Department of Health & Social Care

The Department of Health and Social Care's written evidence to the NHS Pay Review Body for the pay round 2026 to 2027

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1. Introduction

In July, the government remitted the NHSPRB to provide recommendations for the 2026 to 2027 pay award for the Agenda for Change (AfC) workforce. The remit letter was sent over 2 months earlier than the previous year. The NHSPRB responded and asked us to provide evidence on all aspects of its terms of reference as well as a number of additional points of interest such as the impact on recruitment and retention of non-pay terms and conditions, this document is the written part of the governments evidence. Once it has finished collecting evidence for this pay round the NHSPRB will write a report as usual, including recommendations for doctors and dentists pay uplifts for the 2026 to 2027 financial year.

For the 2025 to 2026 pay round, the NHSPRB made 2 recommendations; a headline pay uplift, and recommendation for the government to issue a funded mandate to the NHS Staff Council to address structural issues in the AfC contract. The government accepted both of these recommendations, and talks continue with the NHS Staff Council on the second recommendation.

This document is the governments written evidence to the NHS Pay Review Body (NHSPRB) in response to the NHSPRBs call for evidence, it has been developed jointly between the Department for Health and Social Care (DHSC) and NHS England (NHSE). This chapter provides the context for the department's evidence to the NHSPRB for the 2026 to 2027 pay round, as well as a brief overview of the evidence itself.

Pay structure mandate

The government remains committed to providing the NHS Staff Council with a funded mandate to begin to resolve outstanding concerns with the AfC pay structure. The government continues to operate within an extremely challenging fiscal position, and following the Spending Review (SR), we are finalising the funding allocations that will inform the final pay structure mandate. We are clear about the importance of delivering this mandate and have committed to work with the Staff Council such that changes are made from 1 April 2026.

We recognise the timing constraints involved in delivering this and delivering the mandate by 1 April 2026 and, to ensure continued progress on this priority, the government therefore asked the NHS Staff Council to conduct exploratory talks to identify the areas of the pay structure that it would like to see reformed. We have subsequently requested that these talks are progressed to the next stage, with the aim of identifying joint priorities and seeking a consensus that can feed into formal negotiations once the mandate is finalised. DHSC ministers have had a number of helpful discussions with the NHS Staff Council chairs about these talks.

This document

This year's evidence follows a similar structure to previous years, summarised below. The accelerated timeline means certain datasets have not been updated so some of the data and evidence is the same, however we have still provided it for completeness.

Chapter 2 provides an overview of the economic context and government and NHS finances. This year, as confirmed through the SR, all pay must be funded from departmental budgets and there will be no additional funding available above this for pay settlements. Systems will be asked through a forthcoming multi-year planning process to set out their plans over the next 3 years. Pay awards above what is considered affordable within the SR settlement will require further tough national and local re-prioritisation of the decisions already made through the planning progress and would impact on the speed and delivery of the 10 Year Health Plan.

Chapter 3 outlines the work being undertaken to support workforce strategy and planning, as well as programmes relating to training, education, and international recruitment.

Chapter 4 of our evidence sets out the important context of staff experience, covering morale and motivation, as well as the work being done to improve NHS staff's working lives. Taken with the evidence to the Review Body on Doctors' and Dentists' Remuneration (DDRB) it highlights the importance of considering the workforce as a single joined up whole across AfC staff as well as their medical and dental colleagues, reflecting the reality of how services are delivered in the NHS. Ensuring each member of that team is treated equally and fairly, especially those in lower-paid roles, is important to this government.

In chapter 5 the AfC workforce is broken down into its largest constituent groupings with the context of recruitment, retention, motivation, and morale for each part of the remit group. Chapter 6 contains earnings and expenses data, and the labour market context for the workforce.

Finally, chapter 7 reflects the total reward package that NHS staff receive which is above the statutory minimum and exceeds that offered in other sectors. This includes access to a defined benefit pension scheme, as well as a generous holiday allowance, enhanced parental leave, and support for learning, development, and career progression.

The NHS workforce

An engaged workforce is central to delivering government's objectives for the NHS. The 10 Year Health Plan (10YHP) has set out the vision for how this government will make an NHS 'fit for the future'. When the Prime Minister and Secretary of State for Health and Social Care published the plan on 03 July 2025, they made it very clear that the NHS

faces a choice; reform or die, and that the only answer was to choose reform. Making that choice and delivering on the ambitions set out in the plan is not possible without an engaged workforce that has been empowered to deliver the 3 big shifts in care: from hospital to community, from analogue to digital, and from sickness to prevention.

The 10YHP set out our vision for the models of care staff will deliver and the tools they should have to do it, as well as how the department will improve the NHS as an employer. A 10 year workforce plan will be published later this year and will detail how the department will ensure it has the right people in the right places with the right skills to deliver on our plan.

Evidence approach

On 13 March 2025 it was announced that the DHSC and NHS England will merge into a single organisation under the mantle of DHSC. This means that the evidence contained in this document will cover what has previously been covered across DHSC and NHS England evidence. This should reduce duplication and further streamline government evidence. As with last year, rather than including data ourselves, we will reference data in the 'data pack'. As always, we will provide our own narrative and interpretation, signalling clearly where data pack figures, or publicly available data sources, are being referenced. Any feedback on this approach would be appreciated.

Note, where we use the date format '2026 to 2027' we are referencing the financial year, unless otherwise stated.

2. NHS finances

This chapter will outline the financial context including efficiency and productivity within which NHS pay awards will need to be met. The government's position is that pay awards must be funded from departmental budgets and there is no additional funding available for pay settlements.

To set a balanced budget post SR, we have made significant prioritisation decisions across both DHSC and NHS England, and systems will be asked through a forthcoming multi-year planning process to set out their plans over the next 3 years. The productivity and efficiency section sets out the significant ask on both integrated care boards (ICBs) and NHS trusts in relation to productivity and efficiency in 2025 to 2026, with pay and non-pay pressures, alongside unplanned event such as industrial action, directly impacting the scale of the challenge.

Pay awards above what is considered affordable in the SR settlement will require further tough national and local re-prioritisation of the decisions and would impact and challenge

the speed and delivery of front-line services and the 10YHPFor the 2025 to 2026 pay uplift, funding was met from within DHSC budgets through decisions on reprioritisation, the dissolution of NHS England, and reshaping and reducing ICB costs. Further pay awards above what is considered affordable will require difficult government trade-offs from within existing DHSC budgets, including a reduction in ambitions for service or performance improvement.

Under the 2025 SR, NHS funding will rise by an average of 3% in real terms annually and expected to deliver ambitious productivity targets of 2% per year equating to £17 billion in savings. In setting the departmental financial plan for 2026 to 2027, this is predicated on the successful delivery of the 2% productivity target, alongside managing a wide range of material financial risks through 2025 to 2026.

Economic context

Low and stable inflation is a key component of a stable macroeconomic environment and a prerequisite for sustainable economic growth and improved living standards. Headline Consumer Prices Index (CPI) inflation has risen over the past year to 3.8% in September – above the 2% target. Services inflation, an indicator of underlying inflationary pressure, has fallen by 1.0 ppts since the start of Q1 2024 to 2025. Overall, risks to inflation remain 2-sided, reflecting domestic cost pressure from wage growth which has been a major factor in services inflation persistence, and prices as well as external pressures from energy markets and trade policy.

The unemployment rate has risen over the last year, reaching 4.8% in the 3 months to August 2025. Wider sources also suggest that the labour market has continued to loosen. Vacancy levels in the economy have fallen over the past 3 years, and RTI data on payrolled employees shows a gradual fall over the last seven months.

Measures of average wage growth have historically been higher than median pay settlements, as they are affected by compositional changes in the labour force and factors such as changes to working hours. Settlement data are the most comparable data to PRB decisions, as they are a direct measure of consolidated pay awards, and are not directly affected by other factors such as changes to working hours or changes in the composition of employment. According to Brightmine, median settlements across the economy were 3% in Q1 and Q2 2025. Average earnings growth is forecast to slow further over the coming months, with the OBR expecting earnings growth to fall to 2.2% in 2026 to 2027.

Funding growth

Table 1: mandate funding for NHS England

NHS England	NHS England revenue departmental expenditure limits (RDEL) excluding ringfence (RF) (cash) £ billion	NHS England capital departmental expenditure limits (CDEL) excluding ringfence (RF) (cash) £ billion
2023 to 2024	171.036	0.439
2024 to 2025	186.838	0.431
2025 to 2026	195.593	0.394

Source: 2024 to 2025 and 2025 to 2026 financial directions to NHS England

Table 1 above shows the closing mandate for NHS England up to 2025 to 2026 and the opening mandate in 2026 to 2027. This outlines the funding for NHSE over the last few years and the subsequent growth. The figures are adjusted annually to account for reallocation of resource, additional funding, and changes of responsibility between government bodies. Figures exclude depreciation, annually managed expenditure (AME) and the technical accounting budget, namely capital grants or Private Finance Initiative.

The 2025 to 2026 totals will be updated with closing financial directions in April 2026, to reflect any changes to NHS budgets agreed, including funding provided to the NHS for the pay awards announced in May 2025.

Financial position of the NHS

The Autumn Budget 2024 set out that NHS England RDEL budgets will rise to £181.4 billion in 2024 to 2025 and £192 billion in 2025 to 2026. The latest Financial Performance Report for 2025 to 2026 shows that with planning completed, all 42 systems have balanced plans for the year, after receiving £2.2 billion in deficit support funding. The year-to-date (YTD) position points to an overspend of £51 million which is largely driven by a shortfall in efficiency plans. It is expected that YTD system overspends will be recovered in the latter part of the year resulting in a forecast position in line with plan. However, material risks remain from the cost of managing industrial action, implementing planned restructuring and headcount reductions and delivery of efficiency plans over the remainder of the year

Table 2 shows the breakdown of funding provided to NHS providers since the 2017 to 2018 financial year, including preliminary outturn data for 2024 to 2025.

Table 2: NHS providers RDEL breakdown

NHS Providers RDEL breakdown (£m)	2019 to 2020	2020 to 2021	2021 to 2022	2022 to 2023	2023 to 2024	2024 to 2025
Gross deficit	1,560	158	126	1,001	1,606	1,094
Gross surplus	-567	-363	-442	-299	-305	-318
Reporting adjustment	-323	-450	-240	-252	12	0
NHS providers SRP (sector reported performance)	670	-655	-556	450	1,312	776
Plus additional RDEL adjustment	338	-77	-39	528	69	293
Net NHS providers RDEL non-ring fenced (NRF)	1,008	-732	-595	978	1,382	1,070

Share of resources going to pay

The growth rate in NHS trust and foundation trust provider sector (NHS Trusts and NHS foundation trusts only, and so does not include other providers of NHS services such as primary care and some community services) permanent and bank staff spend has exceeded the growth rate in overall NHS England funding in each of the past 3 financial years.

Table 3 shows the proportion of funding consumed by NHS trust and foundation trust permanent and bank staff spend since the 2022 to 2023 financial year. This only covers staff working within hospital and community health settings and excludes agency spend by these organisations. Further information is set out in the 'Productivity in the NHS' section on the elimination of agency expenditure.

Table 3: increases in revenue expenditure and the proportion consumed by pay bill

Year	NHS England RDEL (£ billion)	NHS provider sector permanent and bank staff spend (£ billion)	% of spend on staff	Increase in total spend	Increase in provider permanent and bank staff spend
2022 to 2023	152.553	73.942	48.47%	3.98%	7.37%
2023 to 2024	165.926	82.004	49.42%	8.77%	10.90%
2024 to 2025	179.570	89.910	50.07%	8.22%	9.64%

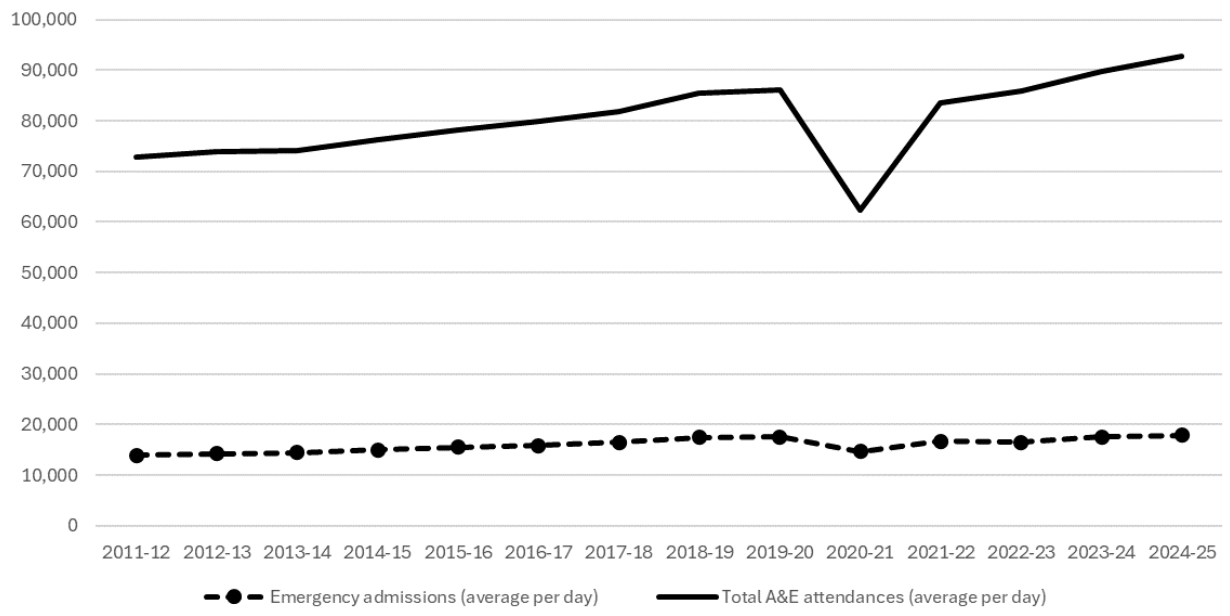
Notes:

- 2022 to 2023: NHS England RDEL figure excludes non-recurrent funding for a non-consolidated pay award compared with the corresponding figure in Table 1. NHS trust and foundation trust permanent and bank staff spend excludes a corresponding amount
- 2023 to 2024: NHS England RDEL figure excludes Health Education England (HEE) funding compared with the corresponding figure in Table 1
- 2024 to 2025: NHS England RDEL figure excludes HEE funding and additional pensions funding compared with the corresponding figure in Table 1. NHS trust and foundation trust permanent and bank staff spend excludes a corresponding amount for additional pensions spend
- figures in the table are correct to the specified level of significance. Percentage increases may not match increases calculated from budget or spend figures as given in the table due to rounding

Demand pressures

Demand for emergency care is now above levels seen before the COVID-19 demand spike, with more accident and emergency (A&E) attendances.

Figure 1: Total and emergency admissions per calendar day



Source: NHS England A&E Attendances and Emergency Admissions

Figure 1 shows the total attendances and emergency admissions to NHSE per calendar day between 2011 to 2012 and 2024 to 2025.

In 2019 to 2020, there were an average of 68,540 A&E attendances and 17,551 emergency admissions per day. In 2024 to 2025, there were 74,941 A&E attendances and 17,873 emergency admissions per day. This equates to a 9% increase in A&E attendances, while emergency admissions grew more slowly demonstrating an increase of 2% between 2019 to 2020 and 2023 to 2024.

Table 4: shows the total patient referral to treatment (RTT) pathways completed per working day

Year	RTT estimated clock starts per working day	RTT total completed pathways and unreported removals per working day	Waiting list
2018 to 2019	82,231	81,272	4,345,467
2019 to 2020	79,712	79,552	4,386,297
2020 to 2021	55,824	53,595	4,950,297
2021 to 2022	74,916	69,322	6,365,772
2022 to 2023	79,511	75,665	7,331,186
2023 to 2024	82,163	81,332	7,538,830
2024 to 2025	82,440	82,878	7,418,598

Source: NHS England consultant led referral to treatment statistics.

Elective reform is a key focus for the government and NHS to deliver on the commitment that 92% of patients will wait no longer than 18 weeks from referral to consultant-led treatment – in line with the NHS constitutional standard – by March 2029. The size of the challenge remains significant. The waiting list currently stands at 7.4 million (as of July 2025). This is down from 7.6 million in July 2024, but up from 4.5 million in July 2019 before the pandemic. At the end of June 2024, the start of the current parliament, only 58.9% of waits are within the 18-week standard with nearly 200,000 patients waiting more than 52 weeks for elective treatment. Currently, in July 2025, the data has shown some improvement with 61.3% of waits now within the 18-week standard, but this is still way below the constitutional commitment of 92%. During this time, between July 2024 and June 2025, 5.2 million additional appointments have been delivered, compared to the previous year, which is more than double the government pledge of 2 million in their first year.

The Elective Reform Plan – published in January 2025 – outlines an ambitious package of reforms that the NHS is expected to deliver with national funding and support. It includes action to manage demand and transform outpatient services, provide faster and more local diagnostics, implement more productive surgical pathways and improve patient experience.

The DHSC 2025 (SR) settlement includes £1.8 billion of additional funding, announced at Autumn Budget 2024, to support the delivery of 2 million extra operations, scans and appointments (equivalent to 40,000 per week) during this government's first year. The government has reached, and surpassed this target.

This is supported by £6 billion additional capital investment over 5 years for diagnostic, elective, urgent and emergency capacity in the NHS to March 2030. This includes £1.65 billion capital funding in 2025 to 2026 to deliver new surgical hubs, diagnostic scanners and beds to increase capacity for elective and emergency care.

Monthly per working day RTT activity across 2024 to 2025 was above pre-pandemic levels, 16% higher than activity seen in 2019 to 2020. However, activity levels are still lower than originally planned; the 2022 Elective Recovery Plan envisaged they would be 30% higher by 2024 to 2025. This has been due to slower productivity recovery, in part due to industrial action. NHS analysis estimates that the waiting list could have fallen by an extra 430,000 from December 2022 to March 2024 without strikes.

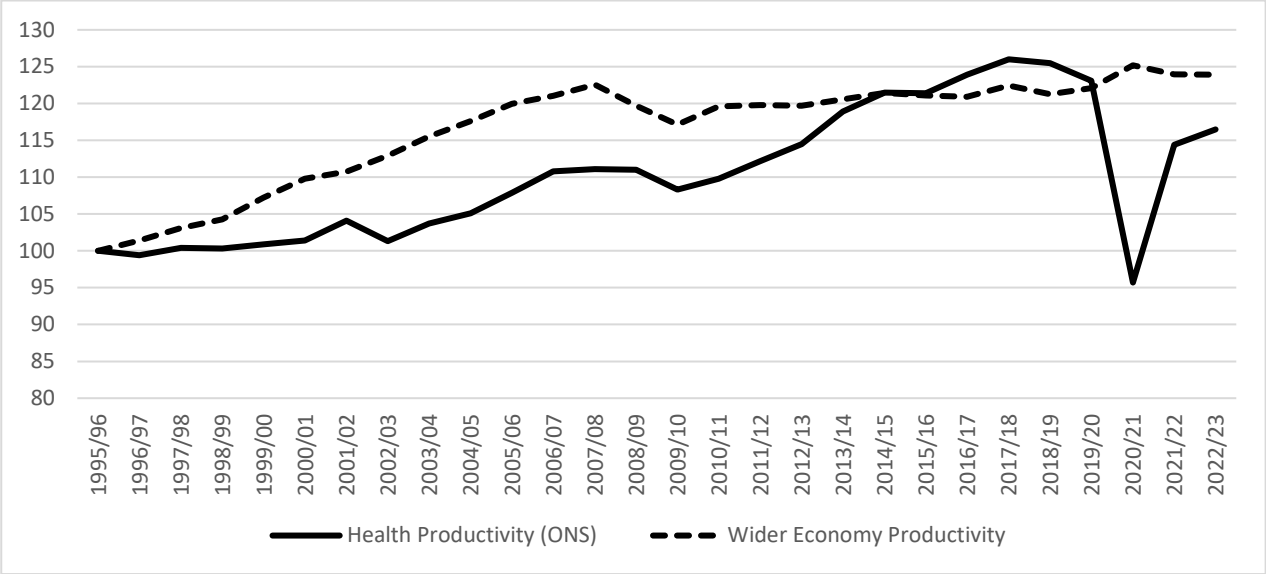
Average elective demand growth pre-pandemic (between October 2016 and February 2020) was 2.1%. Demand returned to pre-pandemic levels in January 2023 and rebounded at a rate of 6.1% across 2022 to 2023. The rate of demand growth has fallen since then, at just 0.3% across 2024 to 2025 (although changes in the reporting of community pathways in February 2024 explain some of this decrease). Demand growth is expected to return to the long-term trend seen before the pandemic at around 2% without mitigations from advice and guidance interventions.

Calculating productivity in the NHS

In England quality adjusted public service healthcare productivity increased on average by 0.9% per annum from 1995 to 1996 until 2019 to 2020 – a similar rate to the wider UK economy.

Office for National Statistics (ONS) figures showed a 22.2% reduction in productivity in 2020 to 2021. ONS has since reported a significant bounce back with productivity back to 5.3% below the 2019 to 2020 level by 2022 to 2023, but some of this recovery is due to the inclusion of Test and Trace and COVID vaccinations. A more modest recovery of 10.2% below the 2019 to 2020 level was reported by York University in 2022 to 2023 who published a similar measure that excluded Test and Trace and most COVID vaccinations.

Figure 2: ONS England Health versus Wider Economy Multi Factor Productivity (index 1995 to 1996 equals 100)



These formal estimates are only published up to 2022 to 2023. However, NHS England has published an in-year measurement of productivity for the acute sector, aligned to the ONS annual approach. The measure was published in February 2025 and March 2025 and estimated acute productivity growth has averaged 2% over the last 3 years (2022 to 2023, 2023 to 2024, and YTD 2024 to 2025) but is still 7% to 8% below the 2019 to 2020 level.

The measure has become an official statistic in development since September 2025. It is broken down by provider so organisations can understand their own productivity and opportunities for improvement.

ONS publish an in-year quarterly measure, however this is experimental and has large confidence intervals around its findings. The quarterly public service productivity published in July 2025 found public service healthcare in the United Kingdom was 2.7% more productive in January to March 2025 than in January to March 2024, with 2.9% more output and 0.2% more input. As an experimental measure, it should be viewed with caution.

Sources:

- ONS Public service productivity estimates healthcare England FYE 2023
- Latest CHE research paper on NHS productivity 2022 to 2023 update
- NHS productivity update board meeting February 2025

- NHS England public board meeting agenda and papers 27 March 2025
- ONS Public service productivity quarterly UK: January to March 2025

NHS England has developed the Model Health System (MHS) which is a data driven improvement tool designed to help systems and trusts improve their productivity and efficiency. The MHS gives trust-level benchmarking allowing systems and trusts to compare productivity, quality and responsiveness data to their peers to identify opportunities to improve. Data within the MHS relating to workforce productivity include:

- non-elective admissions per clinical whole time equivalent (WTE)
- elective admissions per clinical WTE
- A&E attendances (Type 1 and Type 2) per Emergency Medicine consultant

Productivity in the NHS

The SR 2025 announcement included a commitment that the NHS would deliver 2% annual productivity growth over the 3 years of the SR (from 2025 to 2026 to 2028 to 2029), driven by significant technology and digital infrastructure investments. This includes up to £10 billion investment to advance NHS technology, supporting the move towards a single patient record, expanding and enhancing the NHS App, and harnessing AI and other digital tools. These investments will free up staff time, improve patient experience, and ensure the NHS is better equipped to meet future demand. The 2% annual productivity target is an integral part of the settlement and does not represent further savings beyond what has already been agreed.

Increasing NHS productivity and efficiency remain essential to meet the growing demand for health services to support enduring improvements in performance and ensure financial sustainability. In recent years, funding and workforce levels within the NHS have gradually increased. However, though there has been some sustained progress since the COVID-19 pandemic, this has not yet translated into significant corresponding improvements in productivity. The 2% productivity growth aims to address this gap, to ensure that increased resources translate into measurable improvements in the quality of services patients receive.

The 10YHP emphasises the need for reform within the NHS, and the critical role that improving productivity must play in this. This includes focusing on system reform, leveraging technology, and investing in workforce development. Lord Darzi's recommendations also stressed that any financial increase, including pay, should be tied to productivity gains and wider systemic improvements. Following the SR announcement in June, future pay decisions should be considered alongside these broader reforms to

ensure sustainable investment that enhances both workforce well-being and service delivery.

To deliver the 2% productivity target, NHS England is focusing on 5 key areas:

- operational and clinical excellence: improving patient flow, reducing discharge delays, adopting best practices to minimise clinical variation, and delivering care in the right place at the right time through new models of care

- workforce - optimising workforce capacity through best practice standards of planning and deployment, improving retention and culture and upskilling staff, including reducing the volume of temporary staffing, which will reduce bank and agency spend

- health rather than illness: focusing on increasing healthy life years through prevention and screening, and shifting care upstream to primary, community, and mental health services

- technology and transformation: modernising technology through the 'One Digital' estate, modernising data infrastructure, transforming the NHS App and digitally enabled services and releasing time for workforce through digital tools and services

- reducing waste: achieving efficiencies in medicines, enhancing commercial processes, and improving corporate services by exploring large-scale automation

Affordability

SR25 set departmental budgets for day-to-day spending until 2028/29. The Government has been clear in the SR that pay awards need to be funded in full from within these budgets and there will be no access to the reserve.

The Government has allocated its SR funding in order to deliver on its commitments in the Plan for Change and the 10 Year Health Plan. These require increased activity particularly in electives and to deliver other service and performance expectations, as well as meeting inflation and other cost increases.

DHSC is balancing these spending commitments across NHS England, its other ALBs and the core department, with an ambitious productivity assumption of 2% each year in the NHS which will be required to deliver to balance the settlement. DHSC have developed financial and delivery plans which currently allow for a pay uplift of 2.5% without having to make trade-offs against headline government health commitments. Should the independent pay review bodies recommend an award above this level, we would need to consider whether and how this could be made affordable from within existing DHSC budgets. Accepting such an award would inevitably have an impact on healthcare delivery.

DHSC, along with NHS, is already managing a wide set of material financial risks including industrial action costs and other demand pressures on the NHS. NHS pay is a significant material pressure where every 0.5% increase to pay costs c. £750m, so anything above the pay plan outlined above will require difficult trade-offs for the Government.

These trade-offs could include reduction in ambitions for service or performance improvement (for example, additional investment in digital and technology to support productivity improvements in future years). As staffing costs are the largest single area of NHS expenditure, it is likely that higher pay awards will affect the ability for the NHS to afford to maintain or expand staffing levels.

As you saw last year, the government has showed its willingness to make the difficult decisions needed to improve outcomes for the public from the health system. Including through identifying how extra funds will be freed up by cutting duplication and waste, and through abolishing NHS England, and reshaping and reducing ICB costs by 50% to empower NHS staff and deliver better care for patients.

3. Workforce planning and strategy, education and training, and recruitment

Summary

This chapter sets out the actions of the government and NHS England to reform the way we train the workforce to meet developing patient demand. It covers the new vision for the workforce, as set out in the 10YHP, and how this will require a new workforce strategy in the upcoming 10 year workforce plan. The 10 Year Workforce Plan will outline strategies for improving retention, productivity, training, and reducing attrition - enhancing conditions for all staff. It also details our aims of reducing international recruitment while improving opportunities for domestically trained staff.

The chapter also sets out how we're educating and training our staff differently to support the 3 shifts outlined in the 10YHP. Additionally, the chapter covers the government and NHS England’s approach to temporary staffing, and the 10YHP recommendations on leadership.

Non-medical workforce - Health and Community Health Services (HCHS)

Decisions around workforce growth are made by employers (mainly NHS trusts) and we expect to see slower growth over the SR period reflecting the reality of tight budgets and multiple competing priorities. Overall NHS workforce numbers (medical and non-medical)

grew relatively fast between the beginning of 2019 to 2020, and the end of 2023 to 2024 (source: NHS workforce statistics). During this period, total Agenda for Change (AfC) workforce growth was 4.3% per annum. AfC growth slowed in 2024 to 2025 to 2.2%, and we expect a further slowdown in 2025 to 2026. NHS operational plans show planned total workforce (medical, non-medical and bank and agency staffing) growth to be 2.0% lower than 2024 to 2025 (source: NHS England operating plan position).

This section describes the trends in the NHS staff employed on AfC terms by NHS provider trusts and integrated care boards. It sets out a high-level picture of the staffing position, covering key issues with regards to patterns of recruitment, retention, and motivation. It does not replicate all the data that is already regularly published into the public domain. A data pack setting out more detail is also available.

By March 2025, there were over 1.38 million AfC staff employed in NHS trusts and integrated care board, the equivalent of over 1.21 million full time equivalents (FTE). AfC workforce comprised of over 368,000 FTE nurses and health visitors, almost 25,000 FTE midwives, almost 22,000 FTE paramedics, over 177,000 Scientific, Technical and Therapeutic (STT) staff, over 411,000 FTE clinical support staff and almost 212,000 staff in NHS infrastructure roles. There are a further 35,000 FTE staff on AfC pay bands working in NHS support organisations and central bodies.

Workforce growth for AfC staff has been slower in 2024 to 2025 compared to the previous 5 year period. Growth in 2024 to 2025 was 2.2% compared with 4.3% per year over the previous 5 years and has been just above the longer run average since 2010 of 2.0% per year.

The slowdown in workforce growth was driven mainly by fewer clinical support and NHS infrastructure staff joining the NHS as well as a slowdown of internationally recruited nurse joiners. Professionally qualified staffing groups such as nurses (4.0%), paramedics (9.5%), midwives (5.5%) and STT staff (4.2%) increased at above the average annual increase, but clinical support staff (0.2%) and NHS infrastructure (0.6%) saw little increase in staffing numbers over the year. Later sections of this chapter highlight the programmes in place to support recruitment.

Published annual leaver rates for non-medical staff continued to fall during 2024 to 2025 and published leaver rates of 9.6% are at lowest levels since 2010, outside of the pandemic period. Leaver rates reflect staff leaving the NHS trust/ICB sector and so include those leaving to work in GP settings or elsewhere in the health and care sector. A key finding from Health Foundation analysis of NHS nurses leavers was that around 43% continued to work in nursing roles elsewhere in the health and care sector (source: the Health Foundation). Nursing and Midwifery Council (NMC) leaver rates give a sense of numbers leaving the profession entirely, including those retiring. NMC leaver rates are low at around 3.5% and have not changed significantly in recent years.

Published leaver rates for lower band staff (mainly bands 2 to 4) have fallen less compared to other AfC staff groups. For example, published annual leaver rates for registered nursing staff have fallen from 10.2% to 8.4% between March 2019 and March 2025 but the rate for staff supporting doctors, nurses and midwives (almost all AfC bands 2 to 4) are 10.6% in year to March 2025 compared to 10.7% in year to March 2019.

Vacancy rates have fallen; however it can be difficult to disentangle the underlying reasons behind the fall and it is not clear what the "natural" level of vacancies would be as people also move between roles (churn), sector or retire.

The headline vacancy rate (7.0% as at March 2025 compared to 9.0% April 2019) continues to mask significant variation between staff groups, trust types and regions. Mental health trusts continue to report the highest vacancy rates. For registered nurses, there remains relatively high vacancy rates in mental health trusts (10.6%) and much lower vacancy rates in acute trusts (5.0%). The North East and Yorkshire and South West see much lower registered nursing vacancy rates (4.1% and 4.0% respectively) than London (7.0%). The review body has asked about why people leave. The wider labour market differs between different professional groups so we would not expect the reasons for all professionals to be the same and there is no single measure that can tell us why people leave. NHS England published data reflects the mechanism behind why people leave the NHS (for example, resignation, end of fixed term contract) rather than why they leave.

Longitudinal Educational Outcomes (LEO) shows nurses tend not to leave for higher wages. UK nursing and midwifery graduates who remain in the healthcare sector 5 years after graduation have a slightly higher median salary than those working in different sectors.

Despite lower rates of staff leaving, there remain signs that the workforce is feeling stretched. Sickness absence rates in the NHS remain above pre pandemic levels despite UK wide rates falling to pre pandemic rates (source: Office for National Statistics: sickness absence in the UK labour market).

Workforce planning

The 10YHP, published in July 2025, set out a bold agenda to deliver the 3 big shifts needed to deliver an NHS fit for the future:

- move healthcare from hospital to community
- analogue to digital
- sickness to prevention

This therefore requires a new workforce strategy, to build a modern workforce that is better treated, better trained and more fulfilled. Through the 10YHP, the Department has committed to working with the Social Partnership Forum to develop a new set of Staff Standards to make the NHS a great place to work. Additional commitments included identifying further opportunities to ease the burden on staff, embedding a culture of lifelong learning and modernising staff terms and conditions. Leadership will be key in driving the change needed, and world-class leadership needs to be an ethos in the NHS, not just a training module. Furthermore, the 10YHP has committed to improving diversity and inclusion in the NHS, from widening access to medicine, to increasing the diversity of the Graduate Management Training Scheme, to ensure the NHS is representative of the communities it serves at all levels.

The 10YHP has set a clear direction to the service, stakeholders and the public on the future shape of care, and a new workforce plan will be published later this year to ensure the workforce is equipped to deliver this. The 10 year workforce plan will focus on the workforce we need to deliver the ambitions in the 10YHP, the roles they should carry out, where they should be deployed and the skills they should have. This will mean that while there will be fewer staff in 2035 than previously projected, these staff will be better treated, have better training and more exciting roles. The plan will be based on multi-professional teams, with the skills needed to enable delivery of the 3 shifts.

As well as the 3 shifts, the 10 year workforce plan will also act as the delivery vehicle for many of the policy ambitions set out in the 10YHP. This includes the government's commitment to developing homegrown talent and giving opportunities to more people across the country to join the NHS. The 10 year workforce plan will outline strategies for improving retention, productivity, and training, and for reducing attrition - enhancing conditions for all staff and students [while gradually reducing reliance on international recruitment, without diminishing the value of their contributions]. The 10 year workforce plan will consider how we can make our workforce truly sustainable, and how we can enable a sense of pride and enjoyment of work.

Education and training

We are committed to training more midwives, nurses and allied health professionals (AHPs) in line with the 3 big shifts set out in the 10YHP and we will continue to work closely with partners in education to do so.

The NHS learning support fund (LSF)

Since September 2020, all eligible nursing, midwifery and AHP degree students have received a non-repayable training grant of a minimum of £5,000 per academic year through the NHS Learning Support Fund (LSF). Additional LSF funding is also available for

studying certain courses - for example, mental health nursing and learning disabilities nursing - with further financial support available to students for childcare, dual accommodation costs and travel.

On 20 May 2025, the LSF rules for academic year 2025 to 2026 were published, and extended access to the scheme's travel and dual accommodation expenses (TDAE) provision to pharmacy and healthcare science courses, in line with all other healthcare undergraduate courses that fall under national clinical education and training tariff arrangements.

As part of our 10YHP, we will further help nursing students overcome financial obstacles to learning by reducing delays to reimbursement for their placement travel. To do this, we will work with the NHS Business Services Authority (NHSBSA) to reform and modernise the process of paying travel expenses before the start of the 2026 academic year.

New programmes in education and training

Advanced and enhanced practice

To support healthcare professionals to advance in their careers, we will develop advanced practice models for nurses, midwives, and allied health professionals (AHPs) that are aligned to the delivery of our 3 shifts, reflecting their essential leadership roles in a range of settings, including community and public health services.

NHS England currently has a nationally inclusive training offer to support statutorily regulated professionals across all disciplines to advance their practice. This includes employer-sponsored pathways that equip staff to take on advanced practice roles with area specific capabilities tailored to priority patient pathways such as ophthalmology and paediatrics. However, ongoing financial pressures in services has impacted the supply pipeline and many employers currently lack the resources to create or backfill the posts necessary to support advanced practice development.

To support safe and effective implementation of advanced practice, clear governance guidance is available through the Centre for Advancing Practice, and collaborative work with NHS Employers has helped embed this across the system. At present, non-statutorily regulated professions are excluded from accessing these pathways, presenting a significant retention challenge.

In response to the lack of a clear career pathway for allied health professionals (AHP), NHS England are also developing the AHP Enhanced Practice programme to support professionals into the enhanced practitioner stage. This stage is designed for those several years into their careers and aligns with Band 6 and 7 roles, focusing on supporting professionals to develop both clinical specialisms and generalist professional skills. This

model aims to foster a more skilled, productive, confident, and capable workforce, empowering safe, effective decision-making and improving retention by ensuring staff feel valued and invested in.

Non-medical consultant-level practice

To further support the career progression of healthcare professionals, NHS England has launched a pilot programme for the multiprofessional consultant practitioner training pathway in learning disabilities. which is expected to transition to a commissioned model once funding is secured, and a programme is commissioned. Like the advanced practice programme, funding pressures also risk affecting this model.

Educator capacity

Educators are the backbone of healthcare training, combining clinical knowledge with educational expertise to deliver practice learning. Their work shapes our current and future workforce, ensuring NHS staff receive the training, supervision and support they need to deliver excellent care to the patients and communities they serve. Therefore, we will reverse the decline in clinical academic roles through a new collaboration between government and major charity funders as part of our 10YHP. This collaboration will fund a year-on-year increase in these roles, over the next 5 years. We are also encouraging additional funders to support Clinical Future Leader Fellowships as the scheme develops and matures.

In 2023, NHS England also published an Educator Workforce Strategy setting out the key priority actions that will lead to sufficient capacity and quality of diverse educators to allow the growth in the healthcare workforce needed now and in the future. Service providers, integrated care systems (ICSs) and NHS England will all have a role in leading and commissioning sustainable education supply, including the supply of educators. To support this, we will continue to build strong relationships with the education sector and our key partners in higher education institutions (HEIs) and other education bodies.

Clinical placements

Linked to educator capacity, we are also working to ensure a sufficient number, spread and quality, of clinical placements including providing more placements within community settings. Current work around clinical placement management builds on insights from the 2022 to 2023 discovery phase and subsequent stakeholder engagement. NHS England are co-developing a set of national principles that will guide placement planning and delivery across all professions and settings, aligned with the evolving needs of the NHS, which increasingly require placements in community, primary care, and digitally enabled settings. These principles will support a systematic approach to addressing inconsistencies in placement provision, ensuring that placements are designed into health and care services from the outset and that providers understand the core standards

expected of them. The Chief Nursing Officer (CNO) strategy will build on this and ensure that every nursing student spends sufficient time across a range of clinical settings. This work is being delivered in 2025 to 2026 through strategic collaboration and alignment with wider NHS workforce reform initiatives, including the 10YHP and the 10 year workforce plan.

Financial support for education and training

From the start of 2022 to 2023, NHS England has been sharing statements about the financial support they provide for education and training and the corresponding activity delivered by providers within each of the 42 integrated care system (ICSs) geographical footprints. The aim of sharing these statements is to:

- increase the transparency of educational funding flows to enable ICS-level strategic discussions on our investment, including its alignment to ICS clinical strategy delivery and long-term service sustainability;
- and inform the development of an education and training plan for each ICS

The Education Funding Guide, published annually by NHS England, outlines the funding available to support the education and training of professional roles entering the NHS workforce. This includes, but is not limited to, funding to support the costs of tuition fees for programmes and clinical placement costs. In addition, DHSC publishes the annual Education and Training Tariff Guidance, which sets out the national payment rates for all eligible clinical placement activity.

Blended learning

Since 2020, NHS England has been commissioning and supporting the delivery of highly innovative blended learning programmes in nursing, midwifery, and medicine. These programmes combine cutting-edge, technology-enhanced learning methods with more traditional educational approaches. The courses are designed to attract a broader and more diverse range of students. Currently, NHS England is working with 10 universities that are delivering Blended Learning Nursing and Blended Learning Adult Nursing degrees.

A series of case studies and a Blended Learning dashboard are currently in development, due to be delivered by March 2026. A national evaluation of the effectiveness of the blended learning programmes is currently under development.

Supporting return to practice

A key challenge in supporting return to practice candidates, particularly those who have been out of clinical practice for over 12 months, is their relatively small number across the

country and the high likelihood that they have existing commitments, such as caring responsibilities or employment. To address this, blended learning offers a flexible and accessible solution, enabling individuals to refresh their clinical skills and return to practice with minimal disruption to their personal and professional lives. An innovative partnership between NHS England Technology Enhanced Learning, Sheffield Hallam University, Plymouth University, and Coventry University (CSU) has developed a new Return to Practice Blended Learning Programme, which is now beginning to recruit learners.

The Becoming Simulation Faculty and Peer Enhanced e-Placement programmes

The Becoming Simulation Faculty programme has grown rapidly, with 9,682 learners enrolled as of July 2025, a 32% increase since April 2025 and 97% year-on-year. The 3-phase model includes a flexible online core course (with 3,545 active users), CPD accredited in-person workshops (delivered by 126 facilitators to 664 participants across 29 hospital sites), and advanced online modules (with 2 launched and more in development). Recent feedback data from learners shows that the average eLearning rating across the programme is 4.3 out of 5, where 5 is equal to excellent. The programme also has a high Net Promoter Score of plus 61 for face-to-face workshops, indicating high learner satisfaction.

Supporting this growth, the Peer Enhanced e-Placement (PEEP) programme helps higher education institutions (HEIs) design online, practice-based learning experiences. Freely available, it encourages HEIs to adopt the Nursing and Midwifery Council's updated standards, which allow up to 600 hours of simulation-based practice learning.

Apprenticeships

Expanding access to apprenticeships will be crucial to achieving the ambitions we set out in the 10YHP to recruit more healthcare staff locally from the communities they serve, improving the diversity of our workforce and supporting the NHS's role in boosting local growth. By providing alternative routes into NHS careers and improving progression opportunities, apprenticeships enable NHS organisations to attract and recruit from a wider pool of people, including individuals who are not able to attend university full time and those who wish to earn as they learn.

As of the 2023 to 2024 financial year, the NHS was the largest public sector employer of new apprentice starts, with 19,800 apprentices starting training. This is out of 56,300 new apprentice starts across public sector bodies, with local government having the second largest number of starts in the public sector (12,800 new apprentice starts).

In recent years, across NHS and non-NHS health and social care organisations (for example, private healthcare, primary care, social care and so on), Registered Nurse Degree Apprentice (RNDA) starts have fluctuated. In the 2023 to 2024 academic year

there were 3,039 RNDA starts. This is higher compared to the 2022 to 2023 academic year when there were 2,717 RNDA starts but lower compared to the 2021 to 2022 academic year when there were 3,416 RNDA starts.

Allied health profession (AHP) apprenticeships

AHP apprenticeships are beginning to strengthen workforce supply pipelines, particularly in underserved areas, as evidenced by rising apprenticeship starts. Further support is needed to enable uptake in professions with smaller teams, where access to funding remains a barrier. For example, the Prosthetics and Orthotics (P&O) apprenticeship saw positive uptake when supported by NHS England training grants. Unfortunately, the following year, the absence of these grants led to zero uptake, as small services were unable to sustain training without financial assistance. As a result, there was a fallow year in training, losing essential momentum in workforce development.

Support workforce roles, scopes of practice, and associated training have now been established across 11 of the 15 allied health professions. The next phase involves developing more specific training content to clearly articulate progression pathways into pre-registration and apprenticeship routes. This work is essential to embedding apprenticeship models as a standard entry route into the professions, especially in the hard to recruit to professions or geographies, to draw workforce from local communities and optimise skills mix across services

Education and training reform

Skills development

In line with our 10YHP ambitions, over the next 3 years we will work with professional regulators and educational institutions to overhaul education and training curricula. This will future proof the NHS workforce, ensuring staff leave formal training fully prepared to work in a modern healthcare system and not just “fit for practice”. Reforms will include providing comprehensive training in the use of AI and digital tools and promoting acquisition and retention of generalist skills required for the Neighbourhood Health Service.

Skills England is the leading body in England focused on driving forward the nation's skills development, with a particular emphasis on aligning skills strategies with government priorities and addressing skills shortages. The Growth and Skills Levy, introduced by the UK government, is a key part of reforms aimed at revitalising the skills system and boosting economic growth. A major focus for the future skills strategy is to reverse the decline in NHS apprenticeship starts among young people. From January 2026, the Skills levy funding reforms will see funding being redirected from all Level 7 (master’s level) apprenticeships, except for those aged 16 to 21, to prioritise lower-level training and

ensure the skills system aligns with the Modern Industrial Strategy and economic priorities and workforce needs.

Small and vulnerable professions

A dedicated project is underway to assess the risks facing small and vulnerable professions and to identify targeted interventions. A sustainable domestic supply pipeline is critical to the future of these professions. The scope of this work spans professions across AHPs, Learning Disability Nursing, Psychological Professions, and Healthcare Science. Both shared and profession-specific high-impact actions are being prioritised to secure the future of these essential roles.

These professions play a vital role in addressing key patient pathway bottlenecks and supporting access to education, employment, and wider life opportunities. Apprenticeships and training pathways, backed by funded support, are essential, particularly as small services often lack the capacity to release staff due to tightly commissioned service models. For example, the professional bodies for Prosthetics and Orthotics (P&O) and Orthoptics coordinate 4 nation placement allocation this year, funded in-year by NHS England. This ensures the necessary case mix and skills development within a robust quality assurance framework.

Shortened courses

As outlined in the 10YHP, we will work with higher education Institutions and the professional regulators as they review course length in light of technological developments and a transition to lifelong learning.

To strengthen the midwifery workforce and enhance the pipeline, NHS England is funding a targeted shortened midwifery training programme. This initiative is specifically designed to support adult nurses transitioning into midwifery, building on their existing clinical expertise. The funding package includes a salary contribution to employing trusts ensuring fair compensation for students and covers tuition fees of up to £9,250 per student per year.

Accreditation of prior learning

Pathways into health and care professions can be shortened depending on the level of someone's prior learning through a process called accreditation of prior learning (APL), which recognises previous learning and experience. Expanding these opportunities will help support multiple entry routes into health careers and make education pathways as efficient as possible, widening access and attracting more students.

This includes pathways into midwifery and paramedic programmes where shortened programmes will increase staff supply quicker than the traditional 3 years degree route. The 2plus2 podiatry apprenticeship model offers an accelerated route into the profession

by enabling learners to complete 2 years of study as an assistant practitioner, followed by entry into a pre-registration podiatry degree through APEL (Accreditation of Prior Experiential Learning). This approach is particularly beneficial for those with relevant prior learning or experience, allowing them to qualify more efficiently. Further work is needed to develop and expand similar pathways across the country to ensure broader access and uptake.

International recruitment

The government is committed to developing homegrown talent and giving opportunities to more people across the country to join our NHS. In the year 2024 to 2025, 39.1% of people joining the Nursing and Midwifery Council register in the UK for the first time had non-UK countries of training (source: Nursing and Midwifery Council registration data reports).

Health and Social Care Worker visa data shows that across 2021 to 2023, the average quarterly number of Health and Care Worker visas granted for nurses was 5,680. There has been a significant reduction since 2023, with the data from the Home Office showing 685 visas granted in quarter one of 2025, 76% fewer than in the same quarter in 2024.

Nationality data for health and care worker visa grants to health occupations (excluding doctors) shows in the first quarter of 2025, that those of Indian nationality made up the largest group with 203 visa grants. This is in comparison to 147 of Nigerian nationality and 105 of Filipino nationality, who make up the second and third largest groups in that quarter.

From April 9, 2025, the minimum salary for Health and Care Worker Visa holders increased to £25,000 per year. This applies to new Certificates of Sponsorship assigned on or after that date. Entry level NHS Agenda for Change (AfC) band 3 roles do not meet the new minimum salary threshold for a Health and Care Worker visa.

AfC NHS pay band 3 staff currently on the Health and Care Worker visa are not required to meet the new minimum salary threshold until the point at which they need to renew their visa. At this point, we expect the majority of staff to have accrued 2 or more years' experience and would therefore be at the top of pay band 3, which is above the new minimum salary threshold.

The Immigration White Paper sets out reforms to legal migration, so that we can restore order, control and fairness to the system, reduce net migration and promote economic growth. The reforms set out include a complete overhaul of the relationship between the immigration system, training and the labour market to support sustainable growth as well as a sustainable immigration system.

The first set of changes took effect from 22 July 2025 and includes a rise to the skills threshold for the Skilled Worker visa route (of which the Health and Care Worker visa is a subset) to RQF level 6 or above. Regulated healthcare roles such as nurses and the allied health professions meet the new skill threshold and in turn are expected to remain eligible for the Health and Care Worker visa.

The expanded Immigration Salary List (ISL) and interim Temporary Shortage List (TSL) allow time-limited access (until the end of 2026) to the UK's immigration system for selected occupations of skill level RQF 3 to 5, with restrictions on bringing dependants. Nursing auxiliaries and assistants, laboratory technicians (but jobs requiring 3 or more years related on-the-job experience) and pharmaceutical technicians are included on the ISL. Laboratory technicians are the only Health and Care Visa occupation that appear on the TSL, regardless of years of experience.

Transitional arrangements are in place for those already working in the UK on Skilled Worker visas prior to 22 July. This means individuals working in occupations below RQF level 6 can continue to work, extend their visas, bring dependants, change employment and take supplementary employment provided they meet occupation salary thresholds.

We continue to hold high ethical standards in international recruitment through the Code of Practice for International Recruitment of Health and Social Care. This was updated in March 2025 with minor changes to add further clarity and streamline the guidance.

NHS temporary staffing

Influenced by seasonal factors and broader labour market fluctuations, NHS demand may lead providers to rely on temporary staff.

In 2016, measures were introduced to curb NHS agency spending, including price caps, mandatory use of approved procurement frameworks through the launch of the Agency Rules. These measures, regularly monitored for compliance and effectiveness, aim to reduce costs and give greater assurance of quality. Performance metrics on agency usage are included in the NHS Oversight Framework within the implied productivity levels, reinforcing compliance rules for NHS trusts and foundation trusts.

The measures were relaxed during the pandemic but re-established in September 2022, to control agency expenditure, including a system agency expenditure limit. Further measures to drive down the reliance on agency staff are being implemented in Quarter 3 and Quarter 4 of 2025 to 2026.

The 2025 to 2026 NHS Planning Guidance states that trusts should reduce their agency spend by 30% and their bank spend by 10% in this financial year, and this is factored into the SR settlement. The Secretary of State and Sir Jim Mackey wrote to trusts and ICBs in

June to emphasise the importance of this and set the ambition to eliminate agency spend. In 2024 to 2025, total expenditure on non-medical temporary staffing decreased by 11.27% (£746 million) compared to 2023 to 2024, largely due to a reduction in spending on agency staff. Non-medical agency costs made up 1.7% of the total NHS pay bill in 2024 to 2025, down from 3.1% in 2023 to 2024, representing a cost reduction of approximately £781 million (41%).

The bank staffing expenditure held flat at £4.7 billion in 2024 to 2025, and the proportion of bank staff in the overall pay bill decreased by 0.5 percentage points, from 7.8% to 7.3%.

NHS England will support NHS providers and ICBs to achieve their band expenditure target of 10% by undertaking the following objectives:

1. Support improvements in Medical and Dental bank rates, as this staff group has significantly high rates of pay above those of NHS pay scales.

2. Develop guidance and case studies to support bank attractiveness and performance.

3. Investigate the options of restricting bank use for non-medical/non-clinical role, building on existing agency restrictions for these roles.

Optimise the existing national temporary staffing data collection to increase oversight into bank usage and expenditure, including improved rate transparency and incentives for bank use to support with local decision making. The 10YHP states that we will eliminate agency staffing in the NHS by the end of this parliament, ensuring every pound spent delivers maximum value for patients. This will take a concerted effort to transition agency workers to staff banks. This will improve the quality-of-care patients receive and, we estimate, could release as much as £1 billion over the next 5 years.

NHS England's NHS Interim Management and Support (IMAS) offers NHS organisations short or medium-term interim support. The service operates on the principle of 'by the NHS, for the NHS'. NHS IMAS manages between 120 and 140 assignments at any time, supporting organisations with interim resourcing to senior roles. Any NHS organisation in England can access support from the NHS IMAS talent pools, with no additional commission or recruitment or search fees.

Leadership

The recently published 10YHP reaffirms the importance of strong and effective leadership in driving performance and building a positive and open organisational culture within which the workforce feels valued, motivated, and has the confidence to speak up.

The 10YHP makes a commitment to accelerate delivery of the accepted recommendations from the 2022 Messenger review leadership for a collaborative and inclusive future, which focused on the best ways to strengthen leadership and management across health and its key interfaces with adult social care. The report found that ‘a well-led, motivated, valued, collaborative, inclusive, resilient workforce is the key to better patient and health and care outcomes.’ Delivery of these recommendations also includes – by April 2026 – establishing new national and regional talent management systems to ensure a strategic national approach to identifying and developing future leadership talent. Prioritising a focus on career pathways and identifying high potential at more junior levels will also be needed to build talent pools and pipelines for the future.

NHS England is also developing a Leadership and Management Framework, including professional standards and a national code of practice which are due for completion in autumn 2025. This forms part of a wider programme of measures being taken forward to professionalise NHS leaders and managers while strengthening their professional accountability and includes the commitment to regulate senior NHS leaders via a statutory barring system and establishing a College of NHS leadership to further support and develop managers and leaders across the NHS at all levels.

4. Staff experience and retention

Summary

Good staff experience is crucial in ensuring the NHS is able to recruit and retain staff in the workforce and was acknowledged in Lord Darzi’s report into the state of the NHS. The importance of having an engaged workforce and better workplace culture is recognised and is illustrated in the 10YHP which sets out the government’s commitments to making the NHS a better place to work.

This chapter describes the aims of the 10YHP in addressing staff experience and summarises the work that has been led by NHS England and DHSC during the past year to achieve these ambitions.

10 Year Health Plan

Staff contributing to the engagement exercises which took place to help formulate the 10YHP, shared their views that NHS staff are overworked, undervalued, burdened by bureaucracy and that there was not enough support for training and career development.

The 10YHP, recognises the issues and concerns of NHS staff and the government will be taking forward actions to create a workforce that is more empowered, more flexible and

more fulfilled. For example, working in partnership with the Social Partnership Forum, a series of Staff Standards will be introduced which will for the first time outline minimum standards for modern employment. These will cover access to nutritious food and drink, reducing violence against staff and standards of 'healthy work' and flexible working. Data will be published at employer level every quarter and they will underpin the NHS Oversight Framework and act as an early warning signal for the Care Quality Commission (CQC).

Retention

Alongside the development of the 10YHP, work has continued to be led by NHS England and DHSC to improve retention. This includes the People Promise Exemplar programme, which reflects the factors that influence the decision making and personal choices of people working in the NHS and its complexities. These factors are wide ranging and include opportunities to work flexibly, career progression, access to learning and development, relationships with managers and colleagues. The picture of retention by staff group is explored in the chapter 5 on remit groups.

A review of the People Promise Exemplar programme published in March 2025 found that the number of leavers fell by an average of 11.8% for organisations involved in the pilot, with those implementing more interventions improving their leaver rates the most.

In addition to reducing leaver rates, evaluation of the People Promise Exemplar programme found improvements in staff engagement and morale, with exemplar organisations reporting greater gains in NHS Staff Survey scores compared to the wider NHS. The programme also delivered a positive return on investment and contributed to a greater reduction in agency costs. The most effective approaches combined multiple interventions, such as flexible working, e-rostering, and local listening sessions, supported by strong board-level engagement.

Health and wellbeing

The health and wellbeing of the NHS workforce continues to be of importance and is a focus of the 10YHP, addressing the need to improve the health of staff, their productivity, and therefore patient care. The Growing Occupational Health and Wellbeing Together strategy continues, with NHS England working with stakeholders to achieve the vision of integrated multi-professional health and wellbeing services for all NHS staff.

Published Sickness absence datasets identify that sickness continues to rise and is higher now (5.53%, February 2025) than before the pandemic (4.4%, February 2018). Mental health and musculoskeletal continue to be the prominent reasons for sickness. There is variation across the system where ambulance, nursing/midwifery, support to

clinical/medical, and estates/support staff have the reported highest levels of sickness absence.

The results from the 2024 NHS Staff Survey indicate that staff perceptions toward their health and wellbeing remain unchanged, where the overall ‘we are safe and healthy’ score has slightly increased by 0.01 between 2023 and 2024. This is calculated by variance in Staff Survey sub-scores, where these have improved for experiencing burnout (30.24%) and stress (41.63%) in the past year, whilst other indicators have declined, such as perception their organisation takes positive action on their health and wellbeing (57.06%) presenteeism (55.77%) and musculoskeletal issues (29.24%).

NHS England led a Staff Treatment Access Review (STAR) which identified a negative economic impact in excess of £2 billion a year related to sickness for mental health and musculoskeletal reasons alone. The review demonstrated the clear productivity and economic argument for investing in the health of our NHS staff, particularly for mental health and musculoskeletal treatment services – the main drivers of sickness absence in the NHS. The review has informed the aims set out in the 10YHP with work underway to develop implementation and operational plans for the Staff Treatment Hubs.

Flexible working

Flexible working is central to NHS workforce reform and supports the PRB’s 4 priorities: recruitment, retention, motivation, and inclusion. NHS internal data from the Retention Survey [source: data pack, tab NPS5] shows sustained progress in embedding flexible working. The share of organisations with board-level champions rose from 51% (Q1 2023 to 2024) to 65% (Q4 2024 to 2025), flexible working action plans from 28% (Q4 2023 to 2024) to 43% (Q4 2024 to 2025), and inclusion of flexible working in health and wellbeing training from 63% (Q1 2024 to 2025) to 70% (Q4 2024 to 2025). Staff confidence in approaching managers about flexible working has also increased from 65% (August 2024) to 73% (January 2025).

The NHS Staff Survey results also reinforce these gains with the national flexible working score rising to 6.31 in 2024, up from 6.23 in 2023 and 6.17 in 2022, with steady increases in reported work-life balance and perceived organisational support.

Violence prevention and reduction

While work continues in the above areas, violence against NHS staff remains an issue. Data taken from the NHS Staff Survey in 2024 has identified that staff experiences of physical violence in the last 12 months has gone up in all categories, including from patients or the public (14.38%), managers (0.78%), and colleagues (1.89%). Experiences of harassment, bullying and abuse have improved slightly in all categories, from patients or

the public (25.08%), managers (9.46%), and colleagues (17.56%). This equates to 205,000 NHS staff experienced at least one incident of physical violence annually, and 375,000 NHS staff experienced harassment, bullying or abuse annually.

It is estimated that bullying and harassment costs the NHS £2 billion per year (Building positive workplace cultures in the NHS | Social Partnership Forum) and costs associated with violence and abuse in the NHS cost £2.3 billion per year (Cost of violence in the NHS, during 2021 to 2022).

The NHS Violence Prevention and Reduction Standard (VPR) updated in 2024, guides NHS organisations in risk assessment, prevention, and response to workplace violence. NHS England VPR programme aims to "Empower NHS organisations to adopt proactive violence prevention approaches, embedding it in organisational culture".

NHS England is working with DHSC and the Social Partnership Forum (SPF) to implement improvement recommendations arising from the 2023 AfC Non-Pay agreement which were agreed by the government to be taken forward Ways to tackle and reduce violence against NHS staff Social Partnership Forum. These include a focus on improving VPR incident data, standardised guidelines, and education and training pathways for VPR leads. NHS England is also supporting integrating VPR into the refreshed Statutory and Mandatory Training competencies, supporting developing senior leaders to champion VPR, and continuing to develop VPR communities of practice across regions.

Equality, diversity and inclusion

The NHS equality, diversity and inclusion improvement plan (EDI IP), published June 2023, remains the key mechanism for strengthening equality, diversity and inclusion in the NHS. This plan will be reviewed this year to ensure that the high impact actions and supporting metrics align to the ambitions now set out in the NHS 10YHP and the forthcoming 10 year workforce plan.

Building on this, in Autumn 2025, NHS England will launch a bespoke EDI improvement plan for primary care setting out best practice to address some of the challenges and inequalities faced by staff.

The NHS WRES data for 2024 showed that the percentage of staff experiencing harassment, bullying or abuse from other staff in the last 12 months was higher for Black and minority ethnic (BME) staff (24.9%) than for White staff (20.7%). Although disparities between the experiences of BME and hite staff persist, the trend for harassment, bullying and abuse from staff has been largely downward since 2018. To build on this, protection from and tackling incidents of violence, racism and sexual harassment in the workplace will also form part of the new staff standards, due to be introduced in 2026.

In terms of career progression, there are signs of progress on representation in leadership positions, with the number of very senior managers in the NHS from black and minority ethnic (BME) backgrounds increasing by 85% since 2018. This has been supported by NHS England who have partnered with Henley Business School to launch a bespoke Senior Leader Apprenticeship for Future Leaders for NHS colleagues. This EDI-focused programme of study aims to champion and encourage inclusivity at all levels.

Gender and ethnicity pay gaps

Since 2019, the UK gender pay gap has fallen by a fifth to 14.3% for all employees in 2023 and this includes the health and care sector. However, the gender pay gap still persists, with male health professionals, on average, still paid 10.2% more than their female counterparts in 2023.

From 2025 NHS workforce systems, such as the Electronic Staff Record, as well as our annual national workforce surveys, will capture socio-economic background information. This will allow organisations to further understand how reflective our workforce is of the communities we support and to improve how people experience recruitment, training and work in the NHS, supporting retention, productivity, patient care and economic growth.

The Race and Health Observatory has announced an independent review into ethnicity pay gaps across the NHS. This will address the structural and systemic factors that contribute to ethnicity pay disparities in the NHS, with a view to informing practical and evidence based sustainable solutions to reduce and eliminate inequalities where they exist.

Staff survey

The NHS Staff Survey continues to provide an indication of the levels of morale and engagement across the NHS workforce and the data referenced is from 2024's NHS staff survey results which was included in the previous PRB evidence.

Employee engagement is strongly correlated with key outcomes such as patient satisfaction, safety, mortality rates, and organisational productivity. The engagement theme score for AfC staff groups has decreased steadily from 2019, it increased in 2023 (6.91) but decreased in 2024 (6.86) (source: NHSPRB Pay review body commission 2627v03) (Source: NHSPRB Pay review body commission 2627v03, NSS, People Promise elements, sub-scores and themes - non-medics - National).

There was improvement across 2 People Promise elements (We are always learning, We work flexibly) and one theme (Morale). Ambulance trusts and acute and community trusts continue to score below the NHS average.

There was a 0.33% decrease in the number of AfC staff groups satisfied with their level of pay from 31.22% to 30.89%. This is below the pre-pandemic score (38.0% in 2019). Satisfaction with pay remains lowest among nursing and healthcare assistants (19.27%) and ambulance staff (25.70%). Ambulance staff are the only group that saw an increase in satisfaction with pay between 2023 and 2024 (Source: NHSPRB Pay review body commission 2627v03, NSS4, Satisfaction with pay by staff group - non-medics - National). Similarly, the percentage of staff feeling that their work is recognised, valued, and appreciated worsened from 2023.

National Quarterly Pulse Survey

Since becoming mandatory in April 2022, the National Quarterly Pulse Survey (NQPS) has consistently gathered around 110,000 responses per quarter (Source: NHSPRB Pay review body commission 2627v03, NPS1, Number of average responses since quarter 1 2022/2023). This response rate contributes to high data reliability and validity. The dataset includes medical and non-medical staff, and these cannot be segregated.

Staff engagement has been declining since its peak of 6.67 in quarter 2 of 2023 to 2024, recording the score of 6.46 in quarter 2 of 2025 to 2026, the lowest since the launch of NQPS in 2022. While seasonal dips, typically in winter, are expected, the recent drop was more rapid than in previous years. This was largely driven by a fall in the advocacy sub-score, recorded at 6.37 (Source: NHSPRB Pay review body commission 2627v03, NPS2, Staff engagement score national average for NHS Staff Survey and National Quarterly Pulse Survey).

5. Remit groups

The AfC contract covers a wide variety of staff groups and professions. This chapter explores the workforce picture for each of these groups, including overall numbers, vacancy and leaver rates, and action being taken to support recruitment, retention, motivation and morale.

Nursing and midwifery workforce

As of March 2025, 657,882 professionals were registered with the NMC in England, with 33.9% from Black, Asian or other ethnic minority backgrounds - a 2.3% increase on the previous year. Retirement remains the main reason for leaving the register, followed by physical and mental health. (Source: Registration data reports - the Nursing and Midwifery Council).

Nursing

The NHS nursing workforce remains at a record high, having grown by 14,166 in the last year to reach 369,449 (Source: NHSPRB Commission 2627v03, NN3, Number of substantive nursing, midwifery and health visitor vacancies, FTE and rate). Vacancy rates have dropped since 2022 for registered nurses and support staff, with 24,628 posts unfilled. The overall leaver rate for registered nurses has fallen to 4.8%, down from a peak of 7.8% in April 2022 (Source: NHSPRB Commission 2627v03, NN1, Nursing Leavers Rate: Registered Nurses and Nursing Support).

The monthly utilisation of agency nurses has decreased from 10,538 in May 2024 to 5,564 in May 2025, and the FTE undertaking monthly bank work has decreased from 32,025 to 29,106 over the same period (Source: NHSPRB Commission 2627v03, NN4, Nurses Temporary Staffing). While these trends suggest greater workforce stability, the transition into employment remains variable for newly qualified nurses, who continue to report inconsistent access to substantive roles within and outside the NHS. The Secretary of State confirmed the government's Graduate Guarantee that this year every newly qualified nurse and midwife in England will have the opportunity to apply to join the health and social care workforce.

Undergraduate applications to nursing programmes in England totalled 33,450 in June 2025. This represents a 0.3% decrease compared to 2024 and an 8.1% decrease from 2023, although applications remain 5.3% higher than in 2019. The data shows a continued shift in applicant demographics, the number of applicants aged under 21 increased by 7.0% compared to 2024, while applications from those aged 21 and over fell by 6.5% (Source: NHSPRB Commission 26/27v03, NN4A, The number of unique applicants to Nursing courses) (Source: Internal data held by NHS England based on UCAS data - unpublished).

Learners continue to report high levels of stress and burnout, often linked to the quality of placements and support from practice staff. These pressures are contributing to uneven retention, particularly in Registered Nurse Learning Disability (RNLD) programmes, where enrolment is declining and long-term sustainability is at risk in some regions. Applications have declined steadily from a peak of 1,270 in 2021 to 720 in 2024, a 43% drop over 3 years (Source: NHSPRB Commission 26/27v03, NN4A, The number of unique applicants to Nursing courses).

Midwifery

The NHS midwifery workforce remains at a record high, having grown by 1,330 in the last year to reach 24,959 (Source: NHSPRB Commission 26/27v03, NW3, Midwives in NHS Trusts and other core organisations, FTE). The midwifery leaver rates declined from 5.9% in April 2019 to 4.1% in April 2025, the lowest leaver rate since April 2019 (Source: NHSPRB Commission 2627v03, NWQ, Midwifery leavers rate). While these trends

suggest greater workforce stability, the NHS Staff Survey continues to show that midwives report the poorest scores for work pressure across all staff groups. Additionally, the transition into employment remains variable for newly qualified midwives, who continue to report inconsistent access to substantive roles within and outside the NHS. As part of the government's Graduate Guarantee, NHS England has reprioritised £8 million of non-recurrent funding for 2025 to 2026 to support the temporary conversion of vacant maternity support worker posts to band 5 registered midwifery roles, creating opportunities for newly qualified staff.

Undergraduate applications to midwifery programmes in England reached 7,320 in June 2025, a 0.4% increase compared to 2024. However, this reflects a 9.5% decrease from 2023, and an 8.3% decrease compared to 2019. The number of applicants aged 21 and over declined by 4.2% compared to 2024 and by 16.5% compared to 2023, continuing a downward trend in mature applicants (Source: UCAS data).

Shared action to support the future workforce

A coordinated programme is in place to strengthen nursing and midwifery education, reduce attrition, and support newly qualified staff into roles:

- the Safe Learning Environment Charter (SLEC) is now active across all HEIs and placement providers
- student coaching models and digital learning tools are being expanded nationally
- insights from the National Education and Training Survey (NETS) are shaping local improvements in placement experience
- £181.7 million Continuing Professional Development funding is in place for 2025 to 2026, supporting access across nursing, midwifery, and AHPs, continuing previous investment
- newly qualified professionals are being supported through targeted recruitment, updated job descriptions, and early career development pathways
- work to reduce student attrition includes improved data oversight, shared best practice, and continued investment in Specialist Community Public Health Nursing programmes

Allied health professions (AHPs)

Addressing workforce supply challenges for smaller and more vulnerable Allied Health Professions (AHPs), such as podiatry, prosthetics and orthotics, and orthoptics, remains complex. These challenges are compounded by a combination of factors, including

declining application and graduation rates from relevant university programmes, geographical challenges (rural and coastal areas), student attrition, and poor transition of newly qualified and Health and Care Professions Council (HCPC) registered professionals into NHS roles, with many instead entering private practice. Notably, over half of the registered workforce in podiatry is now employed outside the NHS.

Between 2023 and 2024, unique university applications to AHP courses increased by 2% overall. However, some professions experienced notable declines, including prosthetics and orthotics (minus 20%), operating department practice (minus 7%), and dietetics (minus 7%) (Source: NHSPRB Commission 2627v03, NET3, The number of unique applicants for AHP degree courses) (Source: Internal data held by NHS England based on UCAS data - unpublished). Acceptance rates for AHP courses rose by 12% from April 2024 to March 2025, with increases ranging from 6% in orthoptics to 96% in therapeutic radiography. Exceptions to this trend include operating department practice, which saw an 8% decrease, and prosthetics and orthotics, where acceptance rates remained static (Source: NHSPRB Commission 2627v03, NET5, AHP student attrition rates) (Source: Internal data held by NHS England Student Data Collection Tool - unpublished). Attrition rates for paramedicine degrees have also improved significantly, falling from 18.7% in 2022 to 2023 to 10.5% in 2023 to 2024 (Source: NHSPRB Commission 2627v03, NET2, Attrition rate for ambulance degree courses).

The average attrition rate across all allied health education and training courses stands at 12.81%, with a general year-on-year increase in starter numbers, reflecting growing interest and enrolment in these programmes. However, 2024 to 2025 presents a wide attrition range, from minus 1.68% (net gain) to 46.67% (high loss), with the maximum attrition rate being the highest recorded across all years, highlighting significant retention challenges in specific courses. The top 6 courses with the highest attrition in 2024 to 2025 include Prosthetics and Orthotics (39.68%), Orthoptics (36.9%), Operating Department Practice (23.84%), Osteopathy (18.87%), Therapeutic radiography (12.83%) and Podiatry (12.88%). Despite this, average attrition in 2024 to 2025 (12.70%) has decreased compared to 2020 to 2021 (19.21%), returning to levels similar to 2018 to 2019.

NHS England has made a focused effort to help prospective students understand AHP roles, so they are clear what they are applying for to reduce attrition for this reason. Notably, AHP and paramedic attrition rates have dropped substantially, with paramedic attrition falling from 19.18% in 2022 to 2023 to 6.56% in 2024 to 2025, marking a 54.1% improvement in retention and workforce stability (Source: NHSPRB Commission 2627v03, NET5, AHP student attrition rates). NHS England has focused work in recent years on ambulance staff learner experience including the Culture review of ambulance trusts NHS England - Culture review of ambulance trusts.

From April 2024 to March 2025, vacancy rates across AHPs in the NHS decreased from 8.6% to 6.6%, with the overall workforce increasing from 89,453 to 93,060 (headcount).

Vacancy rates varied by profession, ranging between 6.6% and 9.4%. Notable exceptions where vacancy rates increased include prosthetists and orthotists (up 2.9%), podiatry (up 0.2%), and arts, drama, and music therapists (up 1.2%) (Source: NHSPRB Commission 2627v03, NAHP2aa, AHP vacancies and vacancy rates by profession).

Leaver rates for AHPs (excluding paramedics) showed a modest improvement, decreasing from 6.0% to 5.7% over the same period. In April 2024, leaver rates ranged from 4.8% in diagnostic radiography to 7.7% in prosthetics and orthotics, compared to a range of 4.1% in diagnostic radiography to 6.9% in podiatry in March 2023. Paramedic leaver rates also improved significantly, falling from 8.4% in April 2022 to 4.5% in April 2025. For ambulance support staff, leaver rates improved from 9.1% in September 2022 to 8.8% in April 2025. Work is ongoing to implement the NHS AHP Preceptorship Framework, and development has commenced on a multi-professional quality mark to further support retention and professional development, despite a challenging financial environment (Source: NHSPRB Commission 2627v03, NAHP1 and NAHP1aa, AHP workforce - leaver rate (Qualified AHP) and leavers by profession).

Healthcare scientists

The healthcare science workforce includes over 58,000 professionals across more than 50 specialisms, with 71% at Band 6 or below (Source: NHSPRB Commission 2627v03, NHCS3, Healthcare Scientist Workforce by AfC Band, FTE). Healthcare scientists work across the NHS, academia, industry, and government agencies. This diversity can lead to variation in employment conditions, benefits, and career development opportunities. There are also differences between NHS roles and other government frameworks, such as the Government Science and Engineering (GSE) pathway, which offers more structured progression.

Healthcare scientists play a central role in delivering the NHS 10YHP and its 3 strategic shifts: moving care from hospital to community (for example, community diagnostic centres), shifting from sickness to prevention (for example, physiologists in prehabilitation), and transitioning from analogue to digital (for example digital imaging in eye care). They are also vital to achieving the UK Life Sciences Vision, which aims to accelerate innovation and improve patient outcomes.

The profession faces several challenges. Consultant-level roles have reduced over time, and professional guidance, such as the framework for employing consultant clinical scientists remain under implemented. Key issues raised by the profession include pay alignment, workforce supply in specialist areas (for example, paediatric audiology, clinical perfusion, toxicology, transfusion and neurophysiology), support to for regulation, access to funded education and training, and the availability of posts following completion of training.

The route to statutory registration for Healthcare Scientist is complex and can limit graduates' ability to meet immediate NHS workforce needs.

Healthcare science undergraduate and postgraduate degree programmes are categorised as 'small and vulnerable' by the NHS England. Given the specialist nature of these courses, ensuring their viability is considered important for future workforce supply.

Multiple entry levels exist, including healthcare science assistant and associate roles, which support diagnostics and enhance skill mix. Undergraduate pathways include the Practitioner Training Programme (PTP) and degree apprenticeships. Postgraduate options include the Scientist Training Programme (STP, 1,672 current trainees), the Echocardiography Training Programme (88 current trainees), and the Higher Specialist Scientist Training (HSST) programme (374 current trainees), which leads to Consultant Clinical Scientist registration. Despite these structured routes, additional pre-undergraduate pathways could widen access and support flexible entry into the profession. Following recommendations from the Diagnostics: Recovery and Renewal report, healthcare science assistant and associate roles have grown through apprenticeships, with degree apprenticeships increasing from 44 in 2017 to 2018 to 220 in 2023 to 2024 (Source: Internal data held by NHS England National School of Healthcare Science - unpublished).

Healthcare science students and staff report variations in financial support and professional development, for example, access to Travel and Dual Accommodation Expenses (TDAE), LSF and employer placement tariffs. They describe CPD funding is unevenly applied, with some receiving less support than peers in other professions. Feedback from NHS England engagement events highlight the ongoing importance of career progression and training access and pay alignment.

Medical associate professions

Medical associate professions (MAPs) include physician associates (PAs) and anaesthesia associates (AAs). These roles are regulated healthcare professionals that work in the wider multidisciplinary team to promote and maintain patient care under the supervision of a senior doctor. The General Medical Council began regulating the roles from December 2024.

PAs work as part of a multidisciplinary team and perform clinical duties, such as medical history taking, examinations and managing illnesses, under the supervision of a named senior doctor. AAs work in hospitals as part of the anaesthesia team, delivering pre and post-operative care and providing anaesthesia during surgery under the direction and supervision of a consultant anaesthetist.

There are over 1,629 FTE PAs and approximately 120 FTE AAs working in NHS secondary care (Source: NHSPRB Commission 2627v03, MAP1, MAPs FTE). Since the publication of the 2023 NHS Long Term Workforce Plan, the roles have been subject to considerable stakeholder and public scrutiny, with concerns raised about their potential impact on training opportunities for resident doctors, care quality and patient safety.

An independent review of the PA and AA professions was established by the Secretary of State for Health and Social Care in November 2024. The review was led by Professor Gillian Leng and considered the safety of the roles and their contribution to multidisciplinary healthcare teams. The conclusions of the review were published on 16 July 2025, with a range of recommendations on how the roles can best support high-quality care for patients as part of multidisciplinary teams. NHS England will work with DHSC, royal colleges, trade unions and other relevant organisations to consider how the recommendations can be taken forward.

To become a PA or AA, an individual will usually be an existing registered health professional or university graduate with a biomedical science or life science degree. They then complete a further 2-year programme of postgraduate education and training either as a Master's level programme or Postgraduate Diploma. Student AAs are employed by the organisations where they train while completing their postgraduate course. NHS England commissions education and training based on a national funding model for each respective profession.

Pharmacy

NHS England recognises system-wide challenges in recruiting and retaining education supervisors, particularly those supporting the training of independent prescribers. These roles are critical to delivering the ambitions of the Initial Education and Training of Pharmacists (IETP) reforms and expanding clinical capability across the pharmacy workforce. To address this, NHS England will invest in the development and training of educators and prescriber supervisors.

In 2021, the GPhC introduced new standards and learning outcomes for the IETP, enabling the registration of independent prescribers with greater clinical capability from 2026. That same year, Master of Pharmacy degree (MPharm) students became eligible for DHSC clinical tariff funding for placements aligned to 2025 learning outcomes. In 2024, as the Statutory Education Body for England, NHS England is accredited by the General Pharmaceutical Council (GPhC) to deliver the Foundation Trainee Pharmacist Programme (FTPP) from the 2025 to 2026 training year. NHS England are on target to integrate prescriber training into the FTPP from 2025, with 3,014 trainees expected and independent prescribe pharmacists out-turning from August 2026. From 2025, undergraduate pharmacy students can access Travel and Dual Accommodation Expenses

via the Learning Support Fund. NHS England continues to invest in training and workforce development for Pharmacy Technicians. In 2025, funding will support the training of approximately 1,600 technicians, exceeding the 16% target from 2024 (approximately 1,356). From 2024, Pharmacy technicians can now supply medicines and services via patient group directions (PGDs).

In June 2025, approximately 78,280 pharmacists and pharmacy technicians were registered with the GPhC in England (Source: The GPhC Register for England, 2025). NHS England's 2025 Community Pharmacy Workforce Survey confirmed that independent prescribers (IPs) now make up 9% of community pharmacists. GPhC register data shows 18,495 pharmacists with IP annotation (33.3% of registrants), a net increase of 3,243 since July 2024. In 2025, 3,300 IP training places are available across England, a 20% increase since 2023. As part of the NHS People Plan, an additional 50 training places per year will be offered from 2025 for community-based specialist mental health pharmacists, initially targeting community mental health services.

Legislative changes will enable pharmacists to deliver more clinical services and allow technicians to expand their role by authorising technicians to prepare, assemble, dispense, sell, and supply medicines, and permitting technicians to supervise preparation and dispensing in hospital aseptic facilities. NHS England is investing in training across community pharmacy and primary care for pharmacists and technicians, covering safe prescribing, contraception, digital health, and long-term condition management (for example respiratory, mental health, cardiovascular, diabetes). These reforms will enhance clinical capability across community pharmacy, primary care and specialist services, enabling service provision within multi-professional, integrated Neighbourhood Health Services.

From 2026, NHS England's Newly Qualified Pharmacist pathway will evolve into an 'Early Careers Pharmacist' pathway, mapped against new registrant and cross-sector workforce need. The pathway will prepare future pharmacists to integrate into cross-sector, multi-professional teams.

Pharmacists joining the register in Summer 2026 will be independent prescribers at the point of first registration. This new workforce with greater clinical capability and legal prescribing rights will be positioned to deliver healthcare via new and evolving models of service delivery.

Estates and facilities

The NHS Estates and Facilities Management (EFM) workforce comprises around 84,000 staff, 7% of the NHS workforce. Responsible for managing 25 million square metres of estate. This includes £11.9 billion in annual occupancy costs and a £13.8 billion maintenance backlog, £2.7 billion of which is high-risk (source: Estates Returns

Information Collection). The scale and complexity of the estate stretches current workforce capacity, requiring strategic intervention to meet infrastructure goals and close the current 8.9% workforce supply and demand gap.

The 2025 10 Year Infrastructure Strategy calls for a skilled EFM workforce to deliver capital projects and reduce critical backlogs. The 10YHP links healthcare productivity directly to estate performance, while the Darzi Review underscores how underinvestment in infrastructure leads to daily service disruptions and safety risks.

Engineering and Building Maintenance roles are pivotal to addressing these challenges. Between 2019 and 2024, the NHS estate expanded from 26.6 million square metres to 27.5 million square metres an increase of around 3% (source: Estates Returns Information Collection). Over the same period, the number of engineering staff increased from 1,927 to 2,038, an increase of 5.8%. Engineers are now responsible for maintaining a significantly larger and more complex estate with a growing maintenance backlog.

Currently, demographics of EFM staff have remained consistent; 41% of EFM staff are aged 55 or older, almost double the NHS average of 21%, while only 4% are under 25, a figure that has remained static for the past 4 years.

Workforce stress and burnout has remained static for the past 3 years, but significantly above the national NHS average. Sickness absence is 7%, compared to the NHS average of 5.2%. In 2024, 32% of EFM staff reported work-related stress and 22% reported burnout. Strategic investment in the EFM workforce is essential to delivering the NHS's infrastructure and patient safety ambitions (source: Estates Returns Information Collection - NHS England Digital). Chapter 4 on staff experience speaks to policies in train to address these issues across the AfC workforce.

Digital, Data and Technology (DDaT)

The shift from analogue to digital, as outlined in the 10YHP, underpins the NHS's ambition to improve healthcare delivery through digital tools; for example, the NHS App, a single patient record, and emerging technologies (AI, automation, ambient tech). These changes aim to enhance service provision, enable preventative care, and deliver half of the targeted 2% annual productivity gains - contingent on an effective digital, data and technology (DDaT) workforce.

The Prime Minister announced in March 2025 plans to support delivery of new digital skills to drive improvements and efficiency on the use of technology across the public sector. The draft Model ICB Blueprint shifts delivery for most digital and data up to national/regional or down to Provider ownership, increasing the skills and capability demands at those levels. There are currently some challenges for this workforce in the NHS, which is in high demand across the labour market.

The DDaT workforce comprises of about 41,000 staff (DDaT Census 2024) with the average leaver rate across the DDaT profession being 21.9% in 2024. The 2024 Digital Maturity Assessment (DMA) survey found that over 70% of providers struggle to recruit for many digital and data profession roles. DDaT workforce forecasting predicts an annual 4.4% growth for the next 5 years, well ahead of the previous 3% annual growth that has been seen historically. This could pose challenges to achieving the NHS's productivity goals. Supplementing the DDaT workforce with contingent labour is estimated to cost around 300% more than permanent staff, resulting in reduced delivery scope within set budgets (Source: Government Digital Services April 2025 Insights report – unpublished).

There are internal skills development or career progression opportunities for DDaT staff, though these can be limited and based on line manager advocacy and resource availability. (NHS SCW Case study Support and Transformation for Health and Care).

6. Earnings and expenses

Introduction and key messages

This chapter is split into 3 sections. It starts by introducing the AfC pay system, its structure and how it is maintained, providing information on pay and earnings for AfC staff in 2024 to 2025. It also provides information on the factors underpinning pay growth in 2024 to 2025.

We then move on to explore some of the key issues facing this pay decision including the National Living Wage and recommendations to resolve structural issues with Agenda for Change.

The final part considers the position of the NHS in the wider economy and covers data on average earnings, earnings growth and wage settlements on the assumption that pay should usually expect to track the wider economy, as well as pay comparisons between the NHS and wider economy. Section 3 also provides data from "Longitudinal Educational Outcomes" - comparing outcomes for health graduates to those from other courses. We find that outcomes for nursing graduates are generally positive with high employability but have median earnings below other courses.

The Agenda for Change (AfC) pay system

Almost all non-medical staff working in the Hospital and Community Health sector (HCHS) sector in England are employed under the AfC contractual framework. Together with pay, AfC provides the terms and conditions of employment for non-medical staff in the NHS. There are a small number of non-medical staff who are not directly engaged under AfC,

including very senior managers and executive senior managers and those who are not directly employed by an NHS organisation (NHS Terms and Conditions of Service Handbook - NHS Employers), for example bank staff, where other local contractual arrangements may apply.

The AfC pay system is underpinned by the Job Evaluation Scheme (JES). This is a fundamental part of AfC and underpins the system of pay with a framework that allows roles across different functions, including clinical and non-clinical, to be rewarded fairly and, where implemented correctly, ensures the principle of equal pay for work of equal value is maintained.

Pay and earnings data

This section provides information on pay and earnings for staff working under AfC terms and conditions in the Hospital and Community Health Sector in England. Unless otherwise stated it draws on earnings data published by NHS England as well as known information about the shape and structure of the AfC pay structure to explain changes in pay over the past year, expected impacts following the 2025 to 2026 pay decision and some of the reasons behind those changes.

Pay and earnings in Agenda for Change pay structure

Under the Job Evaluation Scheme each role is placed in one of 8 bands - Band 8 is divided into 4 divisions - based on the qualifications and responsibilities required. Each pay band then contains between one and 3 unique pay points which staff can move through over time subject to satisfactory performance. To move to the next pay band (or Band 8 division) staff would need to secure promotion to the next pay band (or Band 8 division) in a role with a higher level of skill or responsibility.

Table 5 shows the national basic pay values as of 1 April 2025 with basic pay ranging from £24,465 in bands 1 and 2 to £115,763 at the top of band 9. This is the pay structure after the acceptance of PRB recommendations but before any potential changes to pay structures. Changes to the pay structure will potentially result from the recommendation for the creation of a funded mandate on pay structure reform to be agreed through the NHS Staff Council.

We also show information on the pay differences between adjacent bands which may influence promotion incentives but does not fully capture the benefit of access to the next pay "ladder" and it is not always the case that promotions occur only from the top of the previous band.

Table 5: national AfC pay structure as of 1 April 2025

Band	Pay step 1 (£)	Pay step 2 (£)	Pay step 3 (£)	Minimum time to top of band (years)	Band range (%)	Promotion gap (£)	Promotion gap (%)
Band 1	24,465	Not applicable	24,465	Not applicable	Not applicable	Not applicable	Not applicable
Band 2	24,465	Not applicable	24,465	Not applicable	Not applicable	Not applicable	Not applicable
Band 3	24,937	Not applicable	26,598	2 Years	6.7%	472	1.9%
Band 4	27,485	Not applicable	30,162	3 Years	9.7%	887	3.3%
Band 5	31,049	33,487	37,796	4 Years	21.7%	887	2.9%
Band 6	38,682	40,823	46,580	5 Years	20.4%	886	2.3%
Band 7	47,810	50,273	54,710	5 Years	14.4%	1,230	2.6%
Band 8a	55,690	58,487	62,682	5 Years	12.6%	980	1.8%
Band 8b	64,455	68,631	74,896	5 Years	16.2%	1,773	2.8%
Band 8c	76,965	81,652	88,682	5 Years	15.2%	2,069	2.8%
Band 8d	91,342	96,941	105,337	5 Years	15.3%	2,660	3.0%
Band 9	109,179	115,763	125,637	5 Years	15.1%	3,842	3.6%

Source: NHS agenda for change pay scales 2025 to 2026 Bands 1 and 2 operate a single "spot rate" and Band 1 was closed to new entrants from December 2018. Intermediate points in Band 8a and above were introduced in 2024 to 2025

When making pay recommendations in a system such as AfC we believe that the contractual level of basic pay is likely to be the most appropriate point of comparison as the level of additional earnings that individuals may receive is highly dependent on someone's role or individual rotas. Staff in the same band in different staff groups / roles can have different earnings, depending on the extent to which they might be expected to undertake additional work or operate during unsocial hours.

When considering the structure of the AfC pay system we may consider 3 different sections of the pay structure with different groups of staff, who may have different requirements or benchmarks:

- lower bands (band 1 to 4) - this is the point at which many people enter the NHS and we think it is important that pay at this level remains competitive against similar roles in wider labour markets

- graduate level (band 5 to 7) - many professionally qualified staff will enter the NHS workforce in band 5 after graduation from university and may then seek promotion to roles in higher bands. The PRB may therefore wish to consider how pay at these levels compares against other graduate opportunities

- leadership (clinical and non-clinical, band 8a and above) - a smaller proportion of the workforce are in bands 8a and above which include those in leadership positions in either clinical or non-clinical roles

Pay progression under Agenda for Change

Under AfC there are 3 principal ways someone can increase their basic pay:

- increases to pay values following the annual pay award - all staff are eligible for this as it changes the basic pay value for any point in the pay structure

- pay progression - a minority of staff will be eligible to "progress" to the next pay step within their current pay band. Under the AfC pay structure each band, apart from bands 1 and 2, contain a minimum of 2 pay points which staff can move through over time subject to satisfactory performance. Staff must spend a minimum of 2 years in each pay step and following the reforms to the pay structure in 2018 it takes a maximum of 5 years to be eligible to progress to the maximum pay value for each band

- promotion - to gain access to the following bands "pay ladder" staff must successfully obtain promotion which will generally involve taking a new role with a higher level of responsibility or more advanced practice

- during 2024 to 2025, it is estimated that on average around 52% of staff were already at the top of their current pay band with the other 48% not currently at the maximum pay step within their current band. Of those around 18% of the workforce could be eligible to move to a higher pay step over the next 12-months. This emphasises the importance of the Pay Review Body process as only a small minority of the workforce can see pay progression outside of the annual PRB process (or through promotion)

Average pay and earnings in 2024 to 2025

NHS England publishes information on average pay and earnings for staff working in the HCHS in England. This data does not include any outside earnings such as bank, agency or independent work. These figures are all provided on a "gross" basis before the impact of tax, national insurance and other deductions. Administrative data sources do not separately identify "take-home" pay and we believe that it is most appropriate to make pay comparisons based on gross pay as the impact of tax decisions impacts individuals throughout the economy.

Average basic pay reflects how staff are distributed across the AfC pay structure with average earnings also being impacted by variation in working patterns and additional earnings which these attract.

There are 2 principal measures of earnings which are used dependent on the context:

- basic pay per FTE - the average basic pay which would be received if it were assumed that all staff were working on a full-time basis. This is possible because basic pay is proportional to the number of hours worked. Basic pay per FTE reflects a weighted average of how staff are distributed across AfC bands and points

- earnings per person - the total average amount of pay received per person including both basic pay and non-basic pay elements including supplements for those working additional hours, unsocial hours or in high-cost locations. Additional earnings are not guaranteed and are generally received only if people do additional work or during unsocial hours. NHS England do not produce data on "earnings per FTE" as it cannot be assumed that earnings scale with hours worked like basic pay

- we also provide data excluding 'other' pay which is the payment type that was used to make non-consolidated payments as part of the 2023 to 2024 pay agreement with non-medical staff

- in the 12-months to March 2025 Basic pay per FTE for Agenda for Change staff ranged from around £25,500 for those working in hotel, property and estates to around £83,600 for senior managers while average total earnings per person for these 2 staff groups ranged from around £24,400 to £84,400 respectively

- the growth in basic pay per FTE is broadly consistent with the 2024 to 2025 pay award and changes to staff distribution across Agenda for Change pay points. The growth in basic pay per FTE was higher in staff groups with higher concentrations in bands 8a and above that potentially benefited from the introduction of intermediate points in those bands

- the growth in earnings per person was impacted by the expiry of non-consolidated payments made as part of the 2023 to 2024 pay agreement which led to a one-off increase in earnings in 2023 to 2024. This is evidenced in the difference between the growth in earnings (0.9%) and the growth in earnings excluding other pay (5.9%)

Table 6: average pay and earnings by staff group - 12 months to March 2025

Staff group	Basic pay per FTE (£)	Earnings per person (£)	Earnings per person (excl 'other' pay (£)	Growth in basic pay per FTE (%)	Growth in earnings per person (%)	Growth in earnings per person (excluding other pay) (%)
All non-medical	36,000	35,400	35,300	6.1%	0.9%	5.9%
Nurses and health visitors	40,700	40,900	40,900	5.5%	0.8%	5.5%
Midwives	42,600	39,400	39,400	4.9%	-0.1%	4.4%
Qualified ambulance staff	40,700	49,200	49,100	4.8%	-0.7%	3.3%
Scientific, therapeutic and technical staff	45,900	42,800	42,700	5.8%	0.9%	5.5%
Support to doctors, nurses and midwives	26,000	25,200	25,200	6.0%	0.0%	5.9%
Support to ambulance staff	27,700	31,900	31,900	5.4%	-1.3%	3.7%
Support to STT staff	27,600	25,900	25,900	5.9%	-0.1%	5.8%
Senior managers	83,600	84,400	84,200	8.0%	4.4%	8.1%
Managers	64,000	64,500	64,400	7.5%	3.6%	7.6%
Central functions	35,000	34,000	33,900	5.8%	0.4%	5.7%
Hotel, property and estates	25,500	24,400	24,300	5.6%	-0.7%	4.8%

Source: NHS England earnings statistics, 12-months to March 2025, NHS trusts, core organisations, ALBs and support organisations. All £ figures are rounded down to the nearest £100. Only includes staff recorded as working under Agenda for Change conditions on an Agenda for Change pay band.

Income distribution for agenda for change staff

The structure of the AfC pay system means that pay for individual members of the workforce depend on factors including if they choose to work on a less than full time basis or the extent to which they might be expected or want to work during unsocial hours.

Table 7 provides information on the distribution of earnings per person by staff group in 2024 to 2025. Across all staff groups it shows that some staff will earn more than others depending on the extent to which they undertake additional work or do so during premium time.

Table 7: distribution of earnings per person by staff group in 2024 to 2025

Staff group	25th percentile (measure: £)	Median (measure: £)	75th percentile (measure: £)
HCHS staff excluding HCHS doctors	£25,674	£33,681	£44,962
Nurses and health visitors	£34,685	£40,779	£48,403
Midwives	£32,482	£40,539	£48,156
Ambulance staff	£42,640	£51,309	£58,730
Scientific, therapeutic and technical staff	£33,872	£42,833	£52,809
Support to doctors, nurses and midwives	£20,546	£25,897	£29,925
Support to ambulance staff	£27,331	£32,428	£37,470
Support to scientific, therapeutic and technical staff	£21,284	£25,920	£29,970
Senior managers	£72,293	£91,683	£119,912
Managers	£56,047	£62,215	£72,580
Central functions	£25,674	£31,293	£43,410
Hotel, property and estates	£17,590	£24,135	£29,526

Source: NHS England Earnings Statistics

Additional earnings

In addition to basic pay, staff can access additional earnings depending on time, location or if it was paid at overtime rates under the terms set out in the Agenda for Change contract (see the NHS Terms and Conditions of Service Handbook).

The structure of the AfC contract means that some staff groups are more likely to receive additional earnings. For example, clinical staff are more likely to work unsocial hours to maintain a 24/7 service while ambulance staff have relatively high levels of overtime due to things like 'shift overruns' if an emergency occurs at the end of a shift which results in them having 'compulsory overtime' to complete a job. Because additional payments are not guaranteed and as they generally reflect either additional or "higher tariff" work we believe that it is basic pay that should set the "going rate" for work.

As shown in table 8 additional earnings for ambulance staff account for around 23% of all earnings compared to 4% for senior managers which reflects the profiles and expectations of different jobs. The pattern across different sections of the workforce is unchanged from last year and is in line with our expectations of the responsibilities and requirements of different positions.

Table 8: additional earnings as a proportion of total earnings by non-medical staff group in the 12 months to March 2025

Staff group	**12 months to March 2025**
Nurses and health visitors	11%
Midwives	13%
Ambulance staff	23%
Scientific, therapeutic, and technical staff	7%
Support to doctors, nurses, and midwives	11%
Support to ambulance staff	21%
Support to scientific, therapeutic and technical staff	6%
Senior managers	4%
Managers	5%
Central functions	5%
Hotel, property and estates	15%

Source: NHS England earnings statistics - 12 Months to March 2025.

Drivers of growth in average earnings

In this chapter we have previously provided information on average pay and earnings for the AfC workforce in 2024 to 2025. This section provides more information on factors contributing to the increase in average earnings in 2024 to 2025, and in particular:

- why the increase in total earnings may differ from the increase in basic pay per FTE
- why the increase in earnings per FTE may differ from the headline pay award

Average total earnings per FTE increased by 1.0% in 2024 to 2025, with basic pay per FTE increasing by 6.2% but additional (that is, non-basic pay) earnings per FTE decreasing by 30.7%. The large decrease in additional earnings reflects the 'expiry' of one-off non-consolidated payments to eligible staff in 2023, which do not appear in earnings for 2024 to 2025. Excluding this impact, total earnings per FTE grew by 5.8% in 2024 to 2025 which is more in line with the growth in basic pay per FTE, and over the last 2 years (since 2022 to 2023) total earnings per FTE increased by 10.6% (average annual growth of 5.2% per annum).

Growth in total earnings per FTE can be split into contributions from (a) the headline pay award (including negotiated pay deals, where applicable) and associated impacts, and (b) factors other than the pay award, such as changes in how staff are distributed across the pay structure or changes in the use of additional earnings such as overtime. The impact of factors other than the pay award is measured by 'earnings drift', the difference between total earnings per FTE growth and the headline pay award.

The overall headline pay award impact was 0.9% in 2024 to 2025, reflecting the 'expiry' of the 2023 non-consolidated payments as well as the 2024 to 2025 pay award itself, which had a 5.8% impact after removal of the non-consolidated payments (based on a 5.5% increase to basic pay scales, plus additional uplifts associated with the introduction of intermediate pay points in bands 8a to 9).

This is only slightly below the growth in total earnings per FTE (allowing for rounding), so there was broadly no net impact from earnings drift in 2024 to 2025. However, this reflects the net effect of 2 factors that broadly offset each other, consisting of:

- a negative ‘additional earnings drift impact’ of minus 0.4% due to additional earnings growing by less on average than basic pay (even after allowing for the ‘expiry’ of the 2023 non-consolidated payments). The largest contributors to this were a decrease in the use of additional activity payments, overtime payments, and 'local' payments in 2024 to 2025
- a positive 'staff group mix' effect of 0.3% reflecting an increase in the proportion of staff from higher earning staff groups in 2024 to 2025, with higher FTE growth on average for professionally qualified clinical staff (such as nurses and ambulance staff) than for support to clinical staff

There was also a small positive 'basic pay drift' of 0.1%, indicating that the mix of staff across pay points and bands within staff groups was slightly more expensive in 2024 to 2025.

Table 9 gives further detail on the breakdown of average earnings growth over recent years into its component drivers, where:

- average earnings growth equals headline pay award plus earnings drift
- earnings drift equals basic pay drift plus additional earnings drift impact plus staff group mix effect

Table 9: breakdown of average earnings growth for HCHS non-medical staff between 2019 to 2020 and 2024 to 2025

Pay growth element	2019 to 2020	2020 to 2021	2021 to 2022	2022 to 2023	2023 to 2024	2024 to 2025
Basic pay per FTE growth	2.8%	3.1%	3.9%	4.7%	4.9%	6.2%
Additional earnings per FTE growth	5.5%	5.5%	3.3%	-2.0%	49.5%	-30.7%
Total earnings per FTE growth	3.1%	3.4%	3.8%	4.0%	9.5%	1.0%
Components of total earnings per FTE growth	-	-	-	-	-	-
(a) Headline pay awards	3.3%	2.9%	3.6%	4.7%	10.2%	0.9%
(b) Total earnings drift	-0.2%	0.5%	0.2%	-0.7%	-0.7%	0.0%
Components of (b) Total earnings drift	-	-	-	-	-	-
(b1) Basic pay drift (excluding staff group mix effect)	0.2%	0.4%	0.2%	0.0%	-0.2%	0.1%
(b2) Additional earnings drift impact (excluding staff group mix effect)	-0.1%	0.5%	0.0%	-0.7%	-0.5%	-0.4%
(b3) Staff group mix effect	-0.3%	-0.4%	0.1%	0.0%	0.0%	0.3%

Source: DHSC analysis based on NHS England workforce earnings and size data and NHS Employers pay circulars

The components of total earnings per FTE growth presented in the table are:

- ‘headline pay award', which measures the change in average earnings due to the annual pay award (including negotiated pay deals, where applicable). This also

includes the impact of 'expiry' of one-off non-consolidated awards from a previous year, where applicable

- ‘total earnings drift’, the overall difference between total earnings per FTE growth and the headline pay award

- ‘basic pay drift’, which measures the contribution to earnings drift due to changes in the distribution of staff across pay points and bands within staff groups (for example, band 6 vs band 5 nurses), which affects growth in average basic pay

- 'additional earnings drift impact', which measures the contribution to earnings drift due to non-basic pay earnings growing at a different rate from basic pay. This captures the impact of changes in the use of payments for overtime, shift work, and other non-basic pay earnings

- 'staff group mix effect', which measures the contribution to earnings drift due to changes in the distribution of staff between higher and lower earning staff groups

Basic pay and additional earnings drift are presented excluding staff group mix effects (so basic pay drift just reflects changes in staff distribution within staff groups), to avoid double-counting with the staff group mix effect shown separately. The staff group mix effect is based on the HCHS non-medical staff groups presented in NHS England published data (and used in table 9 above).

Pay growth estimates are based on data on workforce earnings and size published by NHS England. Drift estimates, the difference between pay growth and the pay award, are based on changes to pay values from pay circulars, weighted by pay point workforce size estimates based on NHS England workforce data. The analysis is for all HCHS organisations including NHS trusts, NHS foundation trusts, ICBs and central and support organisations, and is based on earnings per FTE. Growth in earnings per FTE may differ from growth in earnings per person due to changes in average FTE per person.

The impact of the 2025 to 2026 pay decision

The impact of changes to pay scales which took place in April 2025 is yet to be seen in earnings data, however we expect that changes to earnings will follow the changes to pay scales.

- The value of all pay points were increased by 3.6% from 1 April 2025

- In addition, the government accepted the recommendation from the Pay Review Body to provide the NHS Staff Council with a funded mandate to address issues with the

AfC pay structure. The details of this mandate, and the level of funding available, are to be confirmed.

The change to pay point values was implemented from August 2025, along with relevant backpay, and we would expect the impact to be seen in other statistics as the year progresses. The impact of changes to pay structures are dependent on the outcome of the process with NHS Staff Council.

Longitudinal pay analysis

Previous analysis in this chapter has focussed on average pay and earnings across the entirety of the workforce. While this is instructive to assess what is happening in aggregate, and influences the total cost of employing the workforce, we should also be interested in how individual members of the workforce experience the pay system, which will include the impact of pay progression, promotion and pay scale reform.

Using data from the NHS Electronic Staff Record, the HR and Payroll system used throughout the Hospital and Community Health Sector, we can track the experience of individual members of staff who were employed at multiple points in time. Table 10 is based on over 580,000 staff who were employed in both 2015 and 2025 and shows that over that time half of staff saw increases to basic pay of at least 56% after accounting for the impact of annual pay awards, individuals progressing through the pay system and gaining promotion.

The experience of individual members of staff will depend on a variety of factors including if they have been eligible for pay progression over the period, obtained promotion or been in a section of the pay structure that has undergone reform - for example over the past year there have been higher increases for managers and senior managers following the introduction of intermediate points in band 8a and above.

Table 10: shows increase in basic pay after accounting for the impact of annual pay awards and individuals progressing through the pay system and gaining promotion

Staff group in 2025	Number of staff in sample	25th percentile - 25% of staff saw increases of at least (%)	Median - 50% of staff saw increases of at least (%)	75th percentile - 75% of staff saw increases of at least (%)	Mean (%)
All staff	580,000	34.6%	56.0%	74.4%	62.4%
Ambulance staff	10,500	61.1%	74.4%	104.5%	84.3%

Staff group in 2025	Number of staff in sample	25th percentile - 25% of staff saw increases of at least (%)	Median - 50% of staff saw increases of at least (%)	75th percentile - 75% of staff saw increases of at least (%)	Mean (%)
Central functions	58,100	40.5%	61.1%	88.2%	69.2%
Hotel, property and estates	29,400	53.0%	61.2%	61.2%	58.5%
Managers	19,500	51.1%	75.2%	115.9%	90.0%
Midwives	13,200	30.2%	50.0%	73.9%	56.9%
Nurses and health visitors	190,400	30.8%	56.4%	78.3%	61.4%
Scientific, therapeutic and technical staff	90,400	32.2%	56.4%	89.3%	67.0%
Senior managers	8900	53.5%	81.8%	119.8%	94.0%
Support to scientific, therapeutic and technical staff	29,000	33.2%	51.9%	64.3%	52.6%
Support to ambulance staff	7,500	33.2%	51.1%	71.0%	56.1%
Support to doctors, nurses and midwives	122,000	33.2%	53.0%	66.4%	53.0%

Source: DHSC Analysis of Electronic Staff Record Data Warehouse

The National Living Wage (NLW) and low pay policy

From April 2025 the National Living Wage (NLW) rate - the statutory minimum payable to most employees aged 21 and over – increased to £12.21 per hour. Following the outcome of the 2025 to 2026 pay round, the minimum pay rate under AfC is £12.51 per hour, 30p pence per hour or 2.5% above the NLW.

The gap between the bottom of the NHS pay scale and the National Living Wage has fallen in recent years following a series of large increases to NLW to move toward the 2-thirds of median earnings commitment which saw the NLW increase by 9.8% and 6.7% over the past 2 years compared to increases of 5.5% and 3.6% at the bottom of AfC.

The governments' 2025 remit to the Low Pay Commission (LPC) for minimum wage rates to apply from April 2026 re-affirms the commitment that the NLW should not drop below

two-thirds of median income while also taking account of the cost of living, and the impact on business, competitiveness and wider labour markets. The remit also invites the LPC to make recommendations which reduce the gap between the NLW and minimum wage for 18–20-year-olds with the ultimate aim to align the rates.

Alongside the remit the LPC indicated that the current forecast for the NLW in 2026 to 2027 was between £12.55 and £12.86 with a central forecast of £12.71 which would be an increase of around 4.1% and means that the NLW which applies from April is likely to be above the current minimum pay rate in Agenda for Change.

The trade-off between competing objectives, including maintaining competitiveness in the lower paid labour market versus maintaining pay differentials, should remain a factor in determining pay policy towards the bottom of the pay structure. The government remain interested in ensuring that both the National Living Wage and entry pay for NHS staff are effective in attracting people to work in the health system and are particularly interested in seeing the NHS staff council take forward work in this area.

The broader economic context, as well as the recruitment and retention situation, will be key in determining whether further pay targeting is required in this pay round and, if so, where it may be justified. Developments over the coming months may impact the appropriate decision and we expect the NHSPRB will want to consider the latest available data and intelligence as it makes its recommendation. We will be happy to give our views on the emerging situation and what that might mean for pay policy at our oral evidence session.

Wider labour market analysis

NHS pay cannot be treated in isolation, and it is important that the PRBs take account of developments in the wider economy and external labour markets to help ensure that recommendations are well anchored against the wider economy and ensure that the NHS remains a competitive place to work. Labour market indicators show:

- available data on pay settlements, the measure most closely aligned with PRB recommendations, show median settlements have remained at 3% in the 3-months to July 2025, the same percentage since December 2024

- there is evidence of differences in growth rates across the earnings distribution with higher growth rates for those with lower earnings which may follow substantial increases to the National Living Wage in April 2025

Earnings forecasts for 2026 to 2027

To maintain the position of the NHS within wider labour markets it will usually be the case that the change in NHS pay might expect to broadly align with wider economy earnings growth. We also believe that the Pay Review Body should take consideration to the expected change in earnings over the forthcoming pay period rather than reflecting current conditions.

Average earnings growth is forecast to be lower over 2026 to 2027 than 2025 to 2026, at 2.2% according to the OBR's March 2025 forecast with a reduction over the course of the year, at around 2.4% in the Q2 2026 to 2.0% in Q4 2026 and Q1 2027.

In the August Monetary Policy Report the Bank of England forecast average private sector earnings growth of 3.25% in Q4 2026 - This is an increase from its previous forecast (2.75%) and remains higher than OBR forecasts.

Pay settlements - data and forecasts

General growth in earnings can be broader than that generated through pay settlements alone as it will encompass any changes to average pay / earnings resulting from changes to the composition of the workforce (for example, having more people in higher paid positions) or any changes in additional pay (for example, more people doing additional hours)

While there are no official statistics covering pay settlements we can look to surveys from the likes of Brightmine (formerly XPertHR), Incomes Data Research (IDR) and the Bank of England for insight on the current value of pay awards which may align with decisions facing the Pay Review Bodies.

In August 2025 Brightmine reported that median pay settlements for the quarter to June 2025 stood at 3% and this had remained stable for 8 consecutive rolling quarters. Previous data showed that median pay awards were higher (4.3%) in the public sector following the impact of targeted pay awards for some groups. They noted that over one quarter of awards in the sample were worth exactly 3% while nearly 60% of awards were between 2% and 3%. They also stated that current awards tended to be below those of a year ago with almost 80% of awards being lower than in the previous pay cycle.

Data from Incomes Data Research (IDR) showed median pay increases in 2025 of 3.3% with those in the private sector being around 3.2%. The IDR data shows the impact that increases to the NLW can have on pay settlements with some sectors (for example hospitality or retail) likely to see higher awards to maintain compliance with the NLW. Other sectors, such as engineering, may not face the same direct pressures from changes

to NLW but may feel the need to respond to maintain existing pay differentials to attempt to retain staff.

Data from the Bank of England decision maker panel can also provide insight as to what wage pressures firms expect to face. In the 3 months to July 2025 firms reported wage growth of 4.7% but expected wage growth over the next 12-months was expected to fall by just over one percentage point to 3.6%.

In aggregate this would suggest that for much of the past year pay settlements have been in the region of 3%, and with most settlements in 2025 being lower than in 2024.

Broader economic conditions

In addition to being aware of changes in wider earnings we should also be aware of other economic indicators and the impact they may have on labour markets including any impact for the NHS including things like Recruitment and Retention.

Between April and June 2025 unemployment stood at 4.7% which represented an increase of 0.1 percentage points over the previous quarter and around 0.7 percentage points above pre-pandemic levels. OBR forecasts are for unemployment to remain broadly stable in 2026 to 2027.

Alongside a rise in unemployment the number of vacancies has continued to fall - ONS data shows around 718,000 vacancies in the 3 months to July 2025 which represent a figure that has fallen for 37 consecutive quarters and is back below pre-pandemic levels. The ratio of vacancies to unemployed people, a measure of economic tightness, has continued to fall indicating a looser labour market. The number of unemployed people per vacancy between April and June 2025 was around 2.3 and has slowly increased from a figure of around 1 immediately after the pandemic in 2022. The number of vacancies (and ratio of vacancies to jobs) has reduced across most sectors but with some of the biggest reductions amongst traditionally lower paid occupations including accommodation and food services, the arts and retail.

Job data also shows that many sectors have seen a reduction in the number of payrolled employees over the past year with particular falls in accommodation, food services and wholesale and retail services while the number in human health and social work has increased.

While we may not think that inflation should be central to pay setting it is currently forecast to average around 1.9% in 2026 to 2027 (OBR, March 2025 forecast). This would be a reduction from the forecast 3.2% in 2025 to 2026 (OBR, March 2025 forecast) and be broadly in line with the government's 2% inflation target. For comparison the Bank of England currently forecast average CPI of around 2.5% in 2026 to 2027.

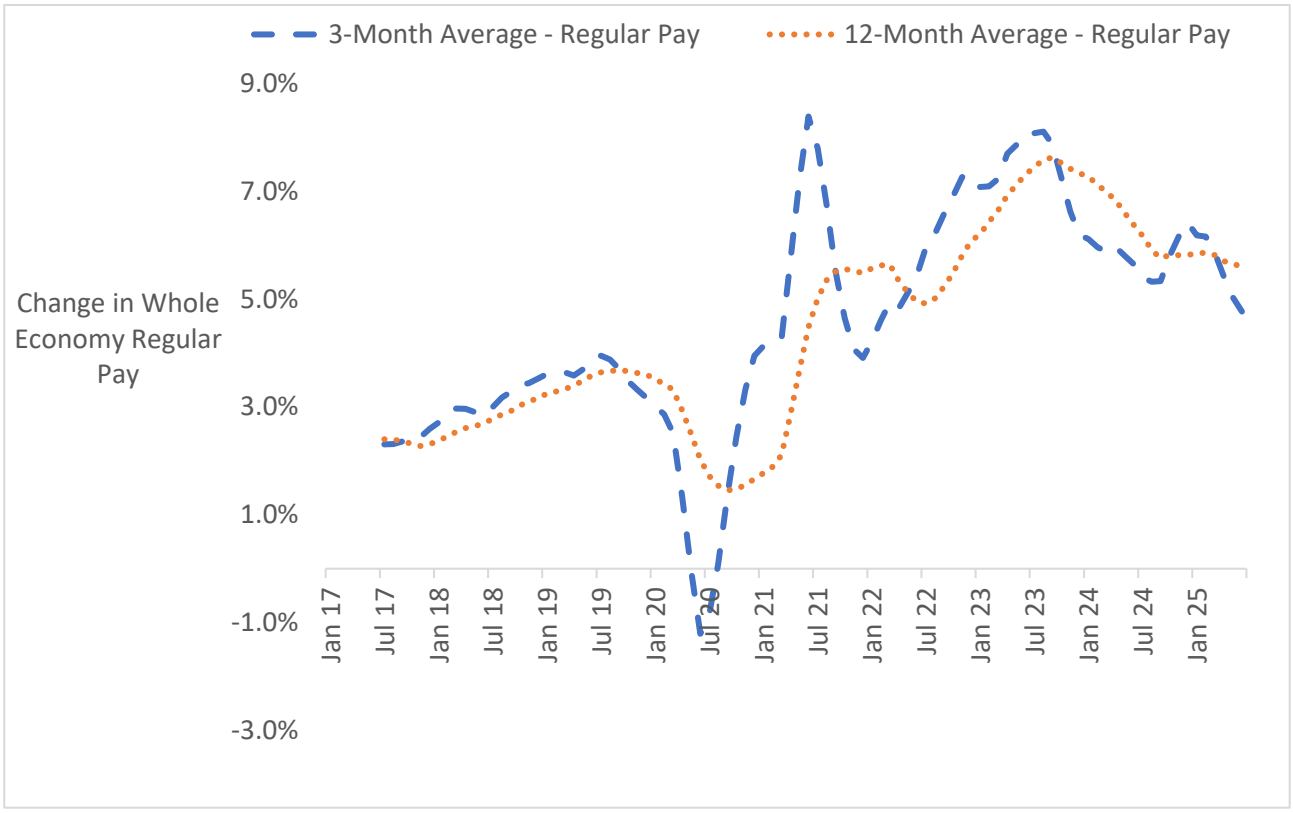
Previous earnings growth

While we believe that forecasts of future earnings growth may be more influential in pay setting, we can also consider other data on earnings growth as that can help assess the extent to which previous pay awards were anchored against external labour market conditions.

ONS publishes data on average weekly earnings which is the lead measure on earnings growth per employee and is based on data from the monthly wages and salaries survey. Changes in average weekly earnings cover more than just pay settlements and include the impact of changes in averages working hours of alterations to workforce composition.

As shown in figure 3 the pace of earnings growth has moderated in after reaching peaks in Autumn 2023 which is expected to continue over coming months. This may also help to indicate that the previous pay award, 5.5% in 2024 to 2025 was broadly consistent with what happened in the wider economy and the 3.6% in 2025 to 2026 is also forecast to align with experience in the wider economy

Figure 3: increase in average weekly earnings in the private sector, 3-month and annual growth rates between January 2017 and June 2025, £ per month, 3 month moving average



Source: Office for National Statistics

Description: this is a chart showing the increase in average weekly earnings in the private sector between July 2017 and June 2025 on both a 3-month and annual average basis. It shows that the increase in earnings, using the 3-month average, is 4.8% as of June 2025 but has reduced from around 8% during 2023.

Annual Survey of Hours and Earnings

In previous years we have provided evidence attempting to compare pay and earnings for NHS staff groups to comparator occupations using the Annual Survey of Hours and Earnings published by the Office for National Statistics.

Due to the timing of this year's pay process we note that no further updates to this data have been possible with ASHE generally being published in mid-Autumn.

Pay percentile analysis

A further way to attempt to assess pay levels is to consider how pay for NHS staff, or AfC pay points, has changed compared to wider economy comparators.

The table below is based on data from the Office for National Statistics (ONS) and compares the standard hourly rate (national rate with no unsocial hours enhancement) against the estimated pay distribution (assuming equal spacing between known percentiles)

It shows that across most pay points the approximate point in the pay distribution was broadly unchanged over recent financial years. Data for 2025 to 2026 are not yet available.

Table 11: estimate of position of AfC pay points within UK income distribution between 2021 to 2022 and 2024 to 2025

Year	2021 to 2022	2022 to 2023	2023 to 2024	2024 to 2025
Band 2 - minimum	22nd	24th	25th	25th
Band 3 - minimum	28th	29th	27th	26th
Band 4 - minimum	36th	36th	34th	34th
Band 5 - minimum	48th	46th	45th	45th
Band 6 -	61st	60th	59th	60th

Year	2021 to 2022	2022 to 2023	2023 to 2024	2024 to 2025
minimum				
Band 7 - minimum	75th	74th	74th	75th
Band 8a - minimum	81st	80th	79th	81st
Band 8b - minimum	88th	87th	85th	87th
Band 8c - minimum	greater than 90th	greater than 90th	greater than 90th	greater than 90th
Band 8d - minimum	greater than 90th	greater than 90th	greater than 90th	greater than 90th
Band 9 - minimum	greater than 90th	greater than 90th	greater than 90th	greater than 90th

Source: Office for National Statistics, Distribution of gross hourly earnings of employees

Longitudinal education outcomes

The longitudinal education outcomes (LEO) dataset combines data from the Department for Education (DfE), Department for Work and Pensions (DWP) and HMRC and can be used to track and compare the outcomes for university graduates from different courses or institutions. It can be used to analyse how earnings (excluding elements of total reward such as pensions) and employability of healthcare graduates (including those from nursing and midwifery courses) compare with graduates from other subjects as a way of comparing the relative returns from different courses.

Overall, the data indicates that for nursing and midwifery graduates:

- after 5 years graduates have average (median) earnings about 27% above average which falls to around 4% below after 10 years
- over 10 years median pay for nurses and midwives increases by around 12% from £31,400 1 year after graduation to £35,400 10 years after graduation
- nursing graduates are amongst the most likely to be in sustained employment or training at all points after graduation

While for allied health graduates:

- after 5 years graduates have average (median) earnings about 5% above average which falls to around 11% below after 10 years

- over 10 years median pay for allied health graduates increases by around 23% from £26,300 1 year after graduation to £32,500 10 years after graduation

- employment outcomes for allied health graduates are above average with just under 90% being in employment after 10 years

Table 12: median earnings for selected healthcare graduates 1,3,5 and 10 years after graduation with comparison to other subjects based on earnings in fiscal year 2022 to 2023

Median earnings for first degree students graduating cohort	**1 year after graduation 2020 to 2021**	**3 years after graduation 2018 to 2019**	**5 years after graduation 2016 to 2017**	**10 years after graduation 2011 to 2012**
Nursing and midwifery	£31,400	£33,200	£34,300	£35,400
Nursing and midwifery rank (35 subjects)	3	10	13	20
Subject average (all subjects excluding nursing and midwifery)	£24,700	£28,300	£31,900	£36,800
Allied health	£26,300	£29,900	£32,100	£32,500
Allied health rank (35 subjects)	11	13	17	27
Subject average (all subjects excluding allied health)	£24,900	£28,500	£32,000	£36,800

Source: Longitudinal education outcomes (LEO) (Department for Education). This will include people who studied nursing / allied health employed outside the NHS or health sector

The data also provides detail on the industry sectors graduates are working in and respective earnings within those industries. It shows that approaching 90% of nursing and midwifery graduates are working in roles linked to human health and social work and have median earnings of £33,200. Of the remaining 11% only 2 industry sectors had higher

median earnings than those in human health which indicates that overall data is not being skewed by a minority of staff who may have left the health sector.

For first-degree allied health graduates, over 57% worked in human health and social work 3 years after graduation and 5 years after graduation, over 54% remained in the same industry. While this proportion is lower than for nursing graduates, allied health subjects are a much wider group of subjects not necessarily leading to work as a regulated professional and can include health sciences, nutrition and dietetics, ophthalmic, environmental and public health, physiotherapy, complementary and alternative medicine, and counselling, psychotherapy and occupational therapy. Some individuals may also be utilising the degree in a related occupation outside of the traditional healthcare system - for example those with optician degrees working in "retail sales by opticians" roles.

In the 2025 report the PRB invited evidence on reasons why data shows nurses and health visitors have above average earnings immediately after graduation and then have below average earnings as the time since graduation increases. While available data may not provide definitive answers, we may think that:

- a higher proportion of nursing graduates are likely to enter work in graduate level roles compared to other degrees. Newly qualified nurses have a reasonable expectation of joining the NHS workforce in band 5 while graduates from other subjects may be more likely to not immediately enter into a graduate level role and allows more opportunity for rapid pay growth when they move into a graduate level position

- the nursing profession is predominately female, and data shows that female graduates tend to see slower earnings growth compared to male graduates - potentially reflecting the higher likelihood of taking time out of the workforce for family reasons. For example, across all male graduates' median earnings growth between 1 year and 10 years post-graduation was 63% compared to 33% for female graduates

LEO also includes information on employment which highlights the benefit of a nursing degree when it comes to employability. Of the 35 subjects that are monitored, individuals with a nursing or midwifery degree had the highest proportion of graduates in sustained employment or training 3 years after graduation, for 5, and 10 years after graduation, they were second twice, and for one year after graduation, they were third. 10 years after graduation, over 90% of nursing and midwifery graduates are in sustained employment, training or both which are over 4 percentage points higher than average.

Table 13: proportion of selected healthcare first degree in sustained employment, training, or both after 1, 3, 5, and 10 years with comparison to other subjects in 2021 to 2022 fiscal year

Proportion in sustained employment, further study or both % (first degree only) graduating cohort	1 year after graduation 2020 to 2021	3 years after graduation 2018 to 2019	5 years after graduation 2016 to 2017	10 years after graduation 2011 to 2012
Nursing and Midwifery	95.4%	94.6%	93.5%	90.4%
Nursing and Midwifery rank (35 subjects)	3	1	2	2
Average (all subjects excluding Nursing and Midwifery)	89.4%	88.7%	88.6%	85.7%
Allied Health	97.6%	93.6%	92.9%	89.3%
Allied Health rank (35 subjects)	4	7	8	15
Average (all subjects excluding Allied Health)	89.5%	88.8%	88.6%	85.8%

Source: Longitudinal education outcomes (LEO) (Department for Education)

Note: 10 years after graduation, 'Celtic studies' which had fewer than 25 graduates had the highest rate, with Nursing and Midwifery joint first 3 years after graduation with 'Celtic studies'.

7. Total reward

Summary

Pay makes up one part of the overall reward package, and whilst important, there are other benefits which have both financial and non-financial value. These benefits impact the motivation, recruitment and retention of the NHS workforce and should therefore be considered by the NHSPRB.

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 entitlements of up to 12 months pay, 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 above the statutory minimum and exceed those offered in other sectors.

Labour market context

Comparisons between the NHS workforce and the wider labour market should not just be limited to pay but include the full reward package.

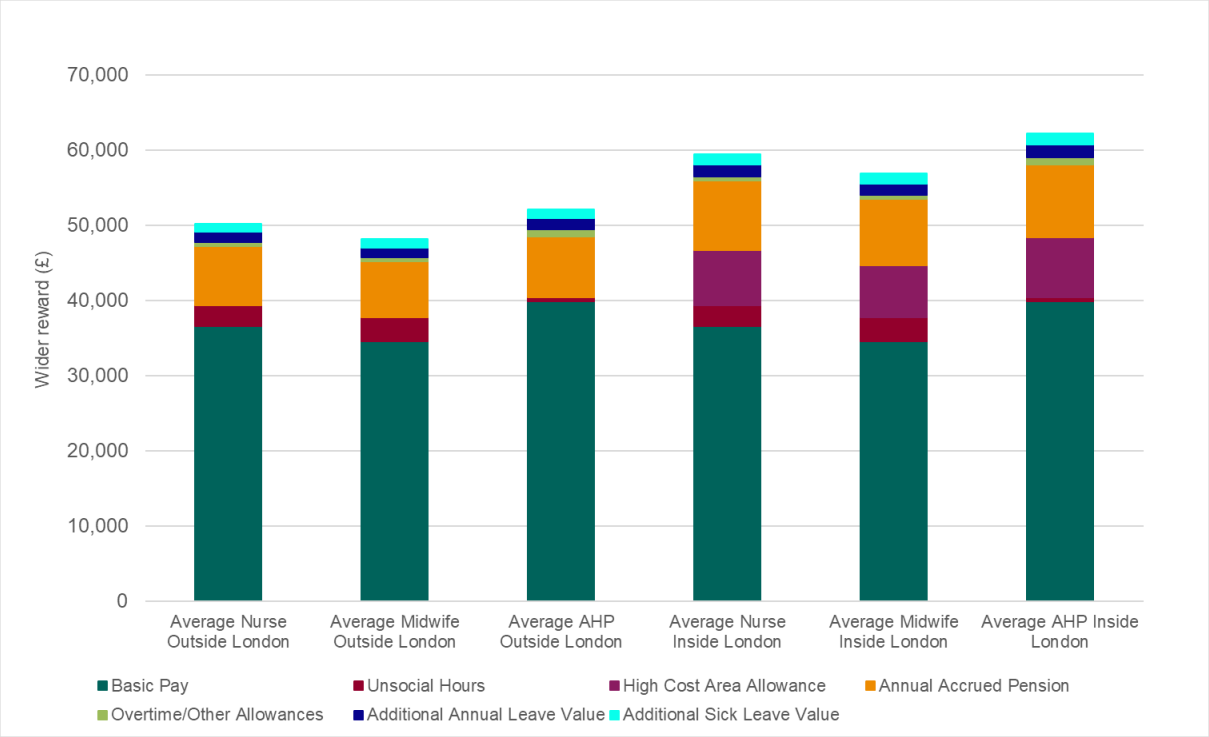
In the UK, employers are required to contribute a minimum of 3% to employee's pensions, and any additional contributions over the 3% are at the discretion of the individual employer. The statutory minimum holiday allowance is 26 days per year (including bank holidays) for full-time members of staff.

Measuring the value of the package

The department commissions the Government Actuary's Department (GAD) to measure the value of the total reward package for a range of NHS roles, as shown in the analysis below.

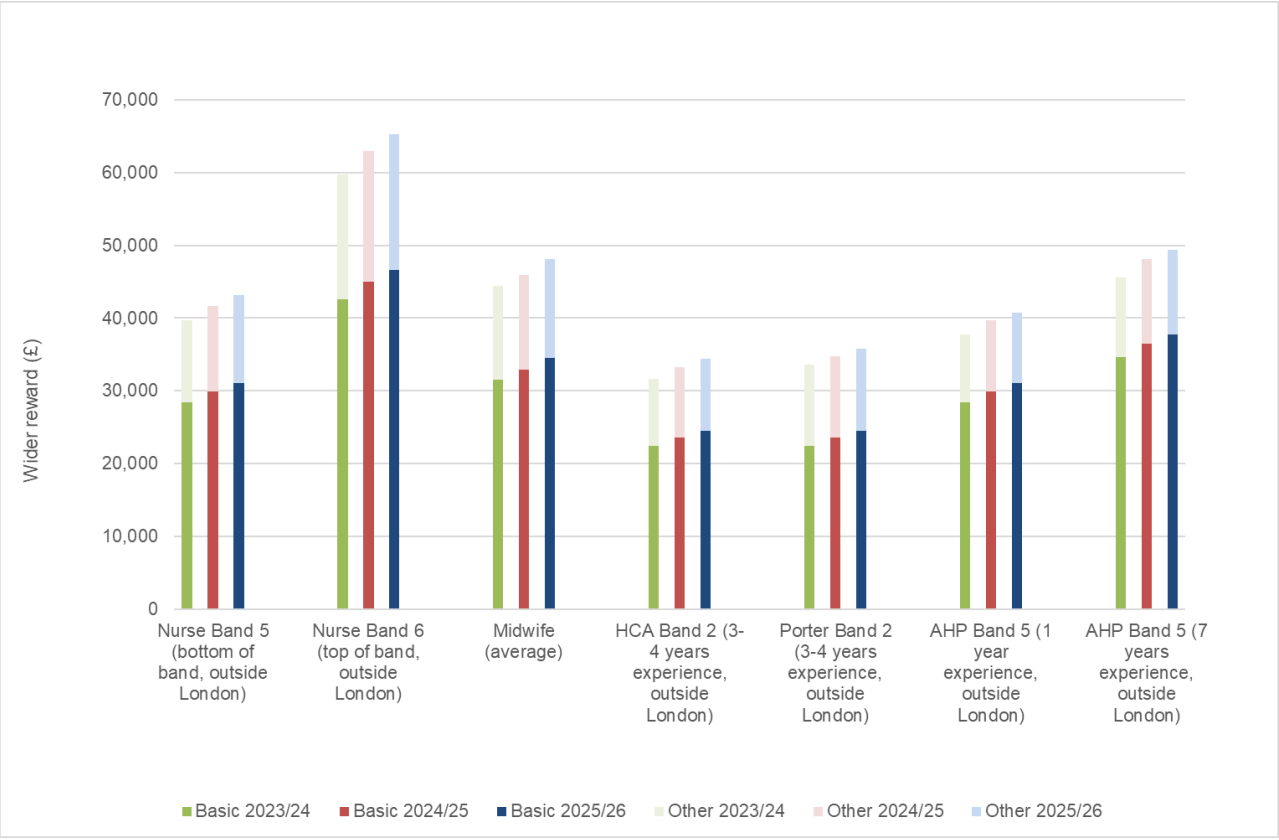
The elements included in the package are basic pay, high cost area allowances (HCAS), overtime or other allowances, unsocial hours, annual accrued pension, and additional annual leave. Annual accrued pension is a measure of the 2015 Scheme pension, which is calculated as the pension accrued over the year multiplied by a factor of 20, less employee contributions.

Figure 4: value of the total reward package for NHS staff



The same roles have been adopted as in last year's analysis. The total values of the wider reward packages have increased compared to those provided last year. This reflects the annual Agenda for Change pay award.

Figure 5: wider reward trends for NHS staff over the period 2023 to 2024, to 2025 to 2026



This analysis for NHS roles shows the split of total reward packages between basic and other pay over the years 2023 to 2024, 2024 to 2025 and 2025 to 2026. Please note, for an average midwife we are comparing average rewards of 31 March 2023, 30 June 2024, and 31 March 2025 with pay bands for all other roles across the respective years. This is consistent with the approach used in previous years.

All NHS roles considered in this analysis have experienced an increase in total reward in monetary terms over the period 2013 to 2014 to 2025 to 2026. Overall, increases are largely driven by increases to basic pay over this period. All roles have at least 24% of total rewards make up of non-basic pay.

Enhanced parental leave

There have been no changes to maternity, adoption or shared parental leave over the past 12 months however work has been done to clarify pension contributions during periods of leave.

From 1 October 2022, members of the NHS Pension Scheme pay a contribution rate that is calculated using their actual annual rate of pay, rather than notional whole-time equivalent (WTE). This meant that many part-time staff had a reduction in member contribution rates. Given that this calculation was made for members who did not work full-time hours, it was deemed appropriate to consider how contributions are calculated where members receive less than full pay. This could be during periods of parental leave or sickness absence, where members are on reduced pay but still contributing based on their full pay.

The department retrospectively amended the NHS Pension Scheme regulations so that, where members are receiving reduced pay, their contributions will be calculated based on their actual annual pay. This clarification was backdated to 1 October 2022 meaning that, in practice, the existing regulations have applied to affected members since 1 October 2022, who may be due a refund having overpaid member contributions during a period of reduced pay.

The overall effect of the change is that members will pay less to continue to be in the NHS Pension Scheme whilst they are receiving reduced pay. This means that they are more likely to continue to accrue pension benefits and retain valuable ancillary benefits, such as life assurance.

GAD estimate that employees with 12 months continuous service with one or more NHS employers are entitled to benefits above the statutory entitlement. NHS staff earning £34,000 would be entitled to earn maternity pay of around £7,300 (gross pay) in excess of

what they would under statutory maternity leave allowance. These figures are provided for illustrative purposes as maternity pay depends on the member's contractual entitlements.

The NHS Pension Scheme

The NHS Pension Scheme remains a valuable and generous part of the total reward package available to NHS staff.

There are 2 NHS Pension Schemes. A legacy Scheme, which includes the 1995 and 2008 sections, and the 2015 Scheme. Both are defined benefit schemes but they have some key differences; the way benefits are calculated, the normal pension ages and the accrual rates. The legacy scheme is now closed to new members and all NHS staff who joined the Pension Scheme since 1 April 2022 are automatically in the 2015 scheme.

Table 14: comparison of retirement ages and accrual rates for members of the 1995 Section, 2008 Section and 2015 Scheme

Scheme or section	Normal pension age (NPA)	Accrual rate
1995 Section	60	1/80th
2008 Section	65	1/60th
2015 Scheme	State Pension Age	1/54th

One key benefit of the 2015 scheme is that for active members, the pension they earn is increased every April by the Consumer Price Index (CPI) in the year before. Accrued pensions are increased by CPI plus 1.5%, which is a rise of 3.2%.

Pension projections

GAD calculates that scheme members can generally expect to receive around £2 to £6 in pension benefits for every £1 contributed.

GAD has also estimated that a nurse who joins the NHS Pension Scheme in 2025 age 21 and works at AfC band 5 before retiring at age 65, can expect an annual pension of around £37,000 in today’s earnings terms. A nurse who joins the NHS Pension Scheme in 2025 age 21 and progresses through AfC bands 5 and 6 before retiring at age 65 can expect an annual pension of around £43,000 in today's monetary terms. These estimates assume that members remain in service and work full-time to retirement.

The table below sets out illustrative projected pensions for members as above, as well as allowing for commutation where 20% of the pension is converted into a tax-free pension commencement lump sum (PCLS) at retirement.

Table 15: projected annual pensions and lump sums for nurses joining the NHS Pension Scheme in 2025 and retiring at age 65

Nurse band	No commutation: projected pension (per year	Allowing for commutation: projected residual pension (per year)	Allowing for commutation: projected pension commencement lump sum (PCLS)
Nurse band 5	£37,000	£29,600	£89,000
Nurse band 5/6	£43,000	£34,400	£103,000

The NHS Pension Scheme membership

Overall, membership rates continue to be high, with an average of around 9 in 10 (88.6%) of non-medical staff in the NHS staff being members of the scheme in June 2025. The table below shows the percentage of staff members, by staff group and AfC band, who were members of the scheme in June 2025 in comparison to June 2024. Staff group workforce totals and band workforce totals are based on data published by NHS England. There has been very little change over the past 12 months with an average of plus 0.4 percentage point change in memberships for non-medical NHS staff.

Table 16: NHS Pension Scheme membership for non-medical staff

Non-medical staff members	June 2025	One year change (percentage point change)
Nurses and Health Visitors	84.6%	0.8pp
Midwives	91.5%	0.3pp
Qualified Ambulance Staff	93.1%	1.1pp
Qualified Scientific, Therapeutic and Technical	92.3%	0.3pp
Support to Doctors, Nurses and Midwives	89.3%	-0.1pp
Support to Ambulance Staff	91.9%	-0.2pp
Support to Scientific, Therapeutic and Technical	90.8%	0.2pp
Central Functions	88.9%	0.5pp
Hotel, Property and Estates	88.2%	0.9pp
Senior Managers	93.3%	0.7pp
Managers	92.0%	0.8pp

Non-medical staff members	June 2025	One year change (percentage point change)
Grand Total	88.6%	0.4pp
Band 1	79.7%	2pp
Band 2	88.5%	-0.2pp
Band 3	89.6%	-0.2pp
Band 4	90.4%	0.7pp
Band 5	81.2%	0.9pp
Band 6	89.5%	0.4pp
Band 7	92.7%	0.6pp
Band 8a	93.8%	0.8pp
Band 8b	94.3%	0.7pp
Band 8c	94.1%	0.4pp
Band 8d	94.5%	0.7pp
Band 9	94.0%	1.1pp

Table 17: NHS Pension Scheme memberships for Band 5 staff by pay point and nationality

Band 5	Years experience	UK	EU	Rest of World	All
Point 1	0-2 Years	92%	85%	64%	82%
Point 2	2-4 Years	89%	82%	46%	72%
Point 3	4 plus Years	90%	85%	65%	85%
All	All	91%	85%	60%	81%

Compared with last year, membership rates for all nationalities across pay points have increased slightly, with the greatest increases in Band 5 staff with "rest of the world" nationality status.

NHS Pension Scheme contributions

Members and employers are required to pay towards the cost of benefits built up in the NHS Pension Scheme. At present, employers contribute 23.7% of each member’s pensionable earnings, plus a charge of 0.08% to fund the administration of the scheme.

DHSC reviewed member contributions in 2021 and introduced changes in October 2022 and April 2024. More information on these changes is available from the relevant consultation documents. Following these changes, the member contribution tier thresholds are now updated automatically each April, in line with CPI from the previous September. If the AfC pay award in England is higher than this figure, the thresholds are updated again. This is known as the 'better of' test. This policy acts to ensure that the tier thresholds remain up to date, and to reduce the likelihood of members moving into the next contribution tier solely as a result of receiving a nationally agreed pay award.

The thresholds for the first tier and entry to the second tier are not increased (either by CPI or AfC) unless the threshold for basic rate income tax changes. This is because the first contribution tier is designed to link to the threshold for basic rate income tax. Scheme members who fall into the bottom tier will work less than full-time hours but are unlikely to receive tax relief on their contributions unless they have an additional income source. The first tier is designed to give these members benefit equivalent to tax relief at source to incentivise pension saving.

Table 18: NHS Pension Scheme member contribution threshold structure (as of 1 April 2025)

Pensionable pay range	Contribution rate from 1 April 2025, based on actual annual pensionable pay
Up to £13,259	5.2%
£13,260 to £27,797	6.5%
£27,798 to £33,868	8.3%
£33,868 to £50,845	9.8%
£50,846 to £65,190	10.7%
£65,191 and above	12.5%

Retirement options

The scheme has a normal pension age (NPA) at which pension benefits are paid without adjustment. Members have the option of taking Voluntary Early Retirement which allows staff to fully retire up to 10 years earlier than their NPA (subject to Normal Minimum Pension Age legislation), although their pension will be actuarially reduced (by around 5% per year), to account for the fact that it is being paid earlier and therefore longer.

The generosity of the accrual model, potentially combined with retirement flexibilities, enables members to take early retirement, with an actuarial reduction, before the normal

pension age in the scheme and still receive a good value pension relative to the amounts they have contributed to the scheme. If a member is physically or mentally unable to reach NPA within their role, ill-health retirement is a feature of the scheme that is available at any age.

Partial retirement was introduced for NHS staff in the 1995 Scheme on 1 October 2023 and allows NHS Pension Scheme members to draw down some or all of their pension while continuing to work and build up further pension, subject to a reduction in pensionable pay of at least 10%, being agreed with their employer. As well as supporting staff with their work/life balance later in their careers, partial retirement also supports NHS employers, by allowing them to retain experienced members of staff who may otherwise retire. As of 22 August 2025, there have been 29,454 applications for Partial Retirement Awards with over £400 million being paid in annual benefits and over £2 billion in lump sums. The NHSBSA estimate that of the 29,454 applications, 14,948 (45.47%) of these were taken by officers, and 13,532 (41.17%) taken by nurses, demonstrating the popularity of partial retirement.

Members who want to claim their pension when it is most valuable to them, but don’t want to change their job, can retire and return. After taking retirement, they can then return to work (full-time or on reduced hours) and re-join the NHS Pension Scheme to continue building further pension benefits. It is difficult to track the popularity of retire and return as members are generally retiring without the initial intention of returning to work. The numbers who return after retiring are not always recorded.

Communicating the package

Total reward statements (TRS) are provided to NHS staff to give a better understanding of the benefits that they have or may have access to as an NHS employee. TRS provide personalised information about the value of staff employment packages, including remuneration details and benefits provided locally by their employer.

All NHS Pension Scheme members also receive an Annual Benefit Statements (ABS) every August, which shows the current value of their scheme benefits. On 25 July 2025, there were 3,073,848 statements available, with 1,091,850 views. In comparison, on 21 September 2024, there were 3,054,253 statements available and 374,657 views.

As part of the NHSBSA 5-year strategy, there is a commitment to invest in communication with members via the UK Pensions Dashboard Programme. This will enable members to access their pension information online, securely, and all in one place. The dashboard will provide clear and simple information about all an individual's pension savings, including their State Pension.

In addition to this, the department and NHSBSA are working together to improve the NHS Pensions App functionality to link with the dashboard. The app will provide members with

user-friendly, clear access to their pension data, allow them to see their pension benefits accruing, and future retirement date options. Using technology to communicate will make information more readily available to members as well as reduce the amount of time and costs spent on traditional communication such as sending letters to update members.

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