groups was 7.9%, up from 7.8% in the previous quarter, and up from 7.7% in the same quarter a year earlier.

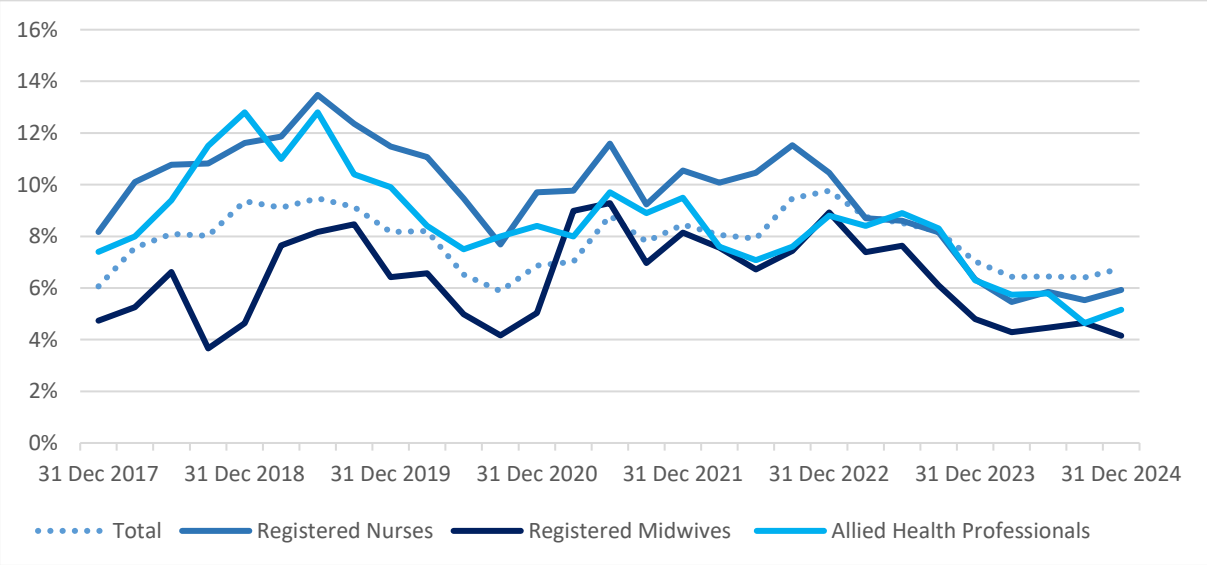
Figure A.6: NHS vacancy rates, nursing and midwifery and other AfC staff groups, England, 2017/18 quarter 3 to 2024/25 quarter 3



Source: OPRB calculations based on data from NHS England

16. For **Northern Ireland**[58] the most recent data shows that at the end of December 2024, there was an overall vacancy rate (including medical and dental staff) of 6.8%, a fall from 7.0% a year earlier. Over the same period: registered nursing vacancies fell from 6.3% to 5.9%; registered midwifery vacancies fell from 4.8% to 4.1%; and allied health professional vacancies fell from 6.3% to 5.2%.

Figure A.7: HSC, Northern Ireland, vacancy rate, December 2017 to December 2024



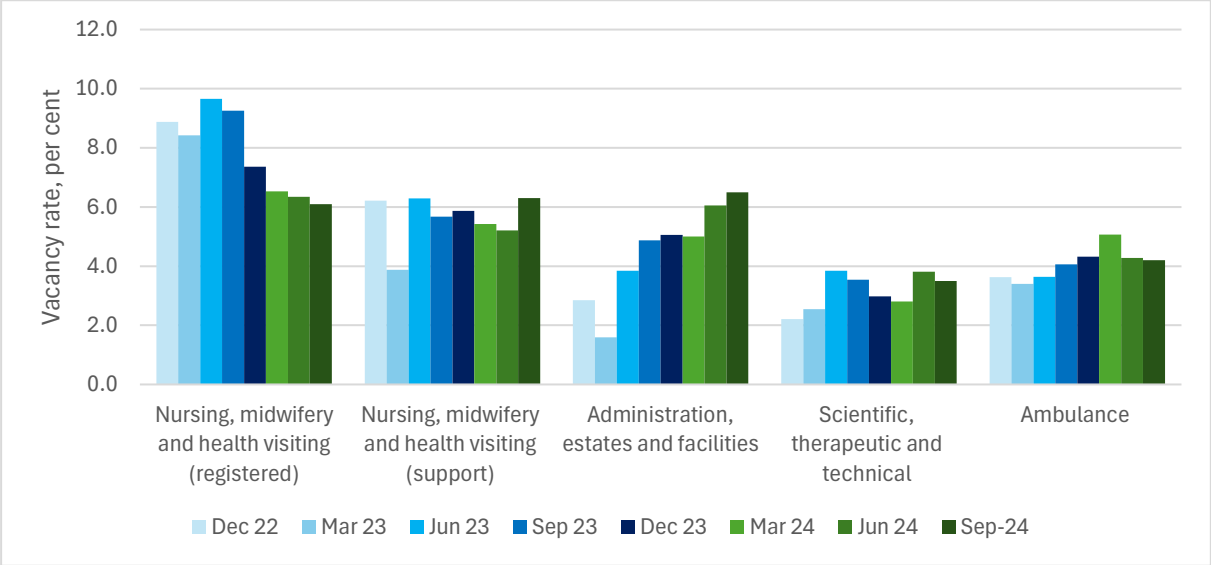
Source: Department of Health, Northern Ireland

17. Stats Wales publish NHS **Wales**[59] vacancy data, on a quarterly basis. The latest data for September 2024, shows a vacancy rate across all staff groups (including medical and dental) of 5.9%, a fall from 6.2% a year earlier. Figure A.8 shows the vacancy rate for individual AfC staff groups. The vacancy rate in September 2024, for registered nursing, midwifery and health visiting staff, was lower than in September 2023, falling from 9.3% to 6.1%. However, the vacancy rates in September 2024 for other AfC staff groups were higher than a year earlier (except for scientific, therapeutic and technical staff where the vacancy rate was unchanged). Between September 2023 and September 2024, the vacancy rates for: administration, estates and facilities staff increased from 4.9% to 6.5%; nursing, midwifery and health visiting support staff increased from 5.7% to 6.3%; ambulance staff increased from 4.1% to 4.2%.

[58] **A vacancy** in Health and Social Care in Northern Ireland is any position that is currently with the recruitment team and being actively recruited to. This will include those going through pre-employment checks, up to the point of a start date being agreed. **The vacancy rate** is the number of vacancies actively being recruited to divided by the sum of the number of active staff in posts and the number of vacancies actively recruited to. Once a start date has been agreed with both parties (i.e. manager and applicant) this will no longer be classed as a vacancy. Vacancies that are on hold by managers are not included.
This information represents the number of vacancies actively being recruited to and does not indicate the whole time equivalent (WTE) for these positions. The data includes both permanent and temporary positions. These figures do not include posts not actively being recruited to at the specific point in time, including those outside the bounds of the definition e.g. those that have not reached recruitment stage yet.

[59] **A vacancy** in the NHS in Wales is defined as the difference between the number of funded full-time equivalent (FTE) posts as recorded on the finance general ledger, and the number of FTE staff in post as recorded on the Electronic Staff Record (ESR) at a point in time. **The vacancy rate** is the number of vacancies divided by the number of funded FTE posts recorded on the general ledger.

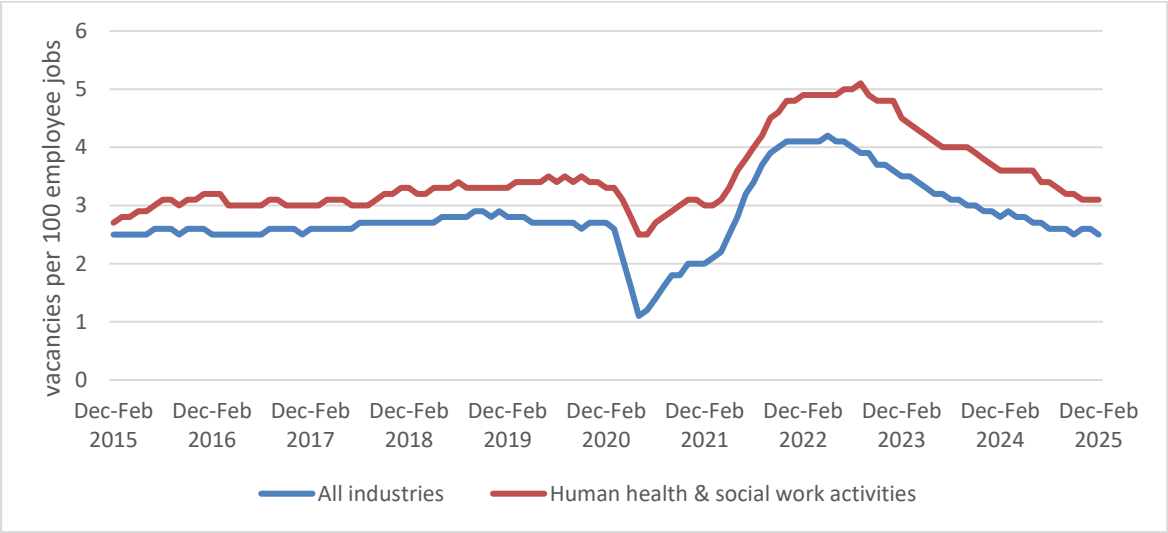
Figure A.8: NHS Wales, vacancy rate, December 2022 to September 2024



Source: Stats Wales

18. In the three months to February 2025, the ONS estimated that there were 816,000 vacancies across all industries, a rate of 2.5 vacancies per 100 employee jobs[60]. This compares with data for the human health and social work activities sector where there were 139,000 vacancies, a rate of 3.1 vacancies per 100 employee jobs. Figure A.9 shows that vacancy rates have been falling since mid-2022 and are now lower than the rates seen prior to the onset of COVID-19.

Figure A.9: Vacancies per 100 employee jobs, UK, seasonally adjusted, December to February 2015 to December to February 2025



Source: ONS

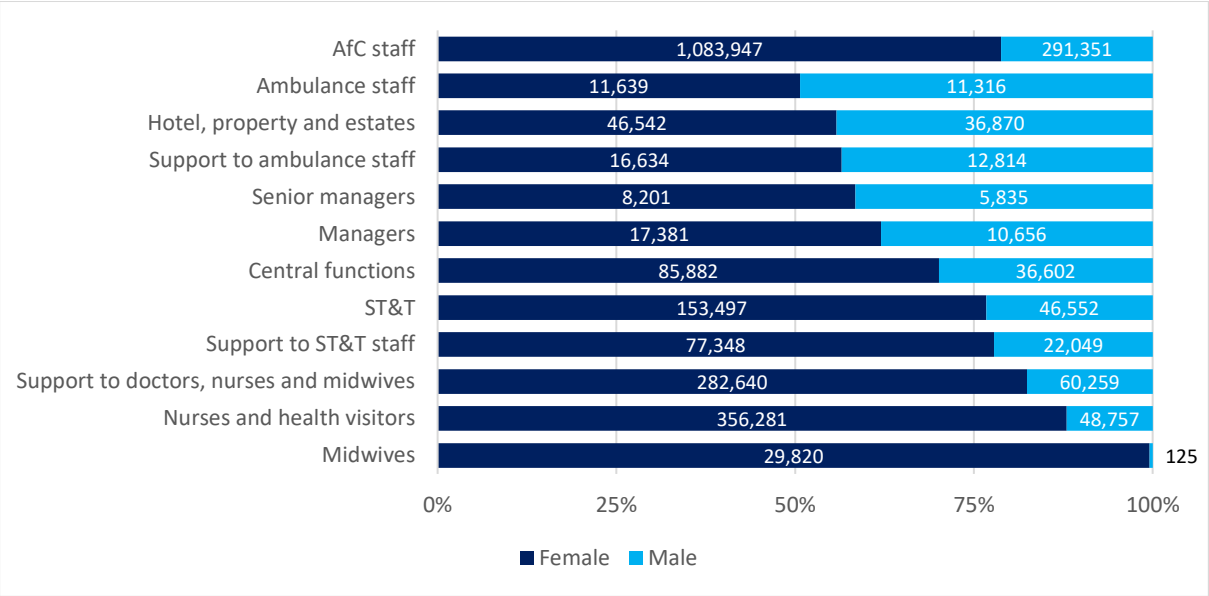
[60] The ONS vacancy survey provides monthly estimates of job vacancies across the whole economy. Approx 6,100 businesses are sampled every month, and responses are collected via an electronic questionnaire**.** Employers are asked to return one number by telephone data entry – the number of job vacancies they have in total for which they are actively seeking recruits from outside their organisation, for example, by advertising or interviewing.
The data for Human health and social work activities covers: Human health activities (includes hospitals, medical and dental practices); Residential care activities; Social work activities.
The number of vacancies for the sector is divided by the number of employee jobs in the sector, to give a ratio of the number of vacancies per 100 jobs.

AfC workforce by protected characteristics[61]

19. The NHSPRB terms of reference state that the Review Body should take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief and disability. In this section we consider those characteristics of AfC staff for which data are available to monitor the representation of different groups in the workforce and how they have changed over time.

20. Figure A.10 shows a breakdown of AfC staff in England, by gender, by broad staff group, in December 2024. The AfC workforce is predominantly female, with women accounting for 79% of employees. However, the relative representation of women and men varies across different staff groups. For example, 88% of nurses and health visitors and more than 99% of midwives were women, while 49% of ambulance staff and 44% of hotel, property and estates staff and support to ambulance staff, were men. Men also accounted for 42% of senior managers and 38% of managers.

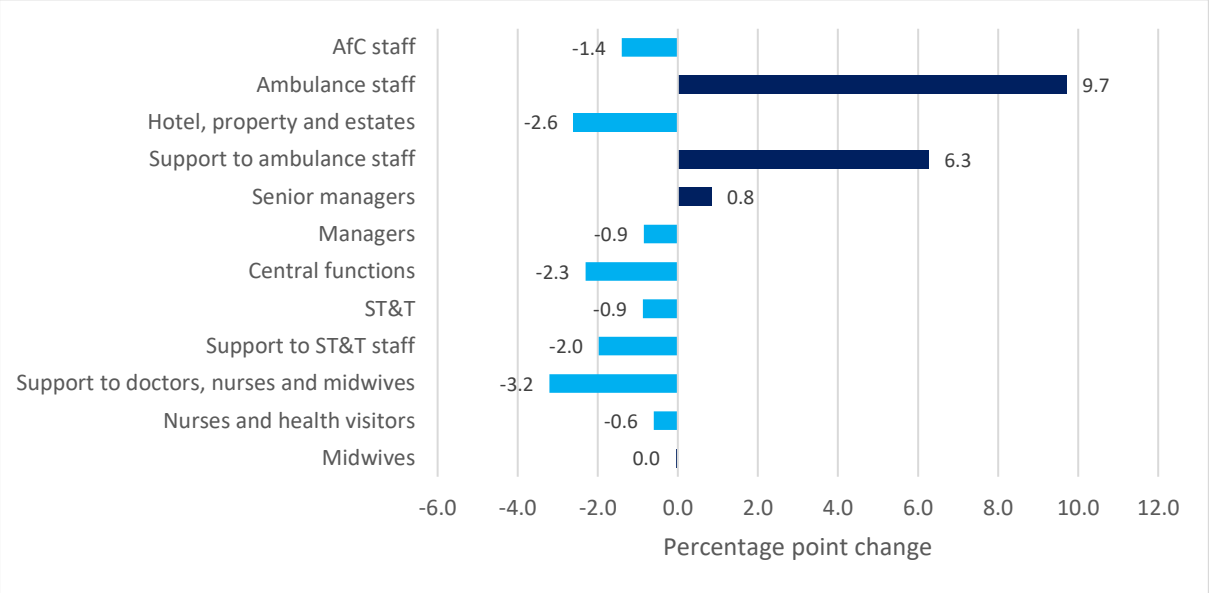
Figure A.10: Staff in AfC roles by gender, by staff group, in England, December 2024, headcount



Source: NHS England

[61] In this section, due to rounding, some totals may not correspond with the differences between the individual figures.

Figure A.11: Staff in AfC roles by gender, by staff group, in England, percentage point change between September 2019 and December 2024, headcount [positive means increased share of female staff]

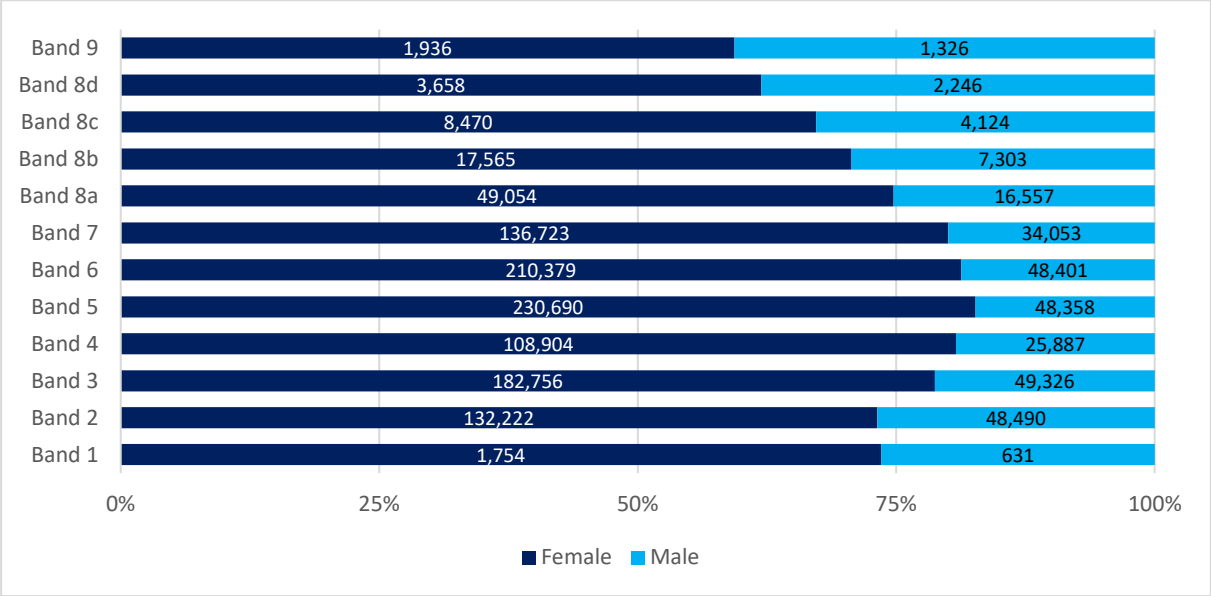


Source: NHS England

21. Figure A.11 shows, in England, the change in the gender mix between September 2019 (pre COVID-19) and December 2024, by staff group. It shows that overall, the percentage of staff that were female fell by 1.4 percentage points (from 80.2% to 78.8%) between 2019 and 2024. Compared with September 2019, in December 2024, female staff made up a greater share of ambulance staff (up by 9.7 percentage points, from 41.0% to 50.7%), support to ambulance staff (up 6.3 percentage points, from 50.2% to 56.5%), and senior managers (up by 0.8 percentage points, from 57.6% to 58.4%). In 2024, male staff made up a greater share of all other staff groups than in 2019, except for midwives, where there was no change.

22. Figure A.12 shows that female staff make up a majority of staff in every pay band, and at least 70% of staff in every band except Bands 8c to 9.

Figure A.12: Staff in AfC roles by gender, by band, in England, December 2024, headcount

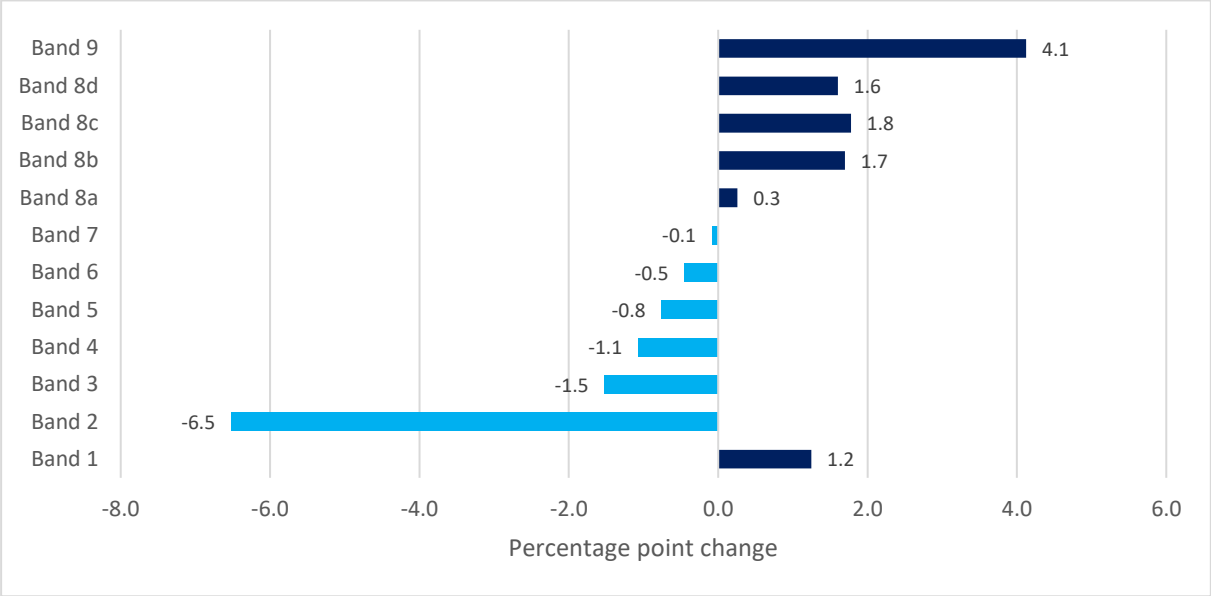


Source: NHS England

23. Figure A.13 shows that in December 2024, female staff made up a greater share of staff at Bands 1 and Bands 8a and above, than in 2019. The largest change was at Band 9 (up 4.1 percentage points, from 55.2% to 59.4%).

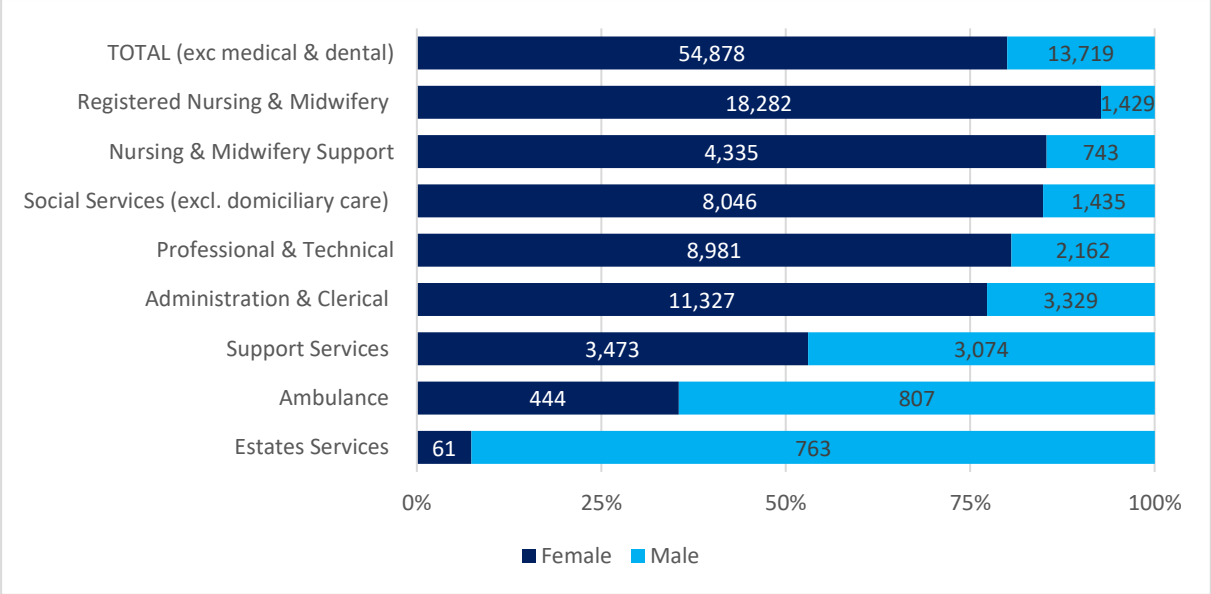
24. Figure A.14 shows a breakdown of AfC staff by broad staff group by gender in Northern Ireland in March 2024. In all staff groups, other than estates services (93%), ambulance staff (65%), and support services (47%), men make up less than 25% of the workforce.

Figure A.13: Changes in gender composition, headcount, in roles at all AfC bands in England, percentage point change between September 2019 and December 2024, [positive indicates increased share of female staff]



Source: NHS England

Figure A.14: Staff in AfC roles by gender, by staff group, in Northern Ireland, March 2024, headcount

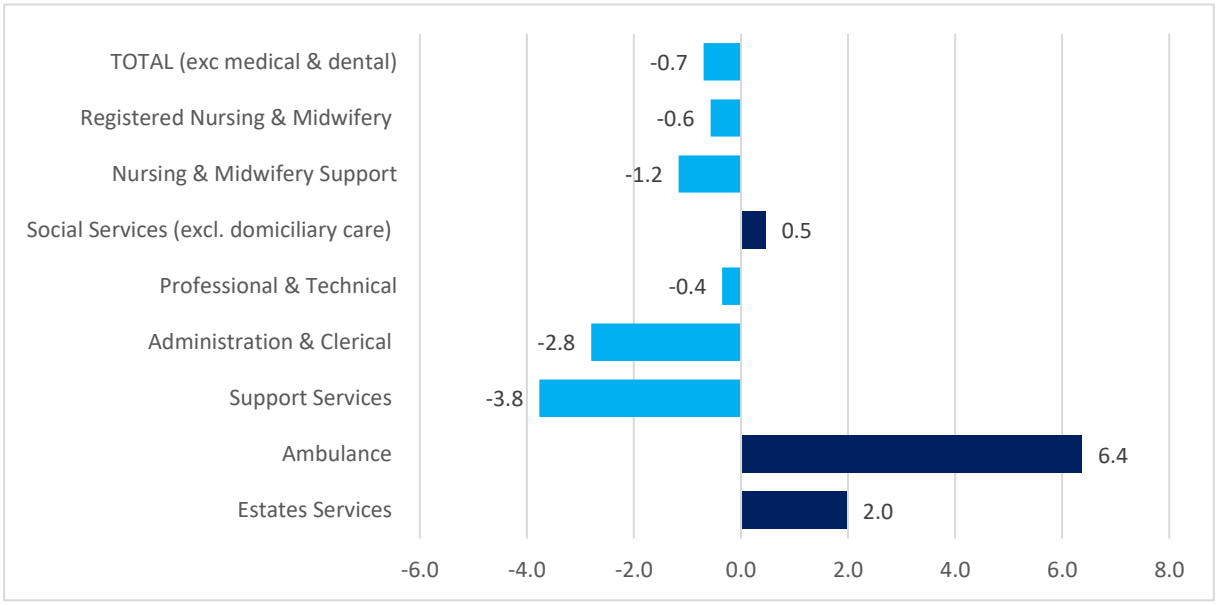


Source: Department of Health, Northern Ireland

25. Figure A.15 shows that overall, in Northern Ireland, the percentage of staff that were female decreased by 0.7 percentage points (from 80.7% to 80.0%) between 2020 and 2024. In March 2024, female staff made up a greater share of ambulance staff (up 6.4 percentage points from 29.1% to 35.5%), estates services (up 2.0 percentage points from 5.4% to 7.4%), social services (excluding domiciliary care) (up 0.5 percentage points from 84.4% to 84.9%) than in 2020. Compared with 2020, in 2024, female staff made up a smaller share of: support services staff

(down 3.8 percentage points, from 56.8% to 53.0%); administration and clerical staff (down 2.8 percentage points from 80.1% to 77.3%); registered nursing and midwifery staff (down 0.6 percentage points from 93.3% to 92.8%); professional and technical staff (down 0.4 percentage points from 80.9% to 80.6%); and nurse support staff (down 1.2 percentage points from 86.5% to 85.4%).

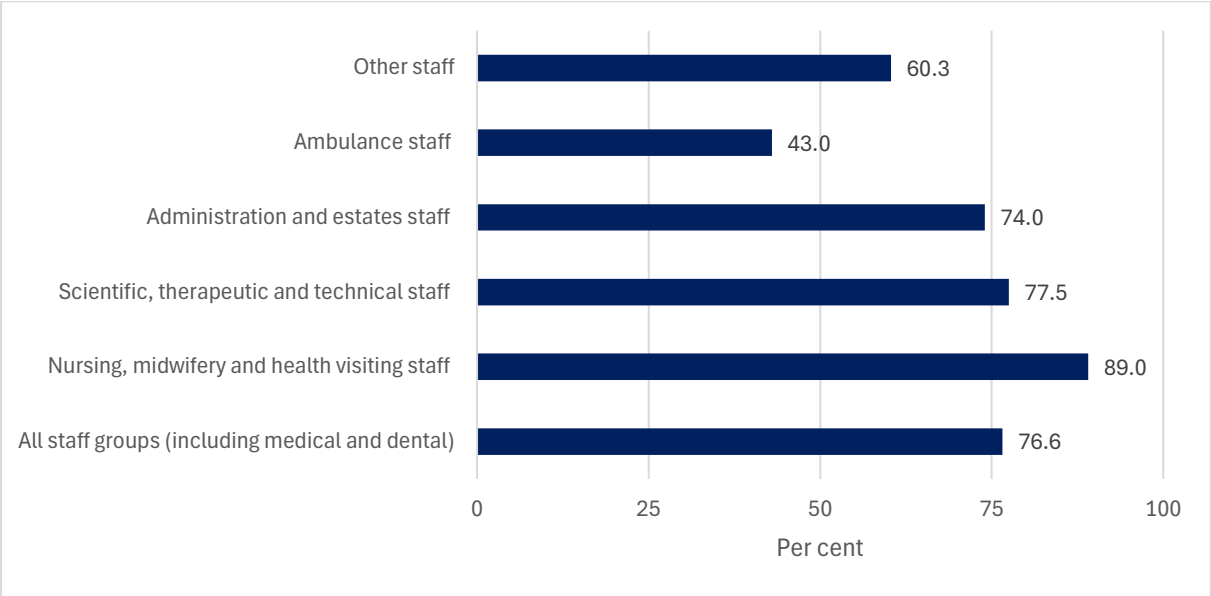
Figure A.15: Staff in AfC roles by gender, headcount, by staff group, in Northern Ireland, percentage point change between March 2020 and March 2024, [positive indicates increased share of female staff]



Source: Department of Health, Northern Ireland

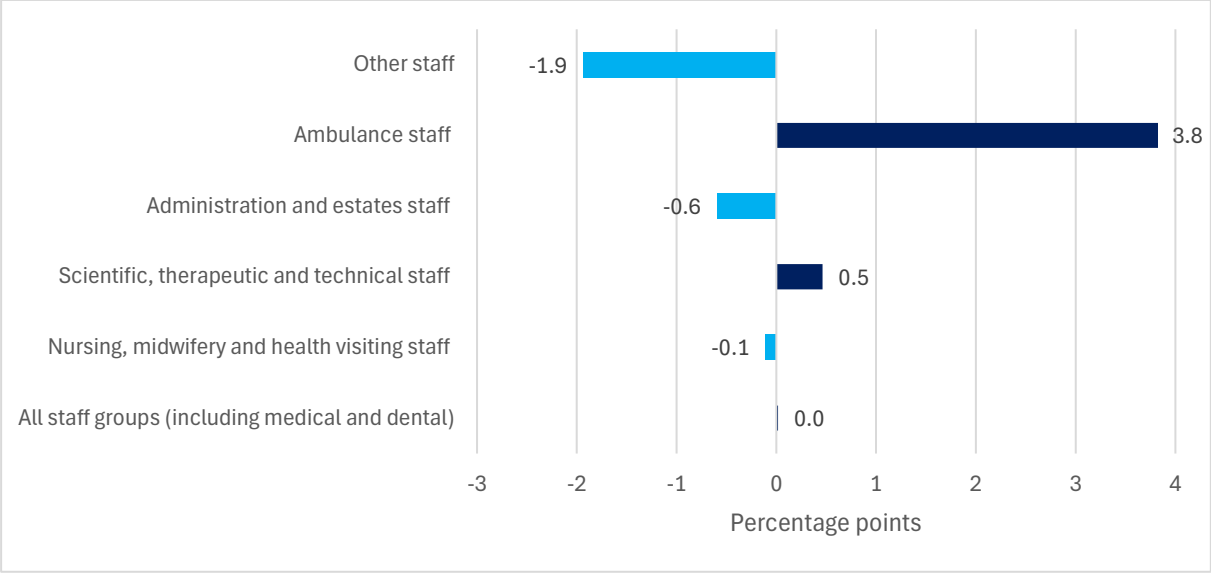
26. Figure A.16 shows the percentage of staff that were female, by broad staff group, in Wales, in September 2024. Overall, including medical and dental staff, 76.6% of staff were female. In all AfC groups other than ambulance staff (43.0%), and 'other' staff (60.3%), at least 74% of staff were female.

Figure A.16: Percentage of staff in AfC roles, that are female, by staff group, in Wales, September 2024, FTE



Source: Stats Wales

Figure A.17: Staff in AfC roles by gender, FTE, by staff group, in Wales, percentage point change between September 2022 and September 2024, [positive indicates increased share of female staff]



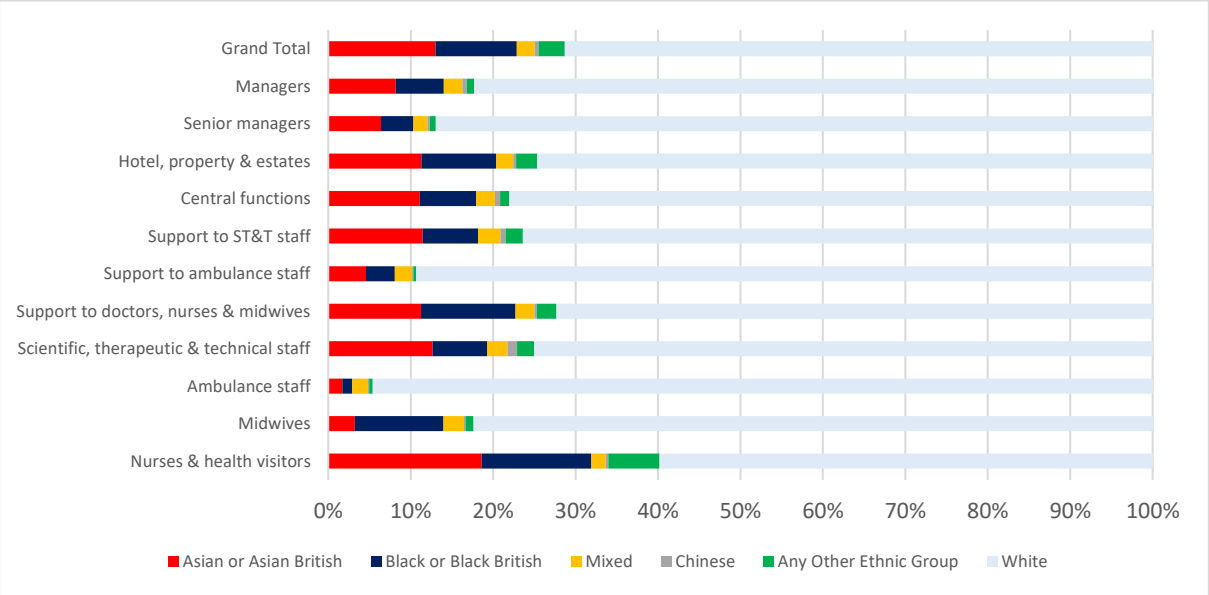
Source: Stats Wales

27. Figure A.17 shows, in Wales, the change in the gender mix between September 2022 (the first date for which data were published) and September 2024, by staff group. It shows that overall, the percentage of staff that were female was unchanged. For individual staff groups, the percentage of ambulance staff that were female increased by 3.8 percentage points (from 39.1% to 43.0%),and the percentage of scientific, therapeutic and technical staff increased by 0.5 percentage points (from 77.0% to 77.5%), while the percentage of: 'other staff' fell by 1.9 percentage points (from 62.3% to 60.3%); administration and estates staff fell by 0.6

percentage points (from 74.6% to 74.0); and nursing, midwifery and health visiting staff fell by 0.1 percentage points (from 89.2% to 89.0%).

28. Figure A.18 shows a breakdown of AfC staff by ethnicity and by broad staff group in England, in December 2024. Overall, excluding those staff whose ethnicity was unknown or not stated, 29% were from ethnic minorities: 13% of staff were Asian or Asian British; 10% Black or Black British; 2% mixed ethnicity; fewer than 1% Chinese and 3% from other ethnic minorities. This compares with data for September 2019 (the data for the period just before the onset of COVID-19), when 19% of staff were from ethnic minorities: 8% of staff were Asian or Asian British; 6% Black or Black British; 2% mixed ethnicity; fewer than 1% Chinese and 2% from other ethnic minorities.

Figure A.18: Staff in AfC roles by ethnic group, by staff group, in England, December 2024, headcount



Source: NHS England

29. The data for December 2024 suggest that by staff group, the most ethnically diverse were nurses and health visitors, with 40% from ethnic minorities (up from 25% in 2019): 19% were Asian or Asian British; 13% Black or Black British; 2% mixed ethnicity; 6% were from other ethnic minorities and 60% were White. In contrast, just 5% of ambulance staff were from ethnic minorities (but up from 3% in 2019): 2% Asian or Asian British; 2% mixed ethnicity; and 1% Black or Black British. This compares with the working age population of England and Wales, which in 2021 was 10.1% Asian, 4.4% Black, 2.5% mixed ethnicity and 2.3% from the Other ethnic group[62].

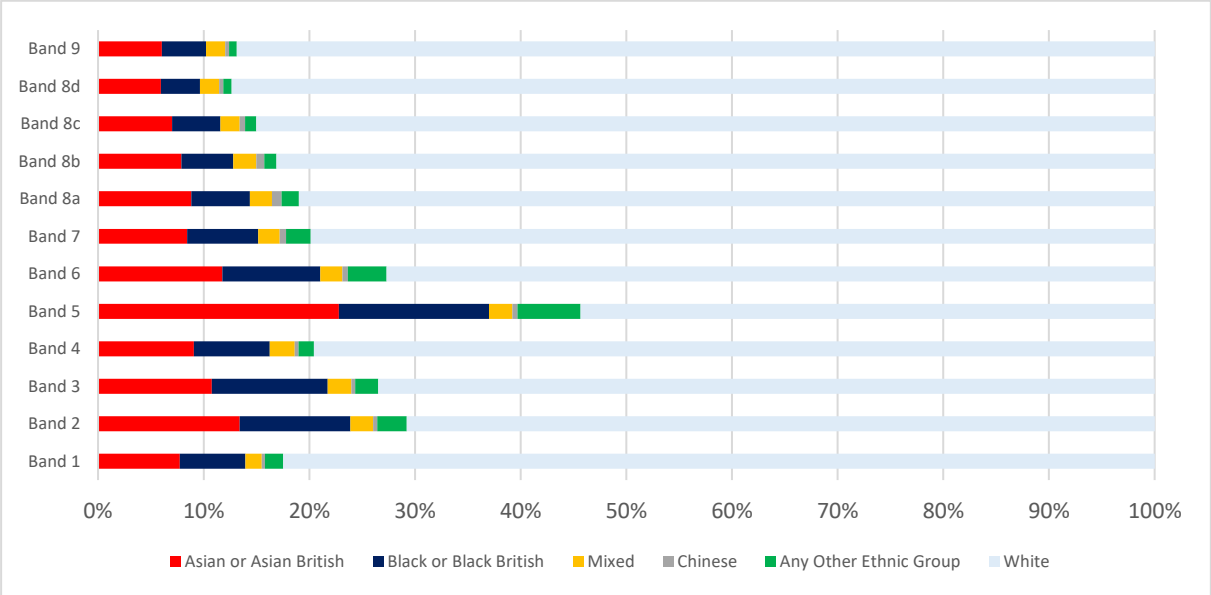
30. Figure A.19 shows a breakdown of AfC staff by ethnicity and by band in England in December 2024. 46% of staff in Band 5 were from an ethnic minority group, with 23% Asian or Asian British, 14% Black or Black British, 2% of mixed ethnicity, 6% from other ethnic minorities and 54% White staff. Bands 2 to 4 and Bands 6 to 7 each had between 20% and 29% of staff from

[62] https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/demographics/working-age-population/latest/#:~:text=80.7%25%20(30.2%20million)%20of%20working%20age%20people%20were%20white,people%20identified%20as%20white%20British

ethnic minorities, but in Bands 8a and above there were fewer than 20% of staff from ethnic minorities, with just 13% of staff at bands 8d and 9.

31. In December 2024, excluding Band 1 which is closed to new entrants, the percentage of staff from ethnic minorities was higher in each band than in 2019. However, the slowest growth has been in the higher bands, where the percentage of staff from ethnic minorities in Bands 7 and above increased by just 5 percentage points. In Bands 2, 3 and 6 the percentage of staff from ethnic minorities increased by nine to ten percentage points over the period. However, by far the largest change came in Band 5, where the percentage of staff from ethnic minorities increased by 19 percentage points, from 27% to 46%.

Figure A.19: Staff in AfC roles by ethnic group, by band, in England, December 2024, headcount



Source: NHS England

32. The NHS in Wales has published data showing an ethnic breakdown of staff since 2022. The data for September 2024, in Table A.4, for all staff (including medical and dental staff), shows 80% of staff were White, 6% were Asian or Asian British, 2% Black or Black British, 1% mixed ethnicity and 2% from other ethnic groups. There were also 10% of staff for whom there was no data. Among AfC staff groups, the most ethnically diverse group were nursing, midwifery and health visitors, while ambulance staff were the least diverse.

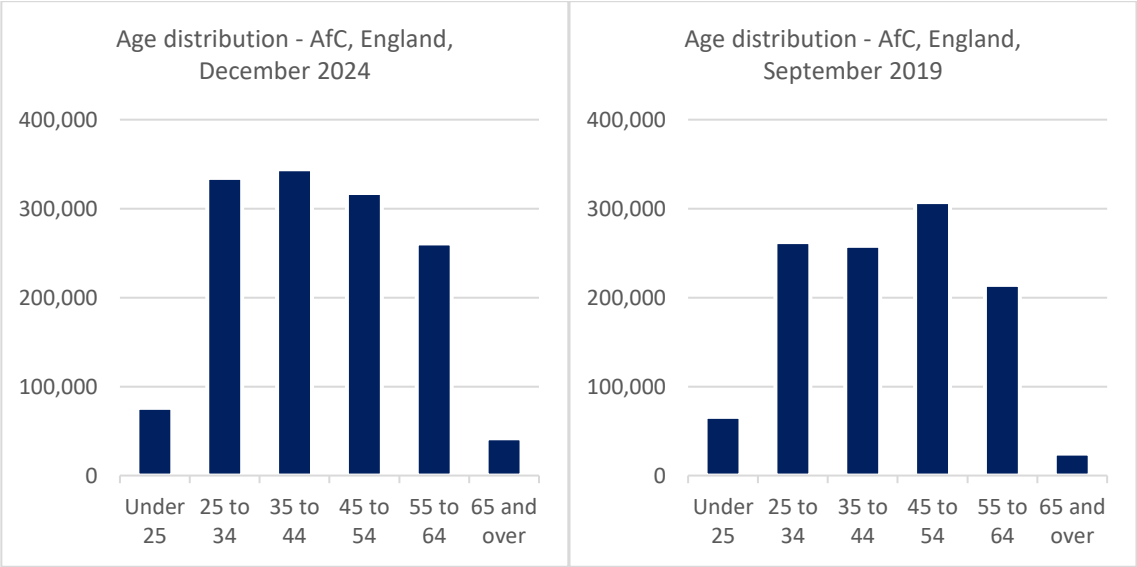
Table A.4: NHS staff in AfC roles by ethnic group, in Wales, September 2024, %, headcount

	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple ethnic groups	White	Other Ethnic Groups	No data
All groups (including medical and dental staff)	5.5	1.7	1.1	80.1	1.7	10.0
Nursing, midwifery and health visiting staff	6.0	1.8	0.9	78.8	1.7	10.8
Scientific, therapeutic and technical staff	3.0	1.6	1.4	86.6	1.1	6.3
Administration and estates staff	1.9	0.9	1.0	88.7	0.6	6.9
Ambulance staff	0.1	0.1	0.6	87.7	0.3	11.3

Source: Stats Wales

33. Figure A.20 shows a breakdown of AfC staff in England, by age group, in December 2024 and September 2019. In December 2024, 24% of staff were aged 25 to 34, 25% were aged 35 to 44, 23% were aged 45 to 54, 19% were aged 55 to 64, 6% were under 25 and 3% were aged 65 and over. Figure A.20 also shows the breakdown of AfC staff in September 2019. Between September 2019 and September 2024, the share of staff aged between 45 to 54 fell by four percentage points, from 27% to 23%, while the share of those aged 35 to 44, increased by two percentage points and those aged 25 to 34 and 65 and over each increased by one percentage point.

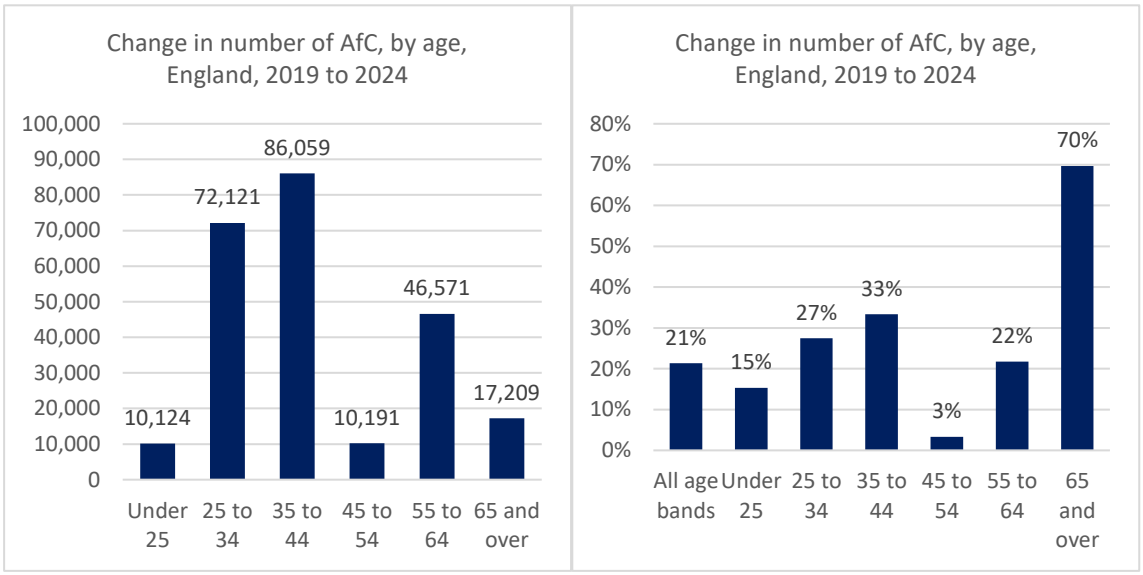
Figure A.20: Staff in AfC roles by age, in England, December 2024 and September 2019, headcount



Source: NHS England

34. Figure A.21 shows that the number of AfC staff increased by 21% between September 2019 and December 2024. Broken down by age group, the number of staff: aged 65 and over increased by 70% (17,209); aged 35 to 44 increased by 33% (86,059); aged 25 to 34 increased by 27% (72,121); aged under 25 increased by 15% (10,124); aged 55 to 64 increased by 22% (46,571); and the number of staff aged 45 to 54 increased by 3% (10,191).

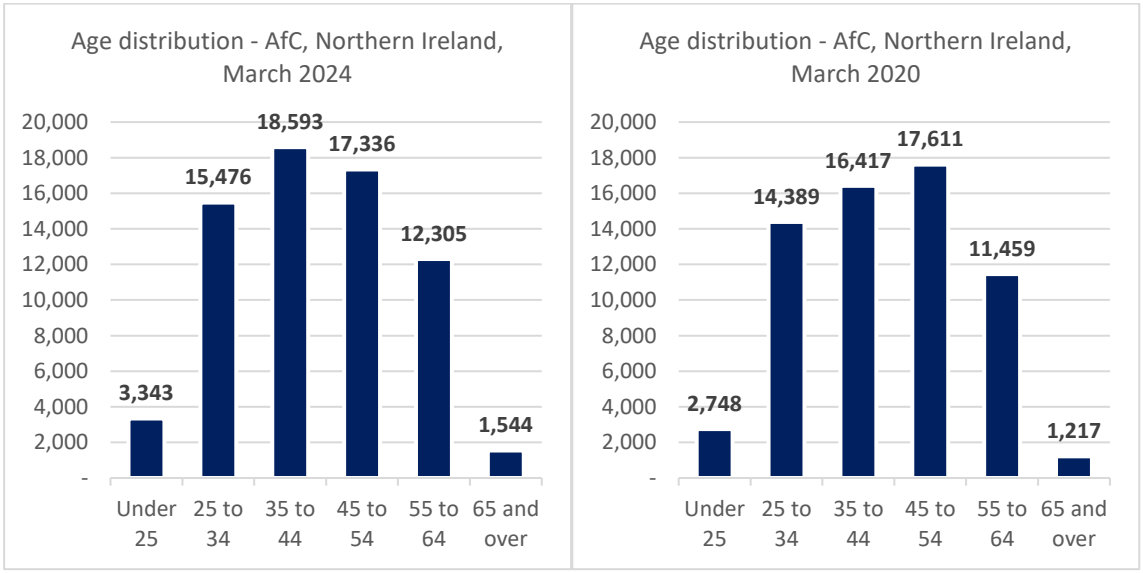
Figure A.21: Change in the number of staff in AfC roles by age, in England, September 2019 to December 2024, headcount



Source: NHS England

35. Figure A.22 shows a breakdown of AfC staff in Northern Ireland, by age group, in March 2024 and March 2020. In March 2024, 27% of staff were aged 35 to 44, 25% were aged 45 to 54, 23% were aged 25 to 34, 18% were aged 55 to 64, 5% were under 25 and 2% were aged 65 and over. Figure 3.22 also shows the breakdown of AfC staff in March 2020. Between March 2020 and March 2024, the share of staff aged between 45 to 54 fell by two percentage points, from 28% to 25%, while the shares of those aged 35 to 44, and under 25 each increased by one percentage point.

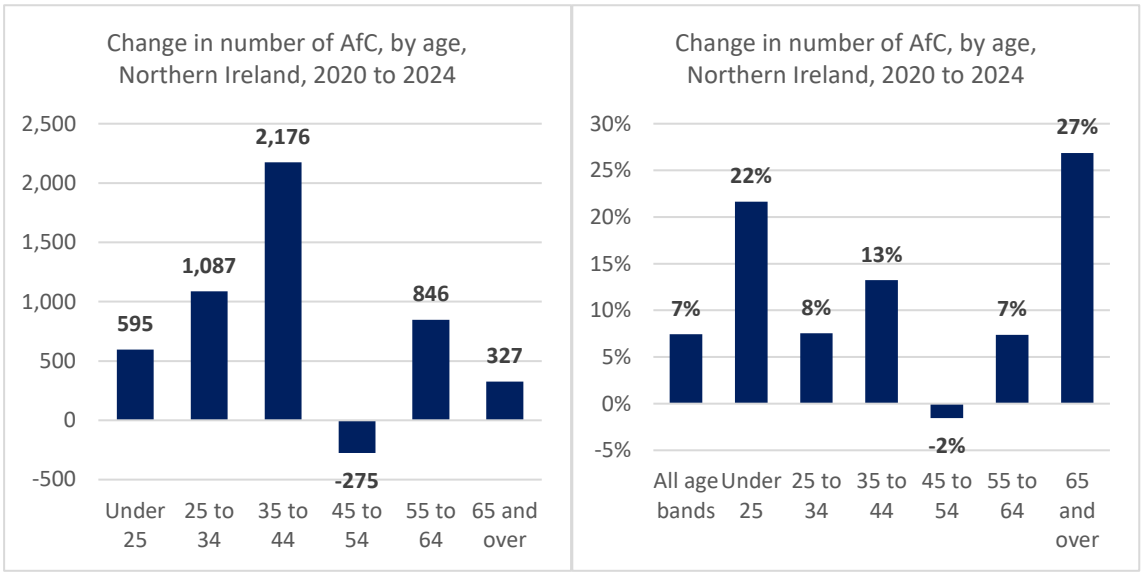
Figure A.22: Staff in AfC roles by age, in Northern Ireland, March 2024 and March 2020 headcount



Source: Department of Health, Northern Ireland

36. Figure A.23 shows the change in the number of AfC staff in Northern Ireland between March 2020 and March 2024. Overall the number of AfC staff increased by 7% over the period, but broken down by age group, the number of staff: aged 65 and over increased by 27% (327); aged under 25 increased 22% (595); aged 35 to 44 increased 13% (2,176); aged 25 to 34 increased by 8% (1,087); aged 55 to 64 increased by 7% (846); and the number of staff aged 45 to 54 fell by 2% (275).

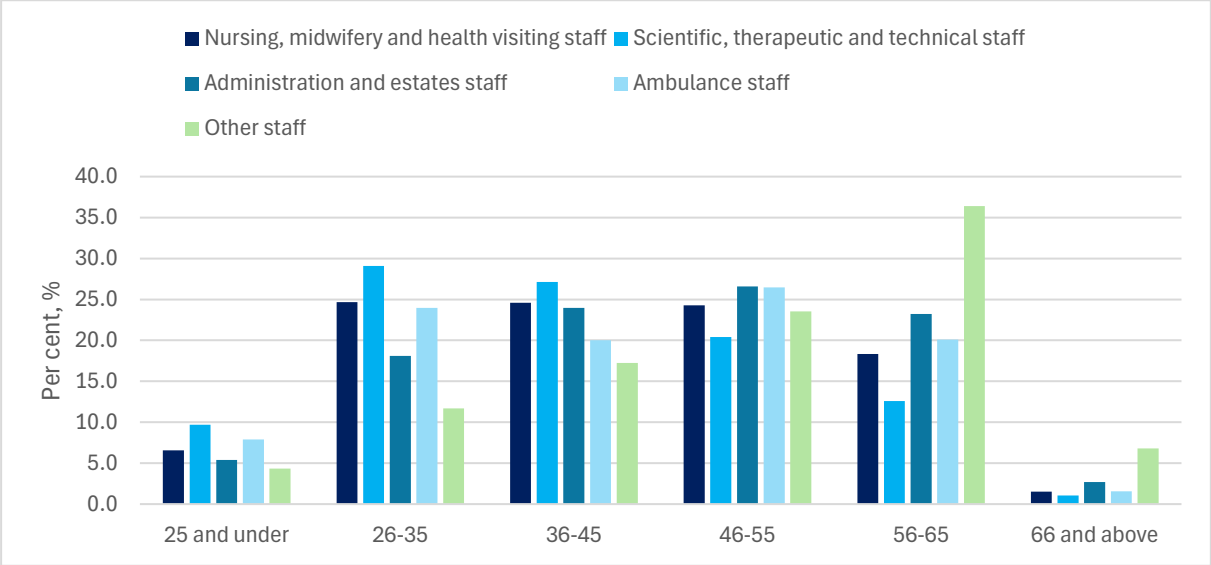
Figure A.23: Change in the number of staff in AfC roles by age, in Northern Ireland, March 2020 to March 2024, headcount



Source: Department of Health, Northern Ireland

37. NHS Wales publish data on the age of staff from 2022 onwards. Figure A.24 shows the age distribution of broad staff groups in September 2024. The age ranges used are slightly different from those used by England and Northern Ireland so impact on cross country comparisons. However, within Wales, there are a larger percentage of scientific, therapeutic and technical staff in the younger age ranges than other staff groups, while there are a larger percentage of administration and estates staff, and 'other' staff in the older age ranges than for other staff groups.

Figure A.24: Staff in AfC roles by age, in Wales, September 2024, headcount



Source: Stats Wales

38. Table A.5 shows a breakdown of AfC staff in England, by disability status. In December 2019, 3.7% of staff said they were disabled, 73.0% said they were not disabled while the disability status of 23.4% was unknown. In December 2024, compared with September 2019, there were increases: to 7.5% in the percentage of AfC staff saying they were disabled; and to 81.3% in the percentage saying they were not disabled. Between September 2019 and December 2024, the percentage of AfC staff whose disability status was unknown, fell from 23.4% to 11.3%.

Table A.5: NHS staff in AfC roles by disability status, in England, September 2019 and December 2024, headcount

Date	Staff group	Disabled	Not disabled	Not known
September 2019	All AfC	3.7%	73.0%	23.4%
December 2024	All AfC	7.5%	81.3%	11.3%
	Nurses & health visitors	6.2%	82.2%	11.6%
	Midwives	7.4%	80.6%	12.0%
	Ambulance staff	8.7%	79.3%	12.1%
	Scientific, therapeutic & technical staff	7.9%	82.4%	9.8%
	Support to doctors, nurses & midwives	7.4%	81.5%	11.1%
	Support to ambulance staff	9.6%	79.5%	10.9%
	Support to ST&T staff	10.2%	80.0%	9.9%
	Central functions	9.7%	80.9%	9.5%
	Hotel, property & estates	5.7%	76.1%	18.3%
	Senior managers	7.0%	82.1%	11.0%
	Managers	8.3%	81.9%	9.8%

Source: NHS England

39. Table A.6 shows a breakdown of NHS staff in Wales, by disability status. In September 2022, the earliest data for which data is available, 3.7% of staff said they were disabled, 71.1% said they were not disabled while the disability status of 25.2% was unknown. In September 2024, compared with September 2022, there were increases: to 5.8% in the percentage of NHS staff saying they were disabled; and to 77.4% in the percentage saying they were not disabled. Between September 2022 and September 2024, the percentage of NHS staff whose disability status was unknown, fell from 25.2% to 16.8%.

Table A.6: NHS staff, by disability status, in Wales, September 2022 and September 2024, headcount

Date	Staff group	Disabled	Not disabled	Not known
September 2022	All NHS staff (inc medical and dental)	3.7%	71.1%	25.2%
September 2024	All NHS staff (inc medical and dental)	5.8%	77.4%	16.8%
	Nursing, midwifery and health visiting staff	5.2%	78.1%	16.7%
	Scientific, therapeutic and technical staff	7.2%	80.3%	12.6%
	Administration and estates staff	7.1%	79.2%	13.6%
	Ambulance staff	7.4%	78.0%	14.6%
	Other staff	5.0%	63.0%	32.0%

Source: Stats Wales

40. Table A.7 shows a breakdown of AfC staff in England, by religious belief. In December 2024, the percentage of AfC staff saying they had religious beliefs was as follows: Christianity (47%); Atheism (16%); Islam (4%); Hinduism (2%), Sikhism (1%); Buddhism (1%); other religious beliefs (8%). Between September 2019 and December 2024 there was an increase in the percentage of AfC staff saying they had belief in each of the religions listed in Table A.7, and there was a fall in the percentage of AfC staff whose religious beliefs were unknown, falling from 32% to 21%.

Table A.7: NHS staff in AfC roles by religious belief, in England, September 2019 and December 2024, headcount

	Atheism	Buddhism	Christianity	Hinduism	Islam	Sikhism	All others	Not Known
September 2019	11%	0%	45%	1%	3%	1%	7%	32%
December 2024	16%	1%	47%	2%	4%	1%	8%	21%

Source: NHS England

41. Table A.8 shows a breakdown of AfC staff in England, by sexual orientation. In December 2024, the percentage of AfC staff describing their sexual orientation was as follows: Heterosexual or Straight (80.0%); Gay or Lesbian (2.0%); Bisexual (1.7%); other sexual orientation (0.2%); undecided (0.2%). Between September 2019 and September 2024, there was an increase in the percentage of AfC staff saying they were Bisexual, Gay or Lesbian; Heterosexual or Straight, Other sexual orientation, Undecided, and there was a fall in the percentage of AfC staff whose sexual orientation was unknown, falling from 28.4% to 15.9%.

Table A.8: NHS staff in AfC roles by sexual orientation, in England, September 2019 and December 2024, headcount

	Bisexual	Gay or Lesbian	Heterosexual or Straight	Other sexual orientation	Undecided	Not known
September 2019	0.7%	1.5%	69.4%	0.0%	0.0%	28.4%
December 2024	1.7%	2.0%	80.0%	0.2%	0.2%	15.9%

Source: NHS England

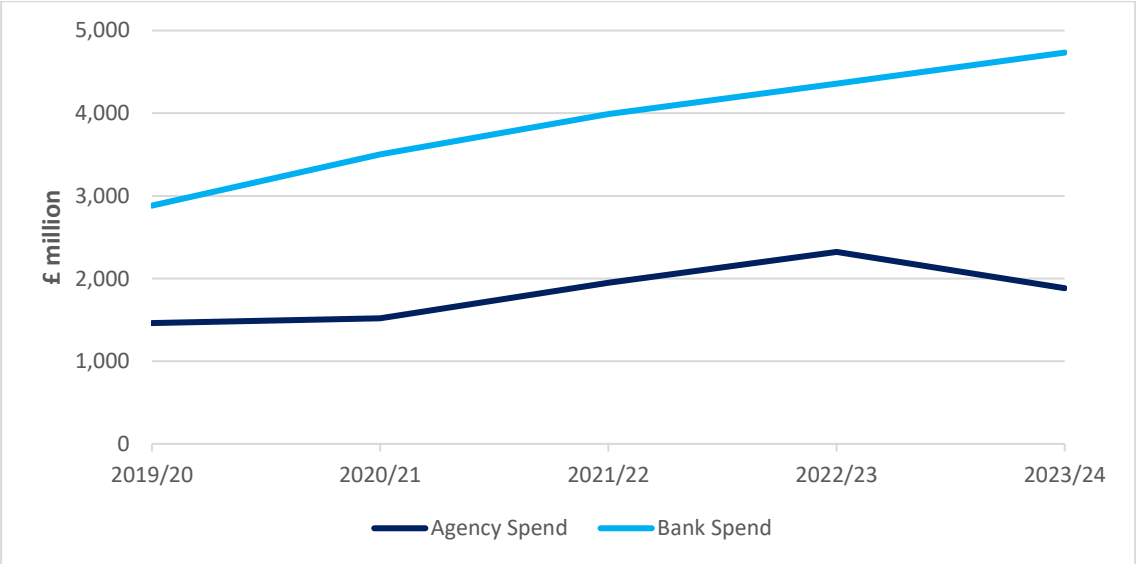
Temporary staff and spend

42. Bank staff are a source of temporary staffing and give NHS trusts the flexibility to respond to demand pressures whilst offering continuity of care. Agency staff are a further source of temporary staffing, which are externally contracted and come at a higher cost.

43. In **England**, NHSE said that in 2023/24 expenditure on bank and agency staff (excluding medical and dental) was £6.6 billion, of which £1.9 billion was agency spend. It said that bank and agency spend combined was equivalent to 10.9% of the paybill, a fall from 11.4% in both 2021/22 and 2022/23. Bank spend was equivalent to 7.8% of the paybill in 2023/24, an increased share from 7.5% in 2022/23, while agency spend was 3.1% of the paybill, a reduced share from 4.0% in 2022/23.

44. NHSE said that between 2022/23 and 2023/24 the percentage of temporary staffing covered by bank shifts increased from 78.4% to 81.3%, while the share covered by agency reduced from 21.6% to 18.7%. The proportion of agency spend as a share of overall temporary staffing costs have fallen from 34.8% in 2022/23 to 28.5% in 2023/24.

Figure A.25: Agency and bank spend, for AfC staff groups, England, 2019/20 to 2023/24

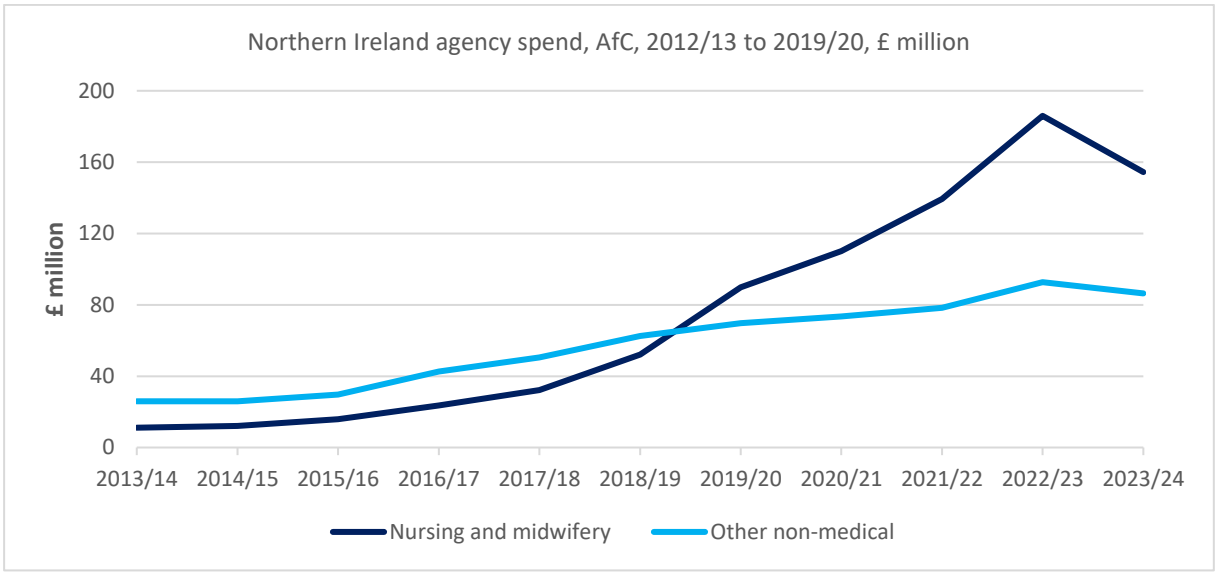


Source: NHS England

45. Figure A.26 shows agency spend in **Northern Ireland** for nursing and midwifery staff and other non-medical staff increasing sharply since 2014/15, from £38 million to £279 million in 2022/23, before falling back to £241 million in 2023/24. The increase in expenditure on

nursing and midwifery staff over that period was from £12 million in 2014/15 to £186 million in 2022/23, before falling back to £154 million in 2023/24.

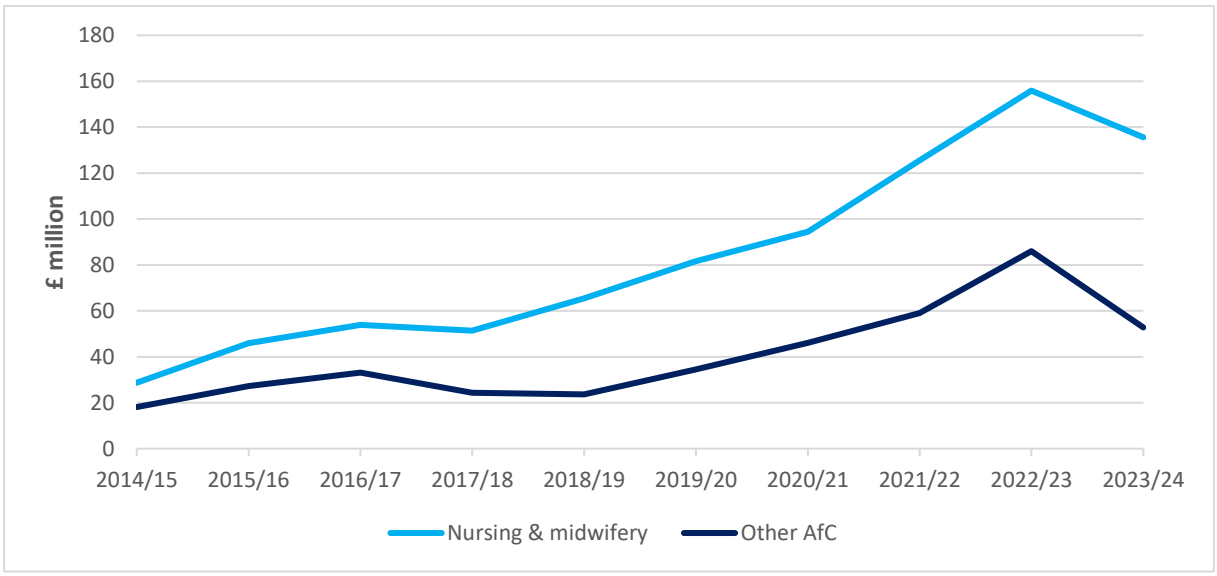
Figure A.26: Agency spend, for AfC staff groups, Northern Ireland, 2013/14 to 2023/24



Source: Department of Health, Northern Ireland

46. The **Welsh Government**'s evidence pointed to reduced agency expenditure in 2023/24, compared with 2022/23. Overall agency expenditure on AfC posts was £188 million, a reduction of £54 million (22%) from 2022/23. The Welsh Government provide agency spend split by some staff groups, and this shows that over that period expenditure to cover nursing and midwifery staff reduced by £20 million (13%) while expenditure on other AfC posts reduced by £33 million (39%) (Figure A.27).

Figure A.27: Agency spend, for AfC staff groups, Wales, 2014/15 to 2023/24



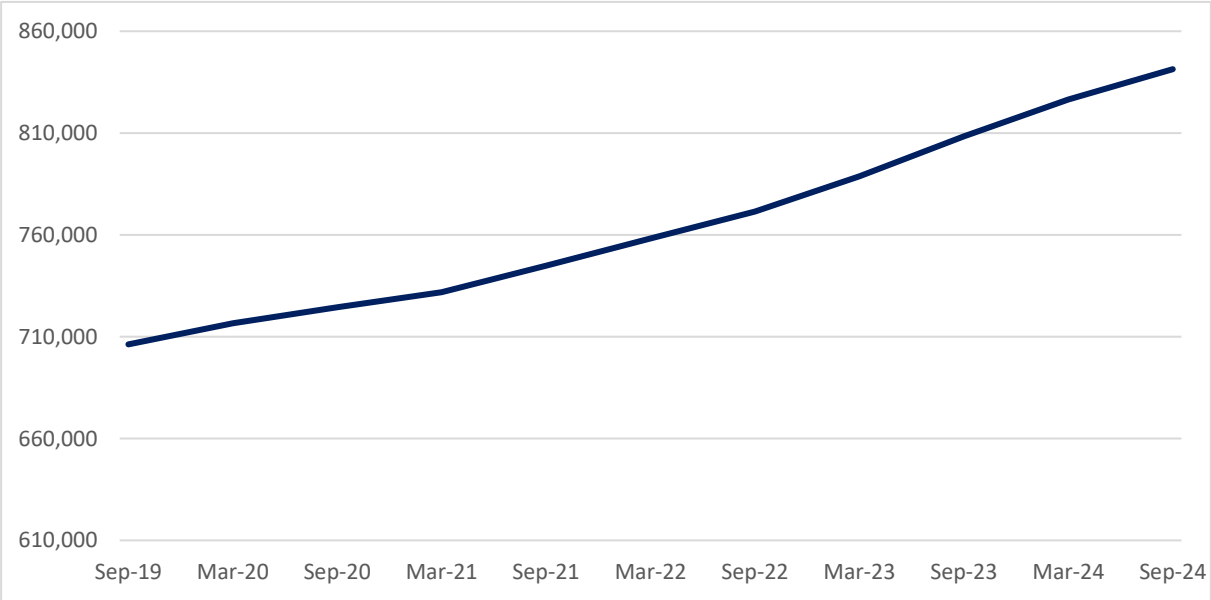
Source: Welsh Government

Nursing and Midwifery Council (NMC) Register

47. Data on the NMC Register helps us understand the total available workforce for nurses, midwives and nursing associates. It shows the numbers able to practice in the United Kingdom, although it will cover those working in the NHS, private and independent sectors or the third sector, and not all of those on the register will be working in their registered roles or working at all.

48. The latest data for September 2024, showed that there were 841,367 nurses and midwives registered to work in the UK (Figure A.28), an increase of 32,900 (4.1%) from a year earlier.

Figure A.28: Number of nurses and midwives on the NMC register, September 2019 to September 2024



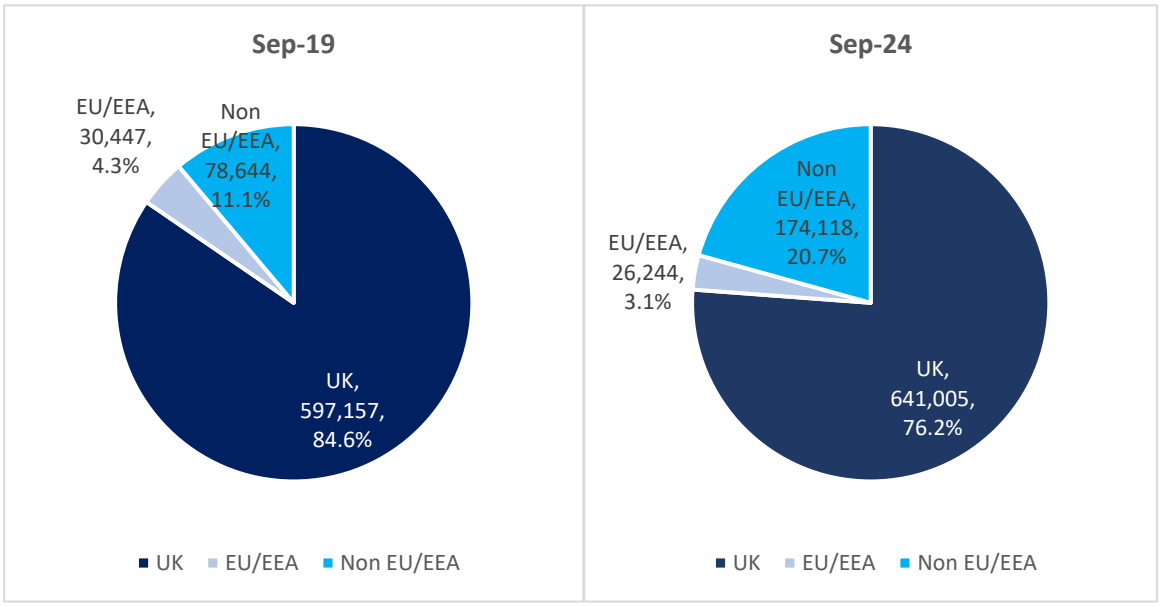
Source: NMC

49. Of the overall total, 641,005 (76.2%) were initially registered in the UK, 26,244 (3.1%) were initially registered in the EU/EEA, and 174,118 (20.7%) initially registered outside the UK and the EU/EEA (Figure A.29).

50. Compared with September 2019, the numbers on the NMC register have increased by 135,119 (19%). There was an increase in the number initially registered in the UK of 43,800 (7%), a fall in the number initially registered in the EU/EEA of 4,200 (-14%) and an increase in the number initially registered outside the UK and the EU/EEA of 95,500 (121%).

51. Between September 2019 and September 2024, the share of those on the register initially registered outside the UK and EU/EEA increased from 11.1% to 20.7%, while the share initially registered in the UK fell from 84.6% to 76.2%, and the share initially registered in the EU/EEA fell from 4.3% to 3.1%.

Figure A.29: Overall number of nurses and midwives on the NMC register by area of qualification, UK, September 2019 and September 2024



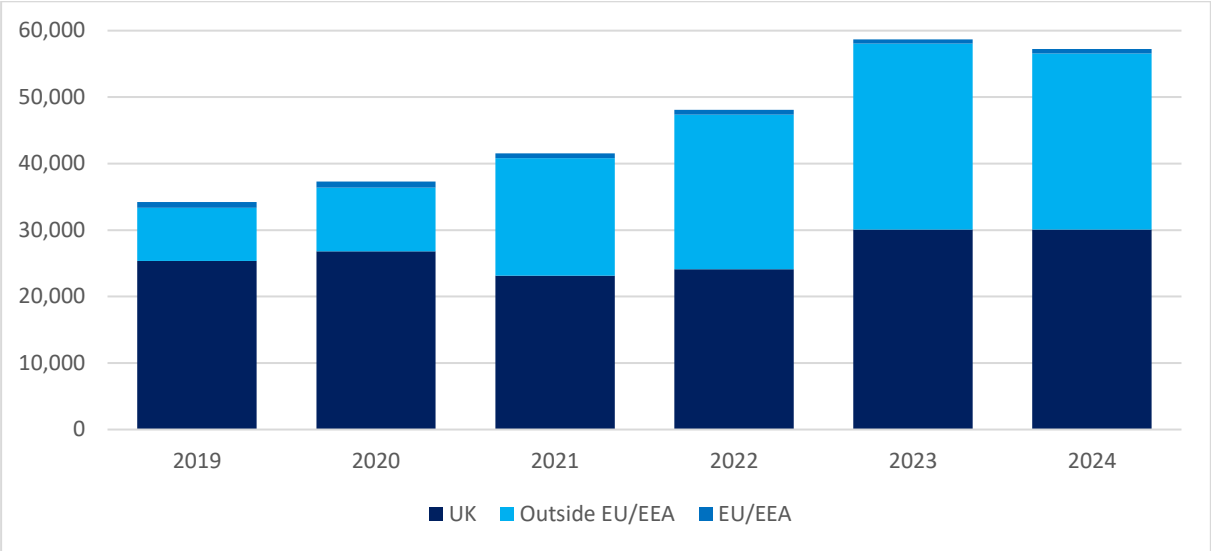
Source: NMC

52. In the year to September 2024, there was an increase of 32,900 (4.1%) nurses and midwives on the register, as 57,220 joined the register for the first time and 28,382 left the register[63].

53. Figure A.30 shows the numbers joining the register for the first time between the year to September 2019 and the year to September 2024. In the year to September 2024, the numbers joining the register were 2% lower than in the previous year. There were: 30,093 joining from the UK, no change from the previous year; 26,459 joining from outside the EU/EEA, a fall of 1,509 (5%) from the previous year; and 668 joiners from the EU/EEA, an increase of 38 (6%) from the previous year.

[63] The joiners data only includes 'new' joiners - those who joined the register for the first time. If someone leaves the register they count as a leaver, but if they re-join the register they do not count as a joiner.

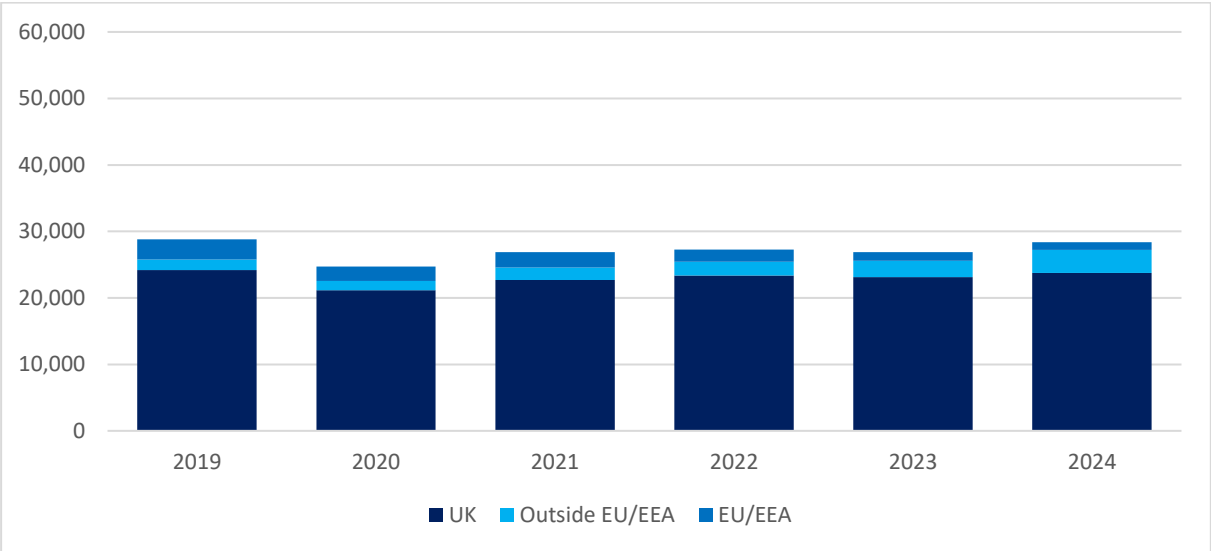
Figure A.30: Joiners to the NMC register, between year to September 2019 and year to September 2024, from the UK, EU/EEA and outside the EU/EEA



Source: NMC

54. Figure A.31 shows the numbers leaving the register between the year to September 2019 and the year to September 2024. The number of leavers each year remains below the number of joiners, as numbers on the register continue to increase. In the year to September 2024, there was an increase in the numbers leaving the register of 1,482 (6%). There was a fall in the number of leavers from the EU/EEA of 140 (11%), more than offset by an increase in the numbers leaving the register from outside the UK and the EU/EEA of 994 (41%) and from the UK of 628 (3%).

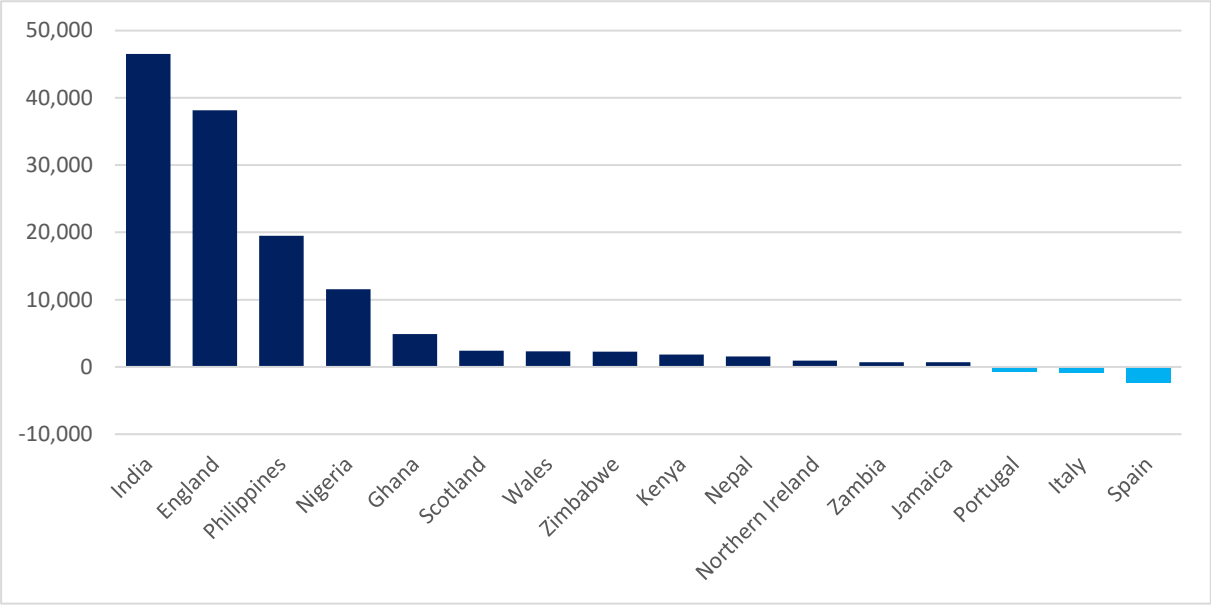
Figure A.31: Leavers from the NMC register, between year to September 2019 and year to September 2024, from the UK, EU/EEA and outside the EU/EEA



Source: NMC

55. Figure A.32 shows the change in the numbers on the NMC register, between September 2019 and September 2024, by country of training. This shows that the growth in the numbers on the register trained in India (46,500) were larger than the growth in the numbers trained in England (38,174). There were also marked increases in the numbers on the register trained in the Philippines (19,500), and Nigeria (11,500). The three countries with the largest fall in numbers on the register over the period were Portugal, Italy and Spain.

Figure A.32: Changes in the numbers on the NMC register, by country of training, September 2019 to September 2024

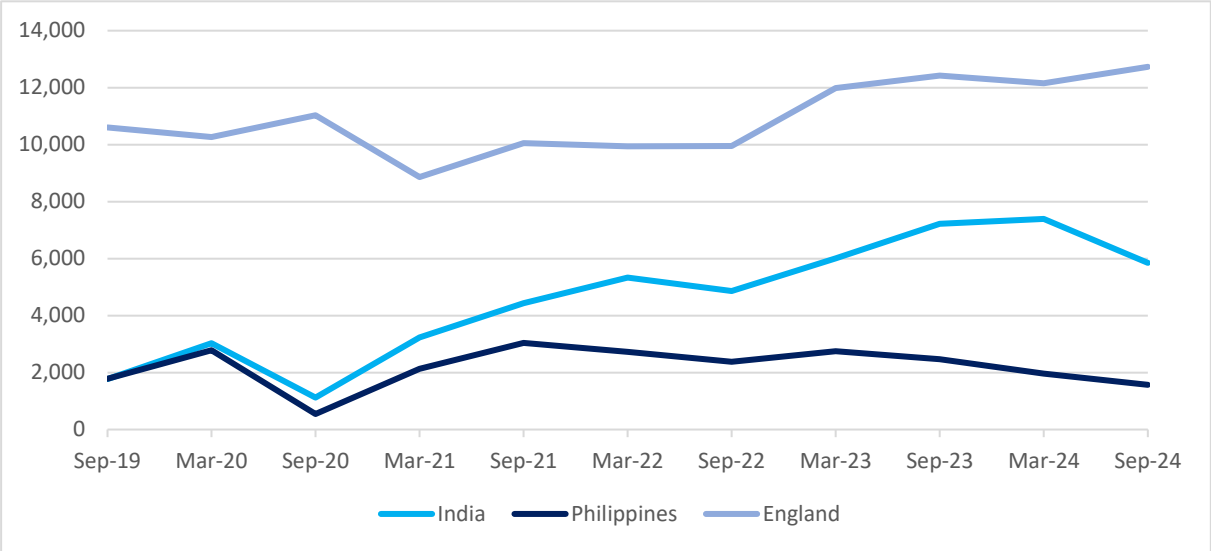


Source: NMC

Note: Only includes those countries where the net change was greater than +/- 600

56. Figure A.33 highlights the growth in the numbers joining the NMC register who were trained in India and the Philippines between the six months to September 2019 and the six months to September 2024. The latest numbers show a fall in the number of joiners from India and the Philippines, while the number of new joiners trained in England increased.

Figure A.33: New joiners to the NMC register, by country of training, England, India and the Philippines, September 2019 to September 2024



Source: NMC

Pre-registration entrants

57. Figure A.34 shows the number of applicants and acceptances to study for nursing, midwifery, and other health related degrees between 2019 and 2024. The numbers of applicants for nursing, midwifery and other health related degrees all rose in 2020 and 2021. However, the numbers of applicants for nursing courses fell in each of the last three years, but in 2024 the number of applicants remained 6% above 2019 levels. The number of applicants for midwifery courses also fell in each of the last three years, and in 2024 the number of applicants was 8% below 2019 levels. The number of applicants to study other health related degrees continued to rise in 2022, fell back in 2023, but increased sharply in 2024, by 17% compared with 2023, and was 49% higher than in 2019.

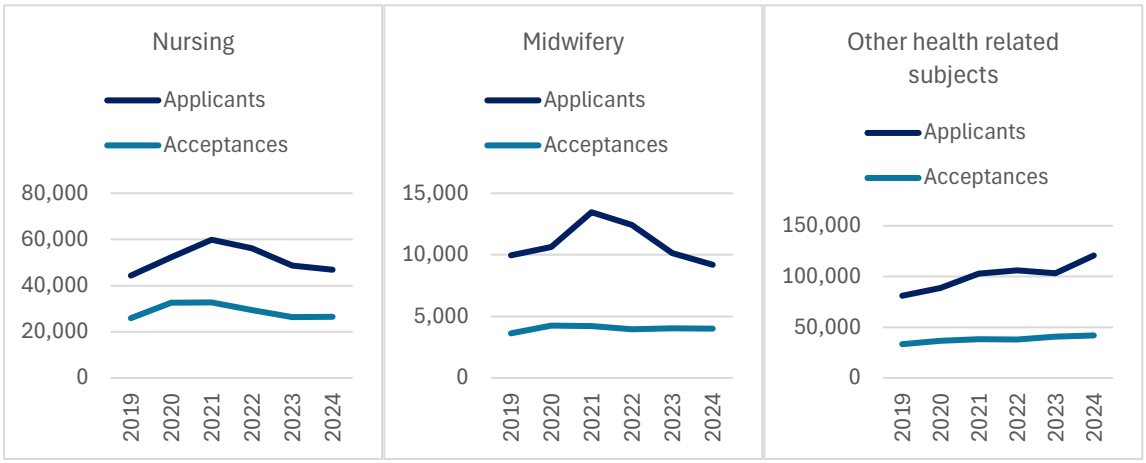
58. The numbers accepted to study nursing and midwifery degrees rose in 2020 and 2021, because of the increase in A-Level grades that resulted from centre assessed grading. However, from 2022 onwards the numbers accepted to study nursing and midwifery have fallen back towards the levels seen in 2019 prior to COVID-19. The numbers accepted in 2024, compared with 2019, were 2% higher for nursing and 11% for midwifery.

59. For other health related degrees, the number of acceptances also increased in 2020 and 2021 before falling back in 2022. However, there has been an increase in the numbers accepted on to courses of this type in both 2023 and 2024, such that in 2024 the number of people accepted to study these subjects was 26% higher than in 2019.

60. Early UCAS data for 2025 showed that the total number of undergraduate applicants, for all subjects, by 29 January 2025, was 600,660, an increase of 1.0% from the same point in the cycle for 2024[64]. The numbers applying to study nursing and midwifery by 29 January 2025, were both lower than at the same point in the cycle for 2024, by 1.8% and 0.4% respectively.

[64] 2025 cycle applicant figures – 29 January deadline | Undergraduate | UCAS

Figure A.34: Number of applicants and acceptances for nursing, midwifery and other health related degrees[65], 2019 to 2024



Source: UCAS

Retention

61. Turnover data, for **England**, showed that the outflow rate for AfC staff as a whole, reached 12.3% in the year to June 2022, the highest rate recorded since at least 2010. Since then, outflow rates have fallen back, to 9.7%, in the year to December 2024, the lowest rate since the year to March 2011 (except for a short period during the COVID-19 pandemic).

62. Table A.9 shows leaving rates, by staff group, for the years to December 2024 (the latest available data), December 2023 (the data available when NHSPRB submitted its 2024 report) and December 2019 (prior to the COVID-19 pandemic). The columns on the right-hand side of the table shows the percentage point changes in leaving rates between 2019 and 2024 and 2023 and 2024.

63. Between 2023 and 2024, the turnover rate for all AfC staff fell by 0.3 percentage points, with falls for nurses and health visitors (0.8 percentage points), midwives (1.1), ambulance staff (1.4), ST&T staff (0.6) and support to ambulance staff (0.9). Over the same period there was an increase in the turnover rate for support to ST&T staff (0.2 percentage points), central functions staff (0.1), hotel, property and estates staff (1.5), senior managers (0.5) and managers (0.7).

64. The turnover rate in 2024, for AfC staff as a whole, was 0.6 percentage points below that of 2019, prior to the COVID-19 pandemic. For all staff groups, the turnover rate in 2024 was lower or the same as in 2019, with the exceptions of support staff groups and hotel, property and estates staff.

[65] Covers: CAH02-02 (pharmacology; toxicology; pharmacy), CAH02-05 (medical technology; healthcare science; biomedical sciences; anatomy, physiology and pathology), CAH02-06 (health sciences; nutrition and dietetics; ophthalmics; environmental and public health; physiotherapy; complementary and alternative medicine; counselling, psychotherapy, and occupational therapy).

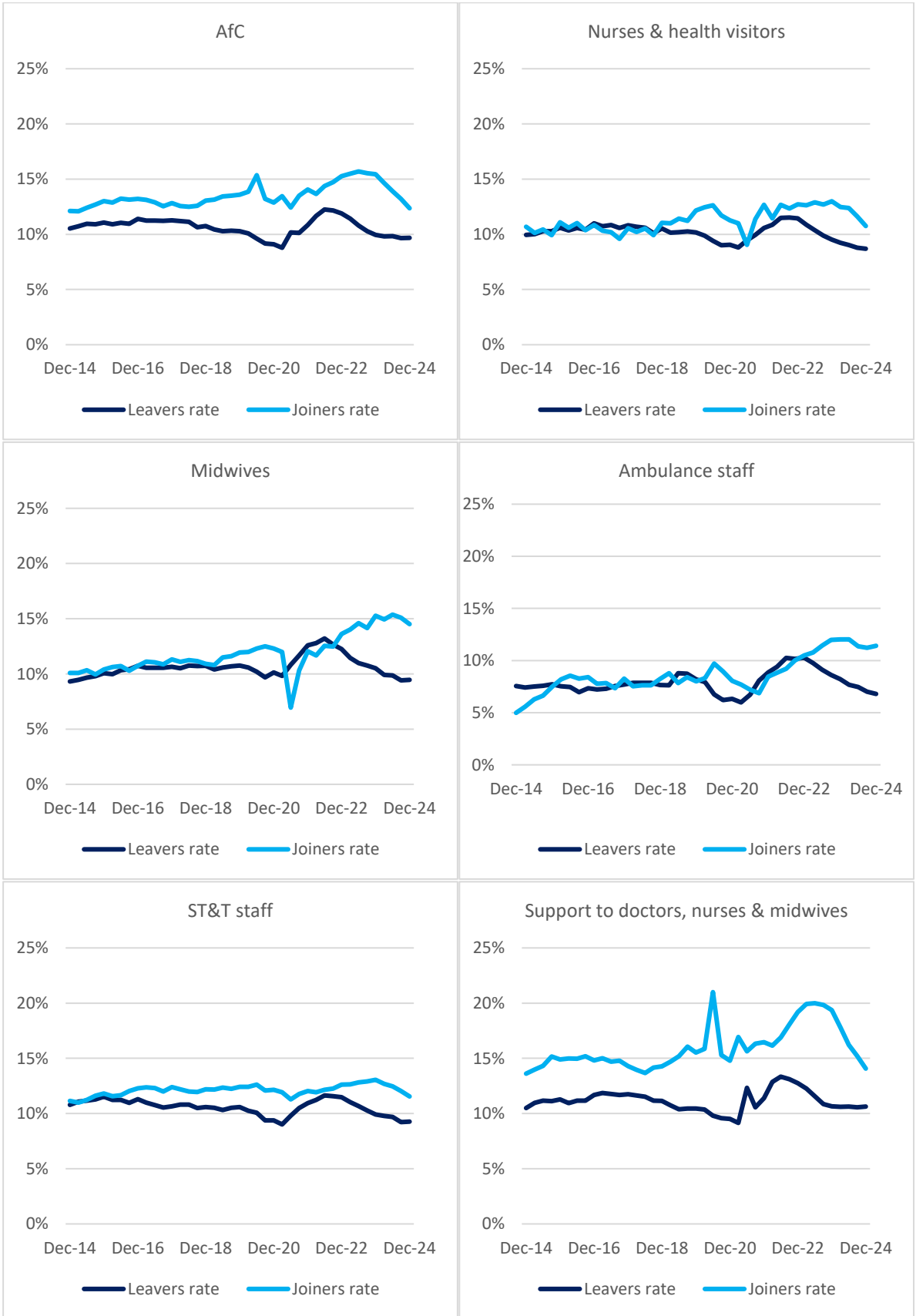
Table A.9: Leaving rates from the NHS by staff group, headcount, year to December 2019, December 2023 and year to December 2024, England

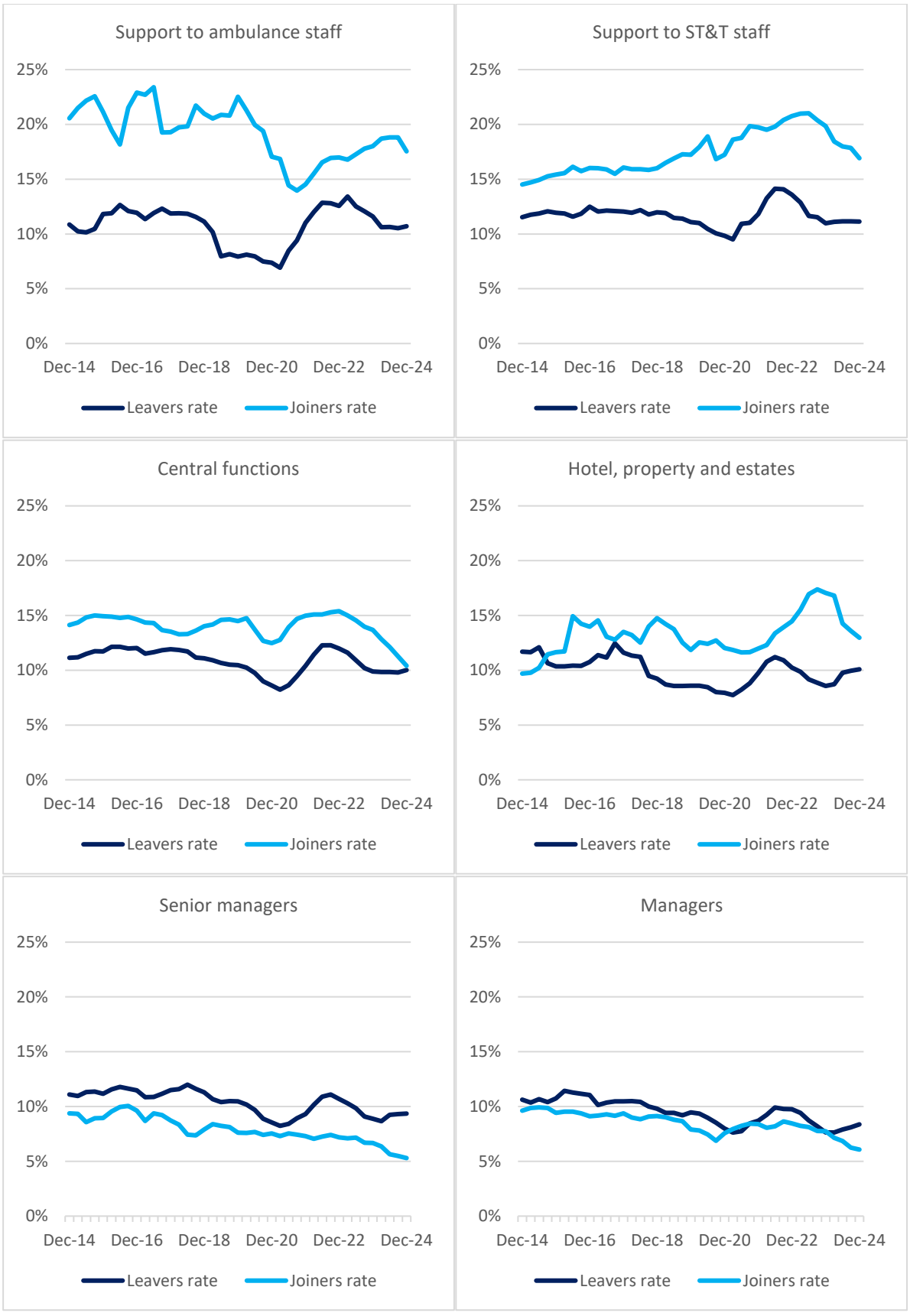
	Turnover in the year to December			Percentage point change between	
	2019	2023	2024	2019 and 2024	2023 and 2024
AfC	10.3%	10.0%	9.7%	-0.6	-0.3
Nurses & health visitors	10.2%	9.5%	8.7%	-1.5	-0.8
Midwives	10.8%	10.5%	9.5%	-1.3	-1.1
Ambulance staff	8.2%	8.2%	6.8%	-1.4	-1.4
Scientific, therapeutic & technical (ST&T) staff	10.6%	9.9%	9.3%	-1.3	-0.6
Support to doctors, nurses, midwives	10.4%	10.7%	10.6%	0.2	0.0
Support to ambulance staff	7.9%	11.6%	10.7%	2.8	-0.9
Support to ST&T staff	11.1%	11.0%	11.1%	0.0	0.2
Central functions	10.5%	9.9%	10.0%	-0.4	0.1
Hotel, property and estates	8.6%	8.6%	10.1%	1.5	1.5
Senior managers	10.5%	8.9%	9.4%	-1.1	0.5
Managers	9.5%	7.6%	8.4%	-1.1	0.7

Source: NHS England. In this table, due to rounding, some changes may not correspond with the differences between the individual figures

65. Figure A.35 shows the leaving and joining rates for staff groups in England, between 2014 and 2024.

Figure A.35: Leaving rates and joining rates from the NHS by staff group, headcount, year 2014 to 2024, England

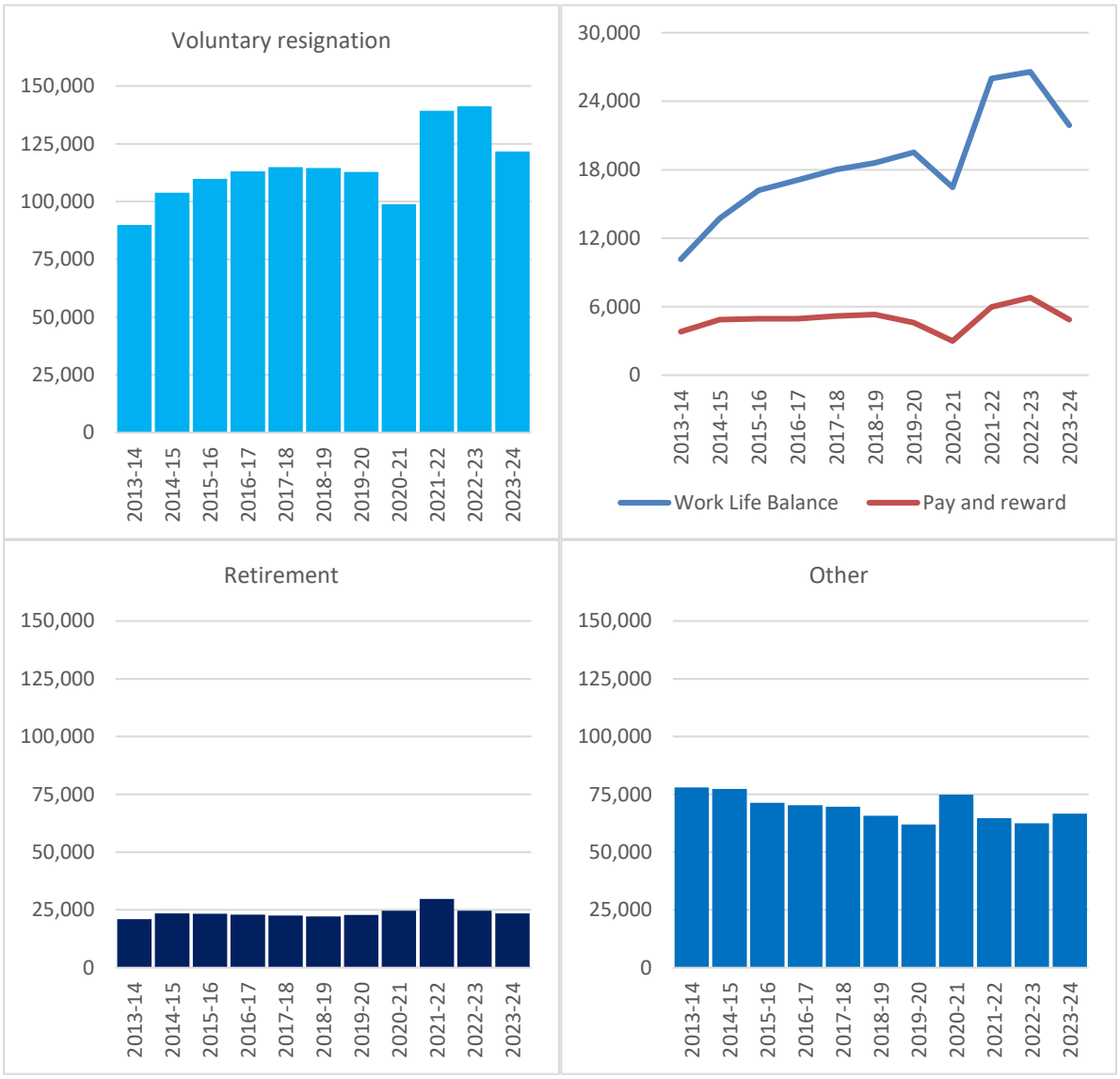




Source: NHS England

66. NHSE publish data of reasons for leaving and staff movement in England. Figure A.36 shows that, for those leaving or moving between April 2023 and March 2024 there were 122,000 voluntary resignations, 23,000 were retirements, and 67,000 left or moved for other reasons. There were 21,900 staff leaving or moving for Work Life Balance, compared with 4,900 who left or moved for reasons relating to pay and reward.

Figure A.36 Timeseries of reasons for leaving and staff movements, 2013-14 to 2023-24, England, all staff groups (including medical and dental)



Source: NHS England

67. In Northern Ireland, the leaving rate for all HSC staff in 2023/24 was 7.7%, down from 8.4% in 2022/23.

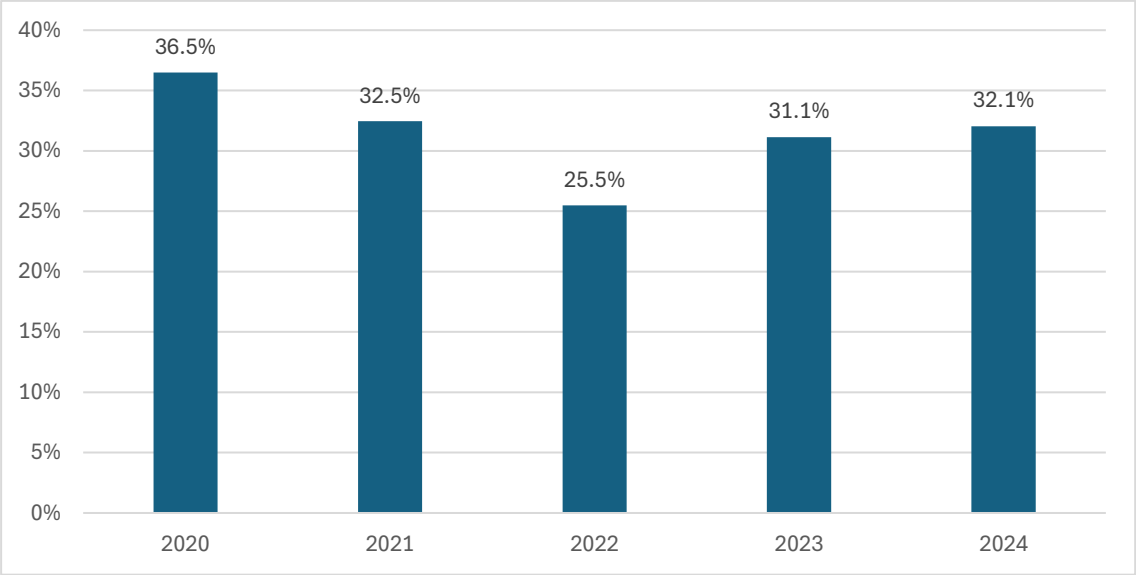
Morale and motivation

NHS Staff Survey (England)

68. Since our 2024 Report, the NHS Staff Survey in England has been published. It was conducted between September and November 2024. There were 775,000 responses, a response rate of 50%, up from 48% in 2023.

69. Figure A.37 shows that in 2024, 32.1% of all NHS staff who responded said they were satisfied[66] with their pay, an increase of one percentage point, from 31.1% in 2023, but a decrease of 4.4 percentage points from 2020.

Figure A.37: All NHS staff, satisfaction with level of pay, England, 2020 to 2024



Source: NHS England

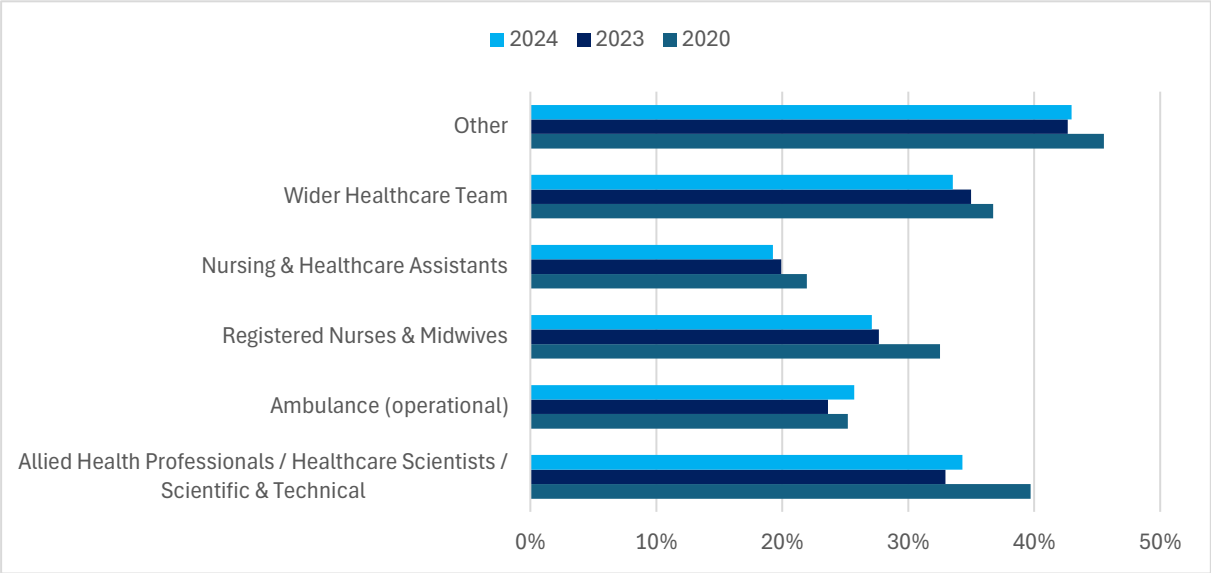
70. Figure A.38 shows satisfaction with pay, broken down by staff group, in 2020, 2023 and 2024. In 2024, the percentage of staff saying they were satisfied with their pay, by staff group were: 34% of the wider healthcare team; 34% of allied health professionals/healthcare scientists/scientific and technical staff; 27% of registered nurses and midwives; 26% of operational ambulance staff; 19% of nursing and healthcare assistants; and 43% of 'other' staff.

71. In 2024, compared with 2023, there was an increase in the percentage of allied health professionals/healthcare scientists/scientific and technical staff and operational ambulance staff saying they were satisfied with their pay, but a reduction in the percentage of registered nurses and midwives, nursing and healthcare assistants, and the wider healthcare team saying they were satisfied with their pay.

72. In 2024, satisfaction with pay for all staff groups, except for ambulance staff, remained lower than in 2020.

[66] Satisfied refers to participants answering that they were 'satisfied' or 'very satisfied' with their level of pay.

Figure A.38: NHS staff, satisfaction with level of pay, by staff group, England, 2020, 2023 and 2024



Source: NHS England

73. Across a range of measures related to job satisfaction (Table A.10) and workload (Table A.11), the results for 2024, were mixed compared with 2023, but remained generally better than in 2022 and 2021.

74. Table A.10 shows that in 2024, compared with 2023, staff were less likely to say that:

- they looked forward to going to work;
- they were enthusiastic about their job;
- time passed quickly when they were working;
- they felt valued by their line manager and organisation; and
- were less likely to recommend their organisation as a place to work.

75. Staff were also less likely to say:

- they were considering leaving the NHS;
- they had experienced harassment, bullying or abuse from patients, relatives or the public.

76. Table A.11 shows that in 2024, compared with 2023, staff were more likely to say that:

- they could meet demands on their time;
- there were sufficient staff to be able to do their job; and
- they achieved a good work-life balance.

77. Staff were less likely to say:

- that there were adequate materials, supplies and equipment to be able to do their job;
- they felt unwell because of work-related stress;
- they were feeling burnt out because of work;
- that they worked over and above their contracted hours, both paid and unpaid hours.

Table A.10: Selected job satisfaction results from the national NHS staff survey, all staff, England, 2020 to 2024

Measure	Question number in 2024 survey	2020	2021	2022	2023	2024	Trend[1]
Engagement and job satisfaction							
I look forward to going to work	2a	58.8%	52.4%	52.6%	55.2%	54.2%	
I am enthusiastic about my job	2b	73.1%	67.4%	66.9%	69.1%	68.1%	
Time passes quickly when I am working	2c	75.6%	72.9%	72.2%	72.0%	70.5%	
The recognition I get for good work	4a	57.2%	51.9%	52.4%	54.7%	54.0%	
My immediate manager values my work	9e	72.7%	70.7%	71.5%	72.7%	72.7%	
Considering leaving the NHS[2]	26d (3 to 5)	18.2%	22.4%	24.0%	21.5%	20.8%	
Recommend my organisation as a place to work	25c	66.8%	59.4%	57.4%	61.1%	60.8%	
The extent to which my organisation values my work	4b	48.0%	42.0%	42.1%	44.9%	44.4%	
My level of pay	4c	36.5%	32.5%	25.5%	31.1%	32.1%	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months[2]	14a	27.1%	27.8%	27.9%	25.3%	25.1%	

Source: NHS England

Notes:
[1] Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and the full range of possible scores for each measure.
[2] Lower scores are better in these cases, however, in all other cases, higher scores are better.

Table A.11: Selected workload results from the national NHS staff survey, all staff, England, 2020 to 2024

Measure	Question number in 2024 survey	2020	2021	2022	2023	2024	Trend[1]
Workload							
I am able to meet all the conflicting demands on my time at work	3g	47.5%	42.9%	42.9%	46.6%	47.3%	
I have adequate materials, supplies and equipment to do my work	3h	60.2%	57.2%	55.5%	58.4%	58.1%	
There are enough staff at this organisation for me to do my job properly	3i	38.2%	26.9%	26.2%	32.3%	34.0%	
During the last 12 months have you felt unwell as a result of work related stress? [2]	11c	44.3%	47.1%	44.9%	41.8%	41.6%	
Achieve good balance between work and home life	6c		52.0%	52.4%	55.8%	56.6%	
Feeling burnt out because of work[2]	12b		34.6%	34.1%	30.5%	30.2%	
Percentage of staff working PAID hours over and above their contracted hours?[2]	10b	33.7%	36.8%	38.4%	36.8%	35.0%	
Percentage of staff working UNPAID hours over and above their contracted hours?[2]	10c	55.6%	57.4%	56.6%	52.8%	50.3%	

Source: NHS England

Notes:

[1] *Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and the full range of possible scores for each measure.*

[2] *Lower scores are better in these cases, however, in all other cases, higher scores are better*.

78. Similar tables, for: registered nurses and midwives; AHPs; ambulance staff; nursing and healthcare assistants; the wider healthcare team; and 'other' staff, are set out below in tables A12 to A23.

Registered nurses and midwives

Table A12: Selected engagement and job satisfaction results from the NHS Staff Survey, England, 2020 to 2024

Measure	Question number in 2024 survey	2020	2021	2022	2023	2024	Trend[1]
Engagement and job satisfaction							
I look forward to going to work	2a	60.0%	52.1%	52.4%	56.6%	55.5%	
I am enthusiastic about my job	2b	76.1%	69.0%	68.7%	72.0%	70.8%	
Time passes quickly when I am working	2c	80.2%	77.3%	76.2%	76.4%	74.7%	
The recognition I get for good work	4a	57.6%	51.0%	51.2%	54.7%	53.6%	
My immediate manager values my work	9e	74.1%	72.3%	72.8%	74.5%	74.1%	
Considering leaving the NHS[2]	26d (3 to 5)	19.7%	24.1%	25.7%	21.1%	19.9%	
Recommend my organisation as a place to work	25c	67.1%	58.4%	56.9%	62.4%	62.5%	
The extent to which my organisation values my work	4b	47.8%	40.3%	39.9%	44.3%	43.7%	
My level of pay	4c	32.5%	28.0%	18.6%	27.7%	27.1%	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months[2]	14a	37.5%	38.3%	38.5%	34.7%	34.5%	

Table A13: Selected workload results from the NHS Staff Survey, England, 2020 to 2024

Measure	Question number in 2024 survey	2020	2021	2022	2023	2024	Trend[1]
Workload							
I am able to meet all the conflicting demands on my time at work	3g	43.4%	38.3%	38.8%	44.3%	44.8%	
I have adequate materials, supplies and equipment to do my work	3h	58.7%	54.6%	52.6%	57.2%	56.8%	
There are enough staff at this organisation for me to do my job properly	3i	33.4%	21.4%	21.3%	29.1%	31.2%	
During the last 12 months have you felt unwell as a result of work related stress?[2]	11c	49.0%	52.9%	50.3%	45.8%	45.5%	
Achieve good balance between work and home life	6c		48.8%	48.9%	54.2%	54.9%	
Feeling burnt out because of work[2]	12b		40.5%	39.7%	34.4%	34.2%	
Percentage of staff working PAID hours over and above their contracted hours?[2]	10b	40.9%	44.5%	46.4%	45.0%	43.0%	
Percentage of staff working UNPAID hours over and above their contracted hours?[2]	10c	65.3%	66.8%	65.7%	60.5%	57.6%	

(1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and the full range of possible scores for each measure. (2) Lower scores are better in these cases.

AHPs, Healthcare Scientists, Scientific & Technical staff

Table A14: Selected engagement and job satisfaction results from the NHS Staff Survey, England, 2020 to 2024

Measure	Question number in 2024 survey	2020	2021	2022	2023	2024	Trend[1]
Engagement and job satisfaction							
I look forward to going to work	2a	57.0%	51.2%	51.1%	53.1%	52.4%	
I am enthusiastic about my job	2b	73.4%	68.4%	67.9%	69.7%	69.2%	
Time passes quickly when I am working	2c	76.0%	73.5%	73.1%	72.7%	71.4%	
The recognition I get for good work	4a	58.2%	53.4%	53.6%	55.4%	54.9%	
My immediate manager values my work	9e	74.9%	72.9%	73.6%	74.5%	74.7%	
Considering leaving the NHS[2]	26d (3 to 5)	18.7%	23.3%	25.0%	22.9%	22.0%	
Recommend my organisation as a place to work	25c	67.6%	60.4%	58.2%	61.4%	61.3%	
The extent to which my organisation values my work	4b	48.3%	43.2%	42.9%	45.1%	44.9%	
My level of pay	4c	39.7%	35.3%	27.1%	33.0%	34.3%	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months[2]	14a	20.7%	21.0%	21.3%	19.4%	18.9%	

Table A15. Selected workload results from the NHS Staff Survey, England, 2020 to 2024

Measure	Question number in 2024 survey	2020	2021	2022	2023	2024	Trend[1]
Workload							
I am able to meet all the conflicting demands on my time at work	3g	43.9%	38.7%	37.9%	41.3%	42.5%	
I have adequate materials, supplies and equipment to do my work	3h	56.8%	52.9%	50.9%	53.3%	52.9%	
There are enough staff at this organisation for me to do my job properly	3i	36.3%	24.5%	23.4%	28.6%	30.9%	
During the last 12 months have you felt unwell as a result of work related stress?[2]	11c	44.6%	47.3%	45.0%	42.5%	41.9%	
Achieve good balance between work and home life	6c		51.5%	51.5%	54.4%	55.2%	
Feeling burnt out because of work[2]	12b		35.0%	35.0%	32.2%	31.7%	
Percentage of staff working PAID hours over and above their contracted hours?[2]	10b	29.2%	32.0%	33.3%	31.1%	29.5%	
Percentage of staff working UNPAID hours over and above their contracted hours?[2]	10c	55.7%	57.9%	57.5%	53.7%	50.8%	

(1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and the full range of possible scores for each measure. (2) Lower scores are better in these cases.

Ambulance (operational staff)

Table A16: Selected engagement and job satisfaction results from the NHS Staff Survey, England, 2020 to 2024

Measure	Question number in 2024 survey	2020	2021	2022	2023	2024	Trend[1]
Engagement and job satisfaction							
I look forward to going to work	2a	55.6%	44.5%	44.2%	48.1%	47.7%	
I am enthusiastic about my job	2b	69.1%	58.5%	58.0%	61.8%	60.7%	
Time passes quickly when I am working	2c	54.7%	47.4%	45.8%	48.0%	47.0%	
The recognition I get for good work	4a	35.8%	27.3%	29.5%	32.6%	33.1%	
My immediate manager values my work	9e	59.2%	51.5%	54.2%	57.9%	59.4%	
Considering leaving the NHS[2]	26d (3 to 5)	19.3%	26.5%	28.3%	24.7%	24.0%	
Recommend my organisation as a place to work	25c	55.7%	40.7%	39.4%	45.8%	47.2%	
The extent to which my organisation values my work	4b	31.4%	22.0%	22.7%	26.3%	26.6%	
My level of pay	4c	25.2%	22.6%	15.8%	23.6%	25.7%	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months[2]	14a	53.6%	53.4%	52.1%	50.1%	50.9%	

Table A17: Selected workload results from the NHS Staff Survey, England, 2020 to 2024

Measure	Question number in 2024 survey	2020	2021	2022	2023	2024	Trend[1]
Workload							
I am able to meet all the conflicting demands on my time at work	3g	39.2%	30.5%	30.7%	36.3%	37.8%	
I have adequate materials, supplies and equipment to do my work	3h	58.0%	49.5%	51.4%	56.0%	58.1%	
There are enough staff at this organisation for me to do my job properly	3i	36.1%	18.0%	19.4%	27.6%	34.8%	
During the last 12 months have you felt unwell as a result of work related stress?[2]	11c	51.5%	60.6%	58.7%	53.8%	53.4%	
Achieve good balance between work and home life	6c		33.8%	34.7%	39.2%	40.3%	
Feeling burnt out because of work[2]	12b		51.0%	49.3%	41.7%	41.5%	
Percentage of staff working PAID hours over and above their contracted hours?[2]	10b	79.1%	81.2%	80.8%	77.7%	76.1%	
Percentage of staff working UNPAID hours over and above their contracted hours?[2]	10c	35.5%	36.6%	36.6%	34.5%	33.1%	

(1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and the full range of possible scores for each measure. (2) Lower scores are better in these cases.

Nursing and healthcare assistants

Table A18: Selected engagement and job satisfaction results from the NHS Staff Survey, England, 2020 to 2024

Measure	Question number in 2024 survey	2020	2021	2022	2023	2024	Trend[1]
Engagement and job satisfaction							
I look forward to going to work	2a	63.3%	54.0%	54.6%	59.4%	58.0%	
I am enthusiastic about my job	2b	76.6%	69.6%	69.3%	72.8%	71.3%	
Time passes quickly when I am working	2c	67.8%	63.7%	63.5%	64.2%	62.2%	
The recognition I get for good work	4a	55.9%	47.6%	48.9%	53.1%	52.7%	
My immediate manager values my work	9e	70.7%	66.9%	68.4%	71.0%	71.2%	
Considering leaving the NHS[2]	26d (3 to 5)	15.5%	20.4%	22.0%	18.1%	18.5%	
Recommend my organisation as a place to work	25c	69.9%	59.8%	58.1%	64.1%	63.3%	
The extent to which my organisation values my work	4b	48.3%	39.0%	39.8%	45.2%	45.1%	
My level of pay	4c	22.0%	16.9%	13.3%	19.9%	19.3%	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months[2]	14a	37.2%	38.7%	39.5%	36.1%	36.5%	

Table A19: Selected workload results from the NHS Staff Survey, England, 2020 to 2024

Measure	Question number in 2024 survey	2020	2021	2022	2023	2024	Trend[1]
Workload							
I am able to meet all the conflicting demands on my time at work	3g	55.0%	49.8%	49.9%	54.4%	54.5%	
I have adequate materials, supplies and equipment to do my work	3h	63.7%	60.1%	56.5%	63.0%	63.1%	
There are enough staff at this organisation for me to do my job properly	3i	36.6%	24.7%	24.6%	32.9%	33.9%	
During the last 12 months have you felt unwell as a result of work related stress?[2]	11c	46.0%	49.5%	47.4%	42.2%	42.9%	
Achieve good balance between work and home life	6c		53.2%	53.7%	58.4%	59.1%	
Feeling burnt out because of work[2]	12b		38.0%	37.4%	30.9%	30.9%	
Percentage of staff working PAID hours over and above their contracted hours?[2]	10b	47.8%	50.7%	52.6%	50.6%	49.6%	
Percentage of staff working UNPAID hours over and above their contracted hours?[2]	10c	30.4%	33.1%	32.9%	28.2%	26.3%	

(1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and the full range of possible scores for each measure. (2) Lower scores are better in these cases.

Wider healthcare team

Table A20: Selected engagement and job satisfaction results from the NHS Staff Survey, England, 2020 to 2024

Measure	Question number in 2024 survey	2020	2021	2022	2023	2024	Trend[1]
Engagement and job satisfaction							
I look forward to going to work	2a	55.7%	52.1%	52.5%	53.4%	52.1%	
I am enthusiastic about my job	2b	68.0%	64.3%	64.1%	64.7%	63.3%	
Time passes quickly when I am working	2c	73.5%	71.7%	71.2%	70.1%	68.5%	
The recognition I get for good work	4a	58.3%	55.2%	56.6%	57.5%	56.6%	
My immediate manager values my work	9e	72.1%	71.1%	72.6%	73.2%	73.2%	
Considering leaving the NHS[2]	26d (3 to 5)	18.0%	21.4%	22.2%	21.3%	21.6%	
Recommend my organisation as a place to work	25c	65.6%	60.7%	58.8%	60.6%	59.1%	
The extent to which my organisation values my work	4b	48.2%	45.0%	46.1%	47.1%	46.3%	
My level of pay	4c	36.8%	34.2%	31.1%	35.0%	33.6%	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months[2]	14a	14.2%	15.1%	15.1%	13.6%	13.3%	

Table A21: Selected workload results from the NHS Staff Survey, England, 2020 to 2024

Measure	Question number in 2024 survey	2020	2021	2022	2023	2024	Trend[1]
Workload							
I am able to meet all the conflicting demands on my time at work	3g	55.3%	52.5%	52.5%	54.9%	55.5%	
I have adequate materials, supplies and equipment to do my work	3h	64.8%	64.8%	64.6%	65.9%	65.0%	
There are enough staff at this organisation for me to do my job properly	3i	45.4%	36.7%	35.6%	40.1%	40.4%	
During the last 12 months have you felt unwell as a result of work related stress?[2]	11c	38.1%	38.7%	36.3%	35.0%	34.9%	
Achieve good balance between work and home life	6c		61.0%	62.1%	63.5%	64.0%	
Feeling burnt out because of work[2]	12b		25.1%	24.4%	23.1%	23.1%	
Percentage of staff working PAID hours over and above their contracted hours?[2]	10b	18.8%	21.8%	23.8%	21.5%	19.9%	
Percentage of staff working UNPAID hours over and above their contracted hours?[2]	10c	45.9%	47.6%	46.5%	43.7%	41.3%	

(1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and the full range of possible scores for each measure. (2) Lower scores are better in these cases.

'Other' staff

Table A22: Selected engagement and job satisfaction results from the NHS Staff Survey, England, 2020 to 2024

Measure	Question number in 2024 survey	2020	2021	2022	2023	2024	Trend[1]
Engagement and job satisfaction							
I look forward to going to work	2a	61.9%	57.4%	57.7%	59.1%	57.1%	
I am enthusiastic about my job	2b	75.3%	70.8%	70.5%	71.6%	69.8%	
Time passes quickly when I am working	2c	78.5%	75.9%	75.4%	74.9%	73.4%	
The recognition I get for good work	4a	62.5%	59.1%	59.7%	60.9%	60.2%	
My immediate manager values my work	9e	75.6%	74.0%	75.2%	76.0%	75.8%	
Considering leaving the NHS[2]	26d (3 to 5)	15.4%	18.6%	19.9%	18.4%	18.5%	
Recommend my organisation as a place to work	25c	69.8%	64.2%	62.2%	64.0%	62.5%	
The extent to which my organisation values my work	4b	54.3%	50.2%	50.6%	52.3%	51.2%	
My level of pay	4c	45.5%	42.8%	37.4%	42.7%	43.0%	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months[2]	14a	13.4%	14.2%	14.5%	12.7%	12.1%	

Table A23: Selected workload results from the NHS Staff Survey, England, 2020 to 2024

Measure	Question number in 2024 survey	2020	2021	2022	2023	2024	Trend[1]
Workload							
I am able to meet all the conflicting demands on my time at work	3g	52.8%	50.0%	50.1%	52.1%	51.7%	
I have adequate materials, supplies and equipment to do my work	3h	64.4%	63.2%	62.5%	62.8%	61.8%	
There are enough staff at this organisation for me to do my job properly	3i	44.6%	35.7%	34.3%	38.6%	39.1%	
During the last 12 months have you felt unwell as a result of work related stress?[2]	11c	39.9%	40.6%	39.0%	37.5%	38.0%	
Achieve good balance between work and home life	6c		57.7%	58.2%	60.5%	61.4%	
Feeling burnt out because of work[2]	12b		29.0%	28.6%	26.7%	27.0%	
Percentage of staff working PAID hours over and above their contracted hours?[2]	10b	20.3%	24.0%	24.8%	22.9%	21.1%	
Percentage of staff working UNPAID hours over and above their contracted hours?[2]	10c	62.3%	61.0%	60.5%	58.1%	57.2%	

(1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and the full range of possible scores for each measure. (2) Lower scores are better in these cases.

NHS Staff Survey (Wales)

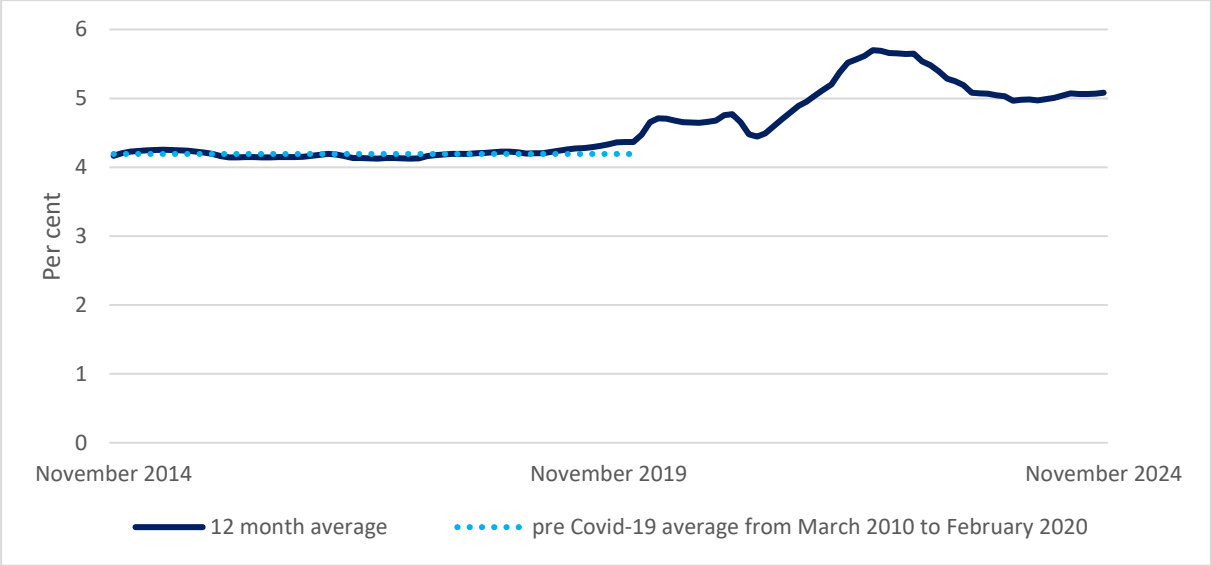
79. In 2024, for the second consecutive year, NHS Wales conducted a staff survey. The survey was conducted in October and November 2024, and generated 24,800 responses, a response rate of 22%, up from 21% in 2023. Detailed results have yet to be published, and the survey does not include a question about satisfaction with pay. The average staff engagement score was 72, a fall from 73 in 2023 and 75 in 2020.

Staff sickness

80. Sickness absence reduces the number of suitably qualified staff available to work and is an indicator of staff engagement and the wellbeing of the workforce.

81. Figure A.39 shows sickness absence rates in **England** for staff as a whole between November 2014 and November 2024. Between March 2010 and February 2020 (prior to the COVID-19 pandemic) monthly sickness absence rates fluctuated in a narrow range, between 4% and 5%, averaging 4.2% over that period. Since early 2020 there has been more volatility in sickness absence rates, with sickness absence peaking at an annual rate of 5.7% in the second half of 2022. Sickness absence rates fell back for most of 2023, but the latest data, for the 12 months to November 2024 shows sickness rates levelling off at 5.1%. The difference between the sickness absence rate for the 12 months to November 2024, and the long-term average is 0.9 percentage points, the equivalent of having 10,800 fewer AfC FTE staff.

Figure A.39: Sickness absence rates in England, all staff, November 2014 to November 2024



Source: NHS England.

82. Table A.24 shows average rates of sickness absence in **England**, by **staff group,** in the year to February 2020 (prior to the COVID-19 pandemic) and the year to November 2024. The staff groups with the highest rates of sickness absence in the year to November 2024 were support to ambulance staff (7.9%), hotel, property and estates staff (7.0%), support to doctors, nurses and midwives (7.0%), and ambulance staff (6.1%).

Table A.24: Rates of sickness absence, England, 12 month average to February 2020 and 12 month average to November 2024, by staff group %

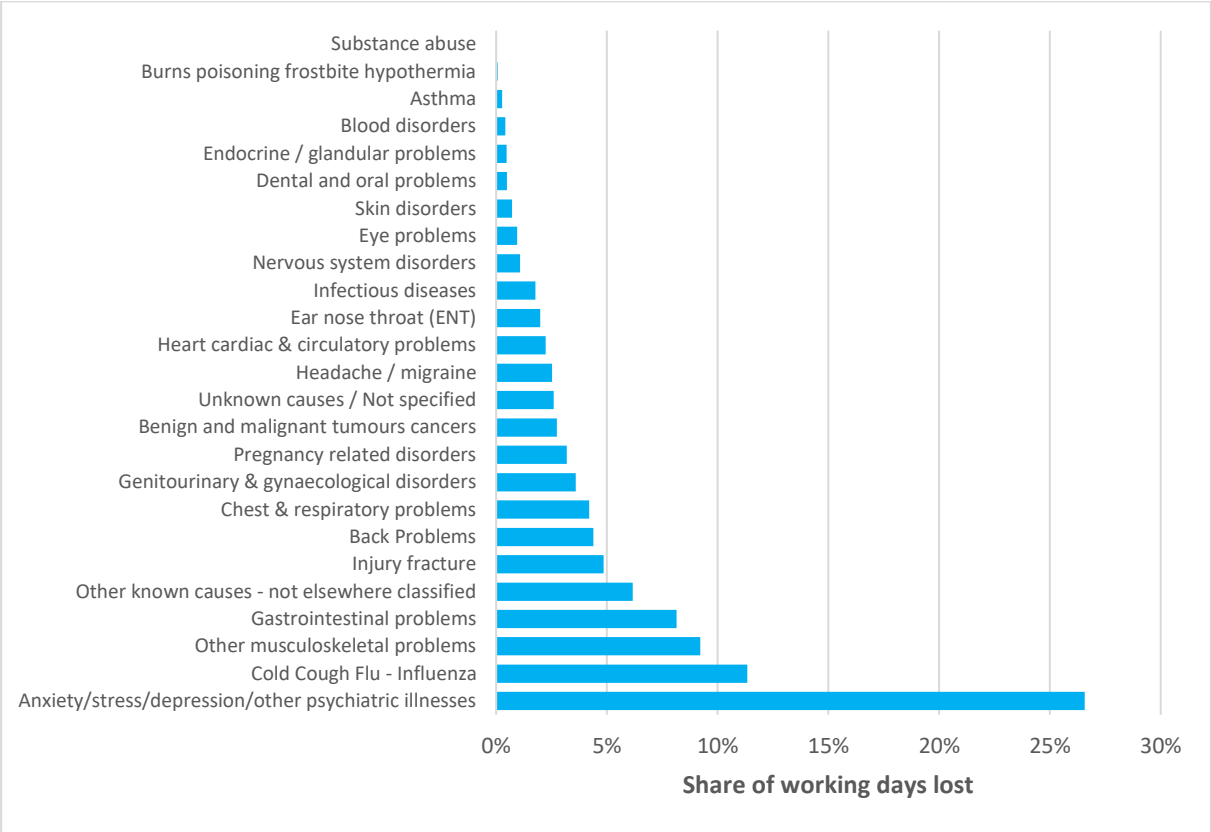
Staff group	12-month average to February 2020	12-month average to November 2024	Change between February 2020 and November 2024
	Percentage points		
All staff groups	4.4	5.1	0.7
Nurses & health visitors	4.6	5.4	0.8
Midwives	5.0	5.7	0.7
Ambulance staff	5.3	6.1	0.7
Scientific, therapeutic & technical staff	3.1	3.9	0.7
Support to clinical staff	5.9	6.8	0.9
Support to doctors, nurses & midwives	6.0	7.0	0.9
Support to ambulance staff	6.6	7.9	1.3
Support to ST&T staff	5.1	5.7	0.6
NHS infrastructure support	4.0	4.5	0.5
Central functions	3.6	3.9	0.3
Hotel, property & estates	6.0	7.0	1.1
Senior managers	1.8	2.1	0.3
Managers	2.3	2.6	0.3
Other staff or those with unknown classification	1.6	0.9	-0.7

Source: NHS England. In this table, due to rounding, some totals may not correspond with the differences between the individual figures

83. The staff groups with the largest changes in sickness absence rates between the 12-months to February 2020 and the 12-months to November 2024 were support to ambulance staff (increase of 1.3 percentage points), and hotel, property and estates staff (1.1). The staff groups with the smallest changes in sickness absence rates over the period were central functions (0.3 percentage points), managers (0.3) and senior managers (0.3).

84. Figure A.40 shows the reasons for sickness absence in England, for AfC staff, in the 12 months to November 2024. The most common reason for sickness absence was 'anxiety, stress, depression and other psychiatric problems', accounting for 27% of all absence. The next most common reasons for sickness were 'cold, cough, flu' (11%), 'other musculoskeletal problems' (9%), 'gastrointestinal problems' (8%).

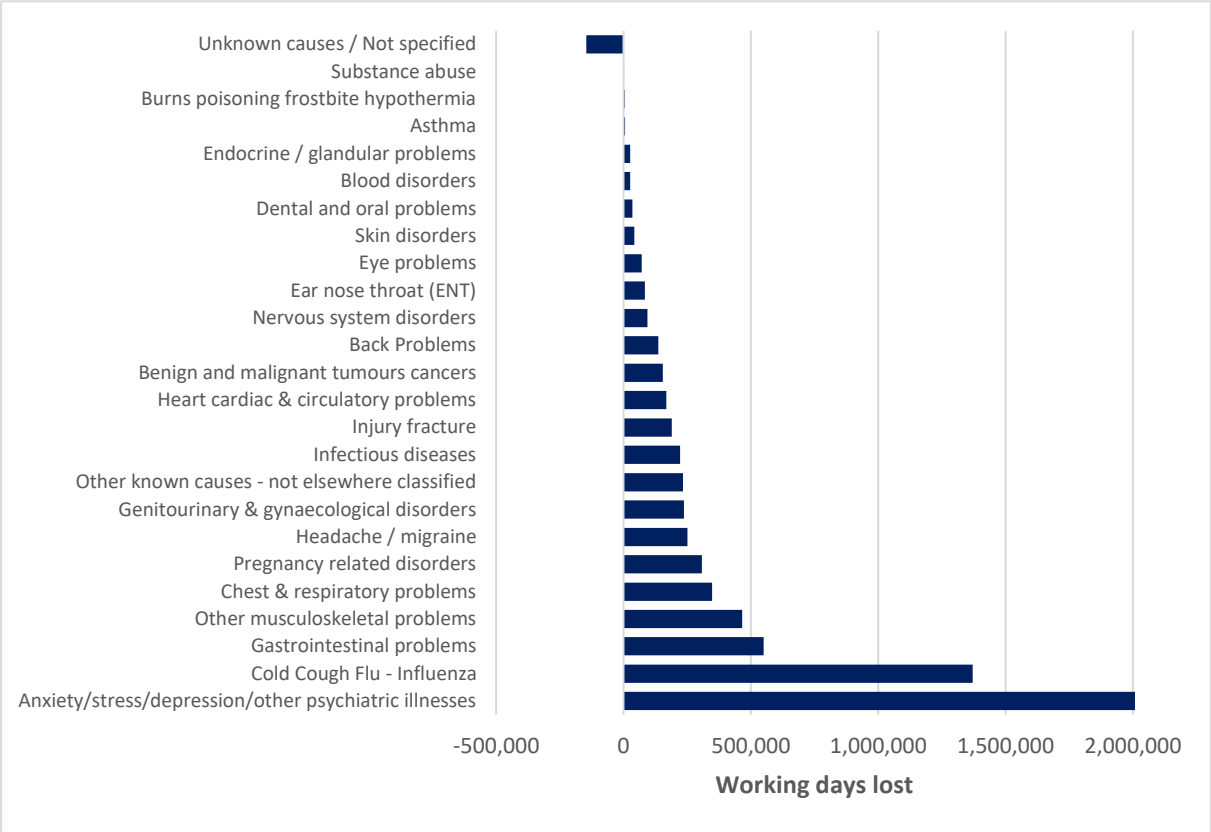
Figure A.40: Sickness absence days, by reason for absence, % of all sickness absence, England, 12 months to November 2024



Source: NHS England

85. In the 12 months to November 2024, there were 25.6 million AfC staff days lost to sickness absence, an increase of 6.9 million, from 18.7 million in the 12 months to March 2020. Figure A.41 shows that half of the extra sickness absence was related to 'anxiety, stress, depression and other psychiatric problems' (2.1 million), and 'cold, cough, flu' (1.4 million).

Figure A.41: Change in the number of sickness absence days between 12 months to March 2020 and 12 months to November 2024, by reason for absence, England, AfC staff

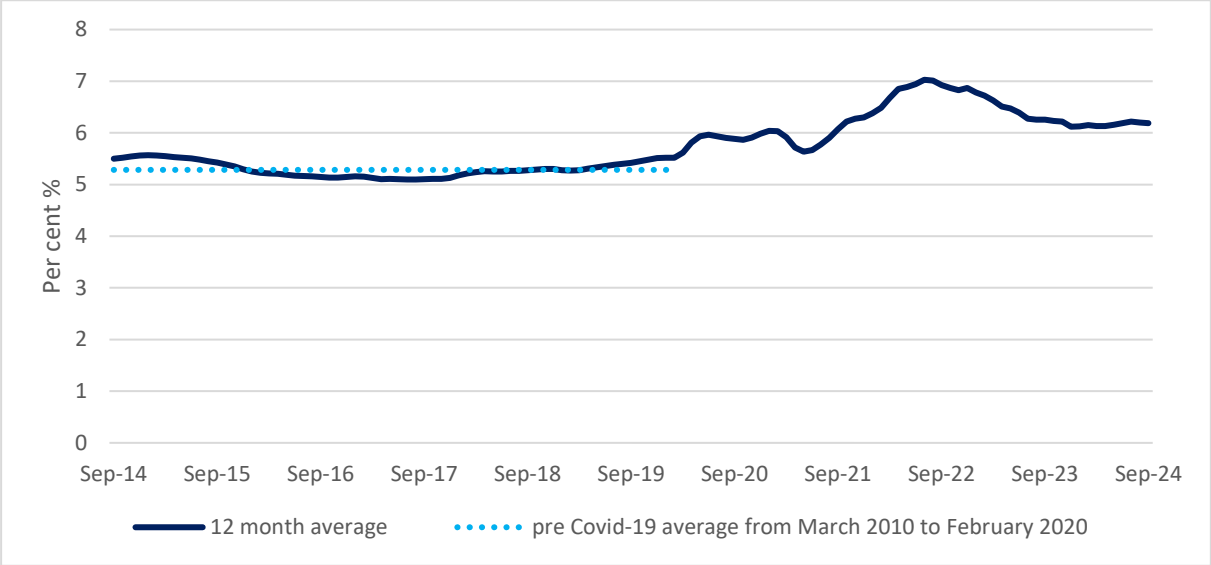


Source: NHS England

86. Figure A.42 shows sickness absence rates in **Wales** for staff as a whole, between September 2014 and September 2024. Between 2010 and February 2020 (prior to the COVID-19 pandemic) monthly sickness absence rates fluctuated in a narrow range, between 5% and 6%, with a 12-month average around 5.3%. Since early 2020 there has been more volatility in sickness absence rates, with spikes in absence in the spring of 2020 and the winter of 2020/2021, followed by periods when sickness absence rates dropped back to 5%. However, following a further spike in sickness absence in the winter of 2021/2022 absence rates remained above 6% every month between June 2021 and March 2023.

87. In the 12 months to September 2024, the monthly average sickness absence rate was 6.2%, down from a peak of 7.0% in the 12 months to August 2022. The difference between the sickness absence rate for the 12 months to September 2024, and the long-term average is 0.9 percentage points, the equivalent of having 800 fewer AfC FTE staff in Wales.

Figure A.42: Sickness absence rates in Wales, all staff, September 2014 to September 2024



Source: Stats Wales

88. Table A.25 shows average rates of sickness absence in **Wales**, by **staff group,** in the year to March 2020 (the 12 months prior to the COVID-19 pandemic) and the year to September 2024. The staff groups with the highest rates of sickness absence in the year to September 2024 were healthcare assistants and support workers (9.2%), ambulance staff (8.9%), and nursing, midwifery and health visiting staff (7.5%).

Table A.25: Rates of sickness absence, Wales, 12 month average to March 2020 and 12 month average to September 2024, by staff group %

Staff group	12 month average to March 2020	12 month average to Sep 2024	Change between March 2020 and Sep 2024
	Percentage points		
All staff groups	5.6	6.2	0.6
Scientific, Therapeutic and Technical staff	4.4	4.8	0.4
Administration, Estates and General Payments staff	4.8	5.4	0.6
Nursing, Midwifery and Health Visiting staff	6.8	7.5	0.7
Ambulance staff	7.6	8.9	1.4
Healthcare Assistants and Support Workers	8.0	9.2	1.3

Source: Stats Wales. In this table, due to rounding, some totals may not correspond with the differences between the individual figures

89. The staff groups with the largest changes in sickness absence rates between the year to March 2020 and the year to September 2024 were ambulance staff (1.4 percentage points), and healthcare assistants and support workers (1.3). The staff group with the smallest change in sickness absence rate over the period was scientific, therapeutic and technical staff (0.4 percentage points).

National, regional and local variations in the labour market across the NHS

Regional and local variation and HCAS

90. The High-Cost Area Supplement (HCAS) allowance, also referred to as London Weighting, is a payment made to employees who work in London and the surrounding areas. The allowance is divided into three levels, Inner, Outer and Fringe (set out in Table A.26).

Table A.26: HCAS rates

Area	Rate
Inner London	20% of basic salary, subject to a minimum payment of £5,414 and a maximum payment of £8,172
Outer London	15% of basic salary, subject to a minimum payment of £4,551 and a maximum payment of £5,735
Fringe	5% of basic salary, subject to a minimum payment of £1,258 and a maximum payment of £2,122

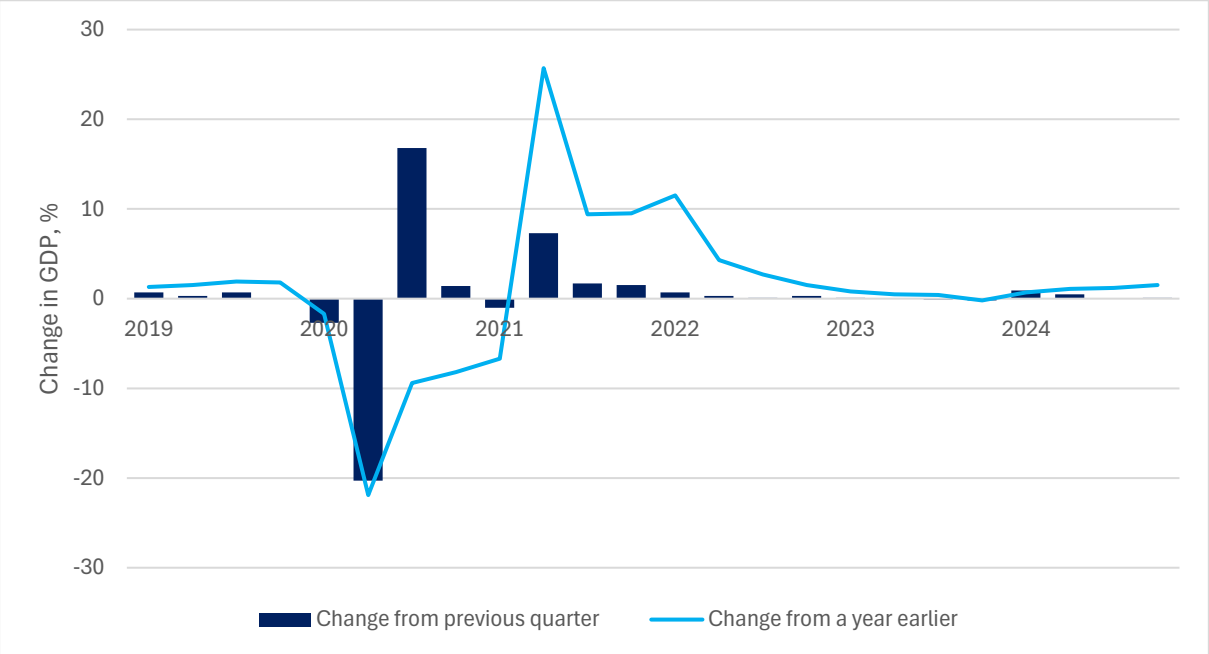
Source: OPRB calculations from NHS Employers data

The Government's inflation target and the economy

Economic growth

91. UK gross domestic product (GDP) is estimated to have grown by 0.1% in the fourth quarter of 2024, compared with the previous quarter, and to be 1.5% higher than in the fourth quarter of 2024 (see Figure A.43). GDP growth in 2024 as a whole was 1.1%.

Figure A.43: GDP growth, UK, 2019 to 2024



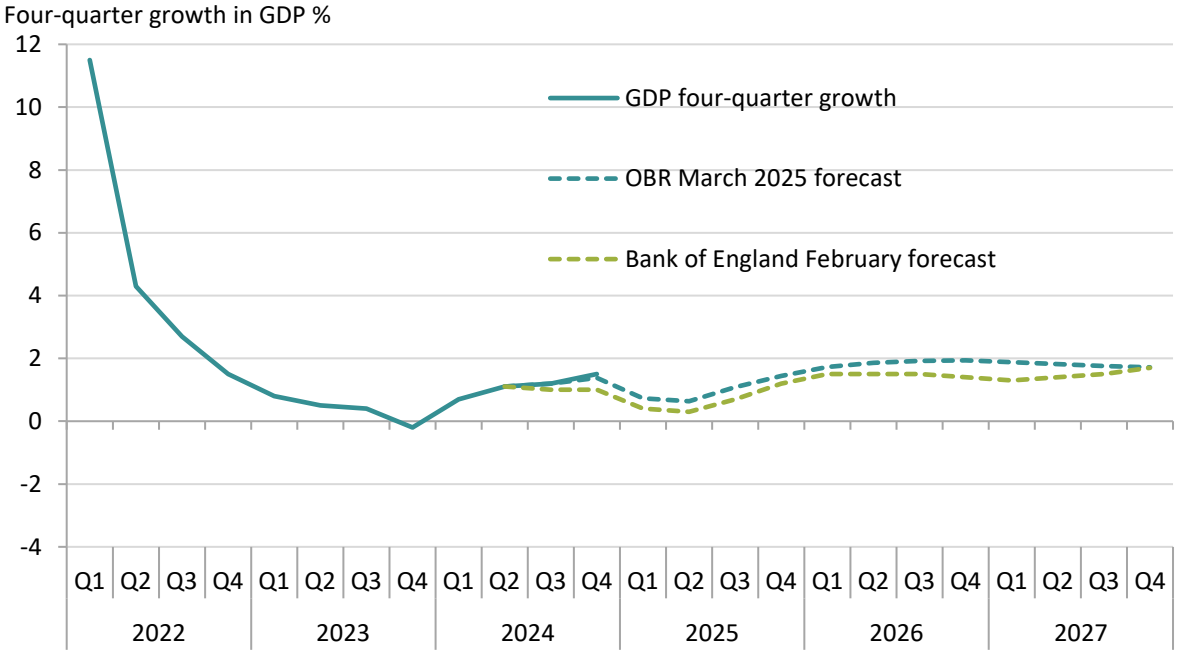
Source: ONS (IHYQ, IHYR)

Note: Chained volume measure at market price, seasonally adjusted.

92. In its March 2025 *Economic and fiscal outlook*, the OBR forecast GDP growth in 2025 of 1%, compared with 2024, a reduction from its previous forecast of 2%.

93. In its February *Monetary Policy Report,* the Bank of England revised down its growth forecast for 2025 from 1½ per cent to ¾ per cent. This followed weak out-turn data on growth and productivity, along with weakening indicators of business and consumer confidence (Figure A.44).

Figure A.44: GDP forecasts, four-quarter growth



Source: ONS(IHYR); OBR; Bank of England

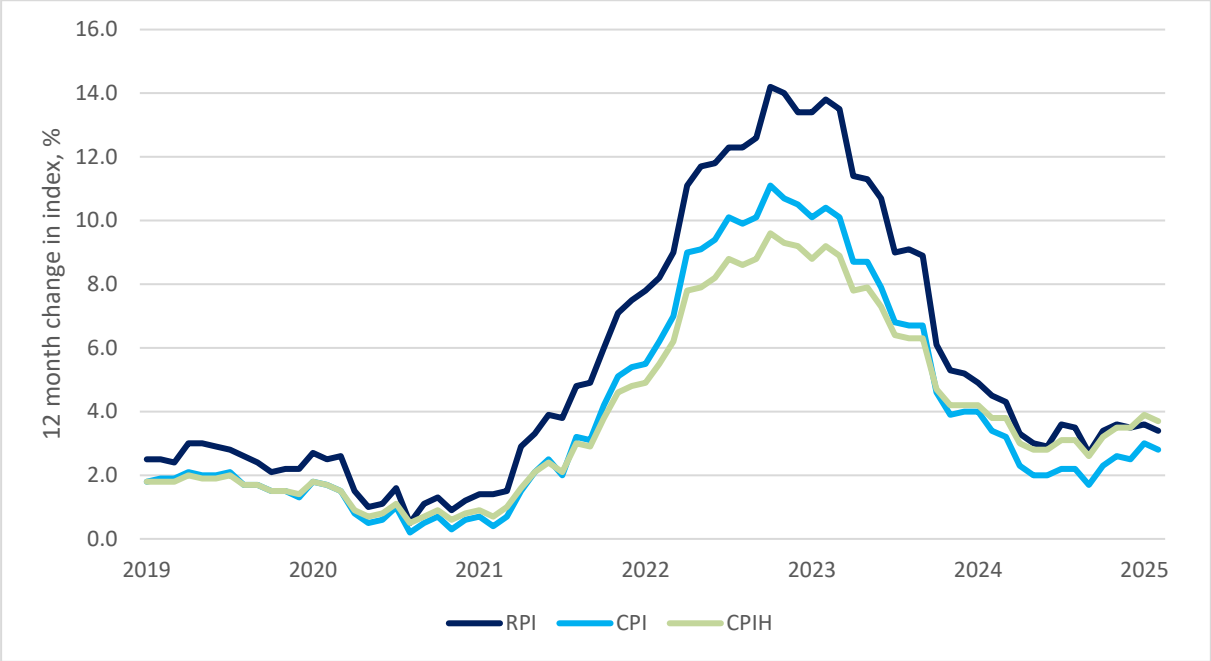
Consumer prices

94. Inflation, as measured by Consumer Prices Index (CPI), was at 2.8% in February 2025. Consumer Prices Index including owner occupiers' housing costs (CPIH) inflation was at 3.7%, and the Retail Price Index (RPI) rate was at 3.4% (see Figure A.45) [67].

[67] The target set by the Government for the Monetary Policy Committee is to maintain inflation (measured by the Consumer Prices Index, CPI) at 2%. Unlike the Retail Prices Index (RPI), the CPI excludes mortgage interest payments and some other housing components. The two indices also have differences in the coverage of goods and services and are calculated using a different formula. RPI is no longer an official national statistic.

CPIH (H for housing) is based on the CPI measure, plus owner occupiers' housing costs. These are the costs associated with owning, maintaining and living in one's own home and have a weight of 16.5% in the CPIH index. It uses 'rental equivalence', the rent paid for an equivalent house, as a proxy for the cost of housing services. The rental equivalence approach does not capture changes in asset value; rather it measures the change in price of housing services provided. CPIH also includes council tax which is excluded from the CPI, and has a weight of 2.8% in the index.

Figure A.45: Inflation, 12-month change, %, 2019 to 2025



Source: ONS, CPI (D7G7), CPIH (L55O), monthly, not seasonally adjusted, UK.

95. In its February *Monetary Policy Report*, the Bank of England revised up its 2025 inflation forecast. CPI inflation is now expected to average 3½% in 2025, up from 2¾%. The Bank's forecast is for CPI inflation to be 2.8% in the first quarter of 2025; 3.5% in the second quarter; 3.7% in the third quarter and 3.5% in the fourth quarter. The upward revision was due to higher global energy costs feeding through to regulated domestic price changes.

96. In March 2025 the OBR forecasts annual CPI inflation to rise from 2.5% in 2024 to 3.2% in 2025, 0.6 percentage points higher than forecast in October. The OBR expects monthly CPI inflation to peak at around 3.8% in July 2025. This is driven by increases in the Ofgem price cap due to higher energy prices, higher food prices due to an increase in domestic costs, and the increase in regulated water bills from April 2025.

Table A.27: Inflation forecasts

	Office for Budgetary Responsibility %	Bank of England central projection %
	March 2025	February 2025
	CPI	CPI
2025 Q1	2.7	2.8
2025 Q2	3.3	3.5
2025 Q3	3.7	3.7
2025 Q4	3.1	3.5
2025 average	3.2	3.5
2025-26 financial year	3.2	3.4

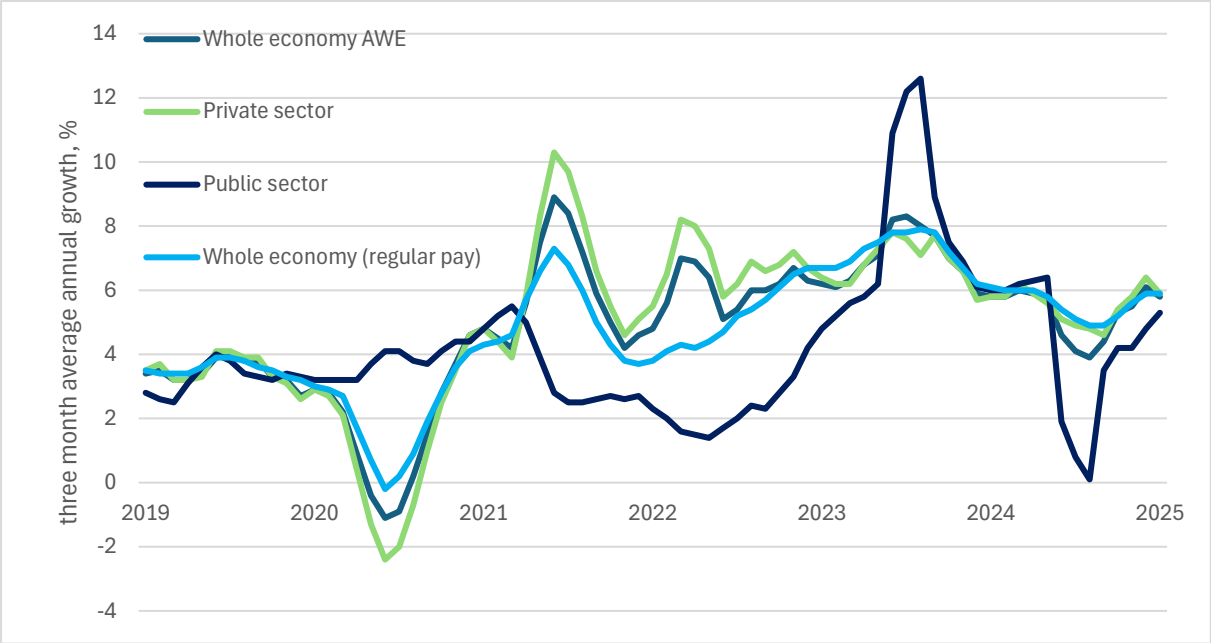
Note: OBR and Bank of England.

Earnings growth

97. Whole economy average weekly earnings growth was at 5.8% in the three months to January 2025. Regular earnings growth (i.e. excluding bonuses) was at 5.9% (see figure A.46).

98. Private sector average earnings growth (including bonus payments) was at 5.9% in the three months to January 2025, with regular earnings growth at 6.1%. Public sector average earning growth was at 5.3% in the three months to January 2025, both including and excluding bonus payments.

Figure A.46: Average weekly earnings growth, 2019 to 2025



Source: ONS, average weekly earnings (AWE) annual three-month average change in total pay for: the whole economy (KAC3); private sector (KAC6); public sector (KAC9); seasonally adjusted, GB.

99. In March 2025, the OBR forecast wages and salaries to grow by 5.2% in 2025. In February 2025, the Bank of England's expectation was for average pay rise of 3.5% to 4% in 2025.

Pay settlements

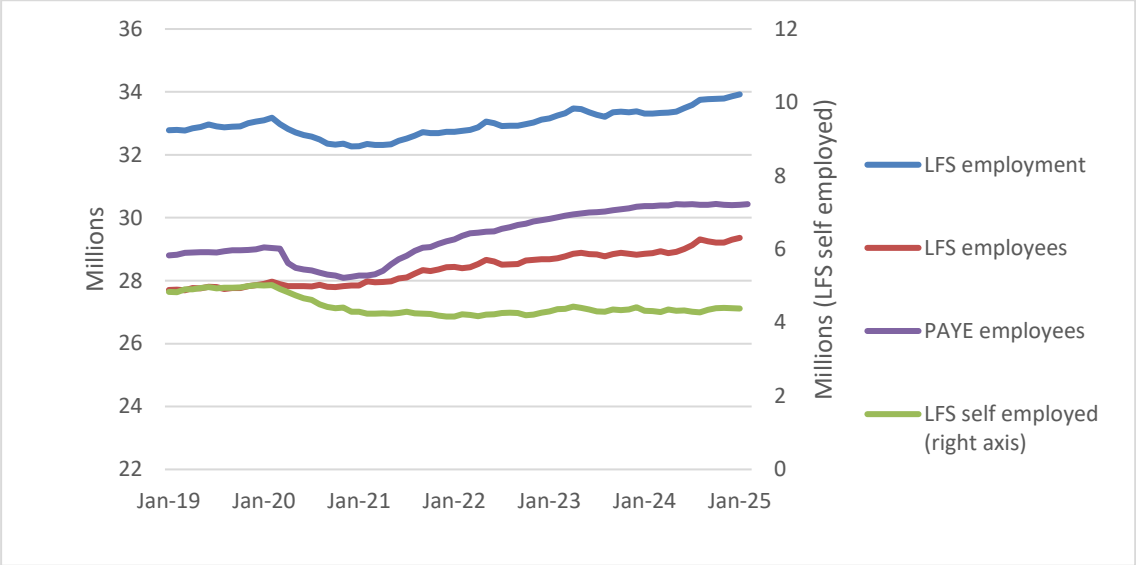
100. The latest data on 2025 pay awards show medians of 3.0% (Brightmine), 3.2% (Incomes Data Research), and 3.4% for the LRD (Labour Research Department), for the three months to February 2025.

The labour market

101. Pay as you earn real time information data indicate that the number of employees on payrolls in February 2025 was 30.4 million, up 21,000 over the month, 67,000 over the year, and up 1.4 million since the pre-pandemic peak in January 2020 (see Figure A.47).

102. According to the Labour Force Survey (LFS), the overall level of employment was 33.9 million in the three months to January 2025, up 608,000 over the year and 740,000 higher than the peak in the three months to February 2020. The number of employees is estimated to have increased by 1.4 million since February 2020, while self-employment is estimated to have fallen by 640,000 over the same period.

Figure A.47: Employment levels, Labour Force Survey (LFS) and payroll data, 2019 to 2025

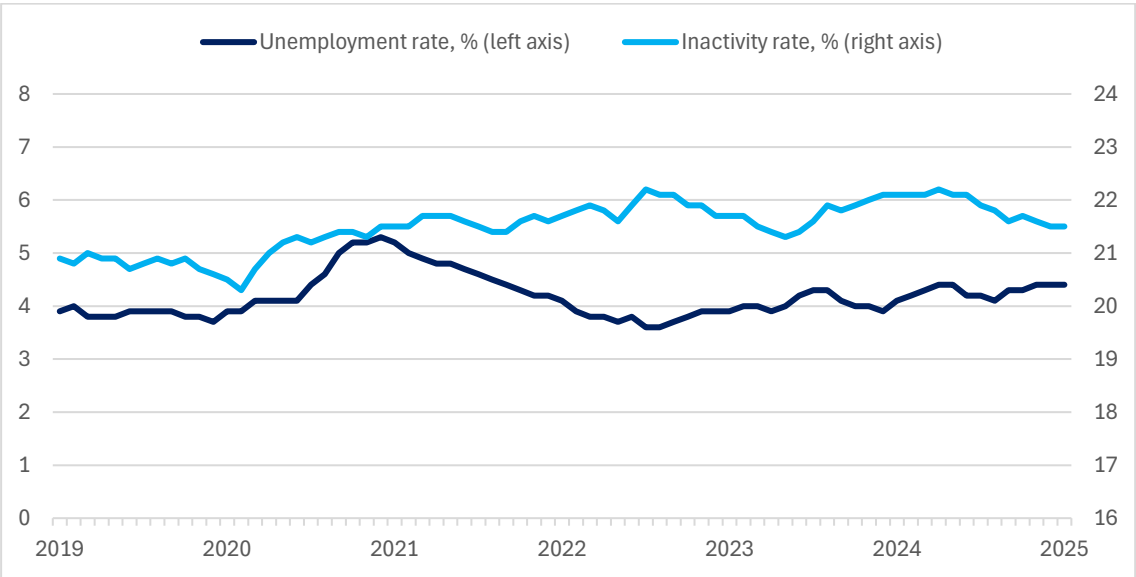


Source: ONS (MGRZ, MGRN, MGRQ); PAYE RTI data

103. The unemployment rate was at 4.4% in the three months to January 2025, up from 4.1% a year earlier (see Figure A.48). The unemployment level was estimated to have increased by 132,000 over the year, to 1.55 million.

104. Economic inactivity has fallen slightly over the last year, to 21.5% (9.27 million) in the three months to January 2025, compared to 22.1% (9.44 million) a year earlier. This is up from 20.3% (8.45 million) just before the Covid pandemic.

Figure A.48: Unemployment and inactivity rates, 2019 to 2025



Source: ONS, LFS (MGSX, LF2S)

AfC Earnings

Earnings growth

105. Table A.28 shows mean annual earnings, by staff group, in England, for the 12 months to December 2024, and the change from the 12 months to December 2023. By staff group, mean annual earnings range between £94,846 for senior managers and £24,122 for hotel, property and estates staff.

106. Except for senior managers and managers, who saw an increase in average earnings of 4.3% and 2.9% respectively, all other staff groups saw changes in average earnings in the 12 months to December 2024, compared with the previous year, of between +0.6% (nurses and health visitors, scientific, therapeutic and technical staff) and -1.3% (support to ambulance staff).

107. All groups saw an increase in average basic pay of between 4.9% (midwives) and 6.8% (senior managers).

108. All staff groups saw a reduction in non-basic pay, of between 14.4% (ambulance staff) and 48.3% (central functions staff). However, these changes should be treated with caution. The 2024 award was not paid to staff until the end of October 2024 and so is only starting to be reflected in these figures. The 2023 award, agreed between government and unions, included two non-consolidated payments: a 2% payment; and a further tiered cash payment equivalent to 4% on the paybill. Together, these non-consolidated payments were worth between 3.5% at the top of the AfC pay scale and 8.2% at the bottom end of the scale. These payments were paid in June 2023, so are now included in the denominator of the annual change calculation, rather than the numerator. This explains why the non-basic pay data shows such a large fall in the latest year.

109. The share of overall earnings accounted for by non-basic pay varies substantially by staff group. The groups with the largest non-basic pay in overall earnings per person are ambulance staff (24% of total earnings), support to ambulance staff (22%), and hotel, property and estates staff (15%).

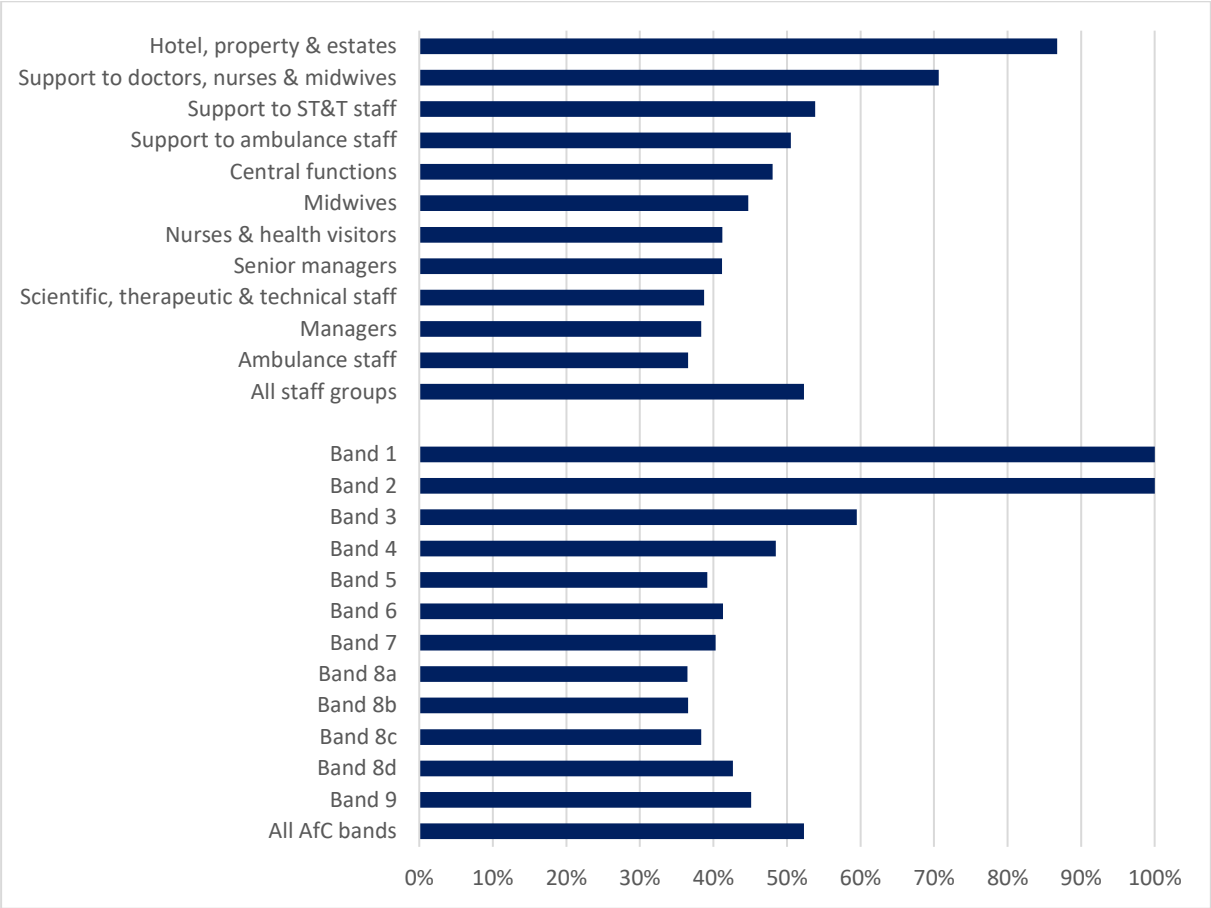
Table A.28: Average basic pay and annual earnings per person, England, December 2024 and change from December 2023

	Average earnings		Basic pay per person		Non-basic pay per person		
Staff Group	**£**	**annual change**	**£**	**annual change**	**£**	**% of average earnings**	**annual change**
Nurses & health visitors	£40,504	0.6%	£36,042	5.6%	£4,463	11%	-27.3%
Midwives	£39,027	-0.3%	£34,118	4.9%	£4,909	13%	-25.6%
Ambulance staff	£49,037	-0.3%	£37,320	5.1%	£11,717	24%	-14.4%
Scientific, therapeutic & technical staff	£42,269	0.6%	£39,315	5.7%	£2,953	7%	-38.8%
Support to clinical staff	£25,447	-0.2%	£22,597	5.9%	£2,851	11%	-31.5%
Support to doctors, nurses & midwives	£24,870	-0.1%	£22,019	5.9%	£2,852	11%	-30.2%
Support to ambulance staff	£31,654	-1.3%	£24,768	5.4%	£6,886	22%	-19.7%
Support to ST&T staff	£25,526	-0.4%	£23,895	6.0%	£1,631	6%	-47.1%
NHS infrastructure support	£37,176	1.0%	£34,478	5.8%	£2,699	7%	-36.2%
Central functions	£33,469	0.2%	£31,730	5.7%	£1,739	5%	-48.3%
Hotel, property & estates	£24,122	-0.6%	£20,420	5.5%	£3,702	15%	-24.7%
Senior managers	£94,846	4.3%	£90,752	6.8%	£4,094	4%	-31.7%
Managers	£63,668	2.9%	£60,423	6.7%	£3,244	5%	-37.6%

Source: NHS England

110. Figure A.49 shows that in England, at the end of March 2024, 52% of AfC staff were at the top of their pay band. The proportion varied across staff groups, between 37% of ambulance staff and 87% of hotel, property and estates staff. Other than Bands 1 and 2, which are both single pay points, the bands with the largest percentage of staff on the top of their pay band were Band 3 (59%) and Band 4 (49%), while the bands with the smallest percentage of staff on top of their pay band were Band 8a (36%), Band 8b (37%) and Band 8c (38%).

Figure A.49: Estimated share of staff (FTE) on top of band by staff group and band, March 2024, England



Source: DHSC

Pay and earnings by gender and ethnicity

111. NHSE have published data showing the differences in mean basic pay, between male and female staff and White and all other ethnic minorities combined (Table A.29).

Table A.29: Differences in mean monthly basic pay per FTE, by gender and ethnicity, England, May 2024

	Gender pay gap (2023 figure in brackets)		Ethnicity pay gap (2023 figure in brackets)	
	White	BME	Female	Male
	Female/Male	Female/Male	BME/White	BME/White
All AfC	-4% (-8%)	3% (0%)	-5% (-6%)	-11% (-13%)
Nurses and health visitors	-5% (-4%)	-3% (-2%)	-15% (-14%)	-16% (-16%)
Professionally qualified staff	-5% (-5%)	-4% (-4%)	-13% (-13%)	-14% (-13%)
Support to clinical staff	-2% (-3%)	1% (1%)	-2% (-1%)	-6% (-5%)
Infrastructure support	-11% (-11%)	-1% (-2%)	-6% (-6%)	-16% (-14%)

Source: DHSC

112. For basic pay:

- White female staff were paid 4% less than White males, with the difference ranging between 11% for infrastructure support staff and 2% for staff supporting clinical staff.
- Female staff from ethnic minorities were paid 3% more than male staff from ethnic minorities. But there were differences by staff group, with the differences ranging between female staff supporting clinical staff paid 1% more than their male colleagues and female professionally qualified staff being paid 4% less than their male colleagues.
- Female staff from ethnic minorities were paid 5% less than White female staff, with the difference ranging between 15% for nurses and health visitors and 2% for staff supporting clinical staff.
- Male staff from ethnic minorities were paid 11% less than White male staff, with the difference ranging between 16% for nurses and health visitors and 6% for staff supporting clinical staff.
- Workforce data shows that male staff were more likely than female staff to reach the higher pay bands and that White staff were more likely than staff from ethnic minorities to reach the higher pay bands. This will be a factor that contributes to the size of these pay gaps.

Pay comparisons: ASHE

113. The Annual Survey of Hours and Earnings (ASHE) has been used for a number of years to compare earnings for the human health and social work activities sector with employees in the public and private sector as well as to certain broad occupational groups. These sector and group earnings (median gross weekly pay) are shown in in Table A.30. In April 2024, compared with April 2023, median gross weekly pay for full-time employees in the human health and social work activities sector increased by 4.9%, compared with 6.0% across the economy as a whole, 5.1% across the public sector and 6.3% across the private sector. Over a longer period, between 2019 and 2024, median gross weekly pay in the human health and social work activities sector increased by 23%, compared with 24% across the economy as a whole, 21% across the public sector and 25% across the private sector.

114. Table A.30 also shows earnings growth in some broad occupational groups. In 2024, compared with 2023, median gross weekly pay increased by: 5.0% for professional occupations; 5.2% for associate professional and technical occupations; 6.0% for administrative and secretarial occupations; 7.2% for skilled trades occupations; and 7.7% for caring, leisure and other service occupations. Over a longer period, between 2019 and 2024, median gross weekly pay increased by: 18% for professional occupations; 12% for associate professional and technical occupations; 24% for administrative and secretarial occupations; 25% for skilled trades occupations; and 33% for caring, leisure and other service occupations. Despite the relatively large increases in earnings for caring, leisure and other service occupations, weekly earnings for these occupations remain lower than those for other occupations listed in the table

Table A.30: Change in median gross weekly pay for full time employees at adult rates, 2019 to 2024, April each year, United Kingdom

		Median gross weekly pay (change on previous year)					
	2019	**2020**	**2021**	**2022**	**2023**	**2024**	**Change 2019 to 2023**
Human health and social work activities sector	£552 (4.3%)	£563 (2.0%)	£575 (2.0%)	£613 (6.6%)	£647 (5.5%)	£678 (4.9%)	23%
All employees	£585 (3.0%)	£586 (0.1%)	£610 (4.1%)	£642 (5.2%)	£687 (7.0%)	£728 (6.0%)	24%
Public sector	£632 (3.2%)	£648 (2.5%)	£664 (2.5%)	£697 (4.9%)	£727 (4.4%)	£765 (5.1%)	21%
Private sector	£571 (4.1%)	£566 (-0.8%)	£585 (3.4%)	£622 (6.3%)	£672 (8.0%)	£714 (6.3%)	25%
Professional occupations [1]	£769 (3.2%)	£777 (1.1%)	£794 (2.1%)	£811 (2.2%)	£862 (6.3%)	£906 (5.0%)	18%
Associate professional and technical occupations [2]	£624 (0.8%)	£612 (-1.9%)	£603 (-1.6%)	£633 (5.1%)	£667 (5.3%)	£702 (5.2%)	12%
Administrative and secretarial occupations	£457 (2.7%)	£461 (0.8%)	£479 (4.1%)	£499 (4.0%)	£534 (7.1%)	£566 (6.0%)	24%
Skilled trades occupations	£541 (3.3%)	£506 (-6.5%)	£551 (8.9%)	£590 (7.2%)	£631 (6.8%)	£676 (7.2%)	25%
Caring, leisure and other service occupations	£392 (5.0%)	£404 (3.0%)	£414 (2.6%)	£442 (6.7%)	£483 (9.5%)	£521 (7.7%)	33%

Source: ONS (Annual Survey of Hours and Earnings)

Notes:

[1] Includes, for example, teachers, solicitors, accountants, doctors and some AHPs and ST&Ts, nurses and midwives

[2] Includes, for example, police officers and some AHPs and ST&Ts.

Pay comparisons: Longitudinal Education Outcomes (LEO)

115. Data from the Longitudinal Education Outcomes (LEO) data set are published each year by the Department for Education (DfE) and track the employment and earnings outcomes of UK-domiciled first-degree higher education (HE) graduates from: HE institutions in the United Kingdom; Further Education Colleges; and Alternative Providers. The latest data is for the tax year 2021/22 (the second year to be affected by the COVID-19 pandemic) and is broken down by subject studied. The data covers graduate earnings and employment by subject: one; three; five; and, ten years after graduation (YAG), for those studying: nursing and midwifery; medical sciences[68]; pharmacology, toxicology and pharmacy; allied health subjects[69]; and health and social care[70]. The figures for each group include the earnings of both full and part time workers, and is not adjusted for geography, age or other factors. It also includes the earnings

[68] Covers (CAH02-05): Anatomy; physiology; pathology; pathobiology; neuroscience; audiology; medical technology; cardiography; radiography.
[69] Covers (CAH02-06): Subjects allied to medicine; physiotherapy; podiatry; osteopathy; alternative medicine and therapies; Chinese medicine; herbalism; beauty therapies; nutrition; dietetics; ophthalmics; optometry; orthoptics; aural and oral sciences; speech science; language pathology; environmental health; occupational health; occupational therapy; counselling; paramedical science; chiropractic; acupuncture; psychotherapy; complementary medicines and therapies.
[70] Covers (CAH15-04) social work, childhood and youth studies, health studies.

of those working in areas unrelated to their degree subject, for example someone with a nursing degree working outside the health sector.

116. Table A.31 shows that one year after graduation median annual gross earnings of those who studied the following subjects were higher than the median for graduates as a whole: nursing and midwifery (32% higher than the median); pharmacology, toxicology and pharmacy (23%); allied health subjects (10%); and medical sciences (8%). Median annual gross earnings for those who studied health and social care subjects were 3% below median earnings for graduates as a whole. However, Table A.31 also shows that the longer the time since graduation, the relative position of median earnings for nursing and midwifery, allied health subjects and health and social care subjects worsens when compared against median earnings for graduates as a whole. Ten years after graduation, median earnings of those who studied nursing and midwifery were broadly in line with the overall graduate median, while median earnings for allied health and health and social care graduates were 8-15% below the overall graduate median. Median earnings for medical science and pharmacology, toxicology and pharmacy graduates better maintained their relative value and were still 20% higher than the overall graduate median.

117. Charts showing earnings, at the lower quartile, median and upper quartile, in 2021/22, by subject studied one, five, and ten YAG are at Figures A.52 to A.54.

Table A.31: Difference between median earnings by subject, compared with overall graduate median, by years after graduation (YAG), %, 2021/22

	1 year	3 years	5 years	10 years
Nursing and midwifery	32%	22%	11%	1%
Medical sciences	8%	25%	26%	20%
Pharmacology, toxicology and pharmacy	23%	33%	29%	20%
Allied health	10%	11%	3%	-8%
Health and social care	-3%	0%	-8%	-15%

Source: OPRB analysis of LEO data set

118. Table A.32 shows that between 2015/16 and 2021/22 median earnings for those who studied health related subjects, for a given number of years after graduation, declined relative to median earnings for graduates as a whole, after the same number of years since graduation. In 2020/21 median earnings for those who studied health related subjects, for a given number of years after graduation, improved relative to median earnings for graduates as a whole, but this improvement was reversed in 2021/22 for graduates one year after graduation.

Table A.32: Difference between median earnings for graduates of health related subjects and overall graduate median, by years after graduation (YAG), %, 2015/16 to 2021/22

	Nursing and midwifery				Medical sciences			
Tax year	**1 YAG**	**3 YAG**	**5 YAG**	**10 YAG**	**1 YAG**	**3 YAG**	**5 YAG**	**10 YAG**
2015/16	35%	19%	10%	-1%	27%	18%	20%	14%
2016/17	30%	17%	8%	0%	20%	20%	19%	13%
2017/18	29%	16%	8%	-2%	20%	19%	17%	12%
2018/19	28%	13%	5%	-4%	18%	18%	17%	12%
2019/20	29%	18%	6%	0%	20%	23%	20%	15%
2020/21	40%	23%	10%	0%	25%	26%	23%	19%
2021/22	32%	22%	11%	1%	8%	25%	26%	20%

	Pharmacology, toxicology, pharmacy				Allied Health			
Tax year	**1 YAG**	**3 YAG**	**5 YAG**	**10 YAG**	**1 YAG**	**3 YAG**	**5 YAG**	**10 YAG**
2015/16	21%	32%	30%	10%	10%	2%	-3%	-12%
2016/17	22%	30%	31%	5%	6%	0%	-4%	-12%
2017/18	18%	25%	24%	11%	5%	2%	-3%	-13%
2018/19	13%	30%	19%	15%	5%	3%	-4%	-12%
2019/20	13%	23%	23%	15%	7%	4%	-1%	-13%
2020/21	22%	29%	31%	19%	10%	9%	3%	-10%
2021/22	23%	33%	29%	20%	10%	11%	3%	-8%

	Health and social care			
Tax year	**1 YAG**	**3 YAG**	**5 YAG**	**10 YAG**
2015/16	6%	-7%	-10%	-13%
2016/17	2%	-7%	-13%	-11%
2017/18	1%	-5%	-11%	-9%
2018/19	3%	-4%	-11%	-9%
2019/20	3%	-4%	-10%	-8%
2020/21	8%	-2%	-8%	-11%
2021/22	-3%	0%	-8%	-15%

Source: OPRB analysis of LEO dataset

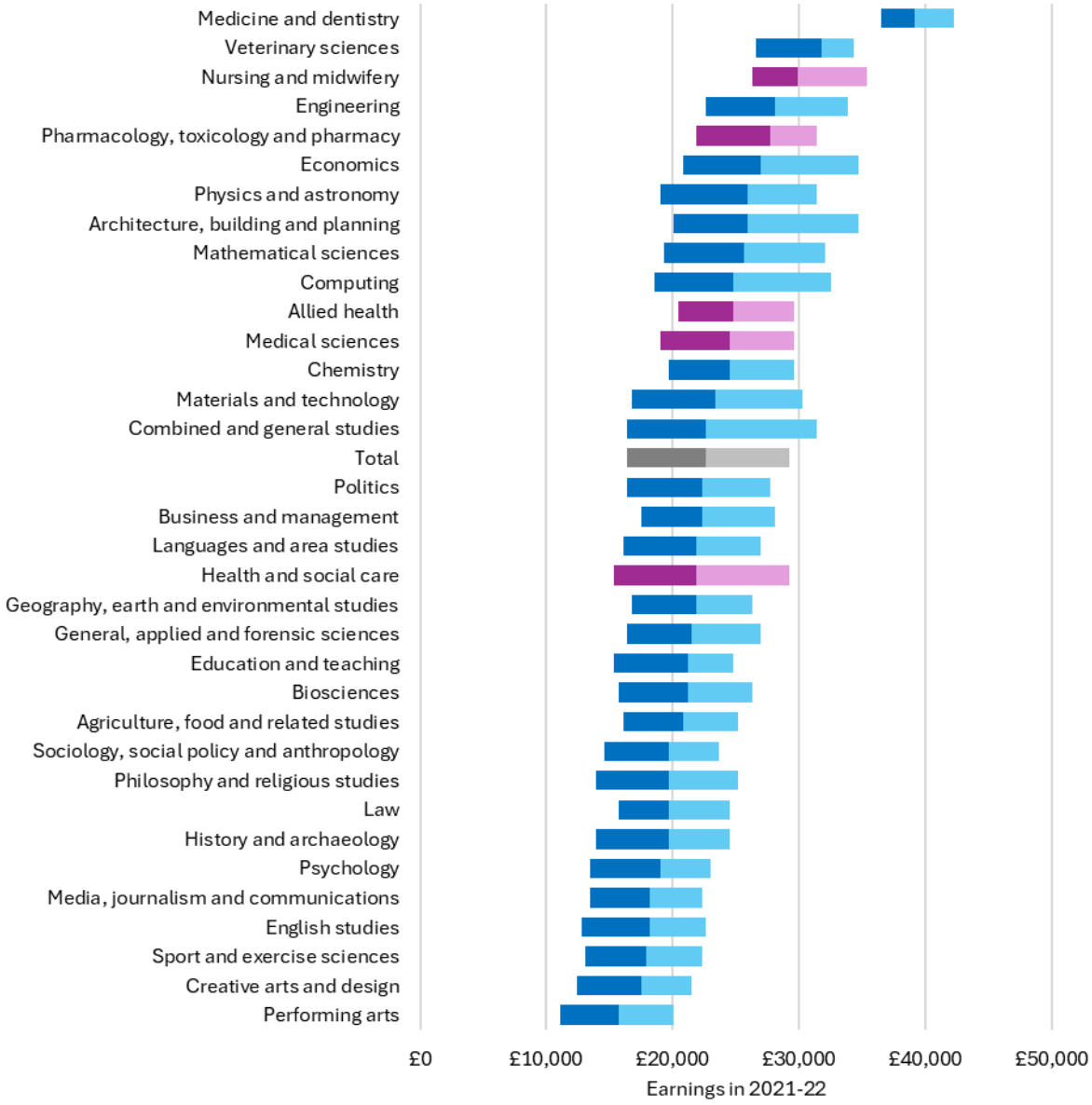
119. Figure A.50 shows median earnings one year after graduation. Only those who studied: medicine and dentistry and veterinary sciences had higher median earnings than those who studied nursing or midwifery. Median earnings of those who studied: medical sciences; pharmacology, toxicology and pharmacy; and allied health subjects were also above the median for graduates as a whole. Median earnings for those who studied subjects related to health and social care, were below median earnings for graduates as a whole.

120. Figure A.51 shows that median earnings, five years after graduation, for those who studied pharmacology, toxicology and pharmacy, and medical sciences were still considerably above median earnings for graduates as a whole. For those who studied nursing or midwifery, median earnings were still above the median for graduates as a whole, but by less than they had been one year after graduation. Median earnings for those who had studied allied health subjects were just above the overall graduate median, while median earnings for those who

studied subjects related to health and social care was still below the median for graduates as a whole.

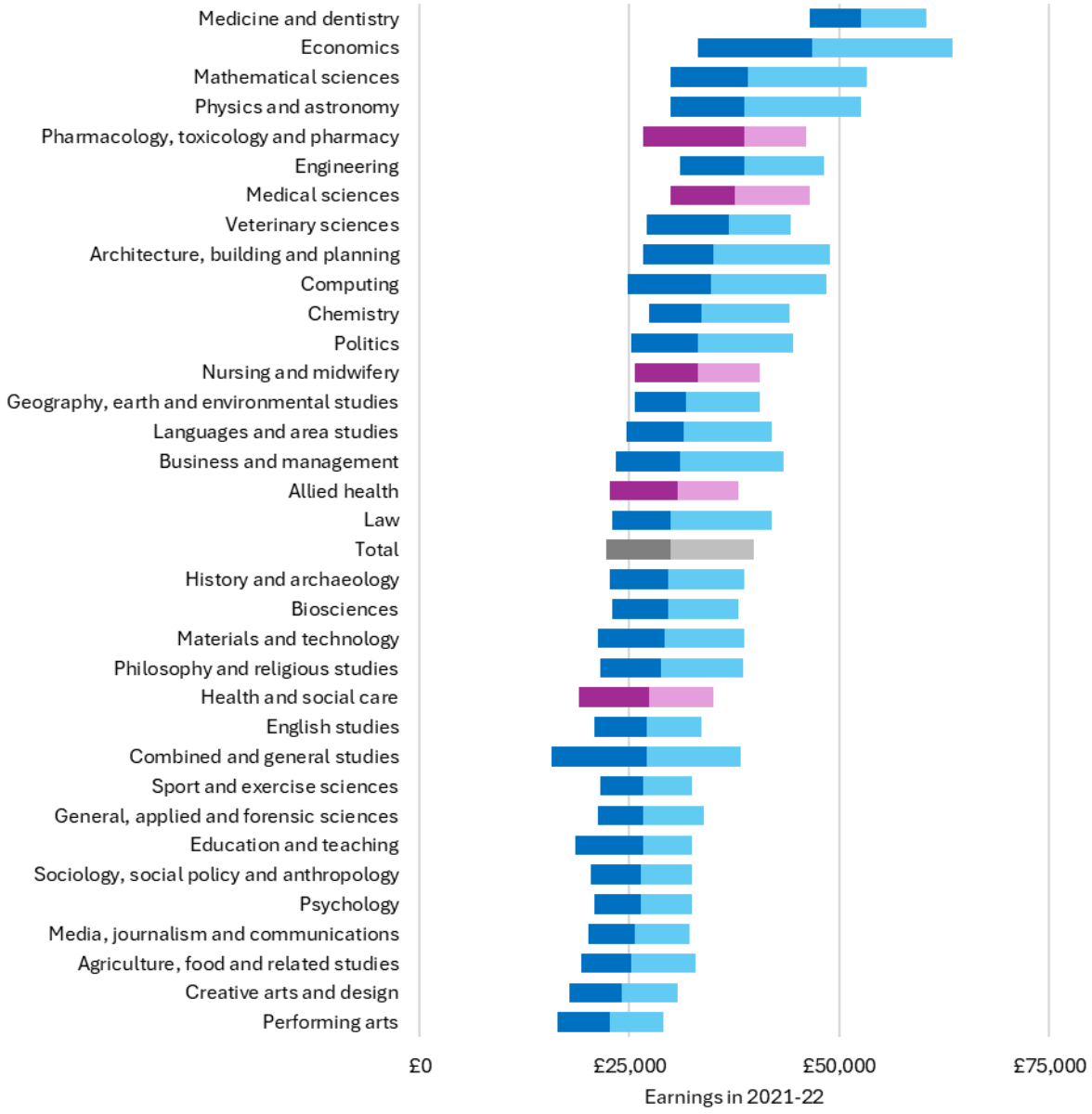
121. Figure A.52 shows that median earnings, ten years after graduation, for those who studied pharmacology, toxicology and pharmacy, and medical sciences were still above median earnings for graduates as a whole. However, median earnings for those who studied nursing or midwifery, were just above the overall graduate median, while median earnings of those who studied allied health subjects and subjects related to health and social care were below the overall graduate median.

Figure A.50: Annual gross earnings one year after graduation (2019/20 cohort), median £



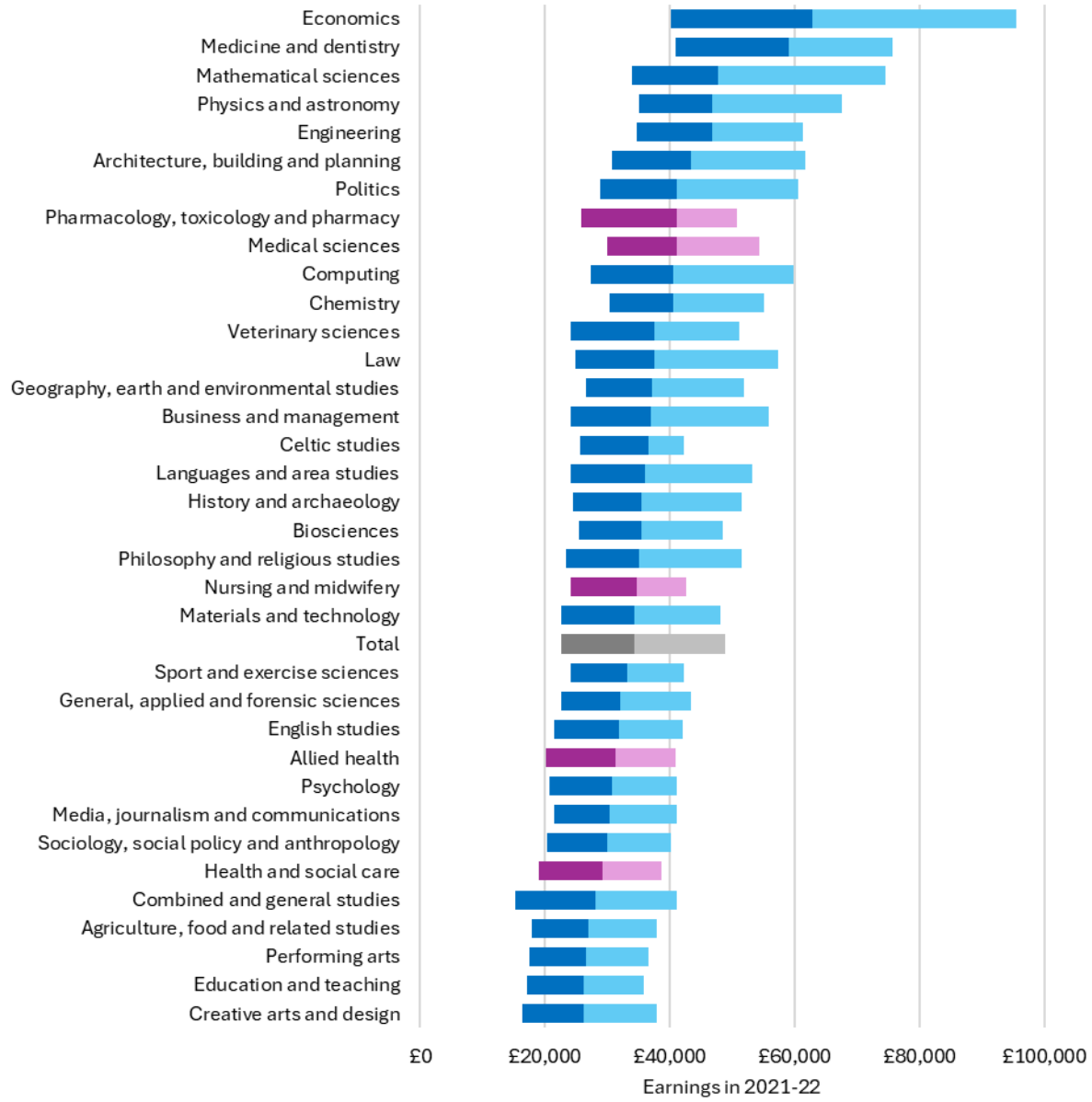
Source: OPRB analysis of LEO dataset

Figure A.51 Annual gross earnings five years after graduation (2015/16 cohort), median £



Source: OPRB analysis of LEO dataset

Figure A.52: Annual gross earnings ten years after graduation (2010/11 cohort), median £



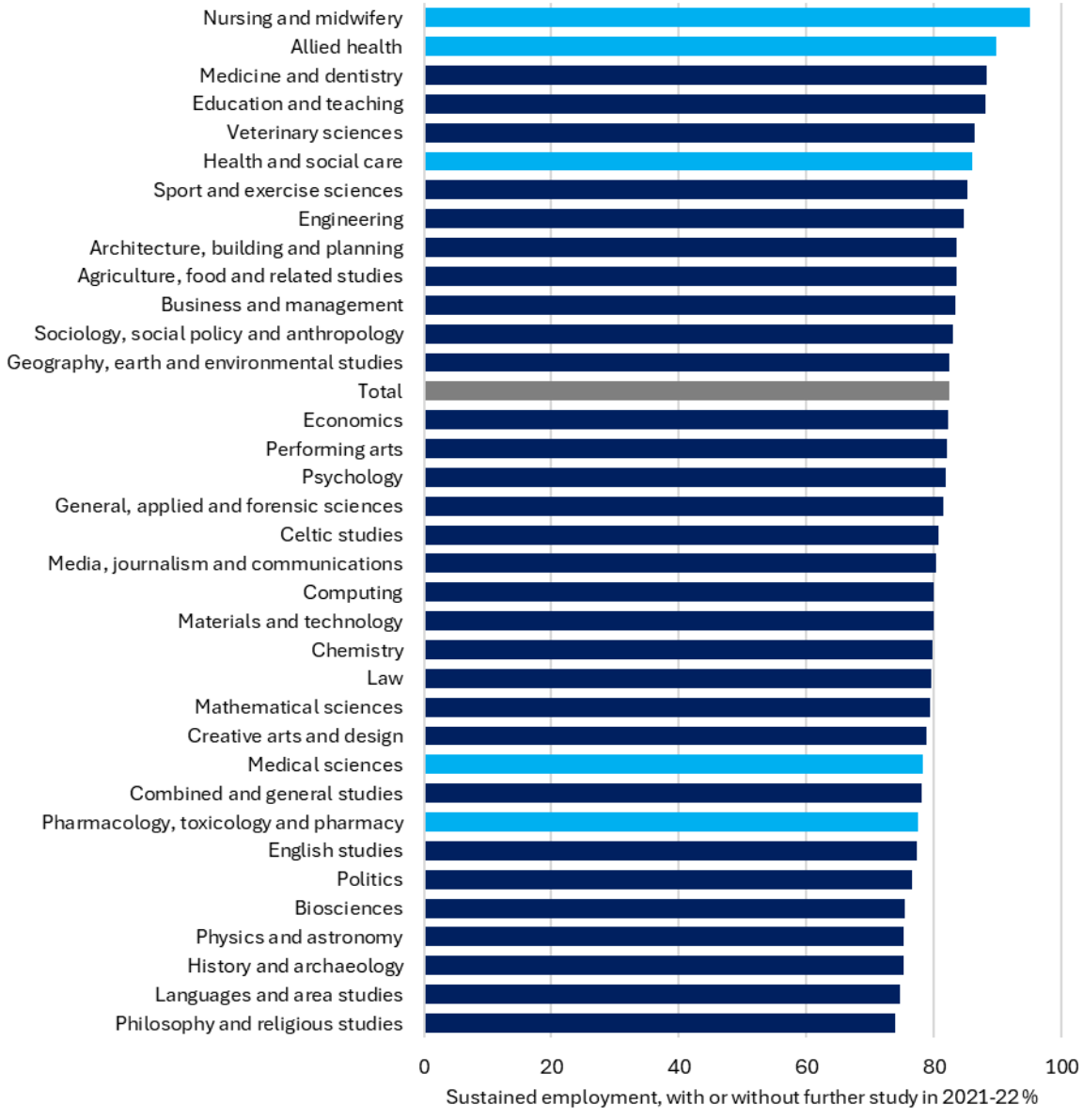
Source: OPRB analysis of LEO dataset

122. Figure A.53 shows, for 2021/22, the percentage of graduates in sustained employment, by subject studied, one year after graduation. 95% of nursing and midwifery graduates in that cohort were in sustained employment, a greater percentage than for any other subject studied. The percentage of those in employment who studied health and social care (86%) and allied health subjects (88%) were greater than the percentage of all graduates in this cohort (82%). The percentage of those who studied medical sciences (78%) and pharmacology, toxicology and pharmacy (78%) were slightly below the overall average.

123. Figure A.54 shows, for 2021/22, the percentage of graduates in sustained employment, by subject studied, five years after graduation. 92% of nursing and midwifery graduates in that cohort were in sustained employment, a greater percentage than for any other subject studied. The percentage of those in employment who studied health and social care (89%), allied health subjects (87%), pharmacology, toxicology and pharmacy (88%) and medical sciences (89%), were greater than the percentage of all graduates in this cohort (86%).

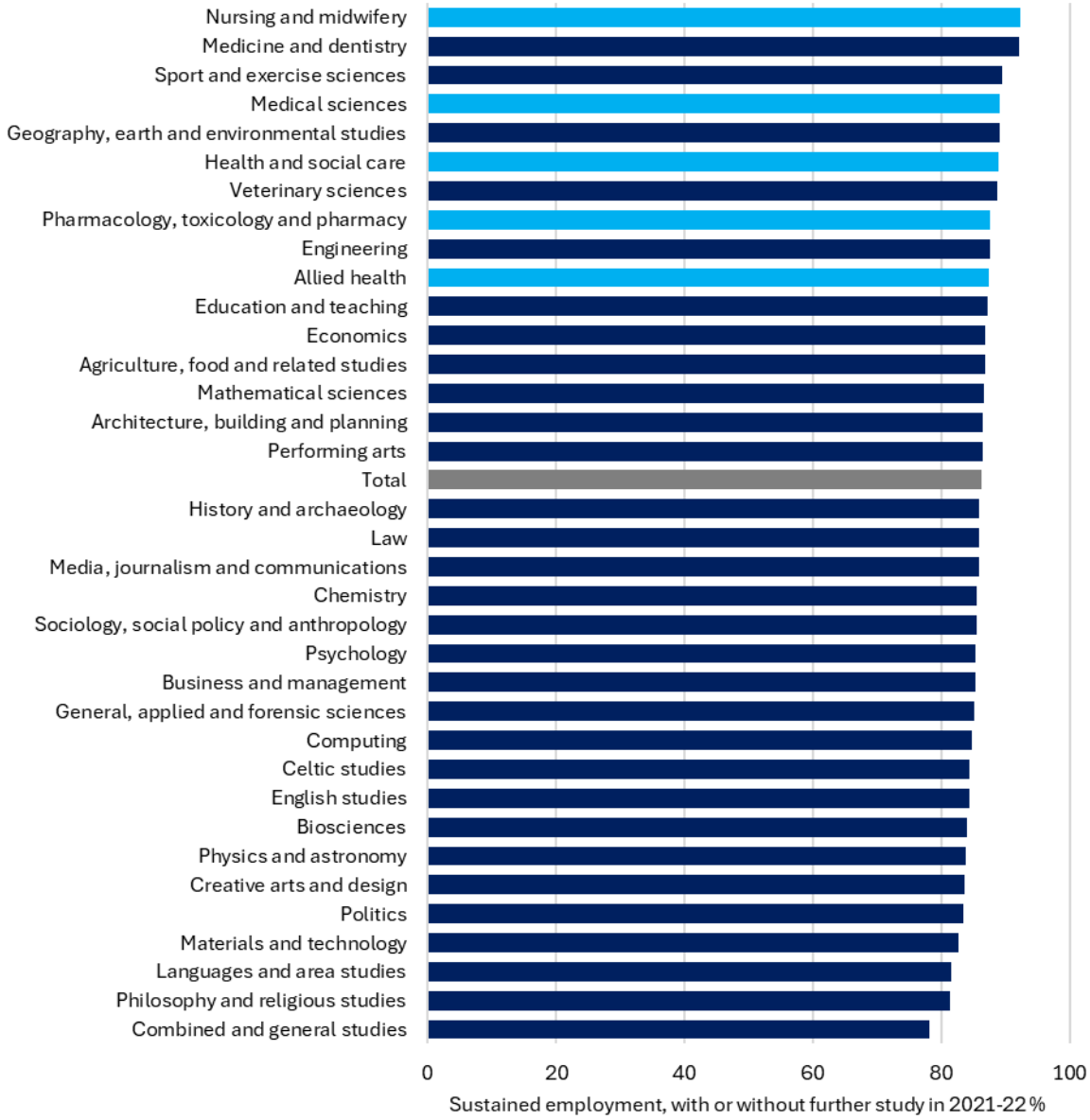
124. Figure A.55 shows, for 2021/22, the percentage of graduates in sustained employment, by subject studied, ten years after graduation. 90% of nursing and midwifery graduates in that cohort were in sustained employment, a greater percentage than for any other subject studied, except for veterinary sciences (also 90%). The percentage of those in employment who studied allied health subjects (86%), medical sciences (88%), health and social care (86%), pharmacology, toxicology and pharmacy (86%), were greater than the percentage of all graduates in this cohort (84%).

Figure A.53: Percentage of graduates in employment, by subject studied, one year after graduation (2019/20 cohort)



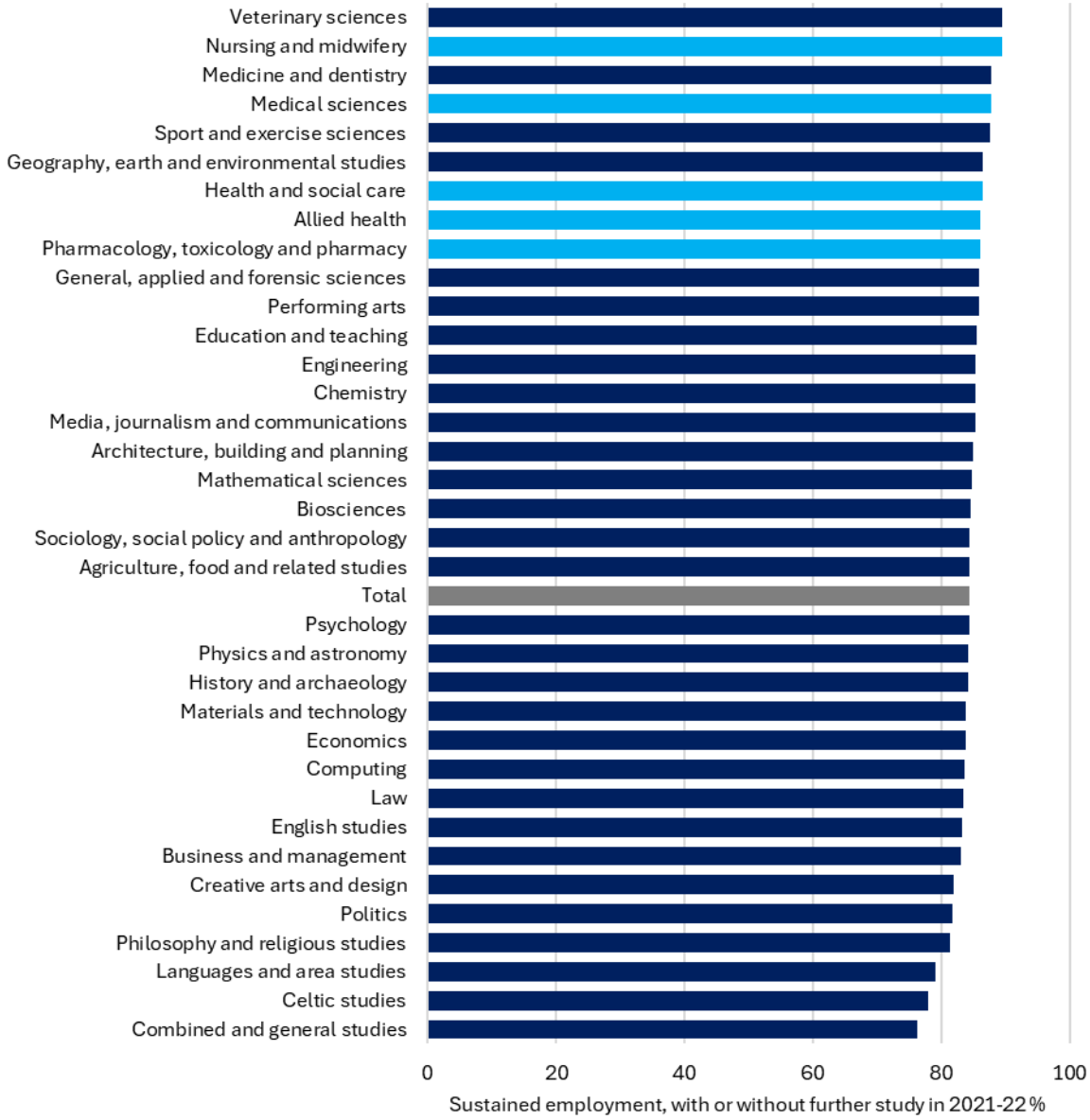
Source: OPRB analysis of LEO dataset

Figure A.54: Percentage of graduates in employment, by subject studied, five years after graduation (2015/16 cohort)



Source: OPRB analysis of LEO dataset

Figure A.55: Percentage of graduates in employment, by subject studied, ten years after graduation (2010/11 cohort)



Source: OPRB analysis of LEO dataset

National Living Wage (NLW)

125. Table A.33 shows changes in the NLW and the Living Wage Foundation Real Living Wage since 2017. Following the implementation of the 2024/25 award in England, the salaries attached to the lowest points on the AfC scale (Bands 1 and 2) equated to an hourly rate of £12.08. With effect from 1 April 2025, the NLW increased to £12.21 per hour. Between 2017 and 2024 the NLW increased by 53%, while the Living Wage Foundation Real Living Wage increased by 42%. Over the same period, the lowest hourly rate of pay in the NHS increased by 53%, as the Band 1 rate was increased to match that of the Band 2 minimum as part of the 2018 AfC agreement, and in 2023 the lowest Band 2 pay point was increased to match the value of the highest Band 2 pay point.

Table A.33: National Living Wage and the Living Wage Foundation (LWF) real Living Wage rates per hour, in place at April, 2017 to 2025

	National Living Wage (NLW)		LWF Real Living Wage		Agenda for Change pay minimum (England)			
Year	£ per hour	change from previous year	£ per hour	change from previous year	£	£ per hour	change from previous year	relative to NLW
2017	7.50		8.45		15,404	7.88		5%
2018	7.83	4.4%	8.75	3.6%	17,460	8.93	13.3%	14%
2019	8.21	4.9%	9.00	2.9%	17,652	9.03	1.1%	10%
2020	8.72	6.2%	9.30	3.3%	18,005	9.21	2.0%	6%
2021	8.91	2.2%	9.50	2.2%	18,546	9.49	3.0%	6%
2022	9.50	6.6%	9.90	4.2%	20,270	10.37	9.3%	9%
2023	10.42	9.7%	10.90	10.1%	22,383	11.45	10.4%	10%
2024	11.44	9.8%	12.00	10.1%	23,615	12.08	5.5%	6%
2025	12.21	6.7%	12.60	5.0%				
Change 2017-2024		**53%**		**42%**	**53%**			

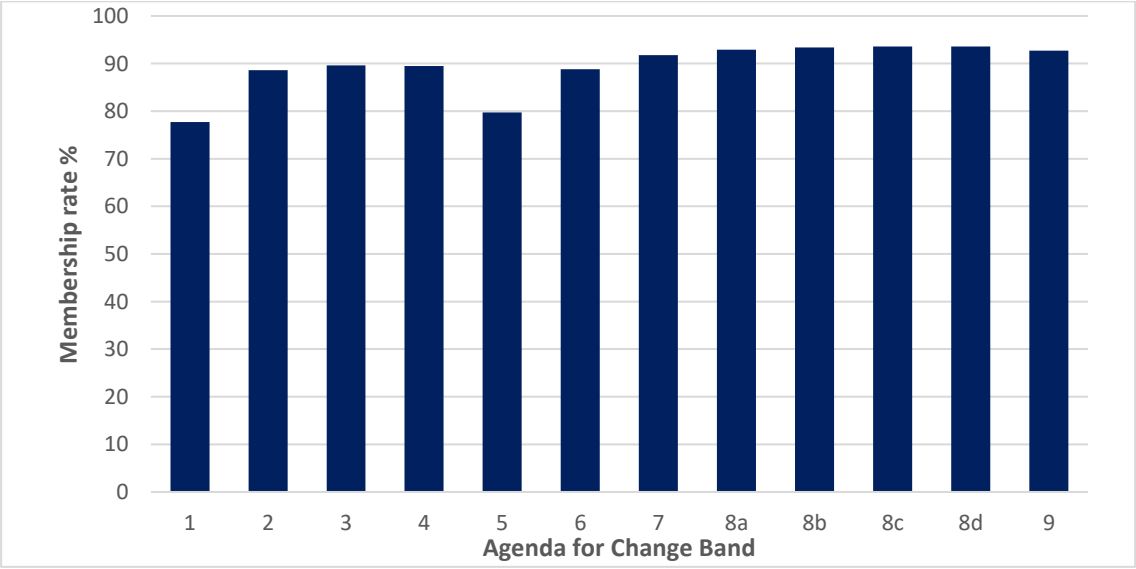
Source: Low Pay Commission, Living Wage Foundation, NHS Employers

Total reward

Pensions

126. The DHSC said that in June 2024, 87.9% of non-medical (AfC) staff were members of the NHS pension scheme. Figure A.56 shows that membership varies by band. Broadly speaking staff in the higher bands were more likely to be scheme members than those in lower bands. Between 92% and 94% of staff between Bands 7 and 9 were pension scheme members, 89-90% of staff in Bands 2-4 and Band 6 were scheme members, while just 78% of Band 1 staff (which is not open to new staff) and 80% of Band 5 staff were members.

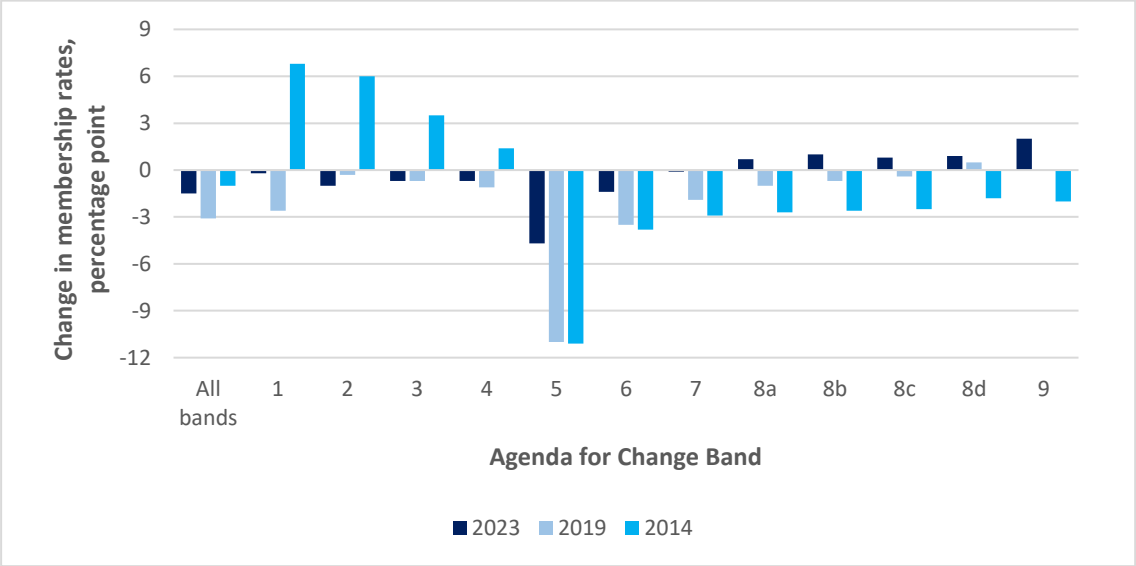
Figure A.56: NHS pension scheme membership, by AfC band, June 2024, England



Source: DHSC

127. Figure A.57 shows changes in the membership rate of the NHS pension scheme by AfC band, between 2024, and each of 2023, 2019 and 2014. Across all bands, membership fell by one percentage point between 2014 and 2024, fell by 3.1 percentage points between 2019 and 2024 and fell by 1.5 percentage points between 2023 and 2024.

Figure A.57: Change in NHS pension scheme membership rate, by AfC band, between June 2024 and: 2023; 2019; and 2014, England



Source: DHSC

128. Between 2014 and 2024, membership rates increased for those in Bands 1 to 4 but decreased for those in Bands 5 to 9. Over that period the largest percentage point increases in membership rates were for those in Bands 1 and 2, where membership rates increased by seven and six percentage points, respectively. Despite the increase in membership rate over the period at Band 1, the membership rate for staff at that Bands remains lower than that for other Bands. The largest fall in membership rates between 2014 and 2024 was for those in Band 5, by eleven percentage points. More recently, between 2023 and 2024, the overall membership rate fell by 1.5 percentage points, with an increase in membership rates at Bands 8a and above more than offset by falls in membership rates at Bands 1 to 7.

129. DHSC said that non-British staff were traditionally less likely to be members of the NHS pension scheme than those with British nationality. DHSC went on to say that the reduction in the scheme membership rate between 2023 and 2024 was greatest at Band 5 (down 4.7 percentage points) and for nurses and health visitors (down 3.6 percentage points), groups with higher than average rates of non-British nationality and higher levels of international recruitment.

Table A.34: NHS pension scheme membership, AfC band 5, June 2024, by pay point and nationality, England

Pay point	Years experience	United Kingdom	Rest of World	Other (EU, EEA, unknown)	All
Point 1	0-2 years	91%	62%	85%	80%
Point 2	2-4 years	89%	43%	80%	73%
Point 3	4+ years	90%	61%	86%	80%
All points		90%	57%	84%	80%

Source: DHSC

130. Table A.34 shows that in June 2024, 90% of Band 5 staff with British nationality were pension scheme members, similar to the share across the NHS as a whole, while just 57% of those with a non UK/EU/EEA nationality were scheme members. The membership rate was lowest amongst Band 5 staff from the Rest of the World with two to four years' experience. 43% of this group were members of the scheme.

AfC pay structure

131. The pay scales for England and Northern Ireland and Wales and the associated differences between pay points are as below. The pay points in Wales are 1.5% above those of England and Northern Ireland, so in general the same differentials are the same (Table A.35). The smallest differentials are between Band 2 and 3 (1.9%) and Band 7 and 8a (1.8%).

Table A.35: AfC pay banding, 2024-25, in England, Northern Ireland and Wales and the associated differentials

	England and Northern Ireland		Wales	
Band/pay point	**Salary (FTE)**	**Differential to next point**	**Salary (FTE)**	**Differential to next point**
Band 1	£23,615	0.0%	£23,970	0.0%
Band 2 (entry step)	£23,615	0.0%	£23,970	0.0%
Band 2 (top step)	£23,615	1.9%	£23,970	1.9%
Band 3 (entry step)	£24,071	6.7%	£24,433	6.7%
Band 3 (top step)	£25,674	3.3%	£26,060	3.3%
Band 4 (entry point)	£26,530	9.7%	£26,928	9.7%
Band 4 (top point)	£29,114	2.9%	£29,551	2.9%
Band 5 (entry step)	£29,970	7.9%	£30,420	7.9%
Band 5 (intermediate step)	£32,324	12.9%	£32,810	12.9%
Band 5 (top step)	£36,483	2.3%	£37,030	2.3%
Band 6 (entry step)	£37,338	5.5%	£37,898	5.5%
Band 6 (intermediate step)	£39,405	14.1%	£39,997	14.1%
Band 6 (top step)	£44,962	2.6%	£45,637	2.6%
Band 7 (entry step)	£46,148	5.2%	£46,840	5.2%
Band 7 (intermediate step)	£48,526	8.8%	£49,254	8.8%
Band 7 (top step)	£52,809	1.8%	£53,602	1.8%
Band 8a (entry step)	£53,755	5.0%	£54,550	5.0%
Band 8a (intermediate step)	£56,454	7.2%	£57,295	7.2%
Band 8a (top step)	£60,504	2.8%	£61,412	2.8%
Band 8b (entry step)	£62,215	6.5%	£63,150	6.5%
Band 8b (intermediate step)	£66,246	9.1%	£67,232	9.1%
Band 8b (top step)	£72,293	2.8%	£73,379	2.8%
Band 8c (entry step)	£74,290	6.1%	£75,405	6.1%
Band 8c (intermediate step)	£78,814	8.6%	£79,996	8.6%
Band 8c (top step)	£85,601	3.0%	£86,885	3.0%
Band 8d (entry step)	£88,168	6.1%	£89,491	6.1%
Band 8d (intermediate step)	£93,572	8.7%	£94,975	8.7%
Band 8d (top step)	£101,677	3.6%	£103,203	3.6%
Band 9 (entry step)	£105,385	6.0%	£106,967	6.0%
Band 9 (intermediate step)	£111,740	8.5%	£113,416	8.5%
Band 9 (top step)	£121,271		£123,091	

Appendix B Structural appendix

1. As discussed at 3.159 – 3.176, we asked parties for their priorities for structural reform. There was not unanimity on what the priorities should be. Suggestions included:

    a) Differentials between pay points needed to be addressed to ensure there are financial incentives for staff to seek promotion;
    b) Pay at the bottom end of the AfC scale needs to be addressed to ensure the NHS is a competitive employer at AfC Bands 1-3. Some parties suggested aligning with the Living Wage Foundation's Real Living Wage could be appropriate;
    c) Graduate pay (Band 5) needs to increase as some say it is currently insufficient to compete in the wider graduate market;
    d) Differential unsocial hours rates at Bands 1-3 distort pay relativities and disincentivise promotion, so unsocial hours rates should be reformed to remove this effect;
    e) Unsocial hours rates should be paid to staff at Bands 8a and above.

2. NHS Employers provided some costings for some of their priority reforms in their evidence, based on pay in 2024/25. These included costings relating to a) pay between bands, either across the board or at certain points b) paying the Real Living Wage and c) enhancing graduate entry pay at band 5.

3. No other costings were provided to us in supplementary evidence. We are conscious there are a number of other priorities presented to us that have not been costed. Some priorities are not possible to cost without parties discussing and developing them in more detail. This is especially true of addressing anomalies resulting from varying unsocial hours payments where there could be a range of options for the parties to consider. We are also aware not all members of the NHS Staff Council participated in the NHSPRB process this year, and they may have additional or different priorities for reform.

4. The costings provided by NHS Employers on gaps between bands considered different options for a 5% increase on promotion, including only applying this at some bands, through to applying it to all bands and maintaining band lengths alongside this. NHS Employers estimated that a simple 5% increase to the first pay point only across all bands would cost 0.8% of paybill (excluding the interim top up cost from April 2025 of NLW compliance). This encompasses one of their costed proposals on graduate entry pay.

5. The costings provided by NHS Employers on paying the Real Living Wage considered this in combination with different potential headline pay awards. Based on the 3.6% headline pay uplift we are recommending, the cost would be 0.1% of paybill.

6. These estimates are approximate, based on 2024/25 pay, and the actual cost would depend on a range of issues including the future path of the Real Living Wage, and the exact size of gaps between the maximum of one pay band and the minimum of the next band.

7. On the basis of this evidence, it is likely that 1.0% is the minimum investment that would be needed to begin meaningful structural reform, noting again that this does not encompass all the priorities presented to us, and that not all members of the NHS Staff Council participated in the NHSPRB process this year, and they may have additional or different priorities for reform.

Appendix C Remit letter from the Secretary of State for Health and Social Care, 30 September 2024

Department of Health & Social Care

From the Rt Hon Wes Streeting MP
Secretary of State for Health and Social Care

39 Victoria Street
London
SW1H 0EU

020 7210 4850

Stephen Boyle
Interim Chair, NHS Pay Review Body
Office of Manpower Economics
First floor
10 Victoria Street
London
SW1H 0NB

30 September 2024

Dear Mr Boyle,

I would firstly like to offer my thanks to the NHS Pay Review Body (NHSPRB) for their work over the past year on the 2024 to 2025 report. The government appreciates the independent, expert advice and valuable contribution that the NHSPRB makes.

I write to you now to formally commence the 2025 to 2026 pay round.

My department's evidence will, as usual, cover the recruitment and retention context alongside pay and earnings data, as well as our workforce strategy, and the expected position following the implementation of the 2024 to 2025 pay award. It will also set out the funds available to the Department of Health and Social Care for 2025 to 2026, which will be finalised through the Spending Review and announced at the Autumn Budget on 30 October 2024. That comes against the backdrop of the challenging financial position this government has inherited, including a £22 billion pressure against the spending plans set out for departments at Spring Budget 2024. My department will continue to strive to deliver on our manifesto commitment to build an NHS fit for the future to ensure it is equipped to efficiently deliver the vital, high quality public service we rely on, while ensuring value for money for taxpayers.

We know that public sector workers delivering our vital public services deserve timely pay awards, so, as the Chancellor said in her July Statement, the government's intention is to announce pay awards as close to the start of the pay year of 1 April as possible for 2025 to 2026. It is unfortunate that, given the knock-on effects from the previous government's delays to the 2024 to 2025 round, it is unlikely that workforces will receive pay increases by April, but by bringing the pay round forward this year, we can more fully reset the timeline in 2026 to 2027.

To this end, where possible I would be grateful if you can deliver recommendations to the government on the 2025 to 2026 pay award for Agenda for Change staff at the earliest point that allows you to give due consideration to the relevant evidence. To support with this, the government will publish its written evidence as soon as possible after the Spending Review is finalised and 2025 to 2026 budgets are set on 30 October 2024, including budgets relating to pay. I recognise that changing the timeline from recent years will present challenges for NHSPRB, but I am sure you also share the government's belief in the importance of returning to more timely annual pay processes, so I hope you will understand the necessity of doing so.

As always, while your remit covers the whole of the United Kingdom, it is for each administration to make its own decisions on its approach to this year's pay round and to communicate this to you directly.

I accepted your recommendations for 2024 to 2025 and in doing so committed to working with the NHS Staff Council to start addressing structural issues within the Agenda for Change contract. This work is ongoing and we will provide further information on this as part of our evidence submissions so that it can be considered accordingly when writing your report this year.

I would like to thank you again for your and the review body's invaluable contribution to the pay round and look forward to receiving your 2025 to 2026 report in due course.

Yours ever,

RT. HON. WES STREETING MP

SECRETARY OF STATE FOR HEALTH & SOCIAL CARE

Appendix D Remit letter from the Cabinet Secretary for Health and Social Care, Welsh Government, 30 October 2024

Jeremy Miles AS/MS
Ysgrifennydd y Cabinet dros Iechyd a Gofal Cymdeithasol
Cabinet Secretary for Health and Social Care

Llywodraeth Cymru
Welsh Government

Our ref: MA/JMHSC/10446/24

Stephen Boyle,
Chair
NHS Pay Review Body
1st Floor, 10 Victoria Street
London
SW1H 0NB

NHSPRB@Businessandtrade.gov.uk

30 October 2024

Dear Stephen,

I would like to thank you for the NHSPRB's hard work and independent observations in the 2024-25 round which have been invaluable.

I am now writing to formally commence the 2025-26 pay round for Agenda for Change staff in Wales.

In order to support your work, I will provide written evidence and I also plan to attend the oral evidence session when arranged.

I would like to take this opportunity to say I truly value the hard work and commitment of all our dedicated healthcare workers in Wales and recognise the pressures on our workforce.

Therefore, I would like to receive your advice and recommendations as soon as possible to ensure that payment of any award to our dedicated NHS workforce is not unduly delayed past April 2025.

Yours sincerely,

Jeremy Miles AS/MS
Ysgrifennydd y Cabinet dros Iechyd a Gofal Cymdeithasol
Cabinet Secretary for Health and Social Care

Bae Caerdydd • Cardiff Bay
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Gohebiaeth.Jeremy.Miles@llyw.cymru
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Appendix E Remit letter from the Minister for Health, Northern Ireland, 25 November 2024

FROM THE MINISTER OF HEALTH

Stephen Boyle
Interim Chair of NHS Pay Review Body
Office of Manpower Economics
Fleetbank House
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EC4Y 8JX

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Castle Buildings
Stormont Estate
BELFAST, BT4 3SQ
Tel: 028 9052 2556
Email: private.office@health-ni.gov.uk

Our Ref: SUB-1775-2024

Date: 25 November 2024

Dear Stephen,

NHSPRB 2024/25 PAY ROUND

I am writing to formally commence the 2025/26 pay round for Agenda for Change (AfC) staff in Northern Ireland. I wish to begin by thanking the NHS Pay Review Body for its invaluable work on the 2024/25 pay round and your observations in relation to the current circumstances around NHS pay, particularly as regards workforce challenges, including recruitment and retention.

We have met with Trade Unions representing Agenda for Change health staff to put a firm proposal on 2024/25 pay to them. This would involve full implementation of your recommendations, initially for part of the financial year. It is important to recognise that further work still needs to be undertaken in order to reach a resolution to the issue of health service pay. It is also important to recognise that the challenges facing public sector pay in general will only be resolved through an all-Executive approach.

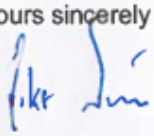
It is recognised that this is not the position we would want to be in; appropriate reward and recognition for our staff is clearly an important part of demonstrating that we value the work that they undertake. I will continue to make the case to Executive colleagues, for additional financial allocations that would allow me to implement a pay award in line with the recommendations from NHSPRB for 24/25.

Working for a Healthier People

I do, however, want to emphasise that the work of the NHS Pay Review Body in providing recommendations will be of great value to the Department.

I would therefore welcome your pay recommendations for health and social care staff in Northern Ireland for 2025/26. The Department will, of course, keep you updated in regard to any progress made in respect of 2024/25 awards.

Yours sincerely



Mike Nesbitt MLA
Minister of Health

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