NHS Pay Review Body

NHS Pay Review Body

THIRTY-NINTH REPORT 2026

Interim Chair: Stephen Boyle

CP 1484

NHS Pay Review Body

Thirty-Ninth Report 2026

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

Presented to the Northern Ireland Assembly
by the Minister of Health

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

February 2026

CP 1484

This publication is available at http://www.gov.uk/official-documents.

Any enquiries regarding this publication should be sent to us at.

Office for the Pay Review Bodies
1st Floor, Caxton House
Tothill Street
London
SW1A 9NA
United Kingdom

ISBN 978-1-5286-6228-4

E03545983 02/26

Printed on paper containing 40% recycled fibre content minimum

Printed in the UK by HH Associates Ltd. on behalf of the Controller of His Majesty's Stationery Office

NHS Pay Review Body Terms of Reference[1]

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

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

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

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

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

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

Members of the Review Body are:

Stephen Boyle (Interim Chair)
Professor Stephen Bach
Stephanie Marston
Kate Nowicki
Mark Pennifold
Paul Wallace

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

[1] NHSPRB's Terms of Reference are set by DHSC.

Contents

Executive Summary

1. We were asked to make recommendations for pay awards for Agenda for Change (AfC) staff working in the National Health Service (NHS) in England and Wales and Health and Social Care (HSC) in Northern Ireland for 2026/27 by the Secretary of State for Health and Social Care, the Northern Ireland Minister of Health and the Cabinet Secretary for Health and Social Care in Wales.

2. The Department of Health and Social Care (DHSC) said that it had developed financial and delivery plans which currently allow for a pay uplift of 2.5% for 2026/27 without having to make trade-offs against headline government health commitments. The Northern Ireland Department of Health (DoH) said there was no capacity [in budgets] for a pay uplift for 2026/27 without making corresponding cuts to expenditure. The Welsh Government did not provide us with an affordability figure, but its Outline Draft Budget said each Main Expenditure Group, including Health and Social Care, was being provided with a 2.2% uplift for public sector pay for 2026/27.

3. Health services in England, Northern Ireland and Wales face multiple challenges. They need to improve performance further, so that the number of patients waiting for treatment can fall more quickly despite increases in the scale and complexity of demand. Simultaneously, they need to achieve transformation so that the NHS/HSC is better placed to deliver for patients in the medium- and long-term. Central to both of these aims is a workforce that is engaged and motivated.

4. In 2025, growth in the number of AfC staff continued to slow. However, this slowing is taking place unevenly; the number of administrative and support staff is growing less quickly than that of professionally qualified clinical staff and even falling in some places. At the same time, vacancies in England and Wales have fallen further, although they have risen in Northern Ireland. Falls in vacancy rates may not be unambiguously positive as they have been driven to some extent by financial constraints. Nevertheless, supply is better meeting demand than for some years.

5. We observe that asking staff to meet the growing and more complex needs of patients within an increasingly pressured financial context may exacerbate challenges of morale and motivation, as indicated by sickness absence rates continuing at elevated levels and by the sentiments expressed to us by front-line staff and management during our visits. We are concerned that industrial relations at a national level are strained and note DHSC's view that industrial action is a material risk to financial plans.

6. There has already been a fall in annual CPI inflation from 3.8% in July and August 2025 to 3.4% in December 2025. Inflation is forecast to continue to fall towards its 2% target over 2026, with the OBR forecasting annual inflation of 2.4% in Q2 2026 and 2.2% over the 2026/27 financial year. Pay settlements are expected to be at or slightly above 3% for the 2026 calendar year.

7. Our process has taken place this year in parallel with structural reform discussions involving the NHS Staff Council, DHSC, DoH and the Welsh Government. It is important that these are resolved quickly and that reforms are implemented as soon as possible. To support this process, we are not making recommendations that change the AfC pay structure.

8. **Taking into account all of the above, our 2026/27 pay recommendation is for a consolidated 3.3% increase with effect from 1 April 2026 for all AfC pay points.**

CHAPTER 1 Introduction

1.1 The NHS Pay Review Body (NHSPRB) received remits from the Department of Health and Social Care, the Department of Health (Northern Ireland) and the Welsh Government for the 2026/27 pay round. This report presents our pay recommendation for 2026/27 for staff paid under AfC contracts in the NHS in England and Wales and HSC in Northern Ireland, and the reasons for this recommendation.

The NHSPRB and its Process

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

1.3 The annual PRB process is initiated by remit letters from the three governments. Our standing terms of reference provide overall direction to us. Following receipt of the remit letters, we formally request that parties, such as trade unions, employers and governments, submit written evidence, and then attend oral evidence sessions with us. Evidence received from the parties is supplemented by statistical information and research published by academics, think tanks and others.

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

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

1.5 The Terms of Reference are included in full at the start of this Report.

Our 2025 Report

1.6 We received remit letters asking us to make recommendations on pay for AfC staff for 2025/26 for England, Wales and Northern Ireland, respectively, during September, October and November 2024.

1.7 We submitted our 2025 report on 11 April 2025. It recommended a 3.6% consolidated pay uplift for all AfC staff across England, Northern Ireland and Wales.

1.8 We also repeated our recommendation from 2024 that the UK Government provide the NHS Staff Council with a funded mandate to resolve outstanding concerns with the AfC pay structure, as there had not been material progress made towards this aim. We again recommended that the Northern Ireland Executive and Welsh Government support the issuance of such a funded mandate, and that they work with the NHS Staff Council, their social partners and with the UK Government on this matter.

1.9 On 22 May 2025, the Secretary of State for Health and Social Care announced that he had accepted the recommendations in full with respect to England, with the 3.6% pay award implemented from August 2025, backdated in full to 1 April. The announcement also committed to issuing the NHS Staff Council with a funded mandate for 2026/27 to begin to resolve outstanding concerns within the AfC pay structure.

1.10 On the same day, the Welsh Government's Cabinet Secretary for Health and Social Care said that he had similarly accepted our recommendations, saying that the UK Department of Health and Social Care would need to lead negotiations with HM Treasury to fund AfC reform. Pay awards were similarly implemented in Wales in August 2025.

1.11 Also on the same day, the Northern Ireland Minister of Health accepted our recommendations in principle, but said that he was unable to implement them until it could be agreed how to fund pay uplifts. In November 2025, it was announced our pay recommendation would be implemented in full and backdated to 1 April 2025, with staff due to receive the pay award in February 2026.

1.12 As we have commented in previous reports, it is important that pay awards for AfC staff are implemented on time. Remit letters from the governments were received earlier in 2024 than had been the case in previous years, although 2025 awards were still paid to staff later than they were due. In addition, the increase to the National Living Wage (NLW) for the 2025/26 financial year, from £11.44 to £12.21 per hour, meant that interim pay uplifts needed to be applied to AfC Bands 1 and 2 from 1 April 2025 to maintain compliance in England and Northern Ireland before the NHSPRB pay recommendation could be implemented. The Welsh Government similarly made an interim pay uplift for AfC Bands 1, 2 and 3 from the same date, based on its policy of paying the Living Wage Foundation's Real Living Wage to all staff.

Our 2026 Process

Remit Letters for 2026/27

1.13 Our remit letters were again received from the three governments earlier than the previous year: on 22 July 2025 from the Secretary of State for Health and Social Care, for England; on 23 July 2025 from the Cabinet Secretary for Health and Social Care, for Wales; and on 29 July 2025 from the Minister of Health, for Northern Ireland. We welcome earlier receipt of the remit letters, as this represents an important and necessary step towards the NHSPRB process being completed sufficiently early for AfC staff to receive their pay awards on time in April.

1.14 The remit letters for England and Northern Ireland explicitly said that DHSC and DoH intended to work with the NHS Staff Council towards issuing them with a funded mandate for structural reforms to AfC, with a view to changes being implemented in 2026/27. We understand that the Welsh Government have also participated in similar discussions. We have taken updates on structural reform from the three governments through our formal evidence-gathering process, and from the NHS Staff Council, over the course of this pay round.

Visits

1.15 We conducted visits to NHS Trusts in England and HSC Trusts in Northern Ireland in September and October 2025. These visits helped us to understand the practical circumstances that employers are operating within and their priorities, as well as how staff, including management, are working to deliver services to patients. The visits were very useful in hearing first-hand views on pay arrangements and the way in which they relate to recruitment, retention and motivation. We would note that this was particularly important this year in the absence of evidence from the majority of trade unions.

1.16 We are grateful to the management, staff representatives, and AfC staff who participated in these visits, and particularly those involved in their organisation. We visited the following organisations:

- Central London Community Healthcare NHS Trust

- Gateshead Health NHS Foundation Trust
- Northern Ireland Ambulance Service
- Nottingham University Hospitals NHS Trust
- Southeastern Health and Social Care Trust
- University Hospitals Bristol and Weston NHS Foundation Trust.

1.17 While it was not possible to organise a visit to an individual Health Board in Wales, we benefitted from an informal discussion with a panel of employer representatives from a number of NHS Wales organisations, including four of the seven local Health Boards. The session provided helpful insights into a number of matters as they related to Wales and thereby helped to inform our deliberations this year.

Evidence Submissions

1.18 Following receipt of the remit letter for England in July 2025, we sent out a call for evidence to all the parties, asking them to submit evidence to us by 30 September.

1.19 We received written evidence from the following parties:

Governments and Government Departments

- Department of Health and Social Care (including NHS England)
- Department of Health, Northern Ireland
- Welsh Government
- HM Treasury (economic evidence to all Pay Review Bodies)

Trade unions representing NHS/HSC staff

- Society of Radiographers (SoR)

Employer bodies

- NHS Employers.

1.20 We received written evidence from NHS Employers, the SoR and the Welsh Government ahead of the deadline. However, both DoH and DHSC missed the deadline for written evidence, with DoH submitting on 9 October 2025 and DHSC on 30 October.

1.21 We received HM Treasury's economic evidence to the Pay Review Bodies in December 2025.

1.22 A number of organisations that had previously provided evidence to us declined to do so this year, including most of the AfC trade unions. We would stress that trade union participation adds considerably to the evidence we receive from employer and government parties, enhancing our understanding of the working experiences of and challenges facing NHS and HSC staff at all levels and types of role, and plays a significant role in shaping our recommendations. The absence of evidence from trade unions apart from the SoR therefore meant that the voices of national representatives of the majority of AfC staff were not heard in the evidence we received this year, although we did hear directly from members of the remit group on our visits programme.

Timings

1.23 We remain committed to our annual pay review process concluding sufficiently early so that it is possible for staff to receive their pay award on time in April, removing the need for the pay award to be backdated. This would also simplify financial planning at national and employer level, and remove any need for interim pay awards to be made to ensure compliance with the National Living Wage. We understand that others share this commitment.

1.24 Following earlier receipt of remit letters this year, we set an evidence deadline for the parties that was approximately two months earlier than the equivalent deadline last year. The subsequent late submission of evidence from DHSC and DoH affected our ability to progress through the round. Delays to evidence can ultimately lead to AfC staff receiving their pay awards later than they should, and we have repeatedly been told over the years that this has a negative impact on industrial relations and motivation and morale.

1.25 We submitted this report to the governments on 5 February 2026. This is almost eight weeks before 1 April, when pay awards become effective, and almost three months before the April pay date. While technical implementation of pay awards can take some time, it may be possible for the 2026/27 pay award to be implemented on time given when our report was submitted. We strongly encourage governments to make best efforts to ensure this is the case.

1.26 In particular, we would wish that this year's pay award in Northern Ireland is paid more quickly than last year's, which at the time of writing had still not reached staff. The delay to the implementation of pay awards in Northern Ireland was frequently raised with us in visits as a major issue of unfairness and financial pressure for staff, and has damaged industrial relations and morale and motivation amongst the workforce. We note that the Minister of Health told us that in 2026 he would implement an interim 'downpayment' award for AfC staff from 1 April, as a signal of his intent that staff would not experience such delays this year.

1.27 We discuss the timings of next year's pay round in more detail in Chapter 4.

Our 2026 Report

1.28 Chapter 2 of this report sets out the context of NHS/HSC developments relevant to our considerations of the AfC workforce. Then, Chapter 3 includes our analysis of the evidence provided to us, and Chapter 4 sets out our conclusions and recommendations based on our independent assessment of the evidence. Appendices A-D set out the workforce data we considered and remit letters received from governments.

CHAPTER 2 NHS/HSC Context

Introduction

2.1 In this chapter we set out at a high level the context within which health services in England, Northern Ireland and Wales are operating, as well as key developments in the last year. This feeds into our analysis of the NHS/HSC workforce context and other aspects of our Terms of Reference in Chapter 3, and ultimately into the recommendations we make in Chapter 4.

Strategy and Workforce Planning

The Strategic Context

2.2 Health services face multiple challenges. They are tasked with improving performance in the NHS/HSC so that it is better able to meet the immediate needs of patients. This includes bringing down waiting lists so that patients can expect to be treated more quickly; for example, the UK Government's target for the NHS in England is that 92% of patients should wait no longer than 18 weeks for treatment by the end of the parliament. They are simultaneously tasked with transforming and modernising health services so that they are better able to meet the changing needs of the population in the medium- and long-term. In this section, we discuss those longer-term transformation efforts, while discussing efforts to meet patient demand in the next section.

England

2.3 In July 2025, *Fit for the Future: The 10 Year Health Plan* (10YHP) was published. This outlined the Government's intention to reinvent the NHS in England through three shifts:

- Hospital to community
- Analogue to digital
- Sickness to prevention.

2.4 The Plan said that, to support delivery against these shifts, the Government would deliver a new operating model for the NHS, usher in a new era of transparency, create a new workforce model with staff genuinely aligned with the future direction of reform, reshape the NHS's innovation strategy, and take a different approach to NHS finances. The 2025 Budget included some further announcements in support of these shifts, including £300 million of additional capital investment in NHS technology, and establishing 250 new Neighbourhood Health Centres across England, of which 120 will be operational by 2030.

2.5 It is also expected that a new 10-year workforce plan aligned to the 10YHP will be published in Spring 2026, which would supersede the NHS Long Term Workforce Plan published in 2023. DHSC said in written evidence to us that this new plan would focus on the workforce that is needed to deliver the ambitions of the 10YHP, the roles they should carry out, where they should be deployed and the skills they should have. It said that it would result in there being fewer staff in 2035 than previously projected but that those staff would be better treated and trained. There would also be a gradual reduction in the reliance on international recruitment. It said that the workforce plan would act as the delivery vehicle for many of the 10YHP's ambitions, including the Government's commitment to developing homegrown talent in the NHS.

Northern Ireland

2.6 DoH said that progress had been made against strategic plans on cancer, elective care, backlogs created by pandemic-related disruption to care and the use of multidisciplinary teams. It said that progress had been made on strategic workforce planning. DoH's current Workforce Strategy covers a period that ends in 2026.

2.7 DoH also said that current levels of funding for training remained inadequate, and it had developed a comprehensive assessment of unmet education and training commissioning requirements, which could be translated into a commissioning plan should additional funding be identified.

Wales

2.8 Health Education and Improvement Wales (HEIW) said that the 10YHP in England would inform an ongoing and iterative discussion about the future shape of care, work and education in Wales, with a key focus on digital technology.

2.9 HEIW also said that the underlying context for workforce planning in Wales was of an ageing population, with the number of 18-year-olds entering the workforce each year due to shrink significantly from 2029. It said that progress had been made to grow the NHS workforce and training pipeline in recent years, but this would be challenged by both the ageing population and the financial pressures that the NHS in Wales faces.

Demand

2.10 Demand on the NHS/HSC continues to grow whilst the service is simultaneously trying to reduce waiting lists, with the number of patients starting on Referral To Treatment (RTT) pathways[2] in England in the year to November 2025 2.2% higher than a year previously[3]. The total waiting list[4] in England in November 2025 was over 7.3 million, down 2.3% on a year previously, but 59.8% higher than its pre-pandemic level[5].

2.11 In Wales, the total waiting list in July 2025 was 0.4% lower than a year previously and 73% higher than its March 2020 level[6]. In Northern Ireland, methodological changes mean that direct comparisons between September 2025 data and those from previous years cannot be made, but outpatient and diagnostic waiting lists both suggest a similar scale of growth to England and Wales[7].

2.12 Total Accident & Emergency (A&E) attendances in England were 1.3% higher in the year to December 2025 than a year previously and 8.4% higher than the year to December 2019[8]. In Wales, A&E attendances were 2.6% higher in the year to August 2025, compared to the year to August 2024[9], and in Northern Ireland they were 1.4% higher in September 2025, compared to September 2024[10].

2.13 Increased demand on health services is driven by a number of factors, including shifting demographics and changing population health. We were repeatedly told on our visits programme that, on average, the care needs of patients were becoming more complex. The number of people aged over 60 in the UK is estimated to have grown by 18% between 2011 and 2022, and the number aged over 70 by 26%[11]. As we discussed last year, the ageing population will lead to greater complexity in care, a higher risk of hospital admissions and readmissions, longer hospital stays and delayed discharge, other things being equal.

---

[2] NHS England » Referral to treatment. This is a measure of the total number of new cases that are being added to the waiting list, and which are scored against an 18-week target.
[3] Taken from https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2026/01/RTT-Overview-Timeseries-Including-Estimates-for-Missing-Trusts-Nov25-XLS-115K-1Xmjkk.xlsx
[4] The waiting list is defined here as the total number of incomplete RTT pathways.
[5] Statistics » Consultant-led Referral to Treatment Waiting Times Data 2025-26. Statistics including estimates for missing data used throughout. The pre-pandemic level is taken to be the February 2020 level.
[6] Patient pathways waiting to start treatment by month, grouped weeks and stage of pathway
[7] Northern Ireland Outpatient Waiting Time Statistics and Northern Ireland Diagnostic Waiting Time Statistics.
[8] Statistics » A&E Attendances and Emergency Admissions
[9] Number of attendances in NHS Wales emergency departments by age band, sex and site
[10] Emergency Care Waiting Time Statistics
[11] Population estimates for the UK, England, Wales, Scotland, and Northern Ireland - Office for National Statistics

2.14 Together, these factors suggest that the absolute demand on the NHS and HSC will continue to grow in the coming years, driven by demographic change and population health factors including increasing complexity of care needs amongst patients. On our visits programme, both management and front-line staff felt that demand was increasing. It remains to be seen to what extent developments in the NHS and HSC, such as those associated with the three shifts envisaged by the 10YHP for England and equivalent transformation activity in Wales and Northern Ireland, will ameliorate some of this demand growth by improving population health, and by mitigating its impact on the services that are under the most pressure through moving the delivery of care to new settings and increasing productivity.

Workforce

2.15 In the year to October 2025, the number of full-time equivalent Agenda for Change (AfC) staff working in the NHS in England grew by 0.7% compared to a year previously, with the overall number of AfC staff 22% higher than in the same month in 2019. The equivalent figures for Northern Ireland (for September 2025) were 1.6% and 14%, and for Wales (for June 2025) were 1.3% and 22%, respectively. Since 2024 there has been a pattern, consistent across England, Wales and Northern Ireland, of faster growth amongst professional or clinical groups (such as nurses or allied health professionals), and slower or negative growth amongst the numbers of support and administrative staff.

2.16 Vacancy rates in England and Wales continued to decrease, after doing so last year, although they rose in Northern Ireland. For England, the vacancy rate for nurses and midwives fell to 6.0% in September 2025, from 7.5% a year earlier, and the non-nursing and midwifery rate was 7.4%, down from 7.8% a year earlier. In Northern Ireland, the vacancy rate rose from 6.4% to 7.3% in the year to June 2025, with the registered nurse vacancy rate at 6.8% in September 2025, higher than a year previously. In Wales, the overall vacancy rate fell from 5.8% to 5.4% during the year to June 2025, with the vacancy rate for registered nursing, midwifery and health visiting staff falling from 6.3% to 4.1% in the same period.

Industrial Relations

2.17 Following the implementation of the 2025/26 pay award in England and Wales, and the acceptance of our recommendations in Northern Ireland, a number of trade unions ran consultative ballots of their membership, asking whether the pay award was acceptable. Although the results of consultative ballots expressed discontent with the level of the pay award, none of the trade unions chose to progress this further to formal ballots for industrial action, and there has been no national industrial action by AfC staff in the last year.

2.18 However, over the past year there has been national industrial action undertaken by parts of the wider NHS workforce in England, with the British Medical Association's resident doctor members having gone on strike in July, November and December 2025. This has inevitably had an impact on AfC staff who have had to deal with the effects of industrial action on patient care.

2.19 During evidence this year, parties described the current state of national industrial relations amongst the AfC workforce as challenging, febrile or fragile, exacerbated by increasing workload pressures. However, we observed on our visits programme that industrial relations at a local level were in practice felt generally to be functioning effectively, unless there were specific local disputes, for example around how certain roles were banded.

2.20 We further discuss the various issues affecting industrial relations at national and local levels throughout this report, including in Chapter 4 concerning the structural reform discussions that are taking place between the NHS Staff Council, DHSC, DoH and the Welsh Government.

Finances

England

2.21 DHSC's funding settlements were set at the 2025 Spending Review (SR), with revenue budgets at £202.0 billion for 2025/26 and £211.0 billion for 2026/27, a 4.5% increase. Within this envelope, NHS England's funding settlement for 2025/26 was £195.6 billion and for 2026/27 was £204.9 billion, a 4.8% increase.

2.22 DHSC said that all 42 Integrated Care Systems had made balanced financial plans for 2025/26, following receipt of £2.2 billion in deficit funding, although risks to these plans included the cost of managing industrial action, implementing planned restructuring and headcount reductions, and delivery of efficiency plans over the remainder of the year.

2.23 The NHS's Medium-Term Planning Framework, which was published in October 2025 and covers the period from 2026/27 to 2028/29, said that Integrated Care Boards (ICBs) would be expected to develop multi-year plans that included financial plans that were balanced or in surplus for every year of the planning period. On our visits and in evidence, we heard from NHS and HSC Trust leaders who said that they were under increasing financial pressure, and that this was leading to them changing their behaviour with respect to recruitment through the introduction of stricter vacancy controls. We discuss this in more detail in Chapter 3.

Northern Ireland

2.24 DoH's funding settlement for 2025/26 was £8.4 billion. Under the draft Budget, published in January 2026, DoH's funding settlement will grow by 0.9% to £8.5 billion. As part of the announcement that our 2025/26 recommendations would be implemented in Northern Ireland, it was said that any resultant overspend for 2025/26 would be taken from DoH's 2026/27 funding settlement.

2.25 DoH also said that following the ringfencing of £165 million of its 2025/26 budget for action to address waiting lists, and as a result of the budget not fully funding the increase in employer National Insurance contributions, there was an in-year funding gap of around £600 million.

Wales

2.26 The Welsh Government's Draft Budget for 2026/27 proposes that funding for the Health and Social Care Main Expenditure Group increases by 3.6% compared with 2025/26, to £12.7 billion.

2.27 The Welsh Government said that NHS Wales's financial position had deteriorated in 2025/26, with a forecast deficit of £173.2 million, compared to a deficit of £123.7 million in 2024/25. It said that even to deliver this outturn position, savings worth c. £275 million would need to be delivered in 2025/26, in addition to the c. £300 million of savings delivered in 2024/25.

Productivity

England

2.28 Productivity in health services is difficult to measure. However, there is a consensus amongst those that attempt to measure productivity in the NHS that it dropped significantly

during and immediately after the Covid-19 pandemic, and that it has yet to recover to pre-pandemic levels[12].

2.29 DHSC said that 2% annual productivity growth was an integral part of the NHS's funding settlement for the period of the SR. It said that it wished to ensure that increased funding and staffing levels in the NHS since the Covid-19 pandemic would translate into measurable improvements in the quality of services patients receive. It said that significant technology and digital infrastructure investment would be made to free up staff time, improve patient experience, and ensure the NHS is better equipped to meet future demand. DHSC said that to deliver against this target NHS England was focused on five key areas: operational and clinical excellence; workforce; health rather than illness; technology and transformation; and reducing waste. Under the Medium Term Planning Framework for England, ICBs' plans were expected to incorporate delivery of the 2% annual productivity growth target.

2.30 DHSC announced in September 2025 that productivity at acute NHS Trusts increased by 2.7% between April 2024 and March 2025[13]. It also said that the data that it had seen suggested that productivity growth in the NHS was on track to meet the target for 2025/26. In October 2025, the Health Foundation suggested that subject matter experts generally doubted that the NHS would be able to meet its productivity growth target[14]. However, an Institute for Fiscal Studies study published in December 2025 suggested that the NHS in England was exceeding its productivity growth target, but this was not translating into the volume of completed care pathways expected[15]. It also noted that if the NHS was able to maintain its current rate of productivity growth whilst reducing the average amount of activity required before patients are discharged from the waiting list to the levels seen in 2023/24, waiting lists would fall much more quickly.

Northern Ireland

2.31 DoH did not refer to a specific productivity target or aspiration for HSC, but said that, through the Encompass programme, it had integrated all HSC Trusts into one digital system that would provide the most comprehensive digital care record in Europe. DoH said that measurable benefits including improved clinic utilisation were already being felt by health services.

Wales

2.32 The Welsh Government said that it had accepted the recommendations of a report of a Ministerial Advisory Group (MAG) into productivity in NHS Wales, with actions including developing and implementing plans to transform outpatient services, adopting national pathways and mandatory electronic referral triage to standardise best practice and establish consistent national performance metrics and dashboards.

2.33 The Welsh Government said that it had not set a specific productivity growth target or aspiration for the NHS in Wales, but was monitoring progress against the recommendations of the MAG.

Conclusion

2.34 Those that manage health services in England, Northern Ireland and Wales are faced with a difficult set of circumstances, driven fundamentally by ongoing shifts in the UK's demographics and population health, which are resulting in ever higher underlying demand for health services. This demand must be met from predetermined resource envelopes, and

[12] CBP-10313.pdf
[13] Patients treated more quickly as NHS productivity rises over year - GOV.UK
[14] Can the NHS meet its 2% productivity challenge? Here's what experts think - The Health Foundation
[15] Why isn't hospital productivity growth bringing down the waiting list more quickly? | Institute for Fiscal Studies

there are emerging signs that services are finding it increasingly difficult to operate within those constraints.

2.35 Given this, there is a clear need for the NHS in England and Wales and for HSC in Northern Ireland to achieve a productivity growth trajectory that will enable them to meet future demand. Simultaneously health services will also need to sustain the current, gradual falls in waiting lists that have been achieved in England and Wales, and successfully modernise themselves, as envisaged by the 10YHP in England. We note that health services in Northern Ireland and Wales face similar challenges and thus a similar need to modernise.

2.36 In order to achieve these outcomes and meet patient demand, the NHS/HSC will require a workforce that is sufficiently large, and sufficiently motivated, to deliver health services day-to-day while also achieving stretching productivity targets and implementing transformation. We discuss this in more detail in Chapter 3 and it is important context for our recommendations in Chapter 4.

CHAPTER 3 Analysis

Introduction

3.1 In this chapter, we analyse the written and oral evidence that we have received and the messages we heard during our visits programme, broken down thematically by the considerations to which our Terms of Reference ask us to have regard. For those parties whose written evidence is not published online, copies are available on request from the NHSPRB secretariat.

Overall NHS Strategy

3.2 We discussed the overarching strategic context for the NHS in England and Wales and HSC in Northern Ireland in Chapter 2. Aggregate demand on the NHS/HSC, as indicated by the total number of Accident & Emergency attendances and Referral To Treatment starts, continues to grow. Whilst waiting lists have begun to fall in England and Wales, they remain high by historical standards. Governments in England, Northern Ireland and Wales have set out the need for health services to be transformed and modernised to be able to serve the needs of patients. They have set current priorities for the NHS/HSC in response to this challenge and in support of their ambitions of reducing waiting lists and times and improving performance.

3.3 The 2025/26 mandate[16] provided to NHS England by the Secretary of State for Health and Social Care included the following objectives:

- Cutting waiting times
- Improving primary care access
- Improving urgent and emergency care
- Reforming the operating model
- Driving efficiency and productivity.

The mandate for 2026/27 had not been published at the time of writing.

3.4 In Northern Ireland, the May 2025 Elective Care Framework Implementation and Funding Plan[17] outlined how £215 million of ringfenced funding to help deal with care backlogs would be spent. However, in November 2025, it was reported that roughly one third of this money would be used to help address DoH's 2025/26 deficit[18].

3.5 The Cabinet Secretary for Health and Social Care in Wales wrote to NHS Wales Chairs and Chief Executives on 3 July 2025, outlining areas of key focus for the NHS in Wales in 2025/26[19]. This letter outlined that the key Welsh Government priorities for the NHS were:

- Reducing waiting times (including ambulance patient handover)
- Reducing pathways of care delays
- Improving women's health services.

Demand and Performance

England

3.6 DHSC said that increasing NHS productivity and efficiency remained essential to meeting the growing demand for health services, to support enduring improvements in performance and to ensure financial sustainability.

[16] Road to recovery: the government's 2025 mandate to NHS England - GOV.UK
[17] Microsoft Word - HE1 25 224533 ECF Implementation and Funding Plan - FINAL VERSION SENT TO MINISTER 29.05.25(3)
[18] NI health: Waiting list money diverted to tackle health deficit - BBC News
[19] A healthier Wales: long term plan for health and social care | GOV.WALES

3.7 On visits, both management and clinical staff talked about the difficulties they were having meeting demand in the NHS, with leaders at some NHS and HSC Trusts saying that demand locally had grown more quickly than they had planned for, leading to more pressure on staff and on funding for transformation. This was also reflected in evidence from NHS Employers.

3.8 SoR said that demand for radiotherapy and diagnostic scans continued to rise ahead of supply. It said that while the number of diagnostic tests performed in England in the year to July 2025 increased by 3.9% to 2.6 million compared to a year earlier, the number waiting for a test increased by 6.0% to 1.7 million over the same period.

3.9 In November 2025, the Public Accounts Committee (PAC) published a report[20] into reducing waiting times for elective care in the NHS in England. It concluded that:

- The pace of change to meet recovery targets was too slow
- NHS England's plans to transform outpatient services were not credible
- NHS England's approach to transformational change was deeply flawed.

3.10 The PAC said that they were not confident that DHSC was being realistic about the immense effort needed to reduce waiting times, with digital solutions being viewed as a 'cure-all', and that NHS England had not demonstrated an ability to secure the clinical engagement necessary to reduce waiting lists. The report also said that DHSC and NHS England were announcing major programmes of reform without delivery plans or secured funding.

Northern Ireland

3.11 DoH said that waiting times for elective care services in Northern Ireland were among the worst in the UK, saying that this was driven by the challenging financial situation, the residual impact of Covid-19 and the increasing gap between health service capacity and demand. The Elective Care Framework Implementation and Funding Plan aimed to address care backlogs, though its funding for 2025/26 was decreased mid-year to address DoH's deficit.

Wales

3.12 Waiting lists in Wales in July 2025 were 0.4% lower than a year earlier. The Welsh Government said that £120 million had been allocated to fund a plan to eliminate long waits and reduce the size of the waiting list by March 2026.

3.13 In the Cabinet Secretary's 3 July letter to the NHS in Wales[21] he said that long waiting times[22] in Wales had been cut by more than 88% since their 2022 peak, but long waits for ambulance handovers in particular were presenting a significant and avoidable risk of harm to service users. The letter also said that in the following year the NHS would:

- Ensure anyone needing hospital-based treatment in the NHS has access in under two years
- Reduce the total waiting list by 200,000, approximately 25%
- Restore faster access to tests and scans by reducing the time patients wait for diagnostics to a maximum of eight weeks by March 2026
- Refresh the approach to the delivery of referral to treatment guidance
- Ensure no patient waits longer than 45 minutes for ambulance-patient handover.

[20] Billions spent to tackle NHS waiting lists but service recovery targets still missed, PAC finds - Committees - UK Parliament
[21] Improving performance together: priority delivery actions for better health and care 2025 to 2026
[22] Here defined as waits of over 2 years.

3.14 The Senedd Health and Social Care Committee said in its most recent monitoring report[23], published in November 2025, that the Welsh Government had so far failed to meet any of the five targets that it had set itself with respect to waiting times.

Delivering Transformation

England

3.15 DHSC said that the 10 Year Health Plan (10YHP) emphasised the need for reform in the NHS and the critical role that increasing productivity can play, with a focus on system reform, leveraging technology and investing in workforce development. DHSC said that Lord Darzi's report recommended that any financial increase, including for pay, should be tied to productivity gains and wider system improvements.

3.16 DHSC also said that it was working with the NHS Social Partnership Forum to modernise and reform the current set of staff standards to focus on improvements to the experience of staff working in the NHS. Additional commitments would include identifying further opportunities to ease the burden on staff, embedding a culture of lifelong learning and modernising staff terms and conditions.

3.17 At the time of writing, the workforce strategy that will accompany the 10YHP for England is expected to be published in Spring 2026. DHSC said that it was expected that the strategy would lead to fewer staff being employed in the NHS in England long-term, compared to what was envisaged in the 2023 Long Term Workforce Plan.

3.18 DHSC also said that the upcoming workforce strategy would act as the delivery vehicle for many of the 10YHP's proposals, including the government's commitment to developing homegrown talent within the NHS.

Northern Ireland

3.19 DoH evidence discussed a number of ongoing actions and activities that would ultimately improve access to services for patients. These included funding for the 60 actions outlined in the Northern Ireland Cancer Strategy, published in March 2022.

3.20 It also said that completing the implementation of a multidisciplinary team model in primary care would lead to an additional one million consultations being delivered in primary care, improving access for patients to a wider range of services in their communities and thereby reducing demand for some Trust-delivered services, making them better able to meet patient needs.

Wales

3.21 The Welsh Government said it published a refreshed set of 35 actions that were being undertaken as part of delivering *A Healthier Wales*, its 10-year plan for health and social care that was published in 2018. It said that priority deliverables for 2025/26 included doing more to prevent ill health, developing community services, getting its digital infrastructure in shape and changing how the NHS is run, including its leadership and culture. More effective prevention, putting more services in the community and realising the potential of digital and innovation were also objectives set out in the Cabinet Secretary's letter to NHS Wales in July 2025[24].

[23] https://business.senedd.wales/documents/s168718/NHS%20waiting%20Times%20-monitoring%20report%20November%202025.pdf

[24] Improving performance together: priority delivery actions for better health and care 2025 to 2026

Our Assessment of Overall NHS Strategy

3.22 To deliver against their strategic priorities, governments and health service leaders must decide how best to deploy finite resources. They must meet the immediate pressures associated with continued demand growth, so that more patients can be seen more quickly given waiting lists remain at elevated levels. However, they must also maintain a suitable level of investment to drive modernisation and transformation.

3.23 Both of these are necessary for services to meet demand in the medium- and long-term. In this context, the falls to waiting lists that have been seen in recent months in England and Wales are positive, although we also note the PAC's findings with respect to elective recovery in England, and would observe that health services in Wales and Northern Ireland are faced with similar challenges and constraints.

3.24 We would highlight that an appropriately sized, engaged and motivated workforce is essential both to health services' ability to recover their performance and to their ability to transform and modernise to meet patient need better. This is also the conclusion that Lord Darzi came to in his 2024 investigation into the state of the NHS, which we discussed last year.

Affordability and the Funds Available to the Health Departments

England

3.25 HM Treasury said that if recommended pay awards exceeded what had been budgeted for, departments would need to meet the associated costs through offsetting savings or productivity improvements. It added that if departments proved unable to do this, they would not be able to accept pay review body recommendations. It confirmed that departments would not have access to reserve funding for pay awards above what had been budgeted for.

3.26 DHSC's funding settlement for 2026/27 includes a revenue budget of £211 billion, an increase of 4.5% in cash terms on 2025/26. DHSC said to us that it had developed financial and delivery plans which currently allowed for a 2.5% pay uplift in 2026/27 without having to make trade-offs against headline government health commitments. It added that if we (and the DDRB) made recommendations above this level, it would consider whether and how this could be made affordable within existing DHSC budgets.

3.27 DHSC also said that accepting a higher award would have an impact on healthcare delivery. It said that this could include a reduction in ambitions for service or performance improvement. When asked for further details, it said that the current funding settlement was tight, and based on ambitious assumptions for productivity growth.

3.28 NHS Employers said that while the 2.8% [2026/27 to 2028/29 average annual real] increase in DHSC's budget was generous compared to other government departments in a challenging fiscal climate, it fell short of the historic average rise of 3.6% and the 4% that the Health Foundation had said was needed to restore services. NHS Employers said that meeting targets to cut waiting times and reform the NHS would be difficult with this level of funding.

3.29 NHS Employers said that the 2025/26 pay awards were only partially funded by the government, with a central allocation covering the first 2.8 percentage points of the pay awards, with the remainder paid for by a combination of internal savings and budget reprioritisation across DHSC, NHS England and Integrated Care Boards. Following this reprioritisation, it said it welcomed that arrangements were put in place to fund the 2025/26 pay award at Trust level and it stressed the need for pay awards to be fully funded

in future to ensure financial sustainability and protect frontline services, and that pay awards needed to be fully funded across the entire health sector.

3.30 Management at most of the NHS Trusts we visited said that the way that their funding was adjusted for pay awards for 2025/26 had exacerbated their deficit positions[25]. They also said that they had put stricter vacancy controls in place in response to underlying financial pressures. These pressures reflected both the need for budgets to be balanced from 2026/27 onwards and the funding trajectory of the NHS. The specific nature of the vacancy controls differed from Trust to Trust. The scale of the financial challenge varied across trusts but was present in all that we visited.

Northern Ireland

3.31 Under the Proposed Draft Budget that was published in January 2026, and which includes proposals for departmental resource budgets until 2028/29, the Department of Health will have a resource budget of £8.5 billion for 2026/27[26]. This is an increase of 0.9% on its 2025/26 resource budget of £8.4 billion[27].

3.32 DoH said to us that there was no capacity to afford a pay uplift for 2026/27 without making corresponding cuts to expenditure. This statement was made prior to the announcement that pay awards for 2025/26 would be implemented in February 2026 and backdated to April 2025. This announcement also said that any resulting DoH overspend would be taken out of its 2026/27 funding settlement, meaning that its financial position for 2026/27 would be further challenged.

3.33 However, the Minister of Health said that his position was that parity in pay with England was a higher priority for him than affordability when considering at what level to set pay uplifts for 2026/27.

3.34 Visits to Northern Ireland reflected a similar picture to England of employers changing their behaviour with respect to recruitment in response to the financial pressures that they were experiencing.

Wales

3.35 The Welsh Government's Draft Budget for 2026/27, published in November 2025, proposes that resource funding for the Health and Social Care Main Expenditure Group (MEG)[28] increase by 3.6% compared to 2025/26, to £12.7 billion[29].

3.36 The Welsh Government did not provide us with an affordability figure in its written evidence. However, its Outline Draft Budget Report for 2026/27 said that each MEG (including Health and Social Care) was being provided with a 2.2% uplift for its public sector pay elements[30]. In oral evidence, the Cabinet Secretary did not provide an affordability figure. He said that the current relative position of Agenda for Change pay points to those in England (which sees every AfC pay point in Wales as of 2025/26 1.5% higher than its equivalent in England) was now 'baked into' financial plans and trade unions' expectations.

[25] How severe this issue was felt to be seemed to be correlated with how severe an individual NHS/HSC Trust's deficit position was; at one NHS Trust that was running a balanced budget, members were told that the pay award had not created additional pressures.

[26] Minister of Finance WMS - Proposed Draft Budget 2026 to 29-30

[27] https://www.finance-ni.gov.uk/sites/default/files/2025-05/Budget%20Document%202025-26%20for%20web.pdf

[28] MEGs are areas of Ministerial responsibility, equivalent in some ways to departments in the UK Government and Northern Ireland Executive.

[29] https://www.gov.wales/sites/default/files/publications/2025-11/2026-2027-budget-expenditure-lines.xlsx

[30] Outline Draft Budget Report 2026 to 2027 – This was published in October 2025, one month before the full Draft Budget.

3.37 The Welsh Government also said that it required savings delivery of £275 million across NHS Wales in 2025/26 in order to achieve a forecast deficit position of £173.2 million, a deficit £49.5 million larger than the outturn position for 2024/25.

3.38 Health Board leaders told us that financial challenges had increased over the previous two to three years, with pressure to deliver major savings programmes and significant risks relating to energy costs, inflation and pay. They said that all NHS Wales organisations had strengthened vacancy controls in response to financial pressures.

Our Assessment of Affordability and the Funds Available to the Health Departments

3.39 It is apparent that affordability for pay awards, and the wider financial position of health services, is very stretched across England, Northern Ireland and Wales.

3.40 The situation is significantly more challenging in Northern Ireland than it is in Wales, which in turn has somewhat more severe challenges than England. We note that resource budgets for DoH and the Health and Social Care MEG in Wales will grow more slowly than DHSC's resource budget for 2026/27. Notwithstanding this, we note what the NI Minister of Health said about parity with England in pay for AfC staff being a higher priority than affordability, and that the Cabinet Secretary for Health and Social Care for Wales indicated that he wished that the pay award would maintain the percentage difference between AfC pay points in Wales and England.

3.41 Financial challenges are apparent at both a whole-system level and at the level of individual employers[31]. The way that funding is disbursed from central health budgets to individual employers differs between England, Northern Ireland and Wales but, generally speaking, employers' funding allocations are adjusted to take account of pay awards as they are implemented.

3.42 Across all three nations there is an emerging picture that the challenging financial context is leading employers to make increasingly difficult decisions to achieve balanced budgets, or to get closer to doing so. It is expected that these challenges will continue into 2026/27 and beyond, given the growth trajectory of NHS and HSC budgets relative to expected demand. These difficult decisions include the introduction of stricter vacancy controls, meaning that financial pressures are having an impact on the recruitment practices of employers. We discuss this further below, including what this may mean for workforce growth. However, employers across England, Wales and Northern Ireland stressed that it is important that pay awards for Agenda for Change staff for 2026/27 are sufficient to maintain recruitment, retention and motivation.

3.43 We recognise that DHSC told us that if pay awards were in excess of 2.5% it would have to consider whether and how this could be made affordable within existing budgets. However, in the absence of further detail about what specific transformation projects or workforce developments would lose funding to implement pay awards above affordability, it is difficult for us to understand the implications of this beyond a general contextual point that implementing awards above 2.5% would result in reprioritisation of some kind.

3.44 There are potential negative effects from pay awards that are too low or perceived as too low, including recruitment and retention difficulties and weakening of staff motivation. There may also be an adverse impact on industrial relations, including increased potential for industrial action. All of these can negatively affect performance and therefore the ability of NHS/HSC to meet demand. In the case of industrial action, they can also worsen the local

[31] NHS Trusts and Foundation Trusts in England, HSC Trusts in Northern Ireland and NHS organisations in Wales including Health Boards.

and national NHS/HSC financial position, offsetting the immediate budgetary benefits of lower awards.

3.45 Finally, we note that it was announced as part of the Autumn 2025 Budget that the National Living Wage (NLW) will be uplifted by 4.1% for the 2026/27 financial year, a figure in excess of the affordability figure provided to us by DHSC, and what we understand is likely to be affordable in Northern Ireland and Wales. We discuss this in more detail in Chapter 4.

Workforce, Recruitment, Retention and Motivation

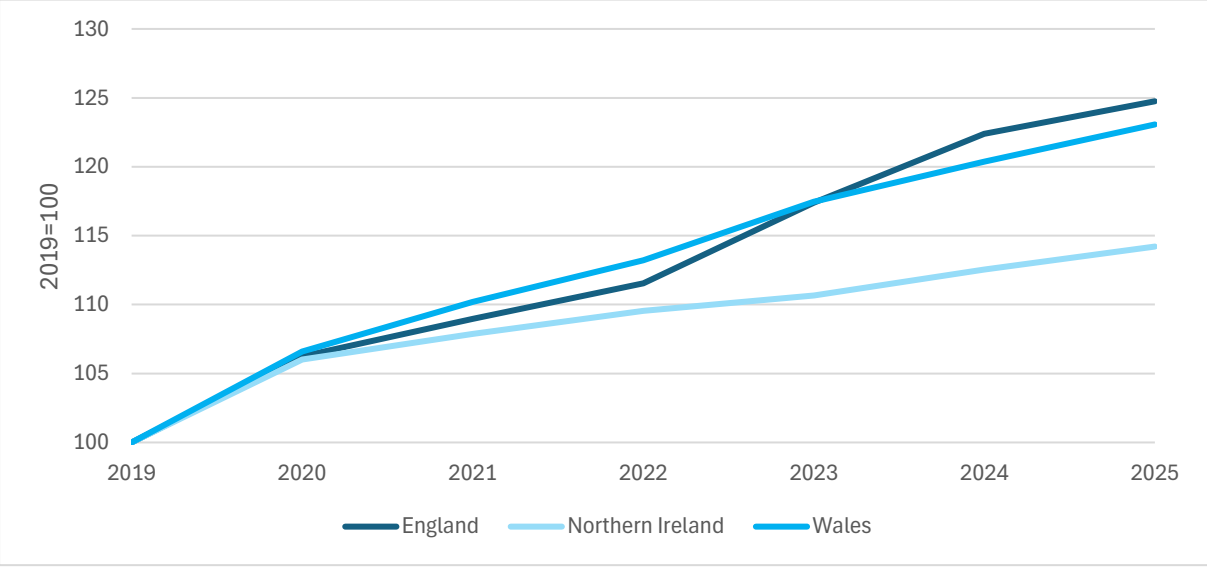
3.46 In this section, we consider the data and evidence we received relating to recruitment, retention and motivation of the AfC workforce. Appendix A sets out the data we discuss in this section in more detail, including breaking down the workforce data by the protected characteristics.

Workforce Numbers

3.47 The latest available workforce numbers at the time of writing are for October 2025 in England, September 2025 for Northern Ireland and June 2025 for Wales. Workforce growth in 2020 was strong in each nation, driven by Covid-19, but slowed in 2021 and 2022. In both England and Wales workforce growth picked up in 2023, before slowing in both 2024 and 2025. In Northern Ireland, workforce growth continued to slow in 2023, to 1%, before picking up to around 1.5% in both 2024 and 2025. The total number of staff grew by

- 0.7% in the year to October 2025 in England, compared to 3.0% in the previous year
- 1.6% in the year to September 2025 in Northern Ireland, compared to 1.4% in the previous year
- 2.2% in the year to June 2025 in Wales, compared to 2.5% in the previous year.

Figure 3.1: Growth in the AfC full time equivalent (FTE) workforce, England, Wales and Northern Ireland, 2019-2025



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

3.48 Within those numbers, workforce growth for professionally qualified clinical staff has generally been higher, while for support staff workforce numbers have stopped growing or have started falling; for example, in the year to October 2025 the number of professionally qualified staff in England grew by 2.6% while the number of staff in other groups fell by 1.2%. This pattern of workforce growth is also apparent in Northern Ireland and Wales.

Table 3.1 NHS AfC FTE workforce, England, by staff group, October 2024 to October 2025

	October 24	October 25	Change 2024-2025	
AfC	1,217,665	1,225,623	7,958	0.7%
Nurses & health visitors	364,459	371,494	7,035	1.9%
Midwives	24,403	25,281	878	3.6%
Ambulance staff	21,071	22,616	1,545	7.3%
Scientific, therapeutic & technical staff	175,861	181,652	5,791	3.3%
Support to clinical staff	411,583	407,074	-4,509	-1.1%
NHS infrastructure support	219,932	217,255	-2,677	-1.2%
Other staff	356	250	-106	-29.7%

Source: NHS England

3.49 DHSC said that decisions around workforce growth are made by employers. DHSC added that it expected to see slower growth through the SR period, due to tight budgets and competing priorities. It added that NHS operating plans showed planned workforce growth to be two percentage points lower in 2025/26 than 2024/25, though this figure includes medical and dental, and temporary staff. The NHS medium-term planning framework, which was published in October 2025 and covers 2026/27 to 2028/29, noted that since 2019/20 the NHS workforce had grown more quickly than activity, and says that future workforce plans must triangulate with finance and activity plans[32]. DHSC also said that 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.

3.50 The latest workforce data are discussed in more detail in Appendix A, including discussion of individual groups within Agenda for Change such as nursing and midwifery.

The NMC and HCPC Registers

3.51 The Nursing and Midwifery Council (NMC) register shows that in September 2025 there were 860,801 nurses and midwives registered to work in the UK, an increase of 2.3% from a year earlier.

3.52 The Health and Care Professions Council register, which covers a number of allied health professions including occupational therapists, paramedics, physiotherapists and radiographers, amongst others, grew in size by 5.8% between August 2024 and August 2025.

[32] NHS England » Medium Term Planning Framework – delivering change together 2026/27 to 2028/29

Table 3.2: Numbers on the HCPC Register, by profession (selected professions only[33]), August 2024 and August 2025

	August 2024	August 2025	Annual change
Clinical scientists	7,750	8,302	7.1%
Dietitians	11,958	12,907	7.9%
Occupational therapists	46,160	48,361	4.8%
Operating department practitioners	16,927	17,325	2.4%
Orthoptists	1,568	1,616	3.1%
Paramedics	38,762	41,381	6.8%
Physiotherapists	73,953	80,297	8.6%
Practitioner psychologists	29,100	30,177	3.7%
Prosthetists/orthotists	1,237	1,306	5.6%
Radiographers	47,582	49,953	5.0%
All professions	345,646	365,621	5.8%

Source: HCPC

Recruitment

Vacancies

3.53 The latest vacancy data are from September 2025 in England and Northern Ireland and June 2025 for Wales. In England, the vacancy rate for nursing and midwifery staff was 6.0%, down from 7.5% in the same quarter a year earlier. The vacancy rate for non-nursing and midwifery AfC staff groups was 7.4%, down from 7.8% in the same quarter a year earlier. Vacancy rates have fallen more quickly for nursing and midwifery staff than for the rest of the AfC workforce in recent years; they were historically significantly higher but since the start of 2024/25 are now lower. Vacancy rates are discussed in more detail in Appendix A.

3.54 The equivalent data in Northern Ireland show an overall vacancy rate of 7.3% in September 2025, up from 6.4% a year earlier[34]. The nursing vacancy rate was 6.8% as of September 2025, which is lower than its historical level but is higher than a year earlier. Trends over a number of quarters suggest that the overall vacancy rate had stabilised at around 7%, having fallen from its peak of just under 10% in September 2022, though there has been gradual growth during the last 12 months.

3.55 Overall vacancy rates in Wales have followed a similar pattern to those in England; falling to 5.4% in June 2025, down from 5.8% a year earlier. Registered nursing, midwifery and health visitor vacancies have similarly fallen below the overall level, to 4.1% in June 2025, from 6.3% in June 2024. Unlike in England, non-nursing vacancy rates have increased.

University Intakes

3.56 Data from UCAS (covering the whole of the UK) to 2025 show the number of applicants to nursing and midwifery courses fell by around a fifth and around a third respectively between 2021 and 2024, following a pandemic-era increase in the number of applicants, but increased between 2024 and 2025 by 1.6% for nursing and 0.7% for midwifery. The number of applicants for nursing courses in 2025 were 7.5% higher than in 2019, pre-pandemic, while the number of applicants for midwifery courses were 7.2% below 2019 levels. The number of applicants to study other health related degrees in 2025 was 5.6% higher than in 2024.

[33] Professions with at least 40% staff listing 'NHS providers' or 'Ambulance service' as their primary workplace are included in this table. The full table is included in Appendix A.

[34] This figure includes medical and dental staff.

3.57 DHSC said that the number of applicants to nursing degrees in England fell by 0.3% between June 2024 and June 2025, but remained 5.3% higher than in 2019. It said that there was a continued fall in the number of applicants aged over 21, with a rise in those aged under 21. The equivalent figures for midwifery in England showed a 0.4% increase in June 2025, compared with a year earlier, but this figure was 8.3% lower than in 2019.

3.58 DHSC also said that unique university applications to Allied Health Professional (AHP) courses increased by 2% between 2023 and 2024, though within this some professions had experienced notable declines, including prosthetics and orthotics, operating department practice and dietetics. It said that the attrition rate across all AHP training courses was 13%, though there was a great degree of variation between courses.

3.59 DoH said that there was continued high demand for places in nursing, midwifery and AHP courses in Northern Ireland. Overall, there were 5,488 applications for 945 nursing places in Northern Ireland in 2025/26. There were 646 applications for 120 midwifery places and 4,550 applications for 505 places across AHP roles[35].

International Recruitment

3.60 DHSC said that the government was committed to developing homegrown talent and giving opportunities to more people across the country to join the NHS. It also said that there had been significant falls in the number of Health and Care Worker visas granted for nurses in the last two years, with the number issued in the first quarter of 2025 76% lower than the same quarter in 2024. NHS England said to us that it had stopped incentivising NHS Trusts to recruit internationally, now that the focus was on domestic workforce supply. However, it was still working to retain existing international staff.

3.61 DoH provided data that showed that the number of international nurses recruited into the HSC in Northern Ireland had also fallen significantly since 2023; 76 international nurses were recruited to the five geographic HSC Trusts in 2024/25, compared with 520 in 2022/23.

3.62 The Welsh Government said that the decline in nursing vacancies that had taken place between June 2023 and December 2024 had coincided with a notable rise in international nurse recruitment. Employer representatives in Wales told us that now that vacancy and turnover rates were falling, and domestic workforce supply routes were delivering good numbers of new staff each year, they were generally no longer recruiting from overseas. The Welsh Government said that its international recruitment was demand-led.

3.63 NHS Employers said that international recruitment had decreased in the last two years, due to central funding from NHS England being cut off and government priorities shifting. It said that the 10YHP had a target of reducing the reliance on international recruitment to 10% by 2035, and the impact of this would be an increased dependence on local labour markets.

3.64 SoR said that growth in the radiography workforce was reliant on internationally trained radiographers wanting to come to the UK; it said that Health and Care Professions Council (HCPC) data suggested that internationally trained radiographers were responsible for nearly two-thirds of the growth in radiographer numbers between 2020 and 2025. It said that efforts to reduce the dependence on internationally trained radiographers, alongside immigration changes, had the potential to prevent the NHS from being able to meet the Government's waiting list targets.

[35] These are not necessarily unique applicants; an individual can apply for multiple courses in a given year.

3.65 The latest data from the NMC, from September 2025, said that 6,321 international professionals joined its Register in the six months between April and September 2025 (inclusive). This was a fall of 50% compared with the equivalent period in 2024.

Financial Pressures

3.66 As discussed in Chapter 2, DHSC said that, following the allocation of £2.2 billion in deficit funding, all 42 Integrated Care Systems in England had balanced financial plans for 2025/26 and, under the NHS's Medium Term Planning Framework, all Integrated Care Boards were expected to develop multi-year plans for the period from 2026/27 to 2028/29 that included financial plans that were balanced or in surplus for every year of the planning period.

3.67 Management on visits reflected to us that this meant in practice that NHS Trusts in England were under more pressure to ensure that their expenditure is under control. Health Board leaders in Wales and HSC Trust management on our visits to Northern Ireland reflected a similar picture, stressing that they were under more pressure to 'balance the books' than ever before.

3.68 DHSC said that some employers had developed a dependency on deficit funding, and it was necessary to address this. NHS England said that financial pressures were a factor in the decisions that employers were making, but it was also considering workforce design and skill mix in light of the transformation agenda.

3.69 NHS Employers also said that employers' financial positions were a factor in the recruitment decisions that they were making, and it was difficult to ensure that services remained safe while managing against these pressures. Many employers had strict vacancy controls in place. It said that this resulted in more being demanded from the staff that remained, and meant that for the first time it was difficult for employers to hire all the nurses, midwives and AHPs that had qualified locally, notwithstanding the current nursing and midwifery graduate guarantee (which we discuss below).

3.70 DoH said that the financial pressures that HSC was operating under were having an impact on service delivery and said that HSC Trusts were being expected to save money under the current climate. It said that it expected this to start to be reflected in workforce statistics in the coming years. We also heard on visits that operational issues with recruitment were exacerbating recruitment challenges in Northern Ireland.

3.71 Employer representatives in Wales told us that Health Boards generally had vacancy controls in place in response to financial pressures, but noted that they were a blunt instrument that could have significant adverse effects on services and the staff that remained. The Welsh Government also said that vacancy controls, even if necessary, slowed the healthy turnover of talent within the NHS, although they said in some cases vacancy controls could also be a part of organisations moving to a new, lower staffing establishment, having reviewed their requirements.

3.72 SoR said that there was no rationale for the vacancy controls that were being put in place beyond responding to immediate, short-term financial pressures. It said that these controls would ultimately prove harmful to the workforce in the long-term.

3.73 All of the organisations that we visited had strengthened vacancy controls in some way, although there was a degree of variation in the strictness of the controls that were in place; some organisations required senior approval for non-clinical roles, while others had instituted an almost total ban on external recruitment. Staff reflected that these controls were having a significant impact on the composition of teams, as staff who left were often not being replaced, or there were long lags in replacing staff, or replacements were being sourced from the same employer. They also reflected that the controls could lead to delays

in recruitment. Many staff commented that this was having a knock-on effect on their motivation, health and wellbeing, and work-life balance, and in some places staff and management said that staff were less likely to seek new opportunities or take on new responsibilities as a result of these pressures.

Retention and Motivation

Turnover and Leaver Rates

3.74 The leaver rate for Agenda for Change staff in England fell back to 9.5% in the year to October 2025, a fall of 0.3 percentage points from the previous year. From the 12 months to June 2025 onwards, the annual outflow rates have been the lowest recorded since the 12 months to November 2010 (except for a short period during the Covid-19 pandemic). In Northern Ireland, the leaver rate for all HSC staff in 2024/25 (including medical and dental staff) was 7.0%, down from 7.7% in 2023/24. These figures are discussed in more detail in Appendix A.

3.75 NHS England publishes the reasons that staff give for leaving. Between April 2024 and March 2025 there were 112,000 voluntary resignations, 23,000 were retirements, and 72,000 left or moved for other reasons. There were 19,300 staff leaving or moving for work-life balance, compared with 4,000 who left or moved for reasons relating to pay and reward.

Motivation

3.76 Since the last report, no new NHS Staff Survey results for England have become available; we expect results for the 2025 Survey to become available in March 2026.

3.77 Quarterly NHS Pulse Surveys, which are conducted during the three quarters of the year that the NHS Staff Survey does not take place, show a year-on-year fall in engagement between equivalent quarters in 2024/25 and 2025/26. However, these surveys include medical and other staff alongside AfC staff.

3.78 In last year's report, we discussed high-level engagement scores in the 2024 NHS Wales Staff Survey. We noted that the response rate had increased from 21% to 22%, and there had been a fall in staff engagement. Since then, more detailed data from the survey have become available. These show that there was a small improvement in morale (positivity score of 55.3%, compared to 55.0% in 2023), and a fall in staff engagement (positivity score of 60.0%, compared to 61.0% in 2023). There had been particularly significant upward movement in the positivity scores relating to patient safety (up 5.1% on 2023), flexible working (up 3.1%) and healthy working environments (up 1.6%).

3.79 On visits, staff generally said that they continued to feel motivated by working for their patients, with their colleagues, at their local hospital and for the NHS/HSC as a whole. However, they also raised concerns that they were working under increased pressure, which related to a mix of increased demand, patient expectations and the financial pressures that their employers were operating under, and the knock-on effects of this on recruitment and therefore staffing. These pressures were felt particularly strongly by Band 5 and 6 clinical staff.

3.80 Staff often said that they were working either with fewer people in their team than previously, or with a more junior staff mix, and this increased the expectations and level of responsibility that they felt they had in work. We were frequently told that staff were being subjected to abuse or violence from patients and their families. Management reflected to us that they were concerned that motivation challenges would affect the discretionary effort that health services depend on.

3.81 Staff also reflected that they felt that the current structure of the overall AfC system disincentivised them from seeking promotion to the next band; the financial incentive was not felt to be sufficiently large compared to the additional responsibilities associated with a more senior position. This could also be exacerbated by the way that unsocial hours payments were calculated at different bands, with some staff potentially seeing their earnings fall on achieving promotion. Relatively small increases in basic pay achieved on promotion were said to be offset by a combination of fewer hours being worked that qualified for unsocial hours payments, and those payments being worth less as a proportion of basic pay in higher bands. We discuss the ongoing structural reform discussions, which included addressing these issues in their stated aims, in Chapter 4.

Sickness Absence

3.82 As well as reducing the number of staff available to work, sickness absence can also function as an indicator of the overall level of staff engagement and workforce wellbeing. Sickness absence rates are higher in Northern Ireland and Wales than in England. In all three nations, rates have now stabilised at a level roughly one percentage point higher than the long-term pre-pandemic level, after a spike during the Covid-19 pandemic. This is equivalent to having 12,200 fewer FTE staff in England and 870 fewer in Wales compared to before the pandemic.

3.83 In the 12 months to September 2025 the sickness absence rate for the AfC workforce in England was 5.2%, the equivalent of 26.6 million staff days lost. Within that figure, rates were generally higher for support to clinical and estates staff, and lower for managers. Nurses and health visitors, and midwives also had sickness absence rates slightly above the overall rate, at 5.6% and 5.8%, respectively, and ambulance staff had a sickness absence rate of 6.1%. The most common reason given for sickness absence by AfC staff in England during this period was 'anxiety, stress, depression and other psychiatric problems', accounting for 28% of all absence. The next most common reasons for sickness were 'cold, cough, flu' (11%), 'other musculoskeletal problems' (10%), 'gastrointestinal problems' (9%). Sickness rates did not change significantly between 2024 and 2025. The rates of sickness absence are discussed in more detail in Appendix A.

3.84 NHS Employers told us in oral evidence that maintaining funding for health and wellbeing initiatives was difficult as post-pandemic central funding was being withdrawn, and this was affecting employers' capacity to support staff with long-term health conditions to return to work. It also reflected that a higher proportion of staff now had long-term health conditions, reflecting trends in the wider population.

3.85 NHS England said to us that the 10YHP anticipated that the sickness absence rate would fall by one percentage point, with actions including a new occupational health strategy and ensuring that quarterly health and wellbeing conversations were taking place with staff members in support of this aim. It said that lowering sickness absence levels was a necessary part of bringing the temporary staffing spend down.

3.86 Data provided by DoH for Northern Ireland showed that the percentage of working hours lost to sickness absence increased from 6.6% in 2018/19 to 8.6% in 2021/22, before falling back to 8.0% in 2024/25. The percentage of all sickness absence hours accounted for by mental health conditions increased from 32.9% to 37.2% between 2018/19 and 2024/25[36]. DoH said that the rate of sickness absence in HSC was out of alignment with the rest of the UK, and it was working with the HSC Trusts to reduce rates, with some progress having been made with the Northern Ireland Ambulance Service, whose sickness absence fell three percentage points in recent years, albeit from a high starting point.

[36] Sickness absence data for Northern Ireland combines medical and dental and AfC staff.

3.87 In the year to June 2025, the overall sickness absence rate for NHS staff in Wales was 6.3%, up from 5.6% in the year to March 2020[37]. Within that figure, the Nursing, Midwifery and Health Visiting staff group had a higher absence rate of 7.7%, as did the Ambulance and Healthcare Assistants and Support Workers staff groups, with rates of 8.1% and 9.5% respectively.

3.88 On visits, sickness absence was frequently raised with us by staff, and was generally felt to be a more salient issue than in previous years, despite the rates of sickness absence themselves appearing to be stable. This is potentially a product of employers cutting back their use of temporary staffing in response to financial pressures, therefore meaning that those staff remaining in work are required to take on additional tasks. On visits we heard that some staff were taking advantage of the relatively generous sick pay and thresholds. We also heard that some staff felt under pressure to return to work whilst still unwell as a result of those thresholds.

3.89 SoR said that high sickness absence rates were driven by long-term strain from the pandemic, exacerbated by a lack of flexible working. It also said that teams were generally running without sufficient staff to cover leave and sickness absence, which put staff under further strain.

Industrial Relations

3.90 As we discuss in Chapter 2, parties described national industrial relations as challenging, febrile or fragile. DHSC said that the costs of managing potential future industrial action were material risks to the NHS's financial position.

3.91 DHSC also said that differences between the pay awards applied to different groups within the overall NHS workforce, including in particular that doctors and dentists had received a higher pay award than AfC staff for 2025/26, had the potential to have a negative impact on industrial relations. DHSC said that it was important to this government that each member of the NHS workforce is treated equally and fairly, across the AfC and medical and dental workforces, especially those in lower-paid roles.

3.92 NHS Employers also made this point, saying that lower-paid staff felt that the 2025/26 pay award was not fair, when compared to the pay award made for doctors and dentists. It also said that the industrial relations landscape within the NHS was delicate, and was being exacerbated by delays to the issuance of a funded mandate for structural reform. We discuss this in more detail in Chapter 4.

3.93 DoH said that the announcement in November 2025 that NHSPRB and DDRB's 2025/26 pay recommendations would be implemented and paid to staff in Northern Ireland had seen off the immediate threat of industrial action amongst HSC staff, but that the delays to the implementation of pay awards had had a negative effect on industrial relations. The Minister of Health said that an interim 'downpayment' pay award would be implemented for AfC staff in Northern Ireland from 1 April 2026, as a demonstration of intent towards implementing pay awards in a timely manner going forward.

3.94 The Welsh Government said that there were some thorny challenges to industrial relations in Wales, including disputes related to how some roles were banded. However, it said that its approach was to generally seek to resolve difficulties in an open and respectful way.

3.95 SoR said that while its members were not generally militant, there was increasing discontent and disengagement amongst its members, reflective of flagging morale and motivation. It

[37] This overall figure for Wales includes combines medical and dental and AfC staff.

also said that its members were particularly aware of the difference between their pay uplift and the one implemented for doctors and dentists.

3.96 On visits, staff only occasionally brought up the difference in the pay awards implemented for AfC and for medical and dental staff in 2025/26. However, they and local management also reflected that pay awards that were too low may lead to a deterioration in industrial relations.

Other Workforce Issues

New Graduates

3.97 DHSC evidence said that the transition into employment was variable for newly qualified nurses, who continued to report inconsistent access to substantive roles within and outside the NHS. It said that the Secretary of State had confirmed that a Graduate Guarantee would be in place for newly-qualified nurses and midwives in 2025, under which thousands of NHS jobs would be made easier to access, with £8 million of non-recurrent funding provided to support the temporary conversion of vacant maternity support worker posts into Band 5 registered midwifery roles. However, no equivalent scheme was put in place for roles outside of nursing and midwifery.

3.98 On visits, staff and management said to us that the Graduate Guarantee was operating differently in different NHS Trusts, influenced by their financial position. Some said that their Trusts were able to offer roles to all new nursing and midwifery graduates that wanted one. Others said that their financial position prevented them from being able to do so and they were instead interviewing new graduates and putting them on a waiting list. Staff across most Trusts that we visited said to us that the NHS being unable to employ the new graduates who had trained locally was a breach of an 'informal contract' associated with training for clinical roles in the NHS, and expressed frustration that young, newly qualified staff members who had grown up and trained in the local area would have to look elsewhere for roles. SoR said that graduate jobs were not available in the way that they had been in previous years.

Alternative Employment Opportunities

3.99 On our visits programme, staff at the lower end of the AfC system often told us they felt that they would be able to earn more working outside of the NHS, including in particular in supermarkets. They often reflected that such roles were less stressful than NHS roles.

3.100 During 2025/26, most UK supermarkets paid staff at or above the Living Wage Foundation's Real Living Wage, itself 39p per hour higher than the National Living Wage[38]. However, these basic pay rates had come alongside reductions in overtime rates, paid breaks and premium rates for bank holidays[39]. The total reward offer for the NHS, including the pension scheme, is more generous than what is available from many such employers. We discuss this in the Total Reward section, below.

Temporary Staffing

3.101 DHSC said that further progress had been and continued to be made towards reducing temporary staffing spend in the NHS in England. It said that the 2025/26 NHS Planning Guidance stated that NHS Trusts were expected to reduce their agency spend by 30% and their bank spend by 10% during this financial year, and this had been factored into the SR Settlement. It said that total expenditure on non-medical temporary staffing decreased by 11.3% in 2024/25, compared to 2023/24, equivalent to a saving of £746 million. It said that

[38] Supermarket pay in 2025: what are store staff's hourly rates? | The Grocer, accessed on 7 January 2026.
[39] Ibid.

non-medical agency costs had decreased by 41% during this period, with bank spending roughly flat.

3.102 NHS Employers also said that encouraging progress had been made towards the goal of reducing spending on agency staffing. It said that employers were developing comprehensive plans to migrate their temporary staffing spend from agency to bank, although it also said that employers had expressed concern that increased dependency on bank staff may lead to some individuals taking on excessive shift patterns that can lead to fatigue, stress and burnout.

3.103 DoH said that 'off-framework' agency staff use in Northern Ireland had fallen from £134 million in 2022/23 to £19 million in 2024/25 across the Nursing and Midwifery and Social Worker staff groups. It said that this had contributed to agency spending overall being £34 million lower in 2024/25, compared to the base year of 2022/23.

3.104 The Welsh Government said that agency expenditure had dropped significantly from 2022/23, with spending dropping 19% in 2023/24 compared to 2022/23, and then a further 34% in 2024/25, compared to 2023/24. It said that the Nursing and Midwifery Registered staff group continues to account for the highest level of agency spend but this had reduced significantly from £94 million to £79 million in 2024/25.

Specific Workforce Shortages

3.105 On our visits programme and in evidence from the parties we heard of a number of specific roles or professions within Agenda for Change that were mentioned as having shortages or recruitment and retention challenges. While there were no groups that came up on a consistent basis, the staff groups that were cited most often across all of our visits as being hard to recruit were generally those where there was significant competition for labour from outside the NHS/HSC. This included both non-clinical roles such as digital and estates staff, but also some clinical roles, including physiotherapists and some specialist roles with only a small absolute number of staff working in them across the UK, such as cardiac physiologists.

3.106 NHS England told us that it had not received any evidence to support the introduction of national Recruitment and Retention Premia for any particular roles in England for this year.

Our Assessment of Workforce, Recruitment, Retention and Motivation

3.107 Overall falls in vacancy rates and turnover, combined with continued growth in staff numbers, suggest that employers are better able than in recent years to recruit and retain staff, to the benefit of health services and ultimately patients.

3.108 Evidence from our visits shows that financial pressures on health services are changing employer behaviour with respect to recruitment. Given this, it is difficult to know to what extent falls in the vacancy rates are a consequence of these pressures, as opposed to improvements to the underlying position of labour supply relative to demand. This is especially important given what we have heard about the effect of recruitment freezes and delays on the workloads of staff that remain. However, falls in vacancy rates do indicate that workforce supply is meeting demand better than in the past, at least in the short-term.

3.109 The impression that workforce supply is growing relative to demand seems to be especially strong for some Band 5 roles, given the falls in international recruitment that have been seen and the evidence we have been hearing that new graduates are finding it difficult to find roles in the NHS/HSC.

3.110 Longer-term, we would expect that the absolute level of demand for staff will continue to rise given the continued long-term growth in demand for health services. Therefore, it is

likely that health workforces will need to continue their growth trajectory despite immediate financial pressures. It is important that decisions made with respect to vacancy controls in response to short-term financial pressures do not affect the ability of the NHS/HSC to deliver against their objectives for the delivery of patient care in the medium- and long-term.

3.111 While we were encouraged by what we heard on visits of staff commitment to their patients, we also heard concerns about motivation and morale amongst the AfC workforce. High demand associated with increased patient numbers and increased patient acuity increase the pressure on staff, in some cases exacerbated by financially-driven changes to staffing models. Retention may be affected by poor motivation and morale, which may lead to a decline in the level of discretionary effort, and may also be a driver of continued elevated rates of sickness absence.

3.112 Whilst our visits programme suggested that industrial relations at a local level were generally functioning effectively, as we discuss in Chapter 2, we remain concerned about industrial relations at the national level, which were described to us as challenging, febrile or fragile during evidence. We are conscious of DHSC's description of industrial action as a material risk to its financial plans for the current and forthcoming financial years, and acknowledge that higher-paid parts of the NHS workforce in England outside of our remit group are currently undertaking industrial action. The ongoing structural reform discussions, which we discuss in detail in Chapter 4, represent an opportunity to improve and stabilise industrial relations.

3.113 We note that detailed NHS Staff Survey results, for England, have not been published since our 2025 report was submitted, and the National Quarterly Pulse Survey, which also include NHS staff outside our remit group, shows a small year-on-year fall in engagement.

National, Regional and Local Variations in the Labour Market

Pay Variation Between and Within Nations

3.114 Pay rates in AfC differ between the parts of the UK. Every pay point is 1.5% higher in Wales than the equivalent in England and Northern Ireland. Pay points in Scotland (where pay is set without recommendations from NHSPRB) are between 1.9% and 14.8% higher than their equivalents in England and Northern Ireland[40]. The implementation of the 2025/26 pay award in Northern Ireland was significantly delayed but is planned for the end of February 2026, after which pay points will be the same as in England[41].

3.115 The Welsh Government is committed to paying the Living Wage Foundation's Real Living Wage, and the Northern Ireland Executive in recent pay policies have committed to doing so where possible. We discuss the implications of this for our recommendations in Chapter 4.

3.116 DoH said that the health service in the Republic of Ireland offered more attractive terms and conditions, which risked staff migrating there or newly-qualified staff choosing to begin their careers there. It said that this issue was most severe in the west of Northern Ireland, due to the proximity of Letterkenny to the border.

3.117 Pay in the NHS in England also varies based on the High-Cost Area Supplement (HCAS), a payment made to employees who work in London and the surrounding areas. The allowance is divided into three levels, Inner, Outer and Fringe (set out in Table 3.3).

[40] NHS staff in Scotland also have a 37-hour working week (falling to 36 hours for 2026/27), compared to a 37.5 hour week in the rest of the UK.

[41] DoH did discuss with us in evidence that there were some differences in terms and conditions for AfC staff in Northern Ireland compared to England, including that sick pay is calculated differently.

Table 3.3: HCAS Rates, 2025/26

Area	Rate
Inner London	20% of basic salary, subject to a minimum payment of £5,609 and a maximum payment of £8,466
Outer London	15% of basic salary, subject to a minimum payment of £4,714 and a maximum payment of £5,941
Fringe	5% of basic salary, subject to a minimum payment of £1,303 and a maximum payment of £2,198

Source: NHS Employers[42]

3.118 We heard on visits from staff who felt that pay in areas outside London and its environs where the cost of living was felt to be elevated should also be enhanced, potentially through making more parts of the UK eligible for HCAS. We also heard on visits of challenges associated with working at NHS Trusts with sites in multiple HCAS areas.

Variation in Recruitment and Retention

3.119 On visits, we did not hear much about differences in pay levels in border areas (either within Great Britain or between Northern Ireland and the Republic of Ireland) having an impact on recruitment and retention, despite us visiting NHS Trusts in England that were relatively close to the borders with Wales and Scotland. However, we did hear about some recruitment and retention difficulties close to the England/Scotland border from one employer representative.

3.120 DHSC said that headline vacancy rates masked significant regional variation. It said that the North East and Yorkshire, and the South West had significantly lower nursing vacancy rates than London. The Welsh Government said that nursing shortages were particularly severe in rural and coastal areas of Wales.

Our Assessment of National, Regional and Local Variations in the Labour Market

3.121 While some parties suggested local recruitment and retention difficulties based on pay differentials between the nations of the UK, and between Northern Ireland and the Republic of Ireland, no quantitative data was provided to illustrate the scale of these difficulties.

3.122 Similarly, we were provided with some information to suggest that there are regional variations in vacancy rates within England and potentially within Wales, although much of this was anecdotal. In the absence of a much more robust, quantitative evidence base, it is difficult for us to come to any clear conclusions.

The Government's Inflation Target and the Economy

3.123 Our terms of reference require us to take account of the Government's inflation target. In this section, we therefore discuss the current rate of inflation relative to this target. We also discuss the wider economic and labour market context. This links to a number of aspects of our terms of reference including the inflation target, recruitment, retention, and motivation within the AfC workforce, and affordability.

3.124 The economic indicators and forecasts included in this section are the most up-to-date that were available at the point at which we make our recommendations, and we discuss how we took account of them in formulating our recommendation in Chapter 4. We would also note that we do not seek to make our recommendations in reference to any particular economic indicator.

[42] 18611.pdf

Inflation and the Inflation target

3.125 The independent Monetary Policy Committee of the Bank of England (BoE) is responsible for bringing inflation to its 2% target in the UK.

3.126 Following the major spike in the rate of CPI inflation in 2022 and the first half of 2023, it started to fall back towards its target over the course of 2023 and the first half of 2024. The rate of inflation increased again during the second half of 2024 and the first half of 2025, reaching a peak of 3.8% in July and August 2025. HMT evidence highlighted that, in its November 2025 forecast, the Office for Budget Responsibility (OBR) expects the rate of inflation to have peaked in Q3 2025 and to fall progressively to the 2% target between then and Q1 2027.

3.127 The rate of CPI inflation was 3.4% in December 2025, and CPIH inflation was 3.6%[43]. Latest forecasts for the CPI inflation rate in Q1 2026 were 3.1% from the BoE and 3.2% from the OBR.

3.128 The most recent OBR forecast was published in late November 2025 and reflects the impact of Budget measures, including those that the OBR estimates will reduce CPI inflation by 0.4 percentage points in 2026/27. The OBR forecasts that the rate of CPI inflation will be 2.4% in Q2 2026. The latest BoE forecast was produced before the Budget and does not include the impact of Budget measures on inflation. Its pre-Budget forecast was that the rate of CPI inflation would be 2.9% in Q2 2026. The OBR (post-budget) and the BoE (pre-budget) respectively forecast CPI inflation rates of 2.2% and 2.6% during the 2026/27 financial year.

Economic Growth

3.129 The size of the economy is an important determinant of the ability of the Government to fund health services. UK Gross Domestic Product is estimated to have grown by 0.1% during the third quarter of 2025, and by 1.3% in the year to September 2025[44]. GDP growth is estimated to remain relatively slow in 2026, with both the BoE and the OBR forecasting 1.4% growth during the 2026 calendar year[4546].

Earnings Growth

3.130 Average weekly regular earnings increased 4.7% year-on-year for the three months to November 2025, according to the latest figures from the ONS[47], while regular pay (excluding bonuses) increased by 4.5%. Average annual regular earnings growth was 7.9% for the public sector and 3.6% for the private sector, although ONS said that the former was affected by public sector pay rises being paid earlier in 2025 than 2024, and the effect of this would phase out over the next three months.

3.131 The OBR forecasted average weekly earnings to increase by 3.2% in the 2026/27 financial year[48]. HMT evidence highlighted that in its November 2025 Monetary Policy Report, the BoE forecasts a slowing in private sector regular pay growth, reaching 3.2% in Q2 2026.

Pay Settlements

3.132 According to Brightmine data, the median pay settlement was 3% for the calendar year 2025[49]. Incomes Data Research's (IDR's) equivalent figure was 3.3%. Brightmine forecast the

[43] Inflation and price indices - Office for National Statistics
[44] Gross Domestic Product (GDP) - Office for National Statistics
[45] Monetary Policy Report - November 2025 | Bank of England
[46] Economic and fiscal outlook – November 2025 - Office for Budget Responsibility
[47] Average weekly earnings in Great Britain - Office for National Statistics
[48] Economic and fiscal outlook – November 2025 - Office for Budget Responsibility
[49] Forecasts for pay awards in 2025/2026 | Survey analysis | Tools | HR & Compliance Centre.co.uk

pay settlement median for the 2026 calendar year to be 3.0%[50], with IDR forecasting it to be between 3 and 3.5%[51]. The BoE Agents' summary, which describes business conditions, reported in December 2025 that early indications for pay settlements for 2026 were around 3½%[52].

The Labour Market

3.133 Pay as you earn real time information data indicated that the number of employees on payrolls in December 2025 was 30.2 million; a fall of 0.6% or 184,000 employees compared to December 2024[53].

3.134 The overall level of employment was 34.3 million in the three months to November 2025, up 500,000 year-on-year and 1.1 million higher than the peak prior to the Covid-19 pandemic in the three months to February 2020[54].

3.135 The unemployment rate was 5.1% in the three months to November 2025, up 0.7 percentage points year-on-year[55].

3.136 The UK economic inactivity rate for people aged 16 to 64 years was estimated at 20.8% in the three months to November 2025, down 0.8 percentage points year-on-year[56].

3.137 The estimated number of vacancies in the UK in the three months to December 2025 was 734,000[57]. The number of vacancies in the economy has levelled off from May 2025 after a sustained decrease from the peak of 1,300,000 in the three months to May 2022.

Our Assessment of The Government's Inflation Target and the Economy

3.138 The links between public sector pay and inflation in the economy are at present likely to be weak. As budgets are fixed, we do not expect pay award decisions to affect how much money is spent by the governments, but instead what existing budgets are spent on. Therefore, we would expect the direct inflationary impact of our recommended pay award to be limited. We observe that the BoE forecasts indicate it sees a slowing in private sector regular pay growth to 3.2% in Q1 2026 to be consistent with reductions in inflation to around 2.5% in Q2 2026 and returning to target in 2027.

3.139 The increase in the rate of inflation, from 2.8% at the point when we set our 2025/26 recommendation of a pay award of 3.6% for AfC staff, to a peak of 3.8% at the point at which the award was implemented in England and Wales, has affected how the value of the pay award was perceived by some members of our remit group. This is particularly in the context of the increases in the rate of inflation that took place in late 2024 and 2025 which have affected the cost of living and the real value of salaries. We discuss this, and how it affects our considerations now that inflation is falling again, in Chapter 4.

3.140 The labour market has begun to loosen after a long period of tightness following the pandemic; increasing unemployment and decreasing vacancies suggest that labour demand is falling relative to supply. However, earnings growth is proving relatively robust despite this. Pay settlements remain close to the current level of inflation and are expected to

[50] Ibid.
[51] Steady outlook for pay in 2026
[52] Agents' summary of business conditions - December 2025 | Bank of England
[53] Earnings and employment from Pay As You Earn Real Time Information, UK - Office for National Statistics
[54] Number of People in Employment (aged 16 and over, seasonally adjusted):000s - Office for National Statistics
[55] Unemployment rate (aged 16 and over, seasonally adjusted): % - Office for National Statistics
[56] LFS: Economic inactivity rate: UK: All: Aged 16-64: %: SA - Office for National Statistics
[57] Vacancies and jobs in the UK - Office for National Statistics

remain at or slightly above 3% for the 2026 calendar year despite anticipated falls in the rate of inflation.

Equal Pay for Work of Equal Value

Pay Equalities

3.141 DHSC said that male health professionals[58] were paid 10.2% more on average than their female counterparts. It also said that the Electronic Staff Record would from 2025 capture socioeconomic background information, enabling further understanding of how reflective the NHS workforce is of the communities it serves, and that the Race and Health Observatory has announced an independent review into ethnicity pay gaps across the NHS.

Job Evaluation

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

3.143 Concern over the effective operation of the JE system in practice at a local level was expressed to us on all of our visits. Staff frequently said to us that they felt that there were inconsistencies in how jobs were banded, and employers generally made it difficult to get jobs rebanded to accurately reflect the level of responsibility that they held.

3.144 As part of the pay deal that was agreed between the UK Government and the AfC trade unions for 2023/24, a JE Task and Finish Group was formed, which aimed to restore confidence, build capacity and invest to modernise in a digital JE platform. The NHS Staff Council (SC) Chairs wrote to us in November 2025 telling us that good progress had been made across the three aims, including a data collection exercise led by NHS England that had had a 90% response rate, focused on Board awareness, organisational readiness and work to review job descriptions for nursing and midwifery roles. They said that the SC had led on drafting an enabling agreement on JE to be incorporated into the NHS Terms and Conditions of Service Handbook. They also said that NHS England was leading work to procure a digital system for JE in England, and that they anticipated that a contract would be awarded before the end of June 2026, with a view to the system being launched by April 2027.

Our Assessment of Equal Pay for Work of Equal Value

3.145 A JE scheme that is capable of ensuring that roles are banded correctly and consistently is an essential part of the functioning of the AfC system as a whole, and we note that the JE system has been found by the courts to suitably protect the principle of equal pay for equal work. Given this, we welcome the steps being taken to make JE activity more transparent and accessible to all staff, and would continue to stress the importance we attach to staff retaining confidence in the effective operation of the JE system. We await with interest more details on the improvements planned to the operation of the JE scheme, and how and when these will be planned to be implemented. We note that, particularly while improvements to the operation of the JE scheme are ongoing, this matter has limited direct influence on our recommendations.

AfC Earnings and Total Reward

Earnings, Pensions and Total Reward

3.146 The latest data available for mean annual earnings by staff groups in England covers the 12 months to October 2025. All staff groups saw average earnings grow during this period

[58] This includes doctors and dentists.

compared to the 12 months to October 2024 by between 1.5% and 7.1%, with basic pay growing by between 4.0% and 7.2%.

3.147 Analysis of pay and earnings since 2010 (the earliest the time series runs) against AWE and inflation and using a range of start years shows that staff groups with a greater share of lower paid staff compare relatively well across these measures when compared with staff groups with relatively few lower paid staff. This will reflect Band 1 being closed to new staff, relatively larger increases to the lower pay points to reflect increases to the National Living Wage, and, in some years, cash pay awards rather than percentage awards. However, when using 2021 as a baseline, pay and earnings for most staff groups did not keep pace with inflation, reflecting high price increases in 2022/23. These figures and analysis are discussed in more detail in Appendix A.

3.148 Data from the Longitudinal Education Outcomes (LEO) data set show that one year after graduation median annual gross earnings of those who studied health-related subjects compared well against graduates as a whole. The longer the time since graduation, the relative position of median earnings for nursing and midwifery, allied health subjects and health and social care subjects worsens when compared against median earnings for graduates as a whole, with, for example, graduates in nursing and midwifery close to the median of all subjects 10 years after graduation. One year after graduation, those who studied health related subjects were more likely to be in employment than graduates as a whole, and this relatively high employment rate is maintained through to the point 10 years after graduation.

3.149 DHSC said that 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. It said that all NHS roles had at least 24% of total reward comprising non-basic pay.

3.150 DHSC provided data that said that overall NHS Pension Scheme membership for non-medical staff continued to be high, with 88.6% of staff members participating in the scheme as of June 2025, an increase of 0.4 percentage points year-on-year. Particularly strong growth in the proportion of staff who were members of the scheme was seen amongst ambulance staff, Nurses and Health Visitors, Hotel, Property and Estates Staff, Senior Managers and Managers, with growth lower or negative amongst support staff. When broken down by AfC band, scheme membership rates generally increased as band increased; the outliers were Band 1 (which only a small number of staff remain working on) and Band 5, which has a scheme membership rate of only 81.2%. It said that the latter was driven by lower scheme membership amongst overseas staff in Band 5, particularly from outside Europe.

3.151 NHS Employers told us that the proximity of the lowest AfC pay points to the NLW affected the ability of the staff employed on those pay points to access salary sacrifice schemes that some NHS Trusts had in place. This was also reflected to us on visits.

Reform to the Agenda for Change Pay Structure

3.152 We discuss the ongoing discussions between the NHS Staff Council, DHSC, DoH and the Welsh Government over reform to the AfC pay structure in Chapter 4.

Our Assessment of AfC Earnings and Total Reward

3.153 The non-pay elements of the reward package, including the pensions schemes that are available to NHS/HSC staff across England, Wales and Northern Ireland, continue to be more

generous than many reward packages in the wider economy. This is an important factor when comparing employment opportunities in the NHS/HSC with others that may be available locally.

3.154 We welcome that NHS Pension Scheme membership has increased amongst members of our remit group in the last year. We note that membership is lower amongst Band 5 staff, and in particular Band 5 staff from overseas.

3.155 We consider the ongoing structural reform discussions, including how they pertain to our recommendations this year, in Chapter 4. However, we would note that the concerns we have raised about the pay structure in recent years have, at the time of writing, gone unaddressed, as no reforms have been agreed.

CHAPTER 4 Conclusions and Recommendations

Introduction

4.1 We were asked to make recommendations for pay awards for AfC staff for 2026/27 by the Secretary of State for Health and Social Care, the Northern Ireland Minister of Health and the Cabinet Secretary for Health and Social Care in Wales, in their respective remit letters, which are included in Appendices B, C and D.

4.2 In this chapter we set out our recommendation for AfC pay for 2026/27, made in line with our Terms of Reference[59] and the remit letters we received, and based on the evidence we received from the parties and from other sources including our visits programme.

Evidence on Pay Awards

4.3 DHSC said that under the 2025 SR, NHS funding would rise by an average of 3% in real terms annually. Under the SR, NHS England's resource funding settlement was due to increase to £204.9 billion in 2026/27, from £195.6 billion in 2025/26, an increase of 4.8%. DHSC said that it had developed financial and delivery plans which currently allowed for a pay uplift of 2.5% for 2026/27 without having to make trade-offs against headline government health commitments. It added that accepting pay review body awards above this level would inevitably have an impact on healthcare delivery. It said the trade-offs associated with implementing higher pay awards under the SR settlement could also include a reduction in the ambitions for service or performance improvement. It also said that industrial action would be a material risk to the financial plans that it had put in place for 2026/27.

4.4 DHSC evidence to us said that it was important to this government that each member of the NHS workforce was treated equally and fairly, across the AfC and medical and dental workforces, especially those in lower-paid roles.

4.5 Both HM Treasury and DHSC said that pay awards needed to be fully funded from within budgets as set in the SR, and departments would have no access to reserve funding for pay awards above what had been budgeted for.

4.6 Under the Proposed Draft Budget for the NI Executive that was published in January 2026, DoH would receive £8.5 billion of resource funding for 2026/27, an increase of 0.9% compared to 2025/26, before any reduction to the 2026/27 settlement to cover 2025/26 overspends associated with the implementation of our and DDRB's 2025 recommendations[60]. DoH said that there was no capacity [in budgets] for 2026/27 without making corresponding cuts to expenditure.

4.7 However, the Minister of Health also said that his position was that parity in pay with England was a higher priority for him than affordability when considering at what level to set pay uplifts for 2026/27. DoH said that the Executive's pay policy in recent years had as one of its principles that staff should receive the Living Wage Foundation's Real Living Wage (LWFRLW), where possible.

4.8 The Welsh Government did not provide us with an affordability figure in evidence. However, its Draft Budget Report for 2026/27, which was published in November 2025, said that the Health and Social Care Main Expenditure Group (MEG)[61] was being provided with revenue funding of £12.7 billion, an increase of 3.6% compared to 2025/26[62]. The Outline Draft

[59] Our Terms of Reference are reproduced at the start of this Report.
[60] See, for example NI health: Pay parity will be delivered for health service staff - BBC News.
[61] These are areas of Ministerial responsibility, equivalent in some ways to departments in the UK Government and Northern Ireland Executive.
[62] https://www.gov.wales/sites/default/files/publications/2025-11/2026-2027-budget-expenditure-lines.xlsx

Budget Report, published the previous month, said that each MEG was being provided with a 2.2% uplift for its public sector pay elements[63].

4.9 In oral evidence the Cabinet Secretary did not provide an affordability figure. He said that the current position of AfC pay points in Wales, compared to those in England (which sees every pay point in Wales 1.5% higher), was now 'baked into' financial plans and trade unions' expectations, suggesting that he expected to implement the same percentage pay uplift in Wales as in England.

4.10 SoR urged us to recommend a significant pay award for all groups of staff in 2026/27, to start to address full pay restoration. It said that, as a minimum, pay awards should be above inflation. Going forward, it said that the workforce plan should include a mechanism to achieve pay restoration, as it described it, such as that pay should increase by 1% above inflation or in reference to average pay until this is achieved, and that NHS/HSC funding should reflect this.

4.11 On visits, we heard a number of requests that the pay award should be above inflation.

Contextual Factors

The National Living Wage, the LWFRLW and the Lowest Points on Agenda for Change

4.12 Following the implementation of our recommendation for 2025/26, the lowest pay points in AfC sat close to the National Living Wage (NLW) rate, which for 2025/26 was £12.21 per hour. As part of the 2025 Budget, it was announced that the NLW would increase by 4.1% to £12.71 per hour, from 1 April 2026.

Table 4.1 Comparisons Between Lowest 2025/26 AfC Pay Points and the 2025/26 and 2026/27 NLW

2025/26 Pay Point	Annual Basic Pay 2025/26 (£)	Hourly Rate (£)	Comparison to 2025/26 NLW (£12.21 per hour)	Comparison to 2026/27 NLW (£12.71 per hour)
Bands 1 and 2 (England and NI)	24,465	12.51	+2.5%	-1.6%
Band 3 minimum (England and NI)	24,937	12.75	+4.4%	+0.3%
Bands 1 and 2 (Wales)	24,833	12.70	+4.0%	-0.1%
Band 3 minimum (Wales)	25,313	12.95	+6.1%	+1.8%

Source: OPRB calculations

4.13 Paying the NLW is a legal requirement for all employers. Therefore, in England and Northern Ireland, the Band 1 and 2 spot rate must be increased by 1.6% from 1 April 2026 to remain compliant. In Wales, the Band 1 and 2 spot rate must similarly be increased by 0.1%.

4.14 Pay points will need to be at or above the NLW from 1 April 2026 regardless of when DHSC, DoH and the Welsh Government implement pay awards in response to our recommendations. We note that this report is being submitted almost eight weeks before this date, and almost three months before the April pay date. We note that the Welsh Government has made a temporary uplift for Bands 1 and 2 that will ensure compliance (see below). We also note that any interim 'downpayment' award for AfC staff in Northern Ireland paid in April and in excess of 1.6% would ensure compliance with the NLW.

[63] Outline Draft Budget Report 2026 to 2027

4.15 The LWFRLW is an unofficial, voluntary minimum pay rate, set by the Living Wage Foundation. The Welsh Government has committed to paying all staff the LWFRLW, and the Northern Ireland Executive has in recent years included as part of its public sector pay policy that staff should receive the LWFRLW where possible, although at the time of writing its 2026/27 public sector pay policy has not yet been published. The Living Wage Foundation announced in October 2025 that the LWFRLW would be increasing to £13.45 per hour (£14.80 per hour in London), an increase of 85p per hour or 6.7% compared to the previous rate[64].

4.16 In January 2026, the Welsh Government issued a pay circular[65] that informed employers in NHS Wales that the Band 1 and 2 spot rate and the Band 3 minimum would increase to the LWFRLW rate from 1 April. This amounted to a 5.9% increase for the Band 1 and 2 spot rate and a 3.9% increase for the Band 3 minimum. As a result of this action, the Band 1 and 2 spot rate will therefore also become compliant with the NLW from 1 April 2026. The Welsh Government said that implementing the LWFRLW in Wales had an estimated impact of 0.2% on the pay planning assumptions for 2026/27.

4.17 The percentage increases that staff at bands 1, 2 and 3 will receive following this Welsh Government decision to pay all staff at least the LWFRLW are significantly in excess of the 2.2% public sector pay growth rate assumption included in its Outline Draft Budget Report. We would also note that this action further compresses the bottom of the AfC structure in Wales and takes place in advance of any agreement being reached on pay structure reform. From 1 April 2026 there will no longer be any difference in basic pay between the Band 1 and 2 spot rate and the Band 3 minimum in Wales.

4.18 Our pay recommendation this year is made recognising that repositioning the bottom of AfC relative to the NLW and reducing the compression of AfC pay points are stated aims of the structural reform discussions that are proceeding alongside our process.

Structural Reforms

4.19 In recent years we have discussed a number of concerns with the AfC pay structure that have been highlighted to us in evidence. Many of these concerns were also reflected to us on visits this year and in previous years. In 2024 we recommended that the NHS Staff Council be provided with a funded mandate to make reforms to the AfC structure to address outstanding concerns. We also asked DoH and the Welsh Government to support the issuance of such a mandate. As progress was not made in the intervening year we repeated this recommendation in our 2025 Report.

4.20 As part of the announcement that our pay recommendation for 2025/26 would be implemented in England[66] the Secretary of State for Health and Social Care said that DHSC would work with trade unions and employers to negotiate positive changes to the pay structure in 2026 to 2027 in partnership with the NHS Staff Council. DHSC also told us that it was committed to working with the Staff Council to enable progress to be made in negotiations such that structural pay changes were made with effect from 1 April 2026.

4.21 The equivalent announcement for Wales said that the Welsh Government was committed to making significant progress towards implementing structural reform before the 2026/27 pay round began[67]. The NI Minister of Health also said in his remit letter to us for this pay round

[64] Real Living Wage Rates Increase to £13.45 in UK and £14.80 in London | Living Wage Foundation
[65] nhs.wales/files/pc-resources/2026-afc-1-2026-living-wage-pdf-pdf/
[66] NHS pay award 2025 to 2026: a fair deal for NHS staff - GOV.UK
[67] Written Statement: Responding to the 38th NHS Pay Review Body and 53rd Doctors and Dentists Review Body (22 May 2025) | GOV.WALES

that he would look more closely at how he can approach supporting NHS Staff Council in taking forward structural reform in 2026/27.

4.22 Discussions on structural reform have been proceeding alongside our process. In September 2025, the Executive and Secretariat of the NHS Staff Council told us that there had been productive discussions with Ministers in England over structural reform, although a formal mandate had not been issued and they had been told that there was only a relatively small amount of money available to fund reform. They also reflected that it would be challenging for reforms to be agreed sufficiently quickly that changes would be seen in pay packets from April 2026.

4.23 In written evidence in October, NHS Employers told us the priorities that employers had identified for pay reform, as follows:

- Competitive pay for entry-level roles
- Targeted action at the entry point of band 5
- Pay incentives for promotion
- Pay progression
- Anomalies in unsocial hours payments
- Pay for apprentice roles.

4.24 In November 2025, the NHS Staff Council shared with us further details of the proposals that they were working on in exploratory and preliminary discussions. This comprised discussion of the structural issues with AfC that they had identified, possible interventions to address these issues, and consequences and benefits of those interventions.

4.25 Also in November 2025, DHSC said to us that it was working with the NHS Staff Council to understand their priorities for reform and the size of mandate required to make meaningful changes in support of those priorities. DHSC said that its priorities were pay for those in the lowest AfC bands, improved progression, and ensuring that pay is competitive for graduates. It also said that it was discussing funding issues with DoH and the Welsh Government, and had been clear that there would be no new funding for reforms beyond what was already determined in the SR.

4.26 In December 2025, NHS Staff Council said to us that they were still yet to be issued with a funded mandate, and said that a structure for negotiations had not yet been agreed, despite the limited time remaining before April 2026.

4.27 The need for reforms to the AfC pay structure has now been acknowledged by all parties; in the absence of such reform, the associated issues of recruitment, retention and motivation remain unaddressed. It is a matter of concern to us that progress towards such reforms has been so slow.

4.28 Given the breadth of our Terms of Reference, and depending on the evidence we receive, we would ordinarily consider the case for making recommendations with a structural dimension that would have the effect of addressing concerns about the AfC structure. The last time we made specific recommendations on the pay structure was in 2024, when we recommended that intermediate pay points were introduced for Bands 8a and above. However, following our recommendation last year, our pay review process this year is taking place in parallel to the structural reform discussions involving the Staff Council, so we are not making recommendations beyond a headline pay uplift this year.

Concluding Remarks and Recommendation

4.29 Health services in England, Wales and Northern Ireland face multiple challenges. They need to improve performance further, so that the number of patients waiting for treatment can

fall more quickly despite increases in the scale and complexity of demand. Simultaneously, they need to achieve necessary transformation so that the NHS/HSC can be better placed to meet patient demand in the medium- and long-term. Central to both of these aims is a workforce that is engaged and motivated to deliver for patients. We observe in Chapter 3 that we expect that the absolute level of demand for AfC staff will continue to rise over the long-term given the continued growth in demand for health services, and the increasing complexity of this demand.

4.30 In 2025 growth in the overall number of AfC staff continued to slow. However, this slowing is taking place unevenly; the number of administrative and support staff is growing less quickly than that of professionally qualified clinical staff, and even falling in some places. At the same time, vacancies in England and Wales have fallen further, although they have risen in Northern Ireland. In all three nations nursing vacancies have fallen significantly more quickly than overall vacancies. These developments suggest that, at least in some professions and in some locations, workforce supply is catching up to or potentially even overtaking demand. The implementation of graduate guarantees for nurses and midwives and the fall in international recruitment further illustrate this.

4.31 Overall falls in vacancy rates and turnover suggest that employers are better able to recruit and retain staff. However, we are concerned that these trends, which can be influenced by a number of factors, are not necessarily unambiguously positive, as they seem to be driven to some extent by the financial challenges being faced by the NHS/HSC. We heard on visits that some employers are responding to greater pressure to control their spending by altering their behaviour with respect to recruitment. This may mean that falls in vacancy rates do not necessarily reflect a straightforward improvement to the underlying staffing position. We also heard on visits about how changing recruitment behaviour was affecting workloads and motivation for existing staff.

4.32 We observe that asking staff to meet the growing needs of patients within an increasingly pressured financial context may exacerbate challenges of morale and motivation, as indicated by sickness absence rates continuing at elevated levels and by the sentiments expressed to us by some front-line staff and management during our visits.

4.33 We are also concerned that industrial relations for AfC staff at a national level are strained. Industrial action has recently been undertaken by parts of the NHS workforce outside our remit group in England. We note that DHSC said that industrial action was a material risk to the viability of the budgets it had set for the NHS in England.

4.34 Governments have ambitious plans to improve care for patients and transform health services. DHSC has said that an award above 2.5% for England would have an inevitable impact on healthcare delivery in the context of fixed and finite budgets. The governments in Northern Ireland and Wales face still more significant health service budget pressures. We note that different judgements from those anticipated in DHSC's evidence last year were ultimately made to fund a pay award in England higher than its stated affordability figure.

4.35 We acknowledge that significant reprioritisation of budgets due to pay awards above affordability levels has the potential to impact care or service improvements for patients. Reprioritisation may also affect the experience and motivation of the workforce if, for example, there are consequences in terms of the approach to filling vacancies which then lead to a further increase in workloads of those staff remaining.

4.36 However, we are also concerned about the potential downsides of pay awards that are too low or are perceived as too low. In addition to the potential for industrial action to affect both budgets and performance, the discretionary effort on which the NHS/HSC depends could reduce, as might recruitment, retention and motivation, which could have longer term

effects on service delivery. This may also lead to higher temporary staffing spend than might otherwise have been the case.

4.37 We recognise that rises to the annual rate of inflation, which increased from 2.8% at the point at which we made our 2025/26 recommendation to a peak of 3.8% at the point at which it was implemented, affected how the value of our recommendation was perceived by some members of our remit group. We heard on visits about ongoing financial pressures on staff from the cost of living, and requests that the 2026/27 pay award this year be above inflation.

4.38 We note that there has already been a fall in CPI inflation since its most recent peak of 3.8% in July and August 2025, to 3.4% for the 12 months to December 2025. At the time of writing, inflation is forecast to continue to fall towards its 2% target over the course of 2026, with the OBR forecasting inflation of 2.4% in Q2 2026 and 2.2% over the course of the 2026/27 financial year. Pay settlements are expected to be at or slightly above 3% for the 2026 calendar year.

Our Recommendations

4.39 We have concluded that a pay uplift somewhat in excess of the affordability figures provided to us will be necessary to sustain recent improvements to recruitment and retention and to protect the engagement and motivation of the workforce, so that health services will be able to better meet patient demand and have the skilled and motivated workforce necessary to achieve productivity growth, service improvement and transformation. However, this must be balanced against the national and local financial pressures that the NHS/HSC are under in the context of fixed funding settlements.

4.40 Based on the evidence we have received, including our visits programme, we have concluded that the overall recruitment and retention situation is largely similar across England, Northern Ireland and Wales. Whilst we concluded that affordability is significantly more challenged in Northern Ireland, and somewhat more challenged in Wales than in England, we also note that the Minister of Health and the Cabinet Secretary for Health and Social Care have both indicated that they would wish that there be parity in our recommendations between England, and Northern Ireland and Wales this year. This year, therefore, we have concluded that we will not make recommendations that differ between England, Northern Ireland and Wales.

4.41 As we discuss above, we are also conscious that our process is this year taking place in parallel to discussions involving the NHS Staff Council, DHSC, DoH and the Welsh Government on reforming the AfC structure, following our recommendation from 2024 and 2025 that the NHS Staff Council be provided with a funded mandate to agree structural reforms. Given this, we have concluded that it would be unhelpful to this process, which we support, if there were a structural dimension to our recommendations this year.

4.42 Taking into account all of the above, our 2026/27 pay recommendation is for a consolidated 3.3% increase with effect from 1 April 2026 for all AfC pay points.

4.43 We expect that implementing this recommendation will add £2.4 billion to the AfC pay bill in England.

4.44 In Northern Ireland, this recommendation is made against 2025/26 pay points, as opposed to pay points as they are following the implementation of any interim 'downpayment' award. We would expect that implementing our recommendation against the 2025/26 baseline will add £120 million to the AfC pay bill in Northern Ireland.

4.45 We note that implementing this recommendation would increase the hourly pay rate of the lowest pay points on Agenda for Change in England and Northern Ireland to £12.92. This is 21p per hour in excess of the National Living Wage.

4.46 We note that the Welsh Government has already taken action to uplift pay for staff at Bands 1 and 2, or on the Band 3 minimum, to bring rates of pay in line with the LWFRLW, but have said that this does not create a new baseline. This amounts to a pay uplift of 5.9% for the Band 1 and 2 spot rate and 3.9% for the Band 3 minimum. We discuss above our concerns about the impact of this on the AfC structure as it causes further compression. We also observe that both of these increases are larger than the increase for the whole of AfC that we have recommended. If the Welsh Government chooses to maintain these pay points at their new level rather than further increasing them following our recommendation, our recommendations will add £160 million to the AfC pay bill in Wales.

4.47 We recognise that some parties have commented on the position of the lowest pay points in AfC relative to the NLW, although we did not receive evidence on what the size of any such 'buffer' should be. We have not taken a view this year on where the bottom of AfC should sit relative to the NLW. If we were to consider this in future years we would do so based on the evidence, in line with our Terms of Reference. We would also note that repositioning the bottom of AfC relative to the NLW is one of the NHS Staff Council's priorities for structural reform.

4.48 DHSC said in evidence to us that it was important to the UK Government that each member of the NHS workforce in England was treated equally and fairly, across the AfC and medical and dental workforces, especially those in lower-paid roles. The issue of the different pay awards between the AfC and medical and dental workforces was only occasionally raised with us by individuals or management on local visits, although a number of national parties discussed concerns about differential pay awards in evidence. In this context, we have carefully considered the trade-offs associated with making our pay recommendation this year, including what we heard about cross-workforce issues, the financial challenges being faced by the NHS/HSC, and the evidence on the potential impact of budget reprioritisations which will need to take place to fund our recommendation.

Forward Look

Our 2027 Process

4.49 As we discussed in Chapter 1, earlier receipt of remit letters and submission of written evidence has enabled this report to be submitted to the Governments on 5 February, over two months earlier than when our 2025 report was submitted.

4.50 We remain of the view that our process should conclude sufficiently early that it is possible for our recommendations to be implemented without the need for pay awards to be backdated, a particular necessity now that the NLW has grown closer to the lowest AfC pay points.

4.51 We welcome that the parties share this aim. This will require all stages of the NHSPRB process, including the receipt of remit letters, the submission of written evidence, oral evidence, our consideration of the evidence, government decision-making and technical implementation of the recommendations to be completed in a timely manner. We ask that for 2027/28 we receive remit letters even earlier than this year, and, importantly, that parties submit evidence to our deadlines so we have sufficient time to give it due consideration. We will work proactively with all parties in support of this, because starting and completing the process in a timely manner enables staff to receive their pay awards promptly, which has benefits for both staff and employers.

Structural Reform and the NLW

4.52 We anticipate that there will be further developments in the structural reform discussions in the coming months, including hopefully that a package of changes can be agreed for the 2026/27 financial year. We anticipate hearing more about the implementation of these changes in evidence next year.

4.53 Given the proximity of the NLW and the lowest AfC pay points, notwithstanding any adjustment agreed as part of structural reform discussions, the future direction of travel for the NLW is an important contextual factor for setting pay for AfC staff. We would welcome receiving specific evidence on how the setting of the NLW and the setting of pay for AfC staff are being considered alongside each other by the Government, based on our Terms of Reference. We would also wish to hear from parties in evidence about the impact of fair pay agreements for social care.

Workforce Planning

4.54 We anticipate receiving evidence for next year's report about the upcoming workforce plan for the NHS in England, which is to be published in the coming months. We would expect that it will make assessments of workforce demand based on assumptions about service demand, itself based on demographic and population health trends, and anticipated shifts in how, where and by whom NHS services are delivered. Doing this will be necessary for developing evidence-based expectations for recruitment, retention and motivation in the medium-term, and consequently for what levels of pay are necessary to ensure that health services are able to recruit, retain and motivate their workforces. The workforce plan will also be most effective if it also includes strategic consideration of the role that pay and reward can play in supporting its aims, and wider organisational aims. We would welcome hearing more about similar workforce planning efforts for NHS Wales and HSC in Northern Ireland.

4.55 We also look forward to seeing more details of the new staff standards that NHS England said it was developing for employers in England.

Workforce, Recruitment, Retention and Motivation

4.56 We anticipate hearing more about how the key trends we have observed during this round have evolved. This includes further detail on how financial pressures on employers are affecting recruitment behaviour and more on workforce supply potentially catching up to demand in some professions. We also expect to see the detailed results of the 2025 NHS Staff Survey in England.

4.57 As we discussed in Chapter 3, there may be workforce shortages or recruitment difficulties in some specific roles within AfC, including in particular digital, data and technology staff, noting their vital importance to the strategic direction of the NHS in England, with the shift from analogue to digital being one of the three shifts envisaged in the NHS 10 Year Health Plan. Given this, we would ask that the parties provide us with evidence that can support us to consider what can be done to address these issues.

4.58 In recent years the timing of the pay review round has meant that we have been able to consider recently published results from the NHS Staff Survey for England, which have been an important factor in our assessment of the morale and motivation of AfC staff. One consequence of producing our report to an earlier timetable this year is that the results of the 2025 Staff Survey for England have not been available for us to take into account.

4.59 Although it has been helpful to have access to the results from the National Quarterly Pulse Surveys (NQPS), which measure the engagement of NHS staff in England, the usefulness of the results from these surveys is limited because they do not specifically identify AfC staff.

4.60 If the timing of the 2026 NHS Staff Survey is unchanged, the only up-to-date national data covering the whole of the AfC workforce available to us to assist in assessing motivation and morale will again be from the NQPS in England.

4.61 We therefore ask that the data on the NQPS is disaggregated for AfC staff and provided to us in written evidence next year. We consider this is likely to be an important piece of evidence to support us making recommendations in line with our terms of reference in next and future years.

Appendix A Data Appendix

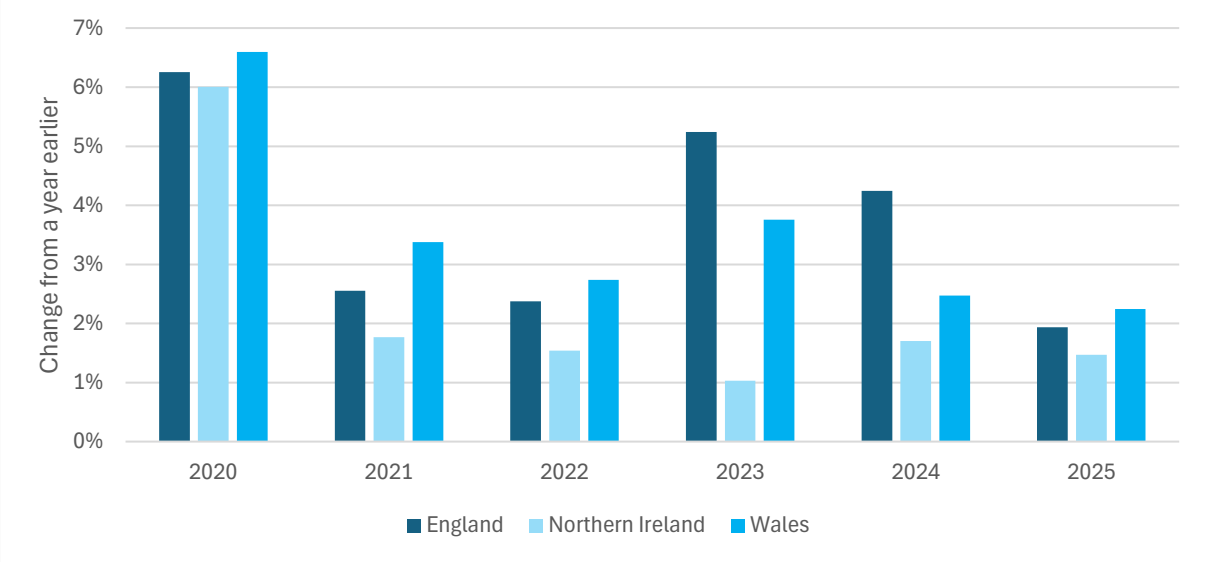
Workforce

AfC workforce across England, Northern Ireland and Wales

1. In the year to June 2025, the AfC workforce grew in all three nations. Between June 2024 and June 2025, the number of FTE staff grew by 2.2% in Wales, 1.9% in England and 1.5% in Northern Ireland. Workforce growth in 2020 was strong in each nation, driven by Covid-19, but slowed in 2021 and 2022. In both England and Wales workforce growth picked up in 2023, before slowing in both 2024 and 2025. In Northern Ireland, workforce growth continued to slow in 2023, to 1% before picking up to around 1½% in both 2024 and 2025.

2. In June 2025, the most recent date for which data is available for all three nations, there were 1.38 million FTE AfC staff in England, Northern Ireland and Wales, of which approximately 1.23 million were working in England, 62,000 in Northern Ireland and 91,000 in Wales. On a headcount basis there were approximately 1.56 million AfC staff as of September 2025, of which approximately 1.38 million were in England, 70,000 in Northern Ireland and 105,000 in Wales. We also track the trends in the workforce and Figure A.1 shows the change in staffing numbers in each year since 2019.

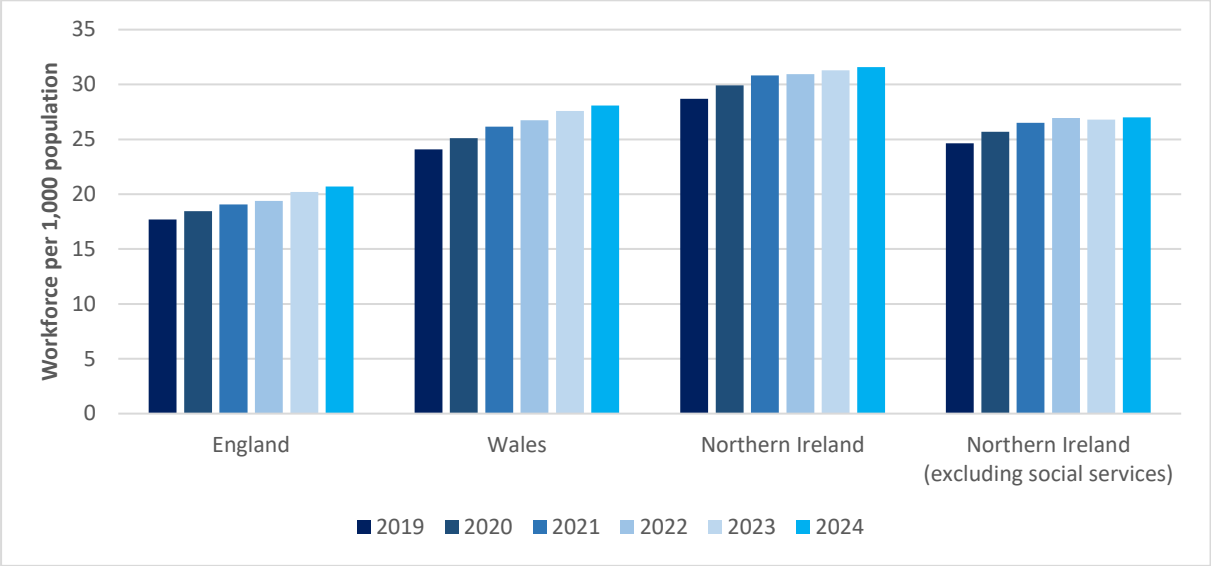
Figure A.1: Changes in AfC FTE workforce, England, Northern Ireland, and Wales, 2020 to 2025



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

3. Figure A.2 shows the number of FTE AfC staff per 1,000 population in England, Northern Ireland and Wales. An increase in the height of the bars shows that the number of FTE staff is growing more quickly than the population. The chart also shows that England has the fewest FTE AfC staff per 1,000 population, whereas Northern Ireland has the largest number of FTE AfC staff relative to population size. Unlike England and Wales, the workforce in Northern Ireland includes those working in social services, although even after adjusting for this difference, in 2024 Northern Ireland still had more FTE AfC staff per 1,000 population than England but a smaller amount than in Wales.

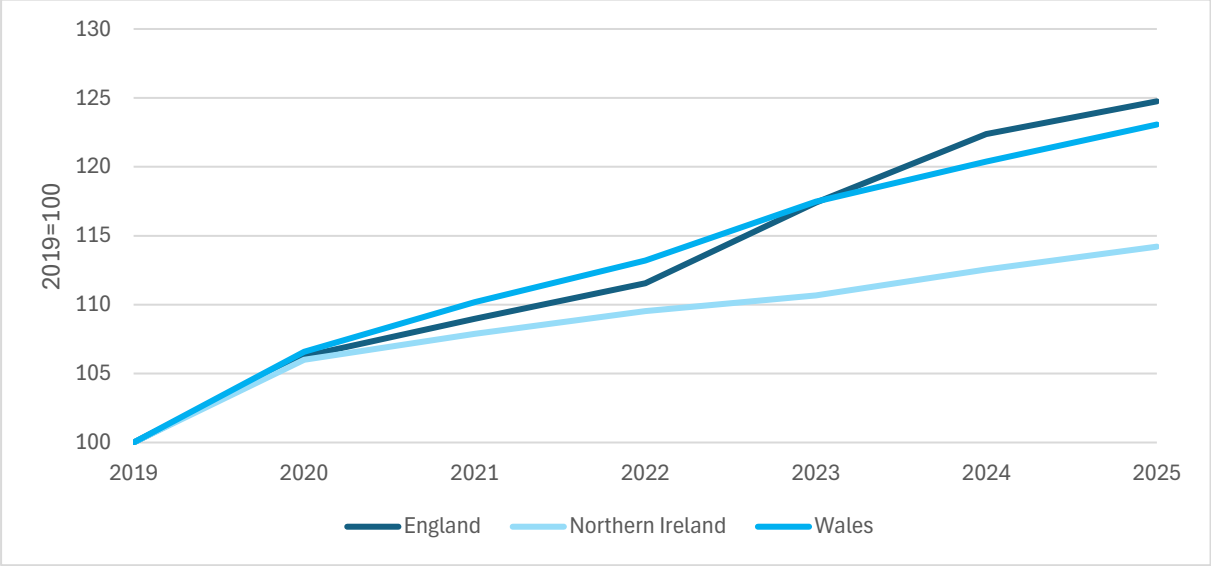
Figure A.2: NHS AfC FTE workforce per 1,000 population, England, Northern Ireland, and Wales, 2019 to 2024



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

4. Between June 2019 (prior to Covid-19) and June 2025, the AfC workforce has grown in each of the three nations (Figure A3). Over the period as a whole, the AfC workforce grew: in England by 25% (an annualised rate of 3.8%); in Wales by 23% (3.5% annualised); and in Northern Ireland by 14% (2.2% annualised).

Figure A.3: Growth in the AfC FTE workforce, England, Northern Ireland, and Wales, 2019 to 2025

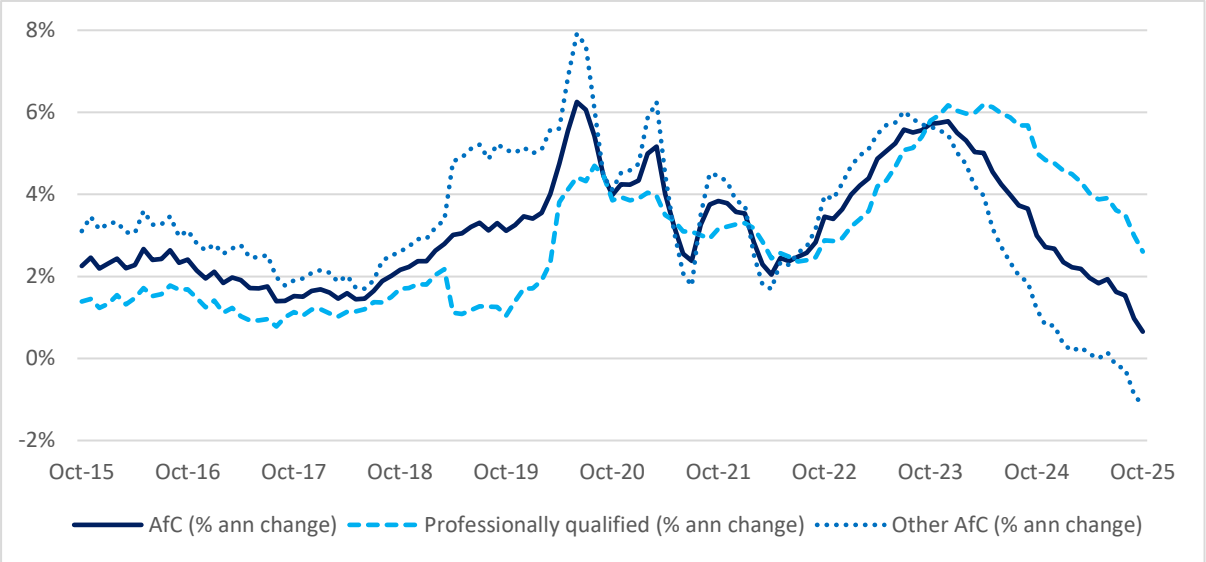


Source: OPRB calculations based on data from NHS England, Department of Health Northern Ireland, Stats Wales, ONS

5. Table A.1 and Figure A.4 show the latest workforce data for England, by staff group. In October 2025, there were 1,225,623 FTE AfC staff, an increase of 7,958, or 0.7% from a year earlier. The overall increase in the number of staff was driven by an increase in the number of professionally qualified staff (15,249, 2.6%), made up of: ambulance staff (1,545, 7.3%); midwives (878, 3.6%); scientific, therapeutic, and technical staff (5,791, 3.3%); and nurses and health visitors (7,035, 1.9%). In the year to October 2025 there was a fall in the number of

other AfC staff (-7,291, -1.2%), made up of: infrastructure support staff (-2,677, -1.2%), staff supporting clinical staff (-4,509, -1.1%), and all other staff (-106, -29.7%).

Figure A.4: NHS AfC FTE workforce growth, England, by staff group, October 2015 to October 2025, %.



Source: NHS England

6. Compared with October 2019, prior to the Covid-19 pandemic, FTE AfC staff in October 2025 had grown by 22% overall and at a compound annual growth rate of 3.4%: 37% for ambulance staff; 26% for nurses and health visitors; 26% for scientific, therapeutic and technical staff; 21% for NHS infrastructure support staff; 20% for support to clinical staff; and 15% for midwives.

Table A.1: NHS AfC FTE workforce, England, by staff group, October 2019 to October 2025

	Oct 19	Oct 24	Oct 25	Change 2024-2025		Change 2019-2025	
AfC	1,001,072	1,217,665	1,225,623	7,958	0.7%	224,551	22%
Nurses & health visitors	295,209	364,459	371,494	7,035	1.9%	76,286	26%
Midwives	22,079	24,403	25,281	878	3.6%	3,202	15%
Ambulance staff	16,481	21,071	22,616	1,545	7.3%	6,135	37%
Scientific, therapeutic & technical staff	144,619	175,861	181,652	5,791	3.3%	37,033	26%
Support to clinical staff	340,362	411,583	407,074	-4,509	-1.1%	66,712	20%
NHS infrastructure support	179,945	219,932	217,255	-2,677	-1.2%	37,310	21%
Other staff	2,376	356	250	-106	-29.7%	-2,125	-89%

Source: NHS England

7. Table A.2 shows the workforce data for England, by pay band. In October 2025, there were more than 200,000 FTE staff in each of bands 3, 5 and 6. Between March 2024 and October 2025, the largest changes in the number of staff were at bands 2 and 3, with a fall of over 53,000 staff at band 2 and an increase of over 43,000 staff at band 3.

Table A.2: NHS AfC FTE workforce, England, by pay band, March 2024 and October 2025

	March 24	June 25	Change
Band 1	1,606	1,203	-403
Band 2	169,954	116,705	-53,249
Band 3	180,958	224,294	43,335
Band 4	121,507	119,955	-1,552
Band 5	247,528	257,309	9,780
Band 6	221,375	234,877	13,502
Band 7	148,214	154,270	6,056
Band 8a	57,217	60,426	3,209
Band 8b	22,398	23,097	699
Band 8c	11,428	11,881	454
Band 8d	5,496	5,593	97
Band 9	3,003	3,144	140

Source: NHS England

8. Table A.3 shows the latest workforce data for Northern Ireland by staff group. In September 2025, there were 61,902 FTE AfC Health and Social Care (HSC) staff, an increase of 989, or 1.6%, from a year earlier. The overall increase in the number of AfC staff was driven by an increase in the number of: ambulance staff of 50 (4.1%); professional and technical staff of 306 (3.1%); registered nursing and midwifery staff of 365 (2.1%); social services staff of 161 (1.8%); estates services staff of 14 (1.7%); support services staff of 72 (1.4%); and admin and clerical staff of 84 (0.6%). There was a fall in the number of nurse support staff (63, 1.5%).

9. Compared with September 2019, before the start of the Covid-19 pandemic, FTE AfC staff in September 2025, had grown by 14% overall: 18% for registered nursing and midwifery staff; 18% for professional and technical staff; 17% for social services staff; 16% for administration and clerical staff, 12% for estates service staff; 5% for ambulance staff; 1% for support services staff. Over the same period, the number of nurse support staff fell by 4%.

Table A.3: Health and Social Care (HSC) FTE workforce, Northern Ireland, by staff group, September 2019 to September 2025

	Sept 19	Sept 24	Sept 25	Change 24-25		Change 19-25	
All staff (excluding medical and dental)	54,492	60,913	61,902	989	1.6%	7,410	14%
Administration & Clerical	11,446	13,160	13,244	84	0.6%	1,798	16%
Estates Services	740	817	831	14	1.7%	91	12%
Support Services	5,049	5,031	5,103	72	1.4%	54	1%
Registered Nursing & Midwifery	15,286	17,622	17,988	365	2.1%	2,701	18%
Nurse Support Staff	4,408	4,273	4,210	-63	-1.5%	-197	-4%
Social Services (excluding Domiciliary Care)	7,697	8,875	9,036	161	1.8%	1,339	17%
Professional & Technical	8,677	9,935	10,241	306	3.1%	1,564	18%
Ambulance	1,189	1,200	1,250	50	4.1%	60	5%

Source: Department of Health, Northern Ireland

10. Table A.4 shows the latest workforce data for Wales by staff group. In June 2025, there were 90,566 FTE AfC staff, an increase of 1,985, or 2.2%, from a year earlier. The increase in the number of AfC staff was driven by increases in the number of: registered nursing staff (1,034, 4.2%); registered midwives (59, 4.2%); health care assistants and other support staff (124,

2.1%); scientific, therapeutic and technical staff (328, 1.9%); administration and estates staff (362, 1.5%); nursing and midwifery support staff (59, 0.5%); and ambulance staff by 12 (0.4%).

11. Compared with June 2019, prior to the Covid-19 pandemic, AfC staff in June 2025, had grown by: 23% overall; 32% for administration and estates staff; 25% for ambulance staff; 28% for scientific, therapeutic and technical staff; 20% for nursing and midwifery support staff; 22% for registered nursing staff; 7% for registered midwifery staff; -2% for health care assistants and other support staff.

Table A.4: NHS AfC FTE workforce, Wales, by staff group, June 2019 to June 2025

	June 19	June 24	June 25	Change 24-25		Change 19-25	
All staff (excluding medical and dental)	73,590	88,581	90,567	1,985	2.2%	16,976	23%
Registered nursing staff	21,227	24,879	25,912	1,034	4.2%	4,685	22%
Registered midwifery staff	1,366	1,406	1,465	59	4.2%	100	7%
Nursing and midwifery support staff	10,459	12,489	12,548	59	0.5%	2,090	20%
Administration and estates staff	18,455	23,923	24,286	363	1.5%	5,831	32%
Scientific, therapeutic and technical staff	13,494	16,960	17,288	328	1.9%	3,794	28%
Health care assistants and other support staff	6,093	5,831	5,956	124	2.1%	-137	-2%
Ambulance staff	2,397	2,975	2,987	12	0.4%	591	25%
Other non-medical staff	101	118	125	7	6.1%	24	23%

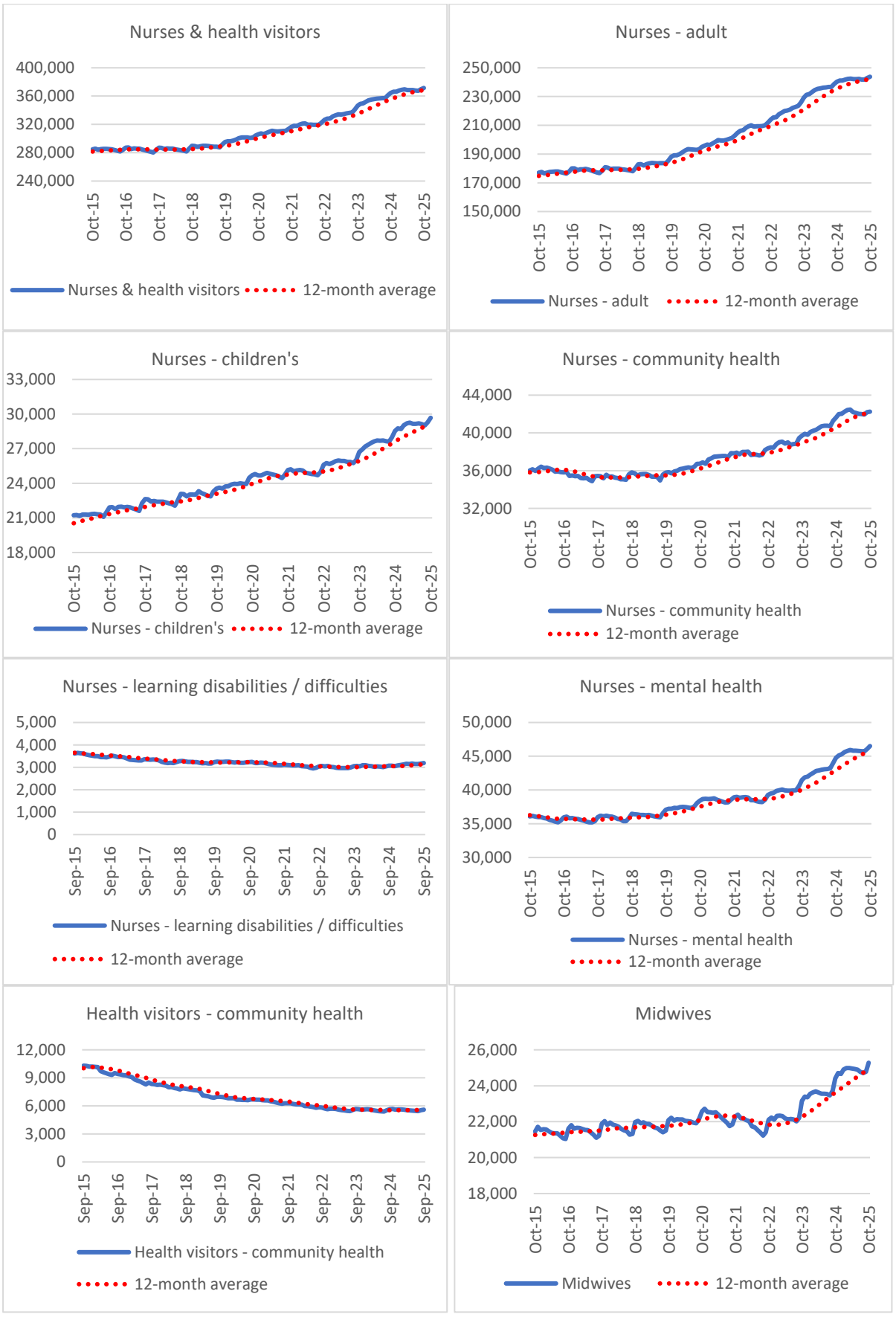
Source: Stats Wales

Nursing, health visitor and midwifery workforce in England

12. Figure A.5 shows the FTE number of nurses, health visitors and midwives, in England, working in HCHS, between 2015 and 2025. The data for the three months to October 2025, compared with the same period one year earlier, show an increase in the number of nurses and health visitors of 2.4%. Within that overall total, there were increases in the number of: mental health nurses (4.8%); children's nurses (4.6%); learning difficulties/disabilities nurses (4.2%); community health nurses (2.3%); and adult nurses (1.8%). Over the same period the number of health visitors fell by 0.1% and the number of midwives increased by 4.4%.

13. The data for the three months to October 2025, compared with the same period in 2019 (prior to the Covid-19 pandemic), show an increase in the number of nurses and health visitors of 27%. Within that overall total, there were increases in the number of adult nurses (31%), children's nurses (26%), mental health nurses (26%), and community health nurses (19%) but falls in the number of health visitors (-20%) and learning difficulties/disabilities nurses (-1%). Over the same period the number of midwives increased by 15%.

Figure A.5: Change in the number of nurses, health visitor staff and midwives, FTE, by nursing category, England, October 2015 to October 2025

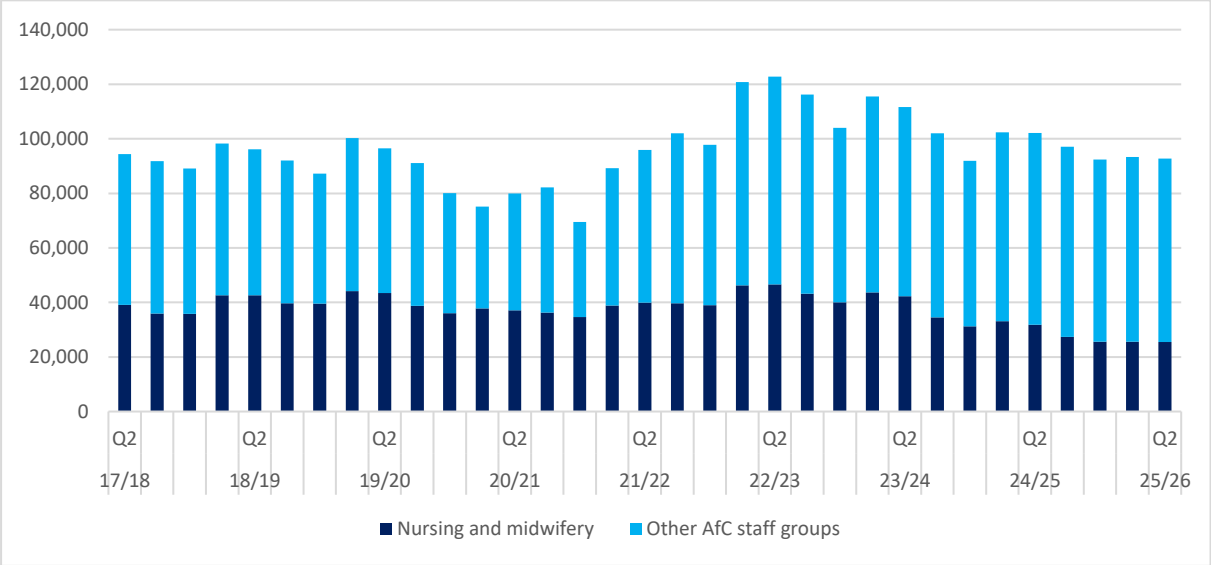


Source: NHS England

Vacancies

14. NHSE publishes quarterly estimates of vacancies across the NHS in **England**[68]. The latest data, for the second quarter of 2025/26, to September 2025, showed that overall, there were 92,775 AfC vacancies in the NHS, of which 25,504 were nursing and midwifery vacancies, and 67,271 were for other AfC roles (Figure A.6).

Figure A.6: NHS vacancies, England, 2017/18 quarter 2 to 2025/26 quarter 2

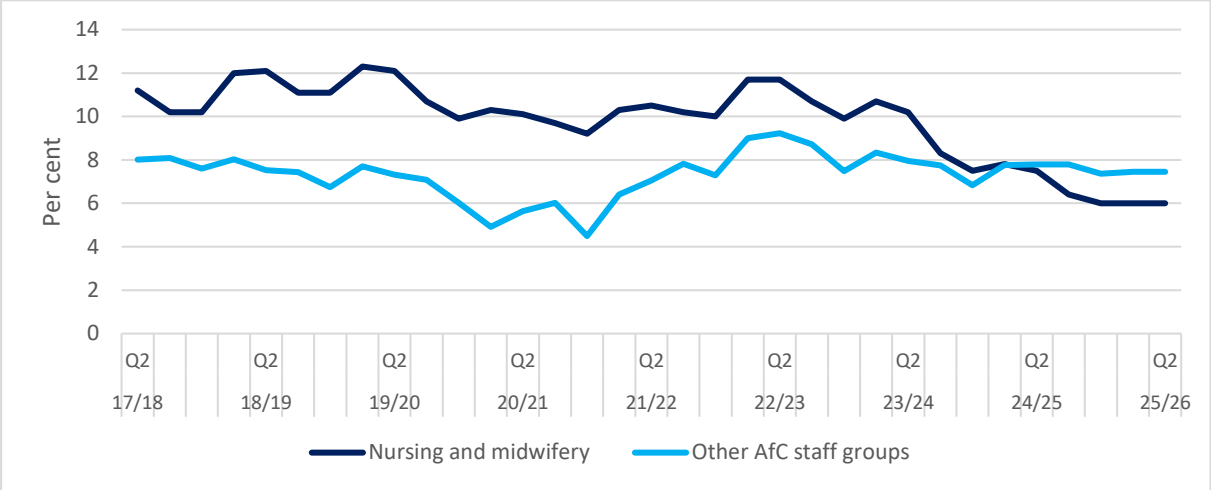


Source: OPRB calculations based on data from NHS England

15. Figure A.7 shows vacancy rates since 2017/18, the earliest date for which there are comparable data. In the second quarter of 2025/26 the nursing and midwifery vacancy rate was 6.0%, unchanged from the previous quarter, down from 7.5% in the same quarter a year earlier, and the lowest rate for at least eight years. The vacancy rate for non-nursing and midwifery AfC staff groups was 7.4%, unchanged from the previous quarter, but down from 7.8% in the same quarter a year earlier.

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

Figure A.7: NHS vacancy rates, nursing and midwifery and other AfC staff groups, England, 2017/18 quarter 2 to 2025/26 quarter 2

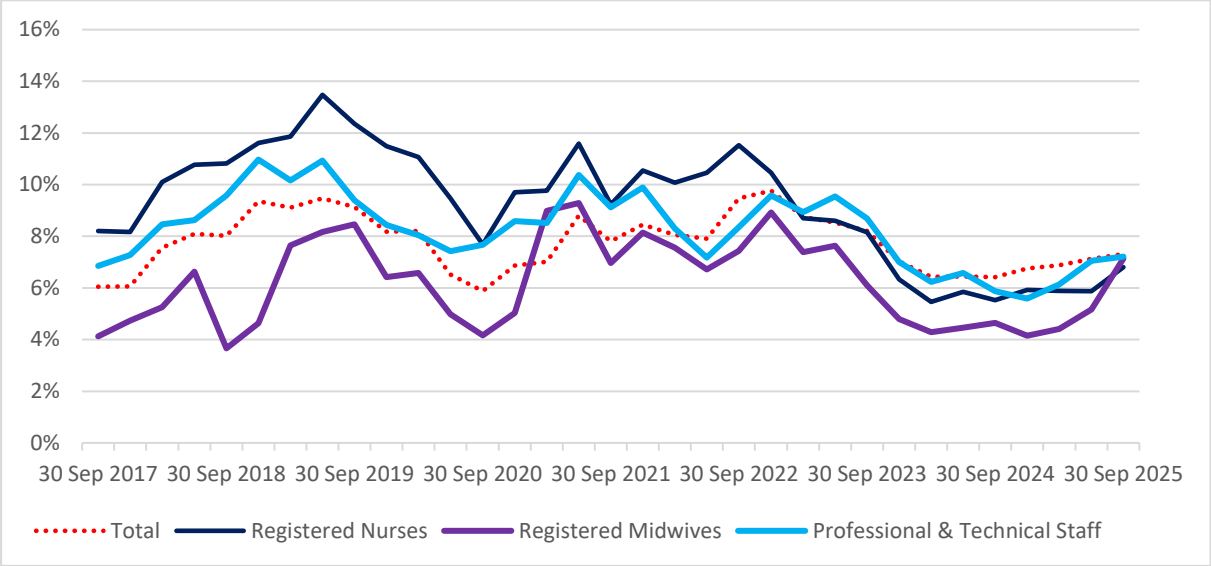


Source: OPRB calculations based on data from NHS England

16. For **Northern Ireland**[69] the most recent data show that at the end of September 2025, there was an overall vacancy rate (including medical and dental staff) of 7.3%, an increase from 6.4% a year earlier. Figures A.8 and A.9 show, over the same period: registered nursing vacancies increased from 5.5% to 6.8%; registered midwifery vacancies increased from 4.6% to 7.1%; professional and technical staff vacancies increased from 5.9% to 7.2%; social services staff vacancies increased from 9.1% to 9.9%; nursing and midwifery support staff vacancies increased from 10.1% to 11.3%; and administration and clerical vacancies increased from 5.3% to 5.9%.

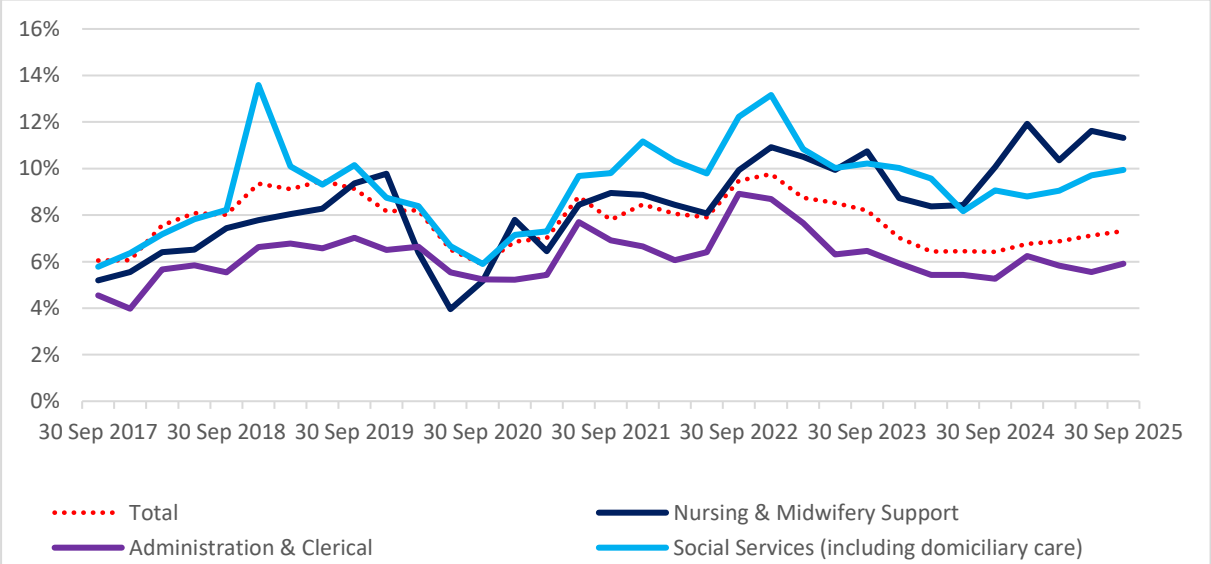
[69] **A vacancy** in Health and Social Care in Northern Ireland is any position that is currently with the recruitment team and being actively recruited to. This will include those going through pre-employment checks, up to the point of a start date being agreed. **The vacancy rate** is the number of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

Figure A.8: HSC, Northern Ireland, vacancy rate, September 2017 to September 2025, overall, registered nurses and midwives, professional and technical staff



Source: Department of Health, Northern Ireland

Figure A.9: HSC, Northern Ireland, vacancy rate, September 2017 to September 2025, overall, social services staff, nursing and midwifery support staff, administration and clerical staff



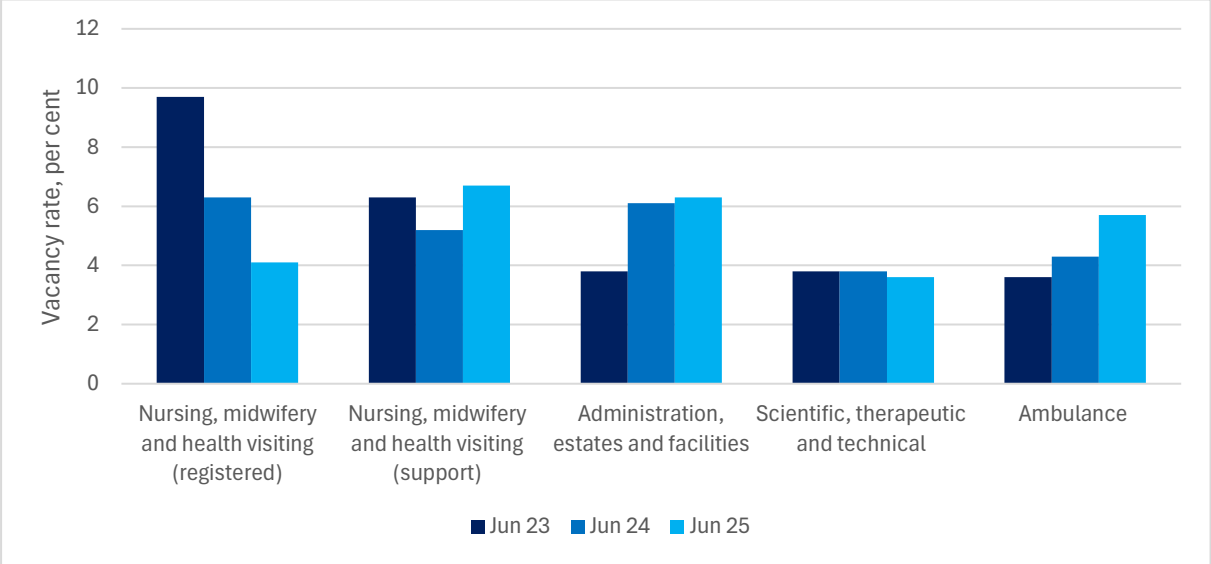
Source: Department of Health, Northern Ireland

17. Stats Wales publish NHS **Wales**[70] vacancy data, on a quarterly basis. The latest data for June 2025, show a vacancy rate across all staff groups (including medical and dental) of 5.4%, a fall from 5.8% a year earlier. Figure A.10 shows the vacancy rate for individual AfC staff groups. The vacancy rate in June 2025, for registered nursing, midwifery and health visiting staff, was lower than in June 2024, falling from 6.3% to 4.1%, and the rate for scientific, therapeutic and technical staff fell over the same period, from 3.8% to 3.6%. However, the vacancy rates in

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

June 2025 for other AfC staff groups were higher than a year earlier. Between June 2024 and June 2025, the vacancy rates for: administration, estates and facilities staff increased from 6.1% to 6.3%; nursing, midwifery and health visiting support staff increased from 5.2% to 6.7%; ambulance staff increased from 4.3% to 5.7%.

Figure A.10: NHS Wales, vacancy rate, June 2023 to June 2025

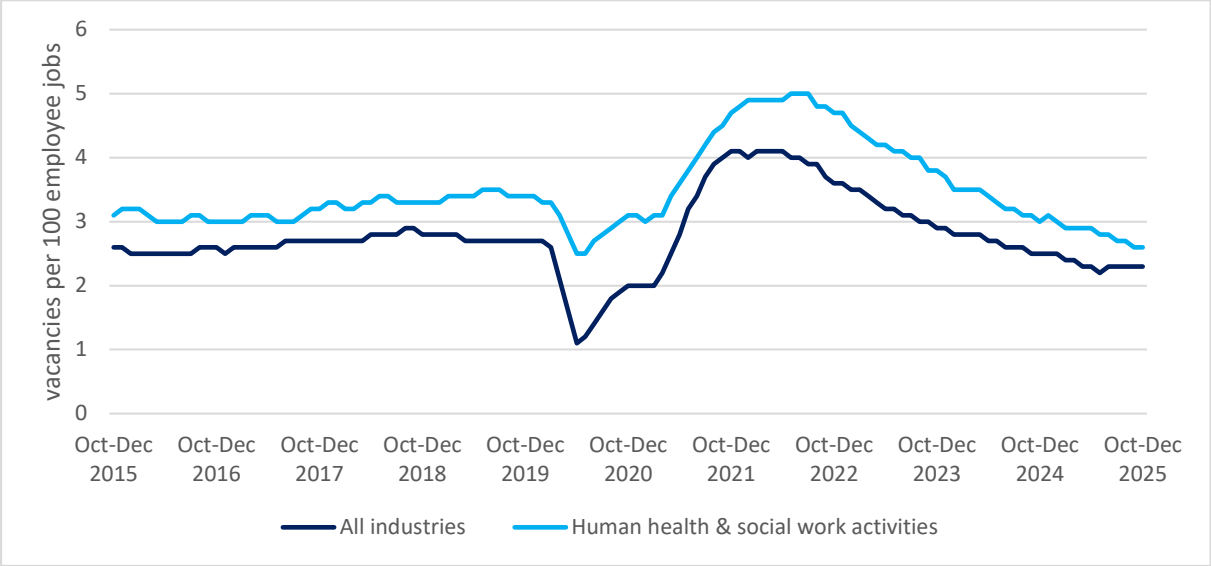


Source: Stats Wales

18. In the three months to December 2025, the ONS estimated that there were 734,000 vacancies across all industries, a rate of 2.3 vacancies per 100 employee jobs[71]. This compares with data for the human health and social work activities sector where there were 120,000 vacancies, a rate of 2.6 vacancies per 100 employee jobs. Figure A.11 shows that vacancy rates have been falling since mid-2022 and are now lower than the rates seen prior to the onset of Covid-19.

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

Figure A.11: Vacancies per 100 employee jobs, UK, seasonally adjusted, October to December 2015 to October to December 2025



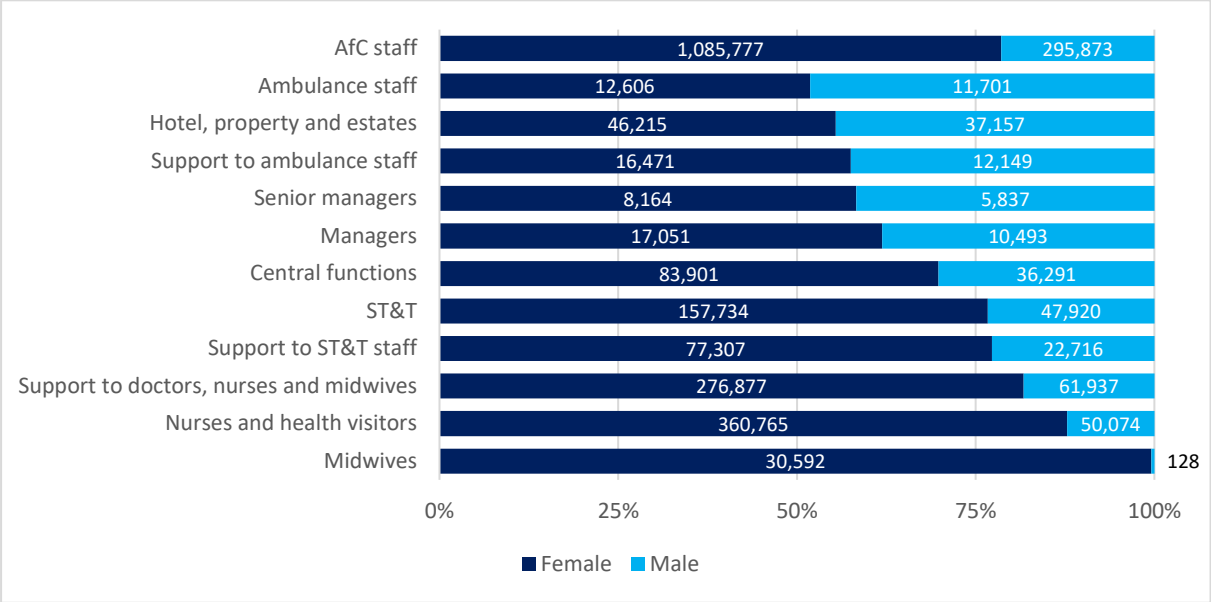
Source: ONS

AfC workforce by protected characteristics

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

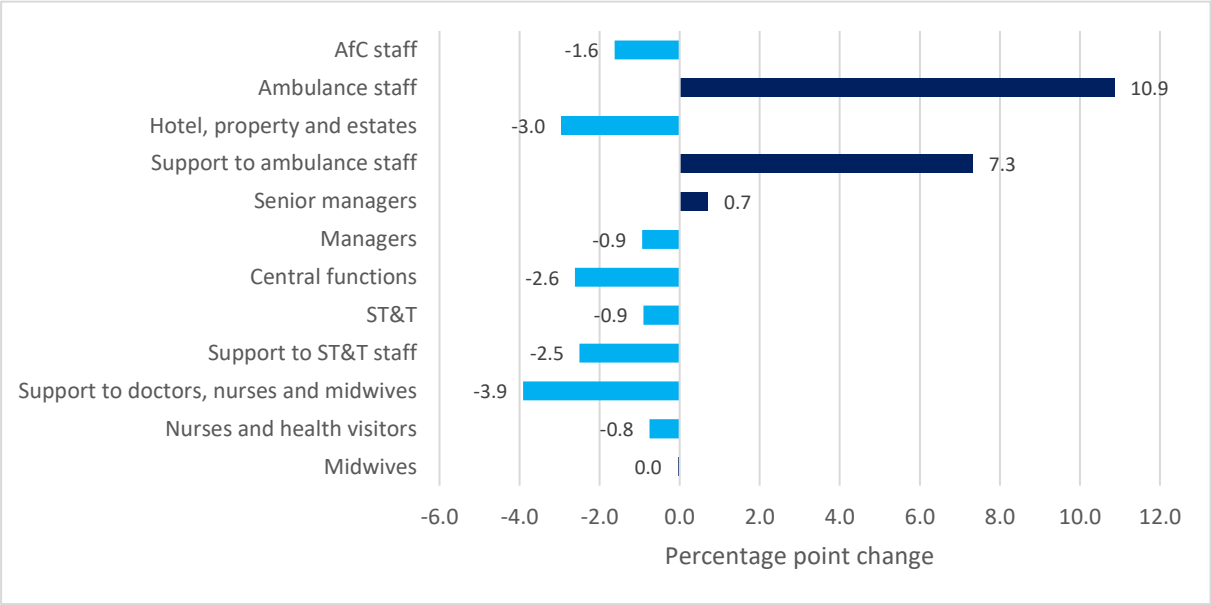
20. Figure A.12 shows a breakdown of AfC staff in England, by gender, by broad staff group, in October 2025. The AfC workforce is predominantly female, with women accounting for 79% of employees. However, the relative representation of women and men varies across different staff groups. For example, 88% of nurses and health visitors and more than 99% of midwives were women, while 48% of ambulance staff, 45% of hotel, property and estates staff and 42% of support to ambulance staff, were men. Men also accounted for 42% of senior managers and 38% of managers.

Figure A.12: Staff in AfC roles by gender, by staff group, in England, October 2025, headcount



Source: NHS England

Figure A.13: Staff in AfC roles by gender, by staff group, in England, percentage point change between September 2019 and October 2025, headcount [positive means increased share of female staff]

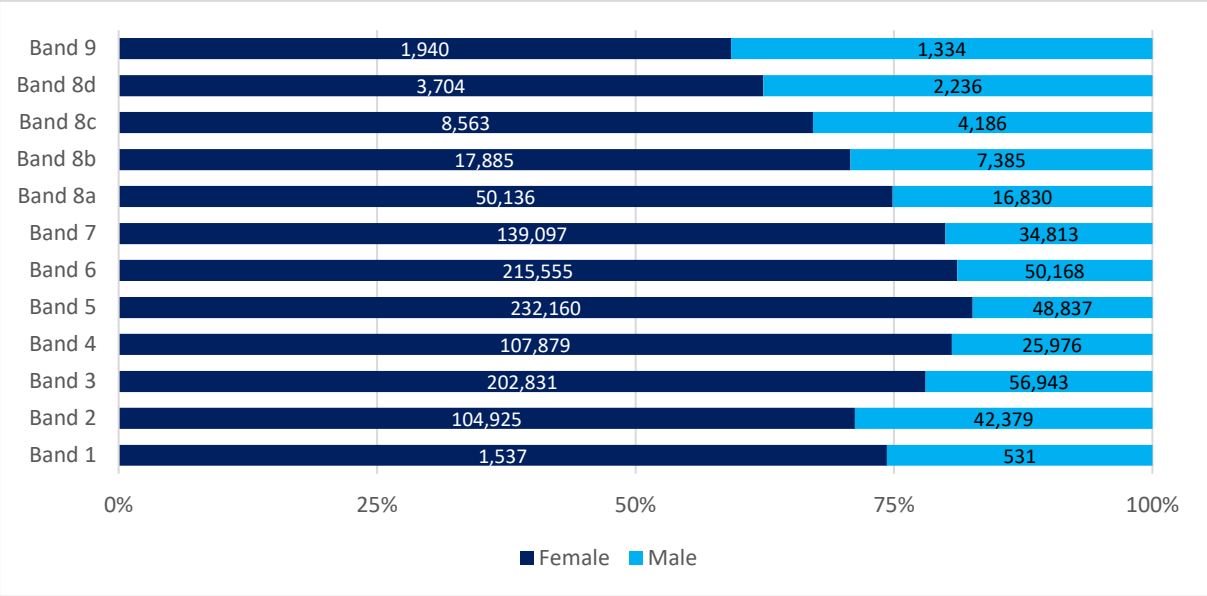


Source: NHS England

21. Figure A.13 shows, in England, the change in the gender mix between September 2019 (pre Covid-19) and October 2025, by staff group. It shows that overall, the percentage of staff that were female fell by 1.6 percentage points (from 80.2% to 78.6%) between 2019 and 2025. Compared with September 2019, in October 2025, female staff made up a greater share of ambulance staff (up by 10.9 percentage points, from 41.0% to 51.9%), support to ambulance staff (up 7.3 percentage points, from 50.2% to 57.6%), and senior managers (up by 0.7 percentage points, from 57.6% to 58.3%). In 2025, male staff made up a greater share of all other staff groups than in 2019, except for midwives, where there was no change.

22. Figure A.14 shows that female staff make up a majority of staff in every pay band, and at least 70% of staff in every band except Bands 8c to 9.

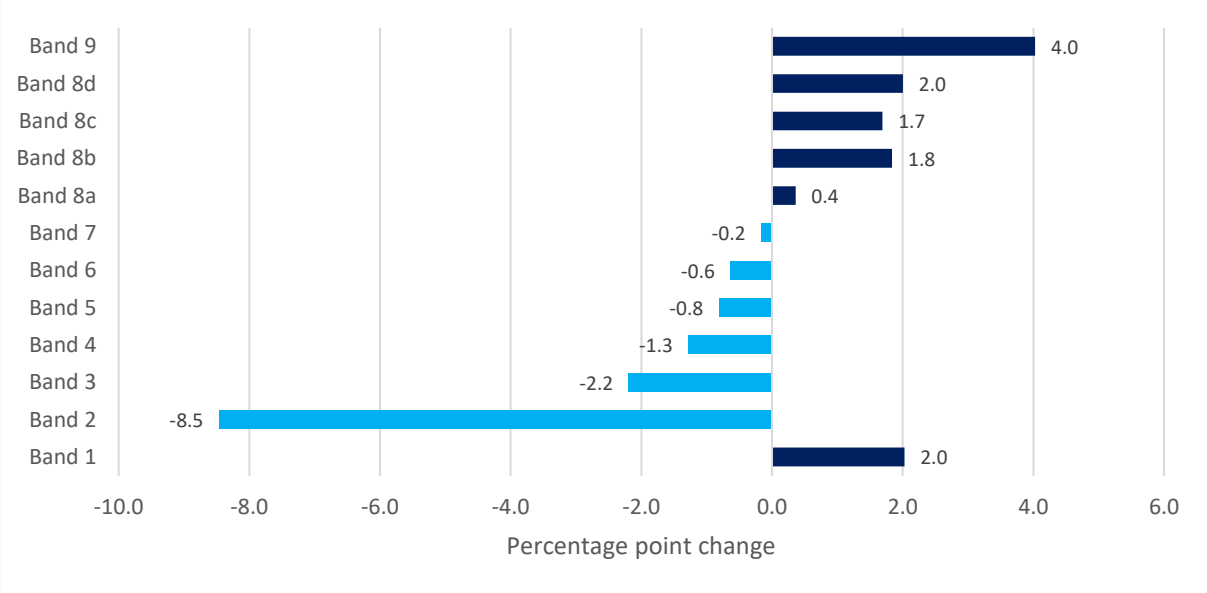
Figure A.14: Staff in AfC roles by gender, by band, in England, October 2025, headcount



Source: NHS England

23. Figure A.15 shows that in October 2025, female staff made up a greater share of staff at Bands 1 and Bands 8a and above, than in 2019. The largest change was at Band 9 (up 4.0 percentage points, from 55.2% to 59.3%).

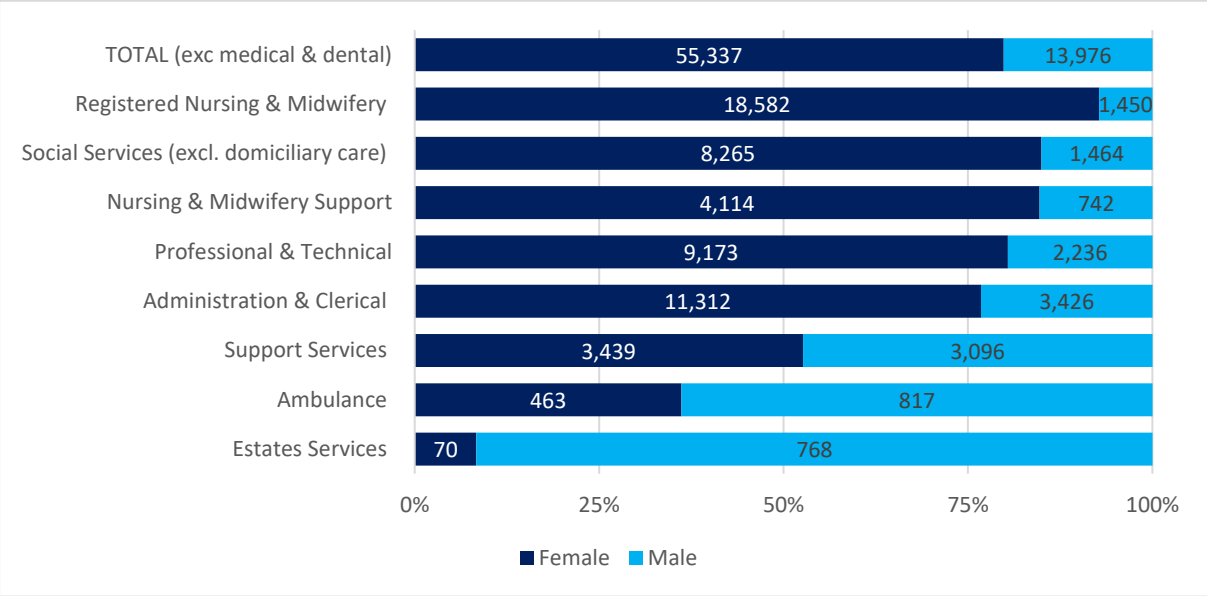
Figure A.15: Changes in gender composition, headcount, in roles at all AfC bands in England, percentage point change between September 2019 and October 2025, [positive indicates increased share of female staff]



Source: NHS England

24. Figure A.16 shows a breakdown of AfC staff by broad staff group by gender in Northern Ireland in March 2025. In all staff groups, other than estates services (92%), ambulance staff (64%), and support services (47%), men make up less than 25% of the workforce.

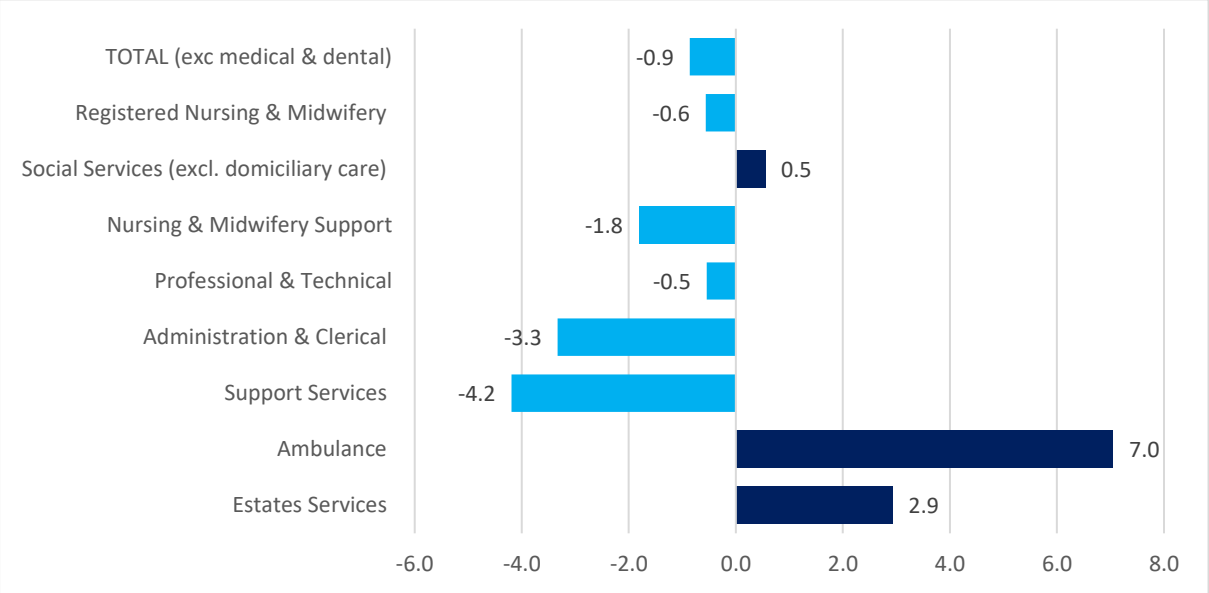
Figure A.16: Staff in AfC roles by gender, by staff group, in Northern Ireland, March 2025, headcount



Source: Department of Health, Northern Ireland

25. Figure A.17 shows that overall, in Northern Ireland, the percentage of staff that were female decreased by 0.9 percentage points (from 80.7% to 79.8%) between 2020 and 2025. In March 2025, female staff made up a greater share of ambulance staff (up 7.0 percentage points from 29.1% to 36.2%), estates services (up 2.9 percentage points from 5.4% to 8.4%), social services (excluding domiciliary care) (up 0.5 percentage points from 84.4% to 85.0%) than in 2020. Compared with 2020, in 2025, female staff made up a smaller share of: support services staff (down 4.2 percentage points, from 56.8% to 52.6%); administration and clerical staff (down 3.3 percentage points from 80.1% to 76.8%); registered nursing and midwifery staff (down 0.6 percentage points from 93.3% to 92.8%); professional and technical staff (down 0.5 percentage points from 80.9% to 80.4%); and nurse support staff (down 1.8 percentage points from 86.5% to 84.7%).

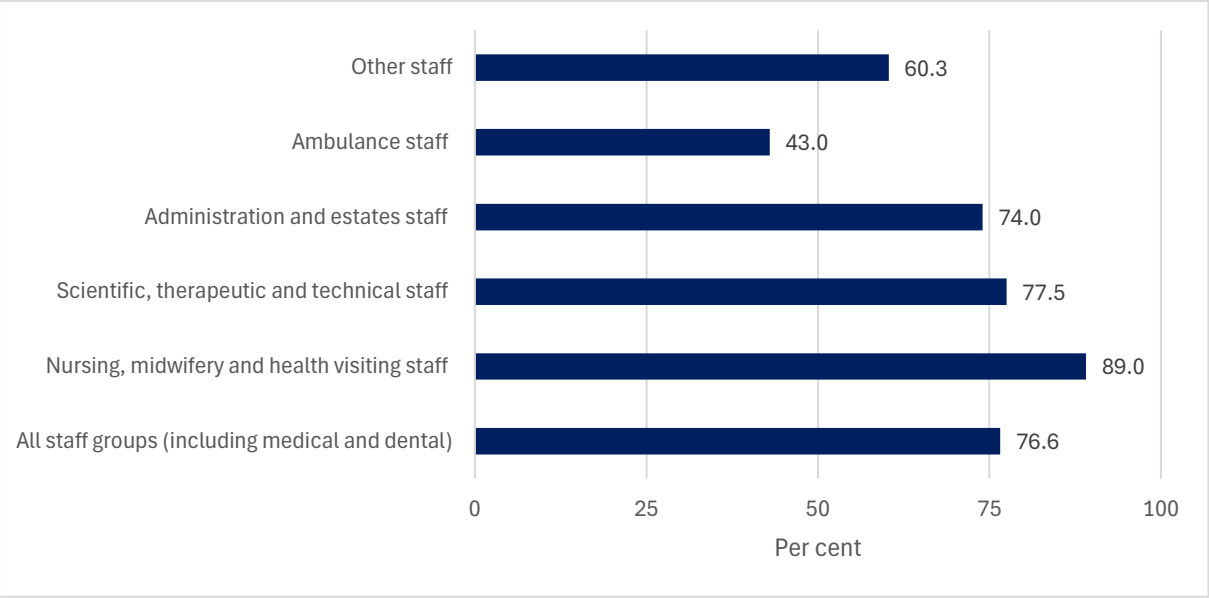
Figure A.17: Staff in AfC roles by gender, headcount, by staff group, in Northern Ireland, percentage point change between March 2020 and March 2025, [positive indicates increased share of female staff]



Source: Department of Health, Northern Ireland

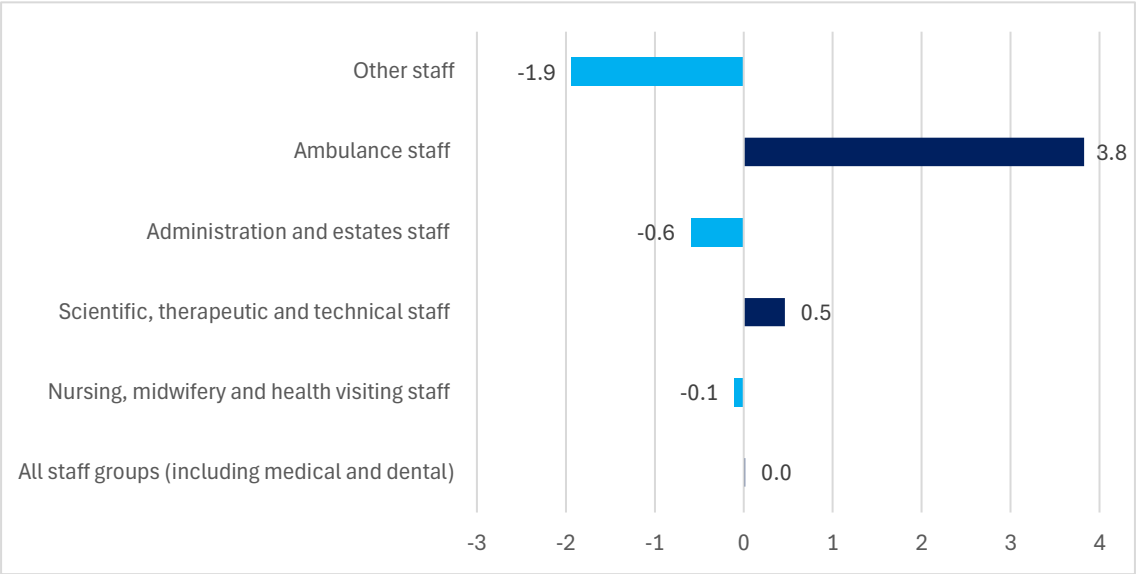
26. Figure A.18 shows the percentage of staff that were female, by broad staff group, in Wales, in September 2024, the latest data available at the time of submitting this report. Overall, including medical and dental staff, 76.6% of staff were female. In all AfC groups other than ambulance staff (43.0%), and 'other' staff (60.3%), at least 74% of staff were female.

Figure A.18: Percentage of staff in AfC roles, that are female, by staff group, in Wales, September 2024, FTE



Source: Stats Wales

Figure A.19: Staff in AfC roles by gender, FTE, by staff group, in Wales, percentage point change between September 2022 and September 2024, [positive indicates increased share of female staff]

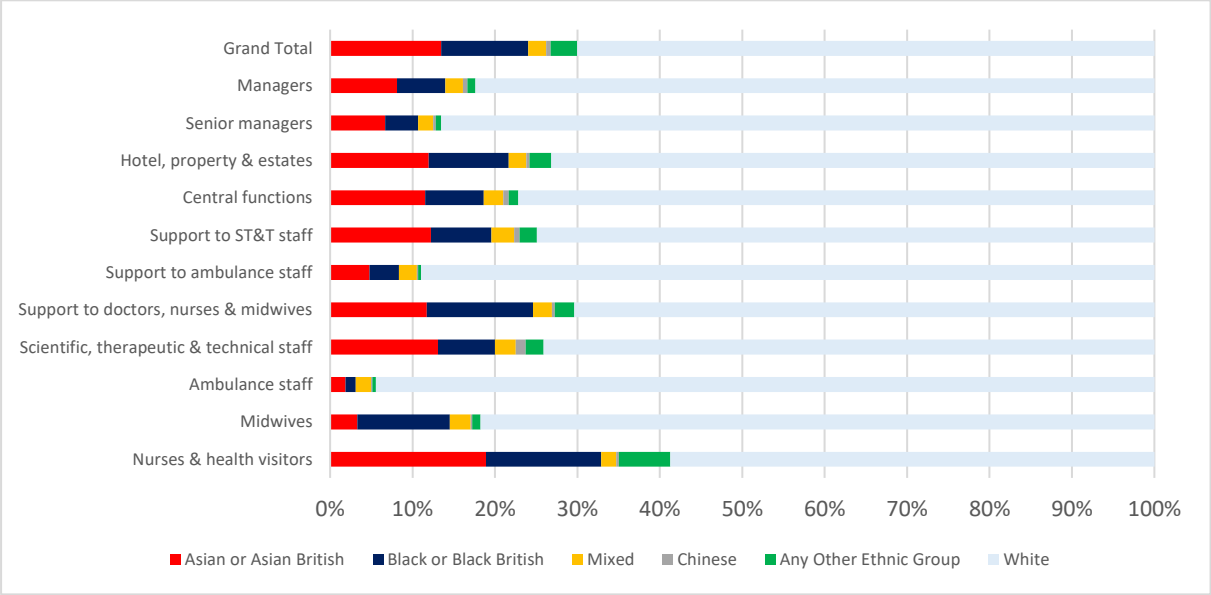


Source: Stats Wales

27. Figure A.19 shows, in Wales, the change in the gender mix between September 2022 (the first date for which data were published) and September 2024, by staff group, the latest data available at the time of submitting this report. It shows that overall, the percentage of staff that were female was unchanged. For individual staff groups, the percentage of ambulance staff that were female increased by 3.8 percentage points (from 39.1% to 43.0%),and the percentage of scientific, therapeutic and technical staff increased by 0.5 percentage points (from 77.0% to 77.5%), while the percentage of: 'other staff' fell by 1.9 percentage points (from 62.3% to 60.3%); administration and estates staff fell by 0.6 percentage points (from 74.6% to 74.0%); and nursing, midwifery and health visiting staff fell by 0.1 percentage points (from 89.2% to 89.0%).

28. Figure A.20 shows a breakdown of AfC staff by ethnicity and by broad staff group in England, in October 2025. Overall, excluding those staff whose ethnicity was unknown or not stated, 30% were from ethnic minorities: 13% of staff were Asian or Asian British; 11% Black or Black British; 2% mixed ethnicity; fewer than 1% Chinese and 3% from other ethnic minorities. This compares with data for September 2019 (the data for the period just before the onset of Covid-19), when 19% of staff were from ethnic minorities: 8% of staff were Asian or Asian British; 6% Black or Black British; 2% mixed ethnicity; fewer than 1% Chinese and 2% from other ethnic minorities.

Figure A.20: Staff in AfC roles by ethnic group, by staff group, in England, October 2025, headcount



Source: NHS England

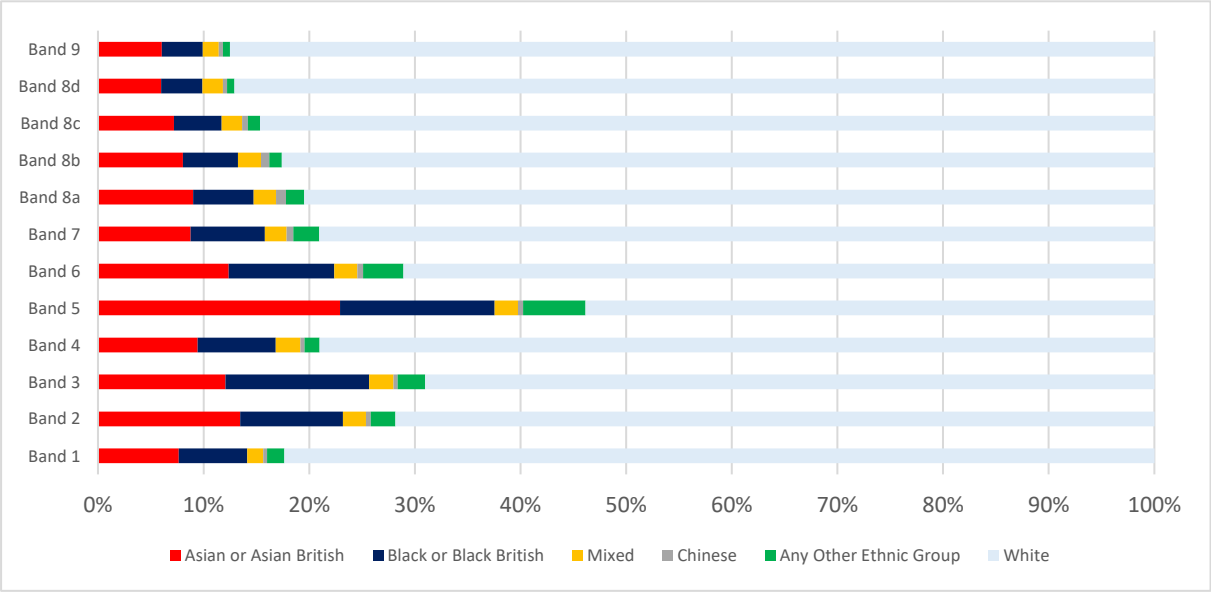
29. The data for October 2025 suggest that by staff group, the most ethnically diverse were nurses and health visitors, with 41% from ethnic minorities (up from 25% in 2019): 19% were Asian or Asian British; 14% Black or Black British; 2% mixed ethnicity; 6% were from other ethnic minorities and 59% were White. In contrast, just 6% of ambulance staff were from ethnic minorities (but up from 3% in 2019): 2% Asian or Asian British; 2% mixed ethnicity; and 1% Black or Black British. This compares with the working age population of England and Wales, which in 2021 was 10.1% Asian, 4.4% Black, 2.5% mixed ethnicity and 2.3% from the Other ethnic group[72].

30. Figure A.21 shows a breakdown of AfC staff by ethnicity and by band in England in October 2025. 46% of staff in Band 5 were from an ethnic minority group, with 23% Asian or Asian British, 15% Black or Black British, 2% of mixed ethnicity, 6% from other ethnic minorities and 54% White staff. Bands 2 to 4 and Bands 6 to 7 each had between 20% and 29% of staff from ethnic minorities, but in Bands 8a and above there were fewer than 20% of staff from ethnic minorities, with just 12% of staff at band 9.

31. In June 2025, excluding Band 1 which is closed to new entrants, the percentage of staff from ethnic minorities was higher in each band than in 2019. However, the slowest growth has been in the higher bands, where the percentage of staff from ethnic minorities increased by 5 percentage points in Bands 8a to Band 8d and by just 4 percentage points in Band 9. In Bands 2, 3 and 6 the percentage of staff from ethnic minorities increased by 9-14 percentage points over the period. However, by far the largest change came in Band 5, where the percentage of staff from ethnic minorities increased by 19 percentage points, from 27% to 46%.

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

Figure A.21: Staff in AfC roles by ethnic group, by band, in England, October 2025, headcount



Source: NHS England

32. The NHS in Wales has published data showing an ethnic breakdown of staff since 2022. The data for September 2024, the latest data available at the time of submitting this report ,in Table A.5, for all staff (including medical and dental staff), shows 80% of staff were White, 6% were Asian or Asian British, 2% Black or Black British, 1% mixed ethnicity and 2% from other ethnic groups. There were also 10% of staff for whom there was no data. Among AfC staff groups, the most ethnically diverse group was nursing, midwifery and health visitors, while ambulance staff was the least diverse.

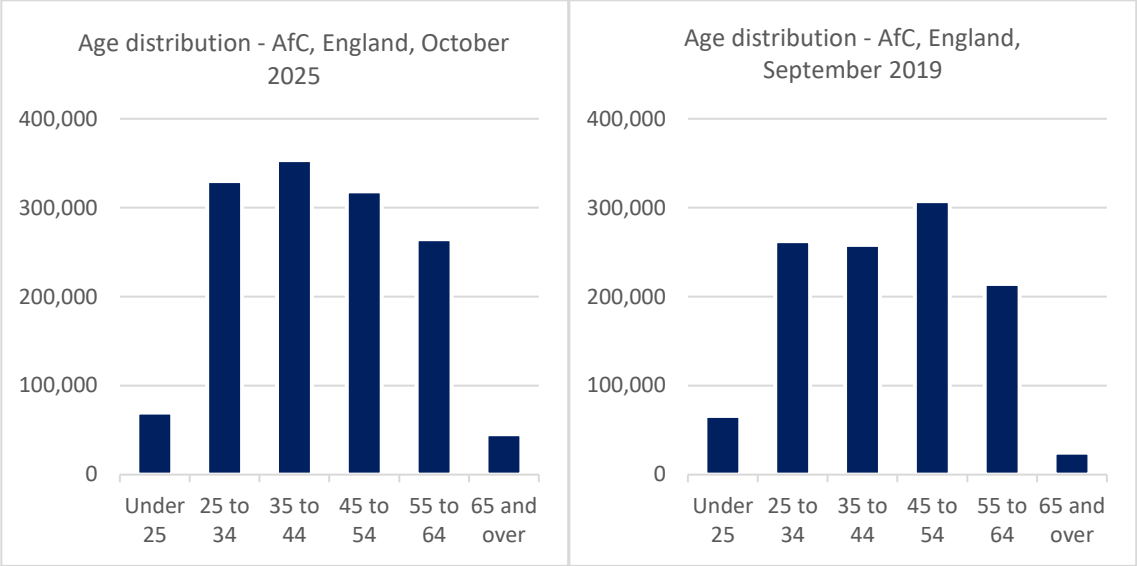
Table A.5: NHS staff in AfC roles by ethnic group, in Wales, September 2024, %, headcount

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

Source: Stats Wales

33. Figure A.22 shows a breakdown of AfC staff in England, by age group, in October 2025 and September 2019. In October 2025, 24% of staff were aged 25 to 34, 26% were aged 35 to 44, 23% were aged 45 to 54, 19% were aged 55 to 64, 5% were under 25 and 3% were aged 65 and over. Figure A.22 also shows the breakdown of AfC staff in September 2019. Between September 2019 and October 2025, the share of staff aged between 45 to 54 fell by four percentage points, from 27% to 23%, while the share of those aged 35 to 44, increased by three percentage points and those aged 25 to 34 and 65 and over each increased by one percentage point. Between 2019 and 2025 the percentage of AfC staff aged 44 and below, increased from 52% to 55%.

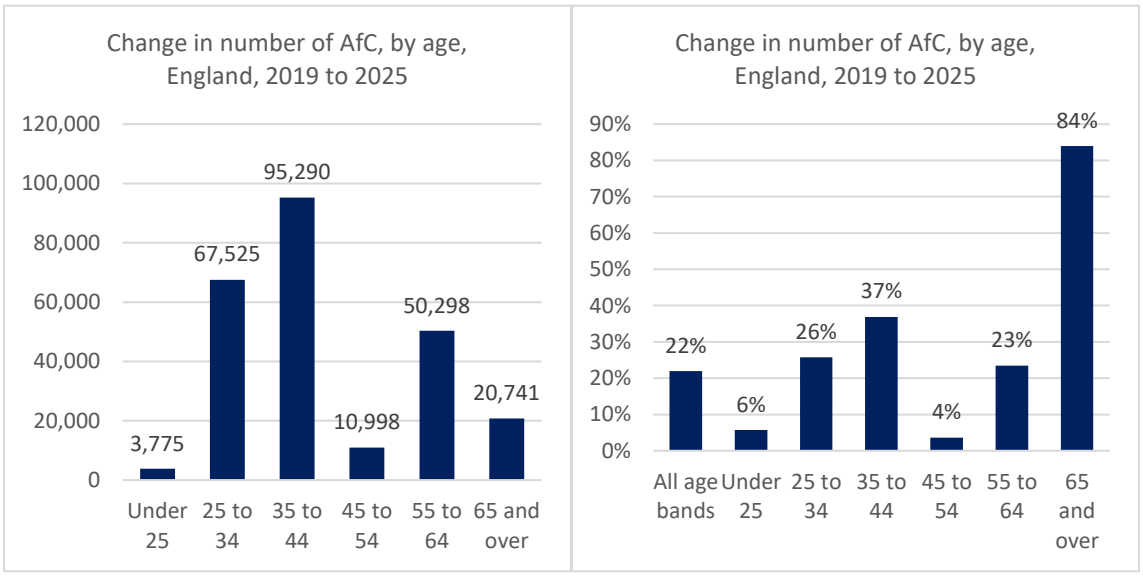
Figure A.22: Staff in AfC roles by age, in England, October 2025 and September 2019, headcount



Source: NHS England

34. Figure A.23 shows that the number of AfC staff increased by 22% between September 2019 and October 2025. Broken down by age group, the number of staff: aged 65 and over increased by 84% (20,471); aged 35 to 44 increased by 37% (95,290); aged 25 to 34 increased by 26% (67,525); aged under 25 increased by 6% (3,775); aged 55 to 64 increased by 23% (50,298); and the number of staff aged 45 to 54 increased by 4% (10,998).

Figure A.23: Change in the number of staff in AfC roles by age, in England, September 2019 to October 2025, headcount

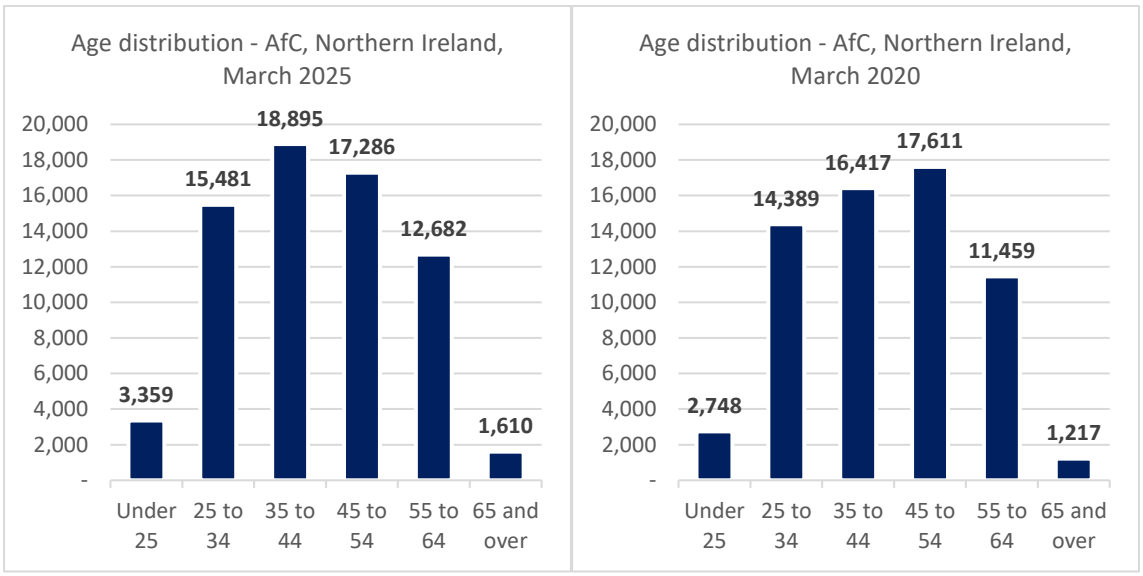


Source: NHS England

35. Figure A.24 shows a breakdown of HSC staff in Northern Ireland, by age group, in March 2025 and March 2020. In March 2025, 27% of staff were aged 35 to 44, 25% were aged 45 to 54, 22% were aged 25 to 34, 18% were aged 55 to 64, 5% were under 25 and 2% were aged 65 and over. Figure A.24 also shows the breakdown of HSC staff in March 2020. Between March 2020 and March 2025, the share of staff aged between 45 to 54 fell by three percentage points, from 28% to 25%, while the shares of those aged 35 to 44 increased by two percentage

points, and under 25 increased by one percentage point. Between 2019 and 2025 the percentage of HSC staff aged 44 and below, increased from 53% to 54%.

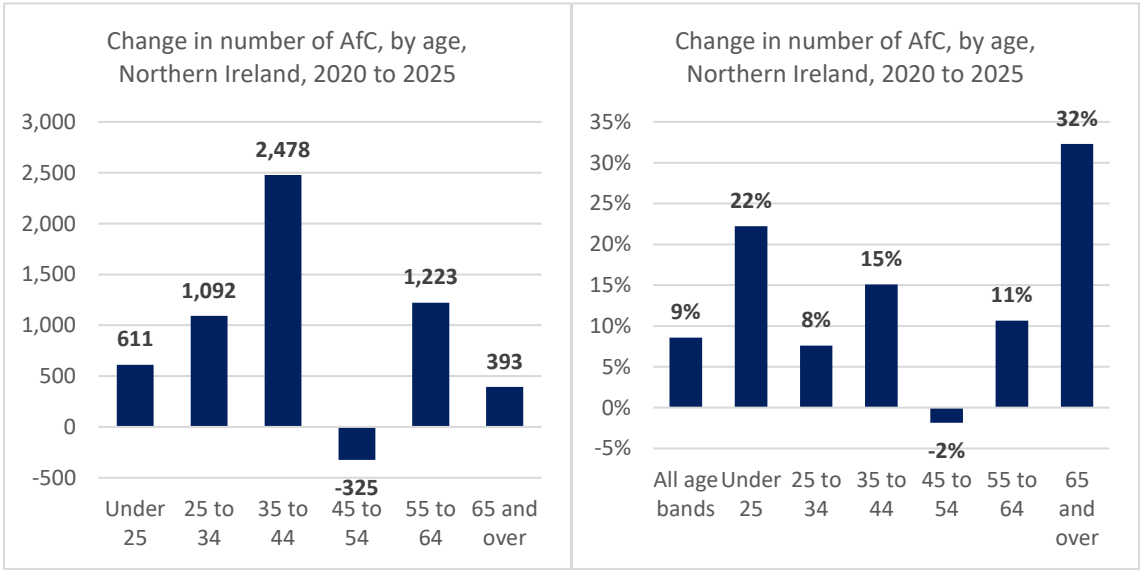
Figure A.24: Staff in AfC roles by age, in Northern Ireland, March 2025 and March 2020 headcount



Source: Department of Health, Northern Ireland

36. Figure A.25 shows the change in the number of AfC staff in Northern Ireland between March 2020 and March 2025. Overall the number of AfC staff increased by 9% over the period, but broken down by age group, the number of staff: aged 65 and over increased by 32% (393); aged under 25 increased 22% (611); aged 35 to 44 increased 15% (2,478); aged 25 to 34 increased by 8% (1,092); aged 55 to 64 increased by 11% (1,223); and the number of staff aged 45 to 54 fell by 2% (325).

Figure A.25: Change in the number of staff in AfC roles by age, in Northern Ireland, March 2020 to March 2025, headcount

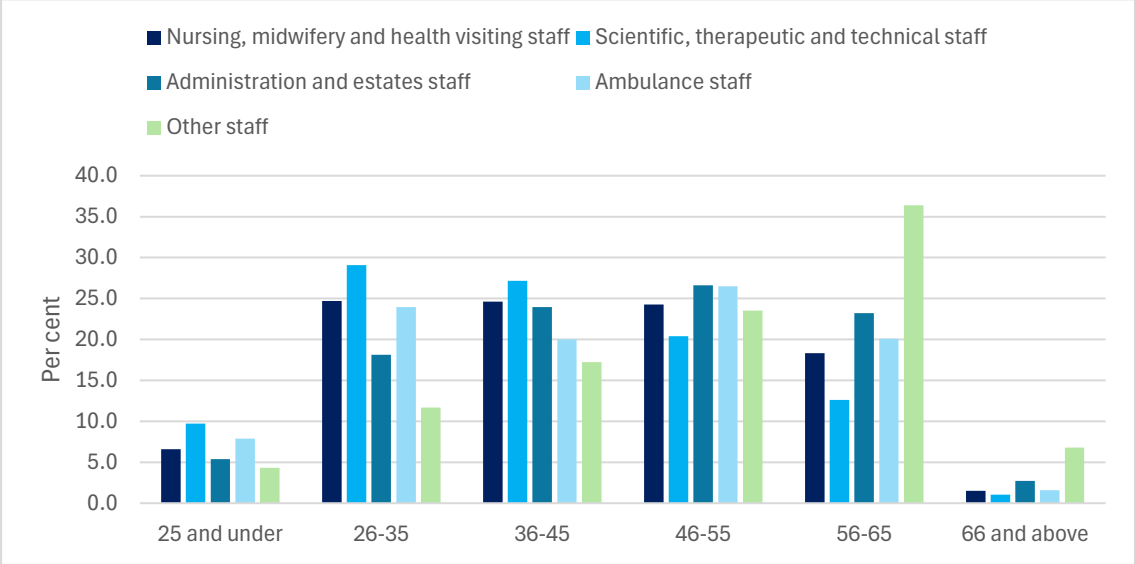


Source: Department of Health, Northern Ireland

37. NHS Wales started publishing data on the age of staff from 2022 onwards. Figure A.26 shows the age distribution of broad staff groups in September 2024, the latest data available at the time of submitting this report. The age ranges used are slightly different from those used by

England and Northern Ireland so impact on cross country comparisons. However, within Wales, there are a larger percentage of scientific, therapeutic and technical staff in the younger age ranges than other staff groups, while there are a larger percentage of administration and estates staff, and 'other' staff in the older age ranges than for other staff groups.

Figure A.26: Staff in AfC roles by age, in Wales, September 2024, headcount



Source: Stats Wales

38. Table A.6 shows a breakdown of AfC staff in England, by disability status. In December 2019, 3.7% of staff said they were disabled, 73.0% said they were not disabled while the disability status of 23.4% was unknown. In October 2025, compared with September 2019, there were increases: to 8.3% in the percentage of AfC staff saying they were disabled; and to 81.9% in the percentage saying they were not disabled. Between September 2019 and October 2025, the percentage of AfC staff whose disability status was unknown, fell from 23.4% to 9.8%.

Table A.6: NHS staff in AfC roles by disability status, in England, September 2019 and October 2025, headcount

Date	Staff group	Disabled	Not disabled	Not known
September 2019	All AfC	3.7%	73.0%	23.4%
March 2025	All AfC	8.3%	81.9%	9.8%
	Nurses & health visitors	6.8%	83.2%	10.0%
	Midwives	8.3%	81.5%	10.2%
	Ambulance staff	9.9%	79.1%	11.1%
	Scientific, therapeutic & technical staff	8.7%	83.0%	8.4%
	Support to doctors, nurses & midwives	8.2%	82.2%	9.6%
	Support to ambulance staff	10.6%	79.2%	10.1%
	Support to ST&T staff	11.3%	80.2%	8.6%
	Central functions	10.7%	80.9%	8.4%
	Hotel, property & estates	6.3%	77.4%	16.4%
	Senior managers	7.8%	82.3%	9.9%
	Managers	9.3%	82.1%	8.6%

Source: NHS England

39. Table A.7 shows a breakdown of NHS staff in Wales, by disability status. In September 2022, the earliest data for which data is available, 3.7% of staff said they were disabled, 71.1% said they were not disabled while the disability status of 25.2% was unknown. In September 2024, the latest data available at the time of submitting this report, compared with September 2022, there were increases: to 5.8% in the percentage of NHS staff saying they were disabled; and to 77.4% in the percentage saying they were not disabled. Between September 2022 and September 2024, the percentage of NHS staff whose disability status was unknown, fell from 25.2% to 16.8%.

Table A.7: NHS staff, by disability status, in Wales, September 2022 and September 2024, headcount

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

Source: Stats Wales

40. Table A.8 shows a breakdown of AfC staff in England, by religious belief. In October 2025, the percentage of AfC staff saying they had religious beliefs was as follows: Christianity (48%); Atheism (17%); Islam (5%); Hinduism (3%), Sikhism (1%); Buddhism (1%); other religious beliefs (8%). Between September 2019 and October 2025 there was an increase in the percentage of AfC staff saying they had belief in each of the religions listed in Table A.7, and there was a fall in the percentage of AfC staff whose religious beliefs were unknown, falling from 32% to 19%.

Table A.8: NHS staff in AfC roles by religious belief, in England, September 2019 and June 2025, headcount

	Atheism	Buddhism	Christianity	Hinduism	Islam	Sikhism	All others	Not Known
September 2019	11%	0%	45%	1%	3%	1%	7%	32%
October 2025	17%	1%	48%	3%	5%	1%	8%	19%

Source: NHS England

41. Table A.9 shows a breakdown of AfC staff in England, by sexual orientation. In October 2025, the percentage of AfC staff describing their sexual orientation was as follows: Heterosexual or Straight (81.5%); Gay or Lesbian (2.1%); Bisexual (1.7%); other sexual orientation (0.3%); undecided (0.2%). Between September 2019 and October 2025, there was an increase in the percentage of AfC staff saying they were Bisexual, Gay or Lesbian; Heterosexual or Straight, Other sexual orientation, Undecided, and there was a fall in the percentage of AfC staff whose sexual orientation was unknown, falling from 28.4% to 14.3%.

Table A.9: NHS staff in AfC roles by sexual orientation, in England, September 2019 and June 2025, headcount

	Bisexual	Gay or Lesbian	Heterosexual or Straight	Other sexual orientation	Undecided	Not known
September 2019	0.7%	1.5%	69.4%	0.0%	0.0%	28.4%
October 2025	1.7%	2.1%	81.5%	0.2%	0.2%	14.3%

Source: NHS England

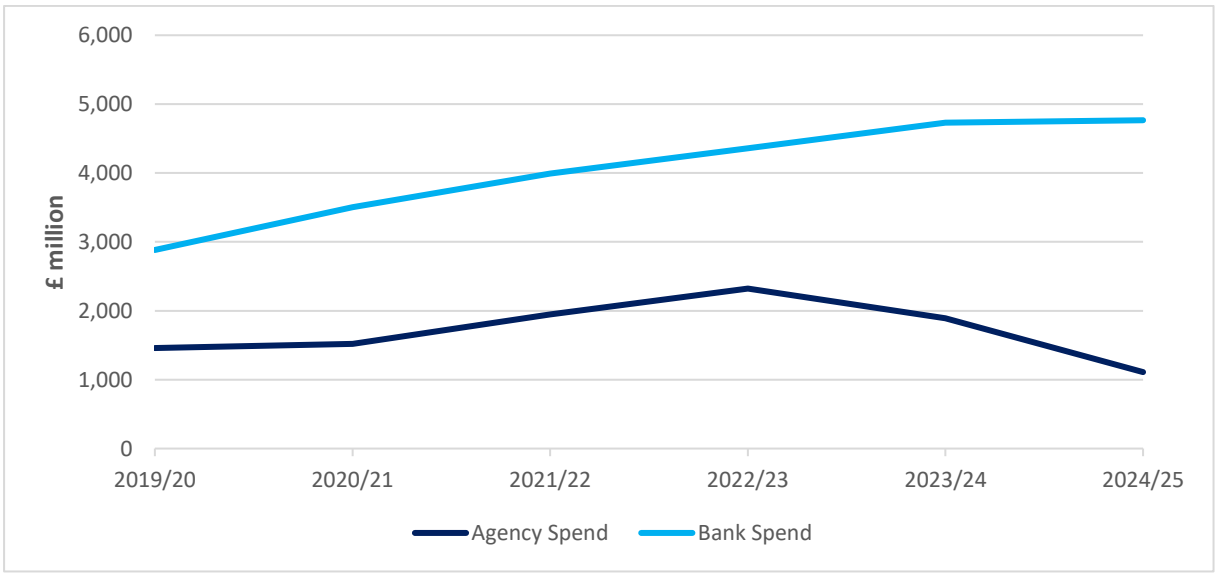
Temporary staff and spend

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

43. In **England**, NHSE said that in 2024/25 expenditure on bank and agency staff (excluding medical and dental) was £5.9 billion, of which £1.1 billion was agency spend. It said that bank and agency spend combined was equivalent to 9.0% of the pay bill, a fall from 11.4% in both 2021/22 and 2022/23. Bank spend was equivalent to 7.3% of the pay bill in 2024/25, a reduced share from 7.8% in 2023/24, while agency spend was 1.7% of the pay bill, a reduced share from 3.1% in 2023/24.

44. NHSE said that between 2023/24 and 2024/25 the percentage of temporary staffing covered by bank shifts increased from 81.3% to 86.9%, while the share covered by agency reduced from 18.7% to 13.1%. The proportion of agency spend as a share of overall temporary staffing costs have fallen from 28.6% in 2023/24 to 18.9% in 2024/25.

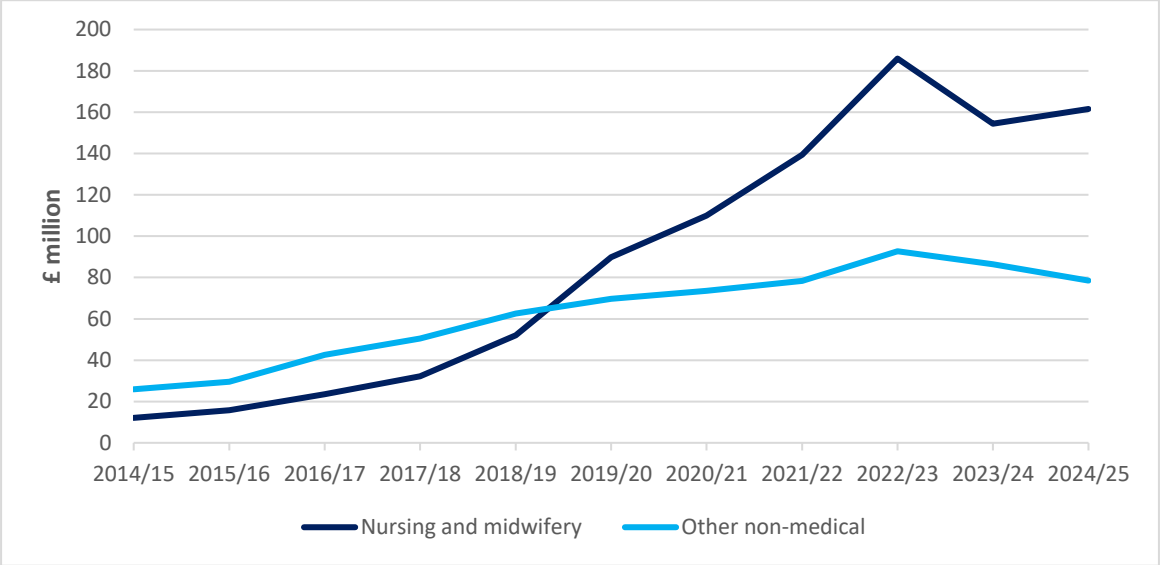
Figure A.27: Agency and bank spend, for AfC staff groups, England, 2019/20 to 2024/25



Source: NHS England

45. Figure A.28 shows agency spend in **Northern Ireland** for nursing and midwifery staff and other non-medical staff between 2014/15 and 2024/25. Expenditure on nursing and midwifery staff increased from £12 million in 2014/15 to £186 million in 2022/23, fell back to £154 million in 2023/24, before increasing to £161.6 million in 2024/25. Expenditure on other non-medical staff increased from £26 million in 2014/15 to £93 million in 2022/23, before falling back to £86 million in 2023/24, and £79 million in 2024/25.

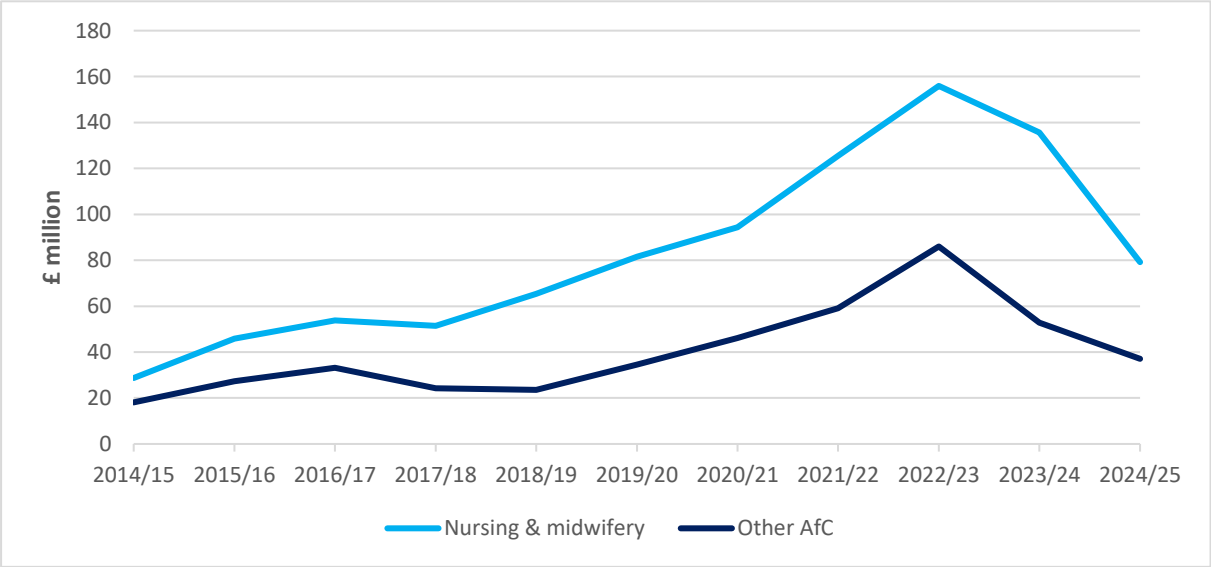
Figure A.28: Agency spend, for AfC staff groups, Northern Ireland, 2014/15 to 2024/25



Source: Department of Health, Northern Ireland

46. The **Welsh Government**'s evidence said that agency expenditure fell in 2024/25, compared with 2023/24. Overall agency expenditure on AfC posts was £116 million, a reduction of £72 million (38%) from 2023/24. The Welsh Government provide agency spend split by some staff groups, and this shows that over that period expenditure to cover nursing and midwifery staff reduced by £56 million (42%) while expenditure on other AfC posts reduced by £16 million (30%) (Figure A.29).

Figure A.29: Agency spend, for AfC staff groups, Wales, 2014/15 to 2024/25



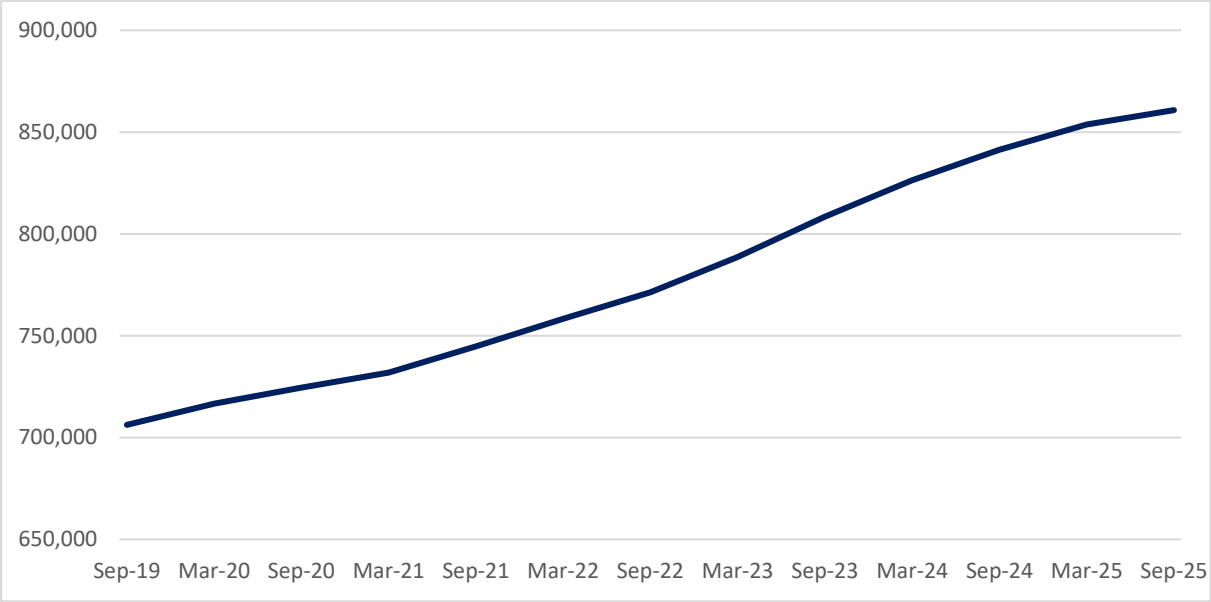
Source: Welsh Government

Nursing and Midwifery Council (NMC) Register

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

48. The latest data for September 2025, showed that there were 860,801 nurses and midwives registered to work in the UK (Figure A.30), an increase of 19,443 (2.3%) from a year earlier.

Figure A.30: Number of nurses and midwives on the NMC register, September 2019 to September 2025



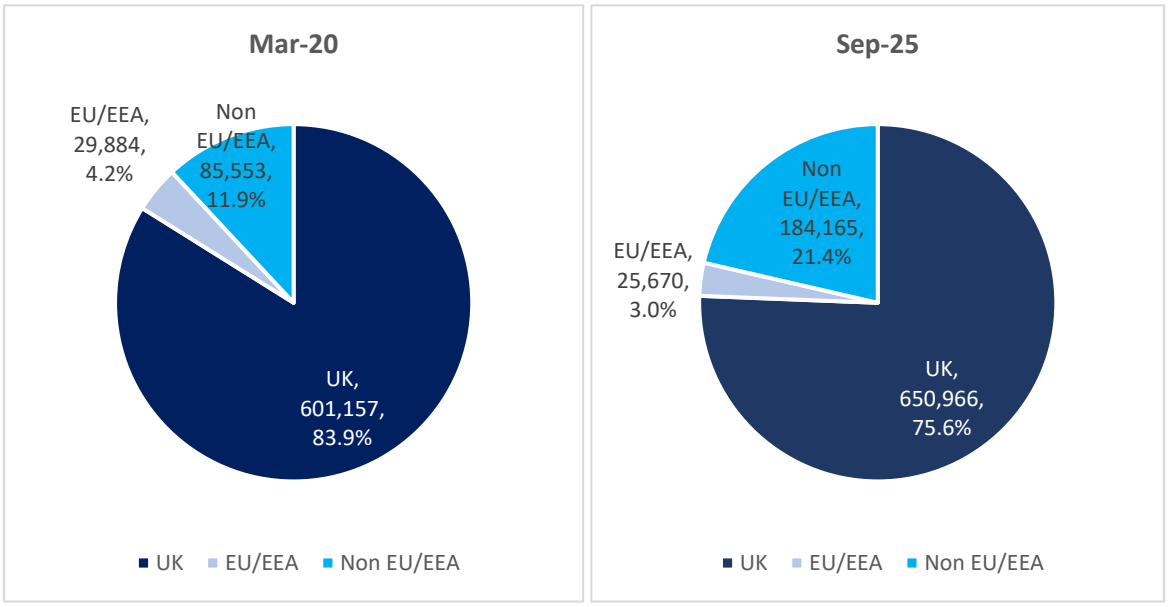
Source: NMC

49. Of the overall total, 650,966 (75.6%) were initially registered in the UK, 25,670 (3.0%) were initially registered in the EU/EEA, and 184,165 (21.4%) initially registered outside the UK and the EU/EEA (Figure A.31).

50. Compared with March 2020, the numbers on the NMC register have increased by 144,206 (20%). There was an increase in the number initially registered in the UK of 49,809 (8%), a fall in the number initially registered in the EU/EEA of 4,214 (-14%) and an increase in the number initially registered outside the UK and the EU/EEA of 98,611 (115%).

51. Between March 2020 and September 2025, the share of those on the register initially registered outside the UK and EU/EEA increased from 11.9% to 21.4%, while the share initially registered in the UK fell from 83.9% to 75.6%, and the share initially registered in the EU/EEA fell from 4.2% to 3.0%.

Figure A.31: Overall number of nurses and midwives on the NMC register by area of qualification, UK, March 2020 and September 2025

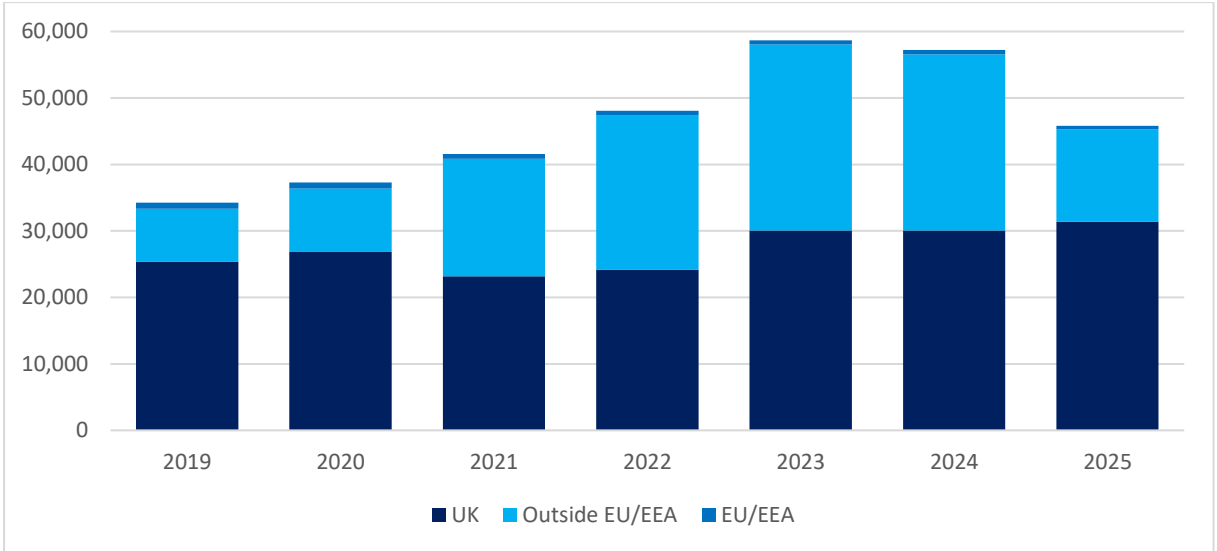


Source: NMC

52. In the year to September 2025, there was an increase of 19,443 (2.3%) nurses and midwives on the register, as 45,823 joined the register for the first time and 30,135 left the register[73].

53. Figure A.32 shows the numbers joining the register for the first time between the year to September 2019 and the year to September 2025. In the year to September 2025, the numbers joining the register were 20% lower than in the previous year. There were: 31,365 joining from the UK, an increase of 1,281 (4%) from the previous year; 13,905 joining from outside the EU/EEA, a fall of 12,553 (47%) from the previous year; and 553 joiners from the EU/EEA, a fall of 116 (17%) from the previous year.

Figure A.32: New joiners to the NMC register, between year to September 2019 and year to September 2025, from the UK, EU/EEA and outside the EU/EEA

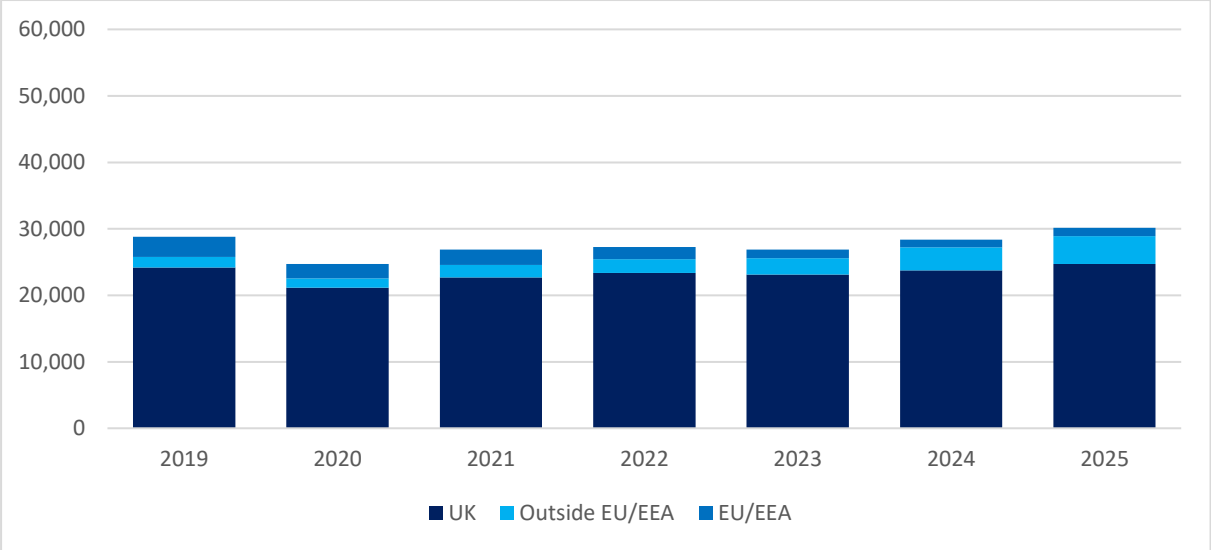


Source: NMC

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

54. Figure A.33 shows the numbers leaving the register between the year to September 2019 and the year to September 2025. The number of leavers each year remains below the number of joiners, as numbers on the register continue to increase. In the year to September 2025, there was an increase in the numbers leaving the register of 1,753 (6%). There were: 24,702 leaving from the UK, an increase of 944 (4%) from the previous year; 4,192 leaving from outside the EU/EEA, an increase of 745 (22%) from the previous year; and 1,241 leavers from the EU/EEA, an increase of 64 (5%) from the previous year.

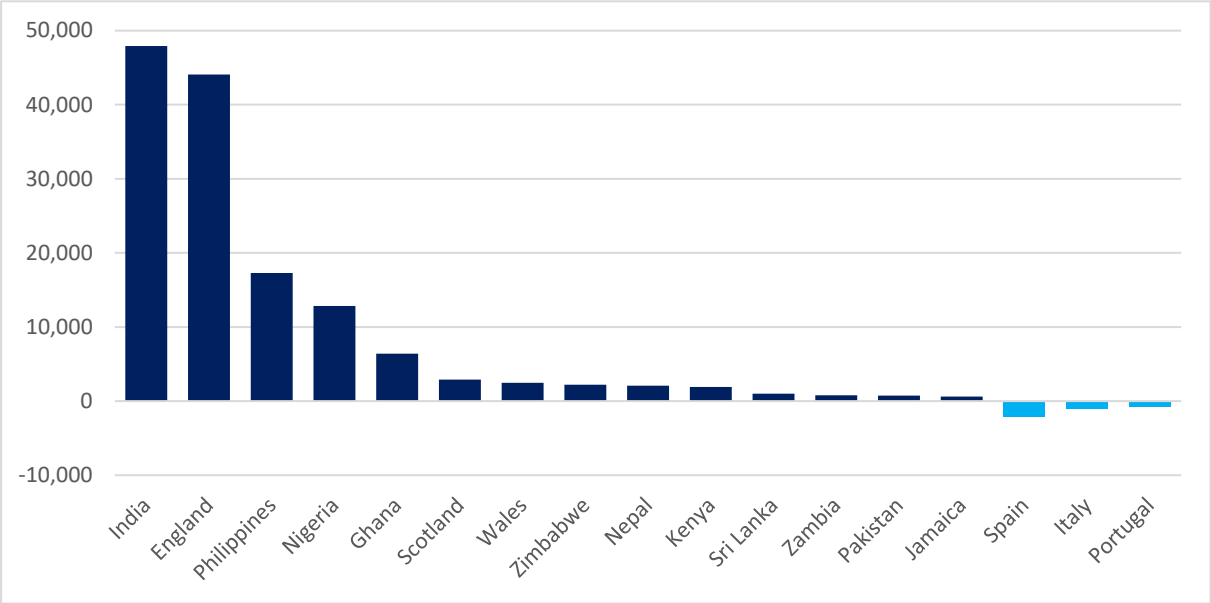
Figure A.33: Leavers from the NMC register, between year to September 2019 and year to September 2025, from the UK, EU/EEA and outside the EU/EEA



Source: NMC

55. Figure A.34 shows the change in the numbers on the NMC register, between March 2020 and September 2025, by country of training. This shows that the growth in the numbers on the register trained in India (47,920) were larger than the growth in the numbers trained in England (44,060). There were also marked increases in the numbers on the register trained in the Philippines (17,293), and Nigeria (12,851). The three countries with the largest fall in numbers on the register over the period were Portugal, Italy and Spain.

Figure A.34: Changes in the numbers on the NMC register, by country of training, March 2020 to September 2025

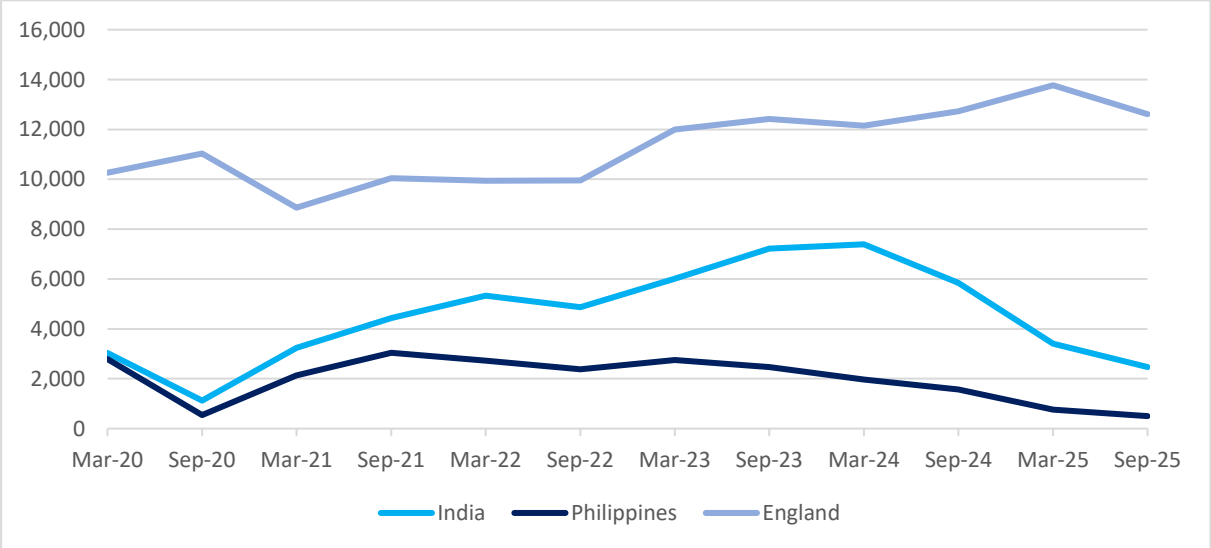


Source: NMC

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

56. Figure A.35 highlights the growth in the numbers joining the NMC register who were trained in India and the Philippines between the six months to March 2020 and the six months to September 2025. The latest numbers, for the six months to September 2025, compared with the same period a year earlier, show a fall in the number of joiners trained in India (58%), and the Philippines (68%). This compares, over the same period, with a fall of 1% in the number of new joiners trained in England.

Figure A.35: New joiners to the NMC register, by country of training, England, India and the Philippines, 6 months to March 2020 to 6 months to September 2025



Source: NMC

Health care professions

57. The Health and Care Professions Council (HCPC) are the regulator of 15 health and care professions in the UK, and by law, individuals must be registered with the HCPC to work in

these professions in the UK (in the NHS or any other setting). Table A.10 shows that there were 365,621 people on the HCPC register in August 2025. The numbers vary by profession, ranging from almost 80,300 physiotherapists, to just over 1,300 prosthetists/orthotists and 1,600 orthoptists.

58. Between August 2024 and August 2025, the number of people on the register grew by 5.8%. There were increases in the numbers registered to practice 14 of the 15 professions, ranging from a 2.4% increase in the number of operating department practitioners to an 8.6% increase in the number of physiotherapists. There was a 2.3% fall in the number of chiropodists/podiatrists on the register.

Table A.10 Numbers on the Health and Care Professions Council (HCPC) register, by profession, August 2024 and August 2025

	August 2024	August 2025	Annual change
Arts therapists	5,714	6,181	8.2%
Biomedical scientists	28,579	30,396	6.4%
Chiropodists/ podiatrists	12,338	12,050	-2.3%
Clinical scientists	7,750	8,302	7.1%
Dietitians	11,958	12,907	7.9%
Hearing aid dispensers	4,571	4,826	5.6%
Occupational therapists	46,160	48,361	4.8%
Operating department practitioners	16,927	17,325	2.4%
Orthoptists	1,568	1,616	3.1%
Paramedics	38,762	41,381	6.8%
Physiotherapists	73,953	80,297	8.6%
Practitioner psychologists	29,100	30,177	3.7%
Prosthetists/ orthotists	1,237	1,306	5.6%
Radiographers	47,582	49,953	5.0%
Speech and language therapists	19,447	20,543	5.6%
All professions	345,646	365,621	5.8%

Source: Register over time | The HCPC

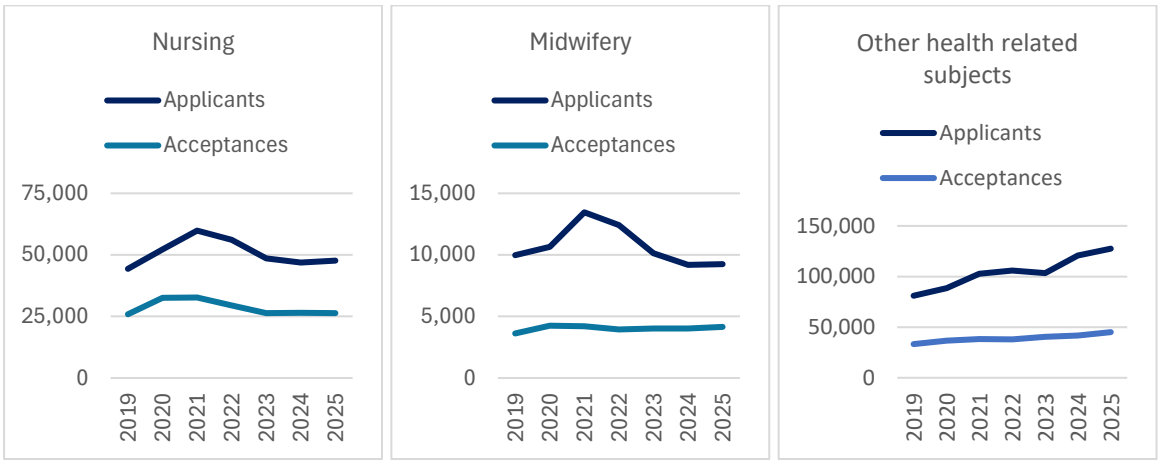
Pre-registration entrants

59. Figure A.36 shows the number of applicants and acceptances to study for nursing, midwifery, and other health related degrees between 2019 and 2025. The numbers of applicants for nursing, midwifery and other health related degrees all rose in 2020 and 2021. However, the numbers of applicants for nursing courses fell in each of the next three years, before growing by 1.6% between 2024 and 2025, to remain 7% above 2019 levels. The number of applicants for midwifery courses also fell in each of the next three years, before growing by 0.7% between 2024 and 2025, but remained 7% below 2019 levels. The number of applicants to study other health related degrees continued to rise in 2022, fell back in 2023, but increased sharply in both 2024 and 2025. In 2025 the number of applicants to study other health related degrees, was 5.6% higher than in 2024, and 57% higher than in 2019.

60. The numbers accepted to study nursing and midwifery degrees rose in 2020 and 2021, likely related to the increase in A-Level grades that resulted from centre assessed grading. However, from 2022 onwards the numbers accepted to study nursing and midwifery have fallen back towards the levels seen in 2019 prior to Covid-19. The numbers accepted in 2025, compared with 2019, were 2% higher for nursing and 14% for midwifery.

61. For other health related degrees, the number of acceptances also increased in 2020 and 2021 before falling back in 2022. However, there has been an increase in the numbers accepted on to courses of this type in each year between 2023 and 2025, such that in 2025 the number of people accepted to study these subjects was 7.6% higher than in 2024 and 35% higher than in 2019.

Figure A.36: Number of applicants and acceptances for nursing, midwifery and other health related degrees[74], 2019 to 2025



Source: UCAS

Retention

62. Turnover data, for **England**, showed that the outflow rate for AfC staff as a whole, reached 12.3% in the year to June 2022, the highest rate recorded since at least 2010. Since then, outflow rates have fallen back to 9.5%, in the year to October 2025. From the 12 months to June 2025 onwards, the annual outflow rates have been the lowest recorded since the 12 months to November 2010 (except for a short period during the Covid-19 pandemic).

63. Table A.11 shows leaving rates, by staff group, for the years to October 2025 (the latest available data), October 2024 and October 2019 (prior to the Covid-19 pandemic). The columns on the right-hand side of the table shows the percentage point changes in leaving rates between 2019 and 2025 and 2024 and 2025.

64. Between 2024 and 2025, the turnover rate for all AfC staff fell by 0.3 percentage points, with falls for ambulance staff (0.3 percentage points), nurses and health visitors (0.5), ST&T staff (0.4), hotel, property and estates (0.1) and senior managers (0.3). Over the same period there was an increase in the turnover rate for midwives (0.3), central functions (0.1), support to ambulance staff (0.6 percentage points), and managers (0.1).

65. The turnover rate in the year to October 2025, for AfC staff as a whole, was 0.8 percentage points below that for the year to October 2019, prior to the Covid-19 pandemic. For all staff groups, the turnover rate in 2025 was lower than in 2019, with the exceptions of support staff groups and hotel, property and estates staff.

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

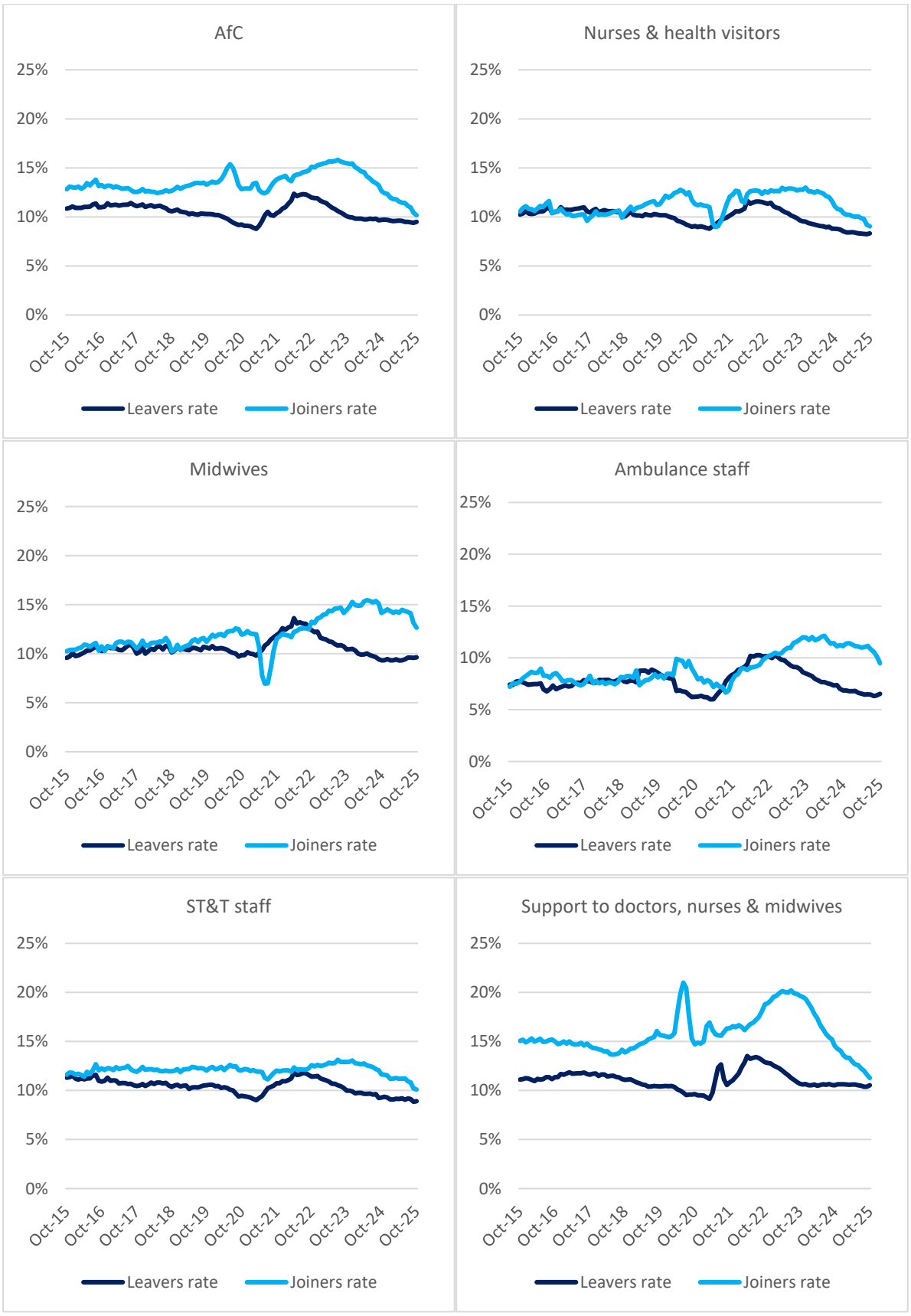
Table A.11: Leaving rates from the NHS by staff group, headcount, year to October 2019, October 2024 and year to October 2025, England

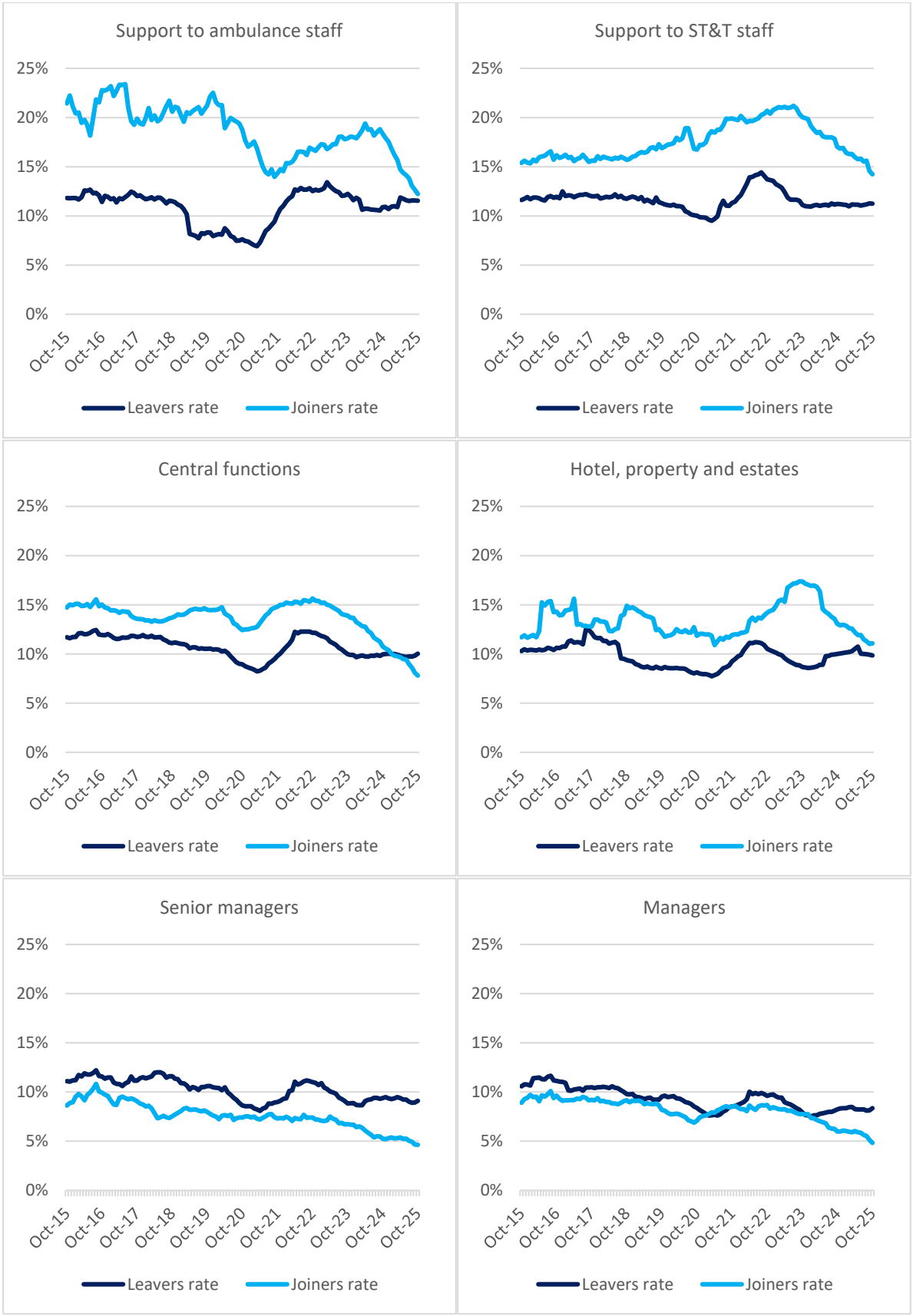
	Turnover in the year to October			Percentage point change between	
	2019	2024	2025	2019 and 2025	2024 and 2025
AfC	10.3%	9.7%	9.5%	-0.8	-0.3
Nurses & health visitors	10.2%	8.8%	8.3%	-1.8	-0.5
Midwives	10.6%	9.3%	9.6%	-1.0	0.3
Ambulance staff	8.6%	6.9%	6.5%	-2.0	-0.3
Scientific, therapeutic & technical (ST&T) staff	10.5%	9.3%	8.9%	-1.6	-0.4
Support to doctors, nurses, midwives	10.4%	10.5%	10.5%	0.1	0.0
Support to ambulance staff	8.3%	10.9%	11.5%	3.2	0.6
Support to ST&T staff	11.3%	11.2%	11.2%	-0.1	0.0
Central functions	10.5%	10.0%	10.0%	-0.5	0.1
Hotel, property and estates	8.5%	10.0%	9.9%	1.3	-0.1
Senior managers	10.6%	9.4%	9.1%	-1.5	-0.3
Managers	9.5%	8.2%	8.3%	-1.2	0.1

Source: NHS England

66. Figure A.37 shows the leaving and joining rates for staff groups in England, between the year to October 2015 and the year to October 2025.

Figure A.37: Leaving rates and joining rates from the NHS by staff group, headcount, year 2015 to 2025, England

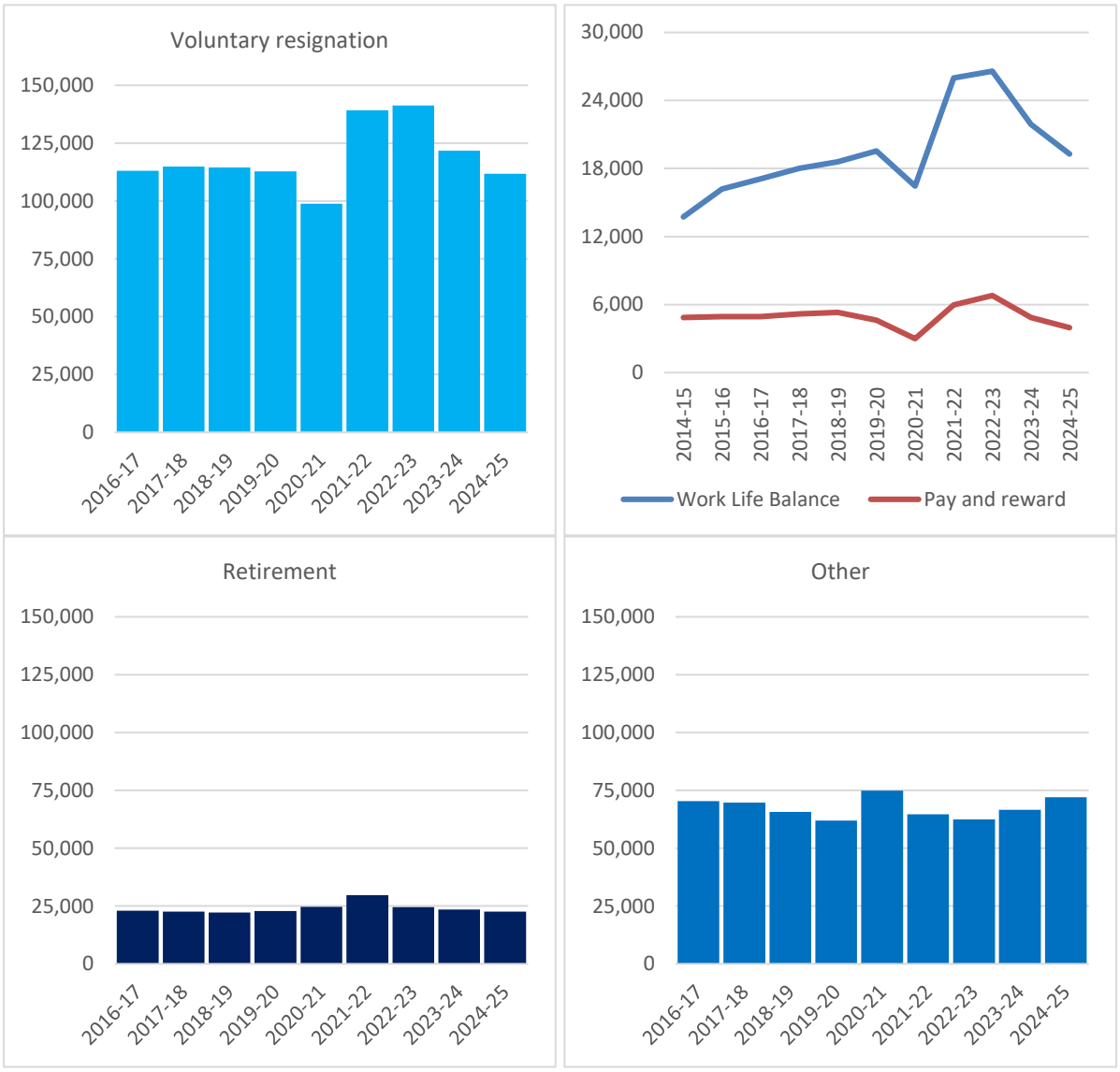




Source: NHS England

67. NHSE publish data of reasons for leaving and staff movement in England. Figure A.38 shows that, for those leaving or moving between April 2024 and March 2025 there were 112,000 voluntary resignations, 23,000 were retirements, and 72,000 left or moved for other reasons. There were 19,300 staff leaving or moving for Work Life Balance, compared with 4,000 who left or moved for reasons relating to pay and reward.

Figure A.38 Timeseries of reasons for leaving and staff movements, 2014/15 to 2024/25, England, all staff groups (including medical and dental)



Source: NHS England

68. In Northern Ireland, the leaving rate for all HSC staff (including medical and dental staff) in 2024/25 was 7.0%, down from 7.7% in 2023/24, and the lowest annual rate since 2020/21 (5.6%).

Morale and motivation

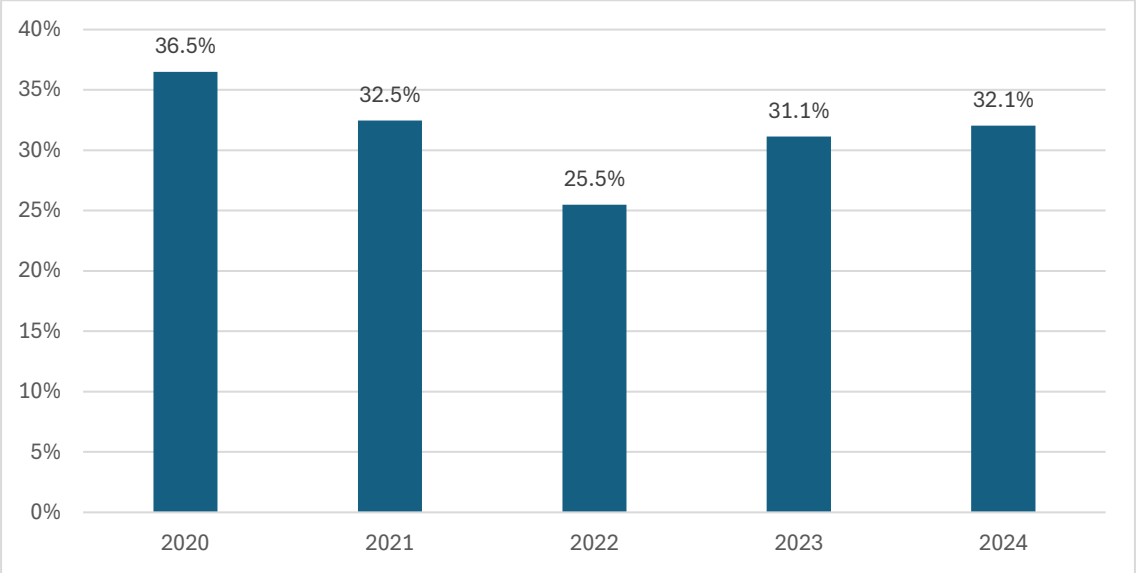
NHS Staff Survey (England)

69. The results of the 2025 NHS Staff Survey in England have yet to be published. Figure A.39 and tables A.12 and A.13 show some of the headline results from the 2024 survey.

70. Figure A.39 shows that in 2024, 32.1% of NHS staff who responded said they were satisfied[75] with their pay, an increase of one percentage point, from 31.1% in 2023, but a decrease of 4.4 percentage points from 2020.

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

Figure A.39: NHS staff, satisfaction with level of pay, England, 2020 to 2024



Source: NHS England

71. Across a range of measures related to job satisfaction (Table A.12) and workload (Table A.13), the results for 2024, were mixed compared with 2023, but remained generally better than in 2022 and 2021.

72. Table A.12 shows that in 2024, compared with 2023, staff were less likely to say that:

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

73. Staff were also less likely to say:

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

74. Table A.13 shows that in 2024, compared with 2023, staff were more likely to say that:

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

75. Staff were also less likely to say:

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

Table A.12: Selected job satisfaction results from the national NHS staff survey, all staff, England, 2020 to 2024

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

Source: NHS England

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

Table A.13: Selected workload results from the national NHS staff survey, all staff, England, 2020 to 2024

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

Source: NHS England

Notes:

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

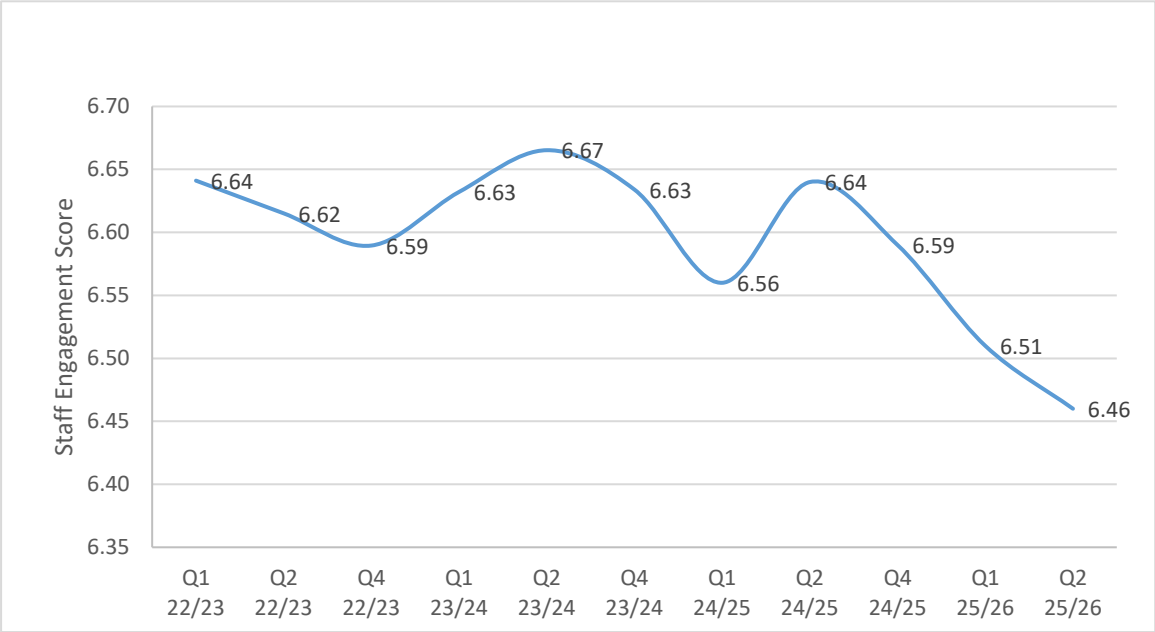
[2] Lower scores are better in these cases, however, in all other cases, higher scores are better.

76. In addition to the annual staff survey (which is usually conducted in Q3 of the financial year), NHS England commission a quarterly Pulse Survey, to track staff sentiment in Q1, Q2 and Q4. The Pulse Survey is conducted three times a year, in: January, April, and July; it usually has between 100,000 and 120,000 responses. This compares with the 2024 annual survey which had in excess of 770,000 responses.

77. In the data pack supporting its written evidence, DHSC included the staff engagement scores from the quarterly surveys conducted between April 2022 and July 2025 (the next survey will not be until January 2026). The engagement scores are for all staff, including medical staff. Figure A.40, showing staff engagement scores over that period. It shows that engagement scores recorded in the pulse surveys have been falling since the second quarter of 2024/25.

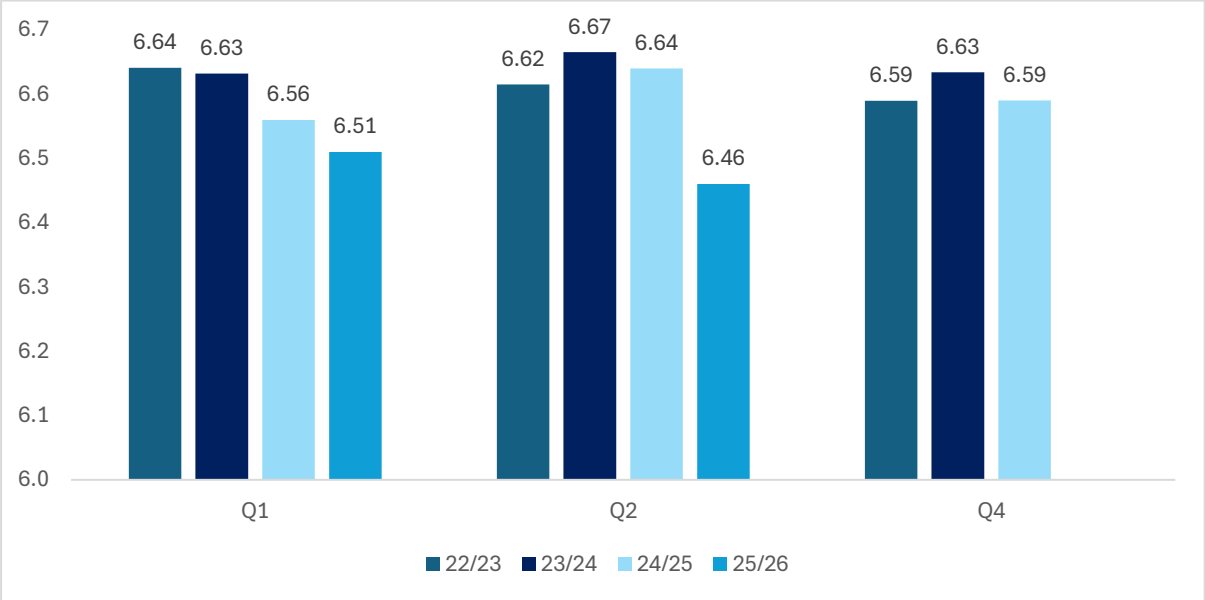
78. DHSC/NHS England said that that there are some signs of seasonality in the data, and comparisons should focus on changes between the same quarter in earlier years, rather than with the previous quarter. Figure A.41 shows the engagement scores from the quarterly surveys, grouped by the quarters in which the surveys were conducted. For each quarter the engagement scores have fallen in each of the last two years.

Figure A.40: National Quarterly Pulse Survey (NQPS), staff engagement scores (from a maximum of 10), Q1 2022/23 to Q2 2025/26



Source: DHSC/NHS England

Figure A.41: National Quarterly Pulse Survey (NQPS), staff engagement scores (from a maximum of 10), Q1 2022/23 to Q2 2025/26



Source: DHSC/NHS England

NHS Staff Survey (Wales)

79. In 2024, for the second consecutive year, NHS Wales conducted a staff survey. The survey generated almost 25,000 responses, a rate of 21.9%, up from 20.7% in 2023. Almost 9,500 responses (38%) were administrative and clerical staff, with a further 5,400 (22%) from registered nursing and midwifery staff.

80. The survey results are grouped together in 10 themes. Comparing the 2024 results with 2023, there were improvements in the results for eight of the themes but declines in the other two

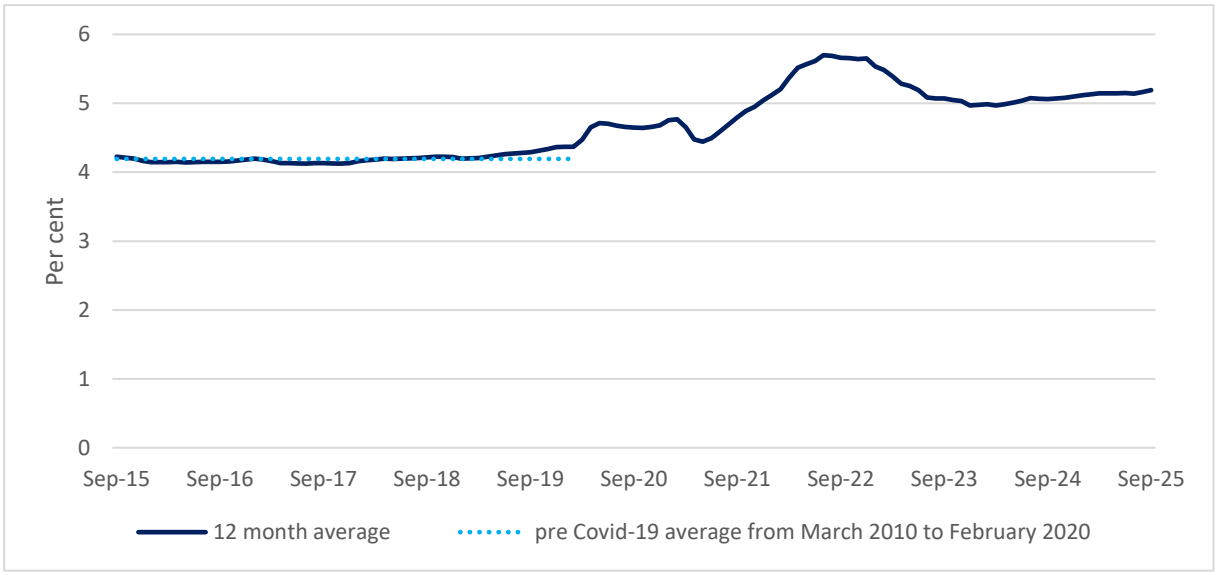
themes (staff engagement and learning and improving). The largest improvements were for the patient safety (+5.1 percentage points) theme, the championing flexible working theme (+3.1 percentage points), and the nurturing a healthy working environment theme (+1.6 percentage points). For the other themes, the results were generally mixed, although on balance an improvement from 2023.

Staff sickness

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

82. Figure A.42 shows sickness absence rates in **England** for staff as a whole between September 2015 and September 2025. Between March 2010 and February 2020 (prior to the Covid-19 pandemic) monthly sickness absence rates fluctuated in a narrow range, between 4% and 5%, averaging 4.2% over that period. Since early 2020 there has been more volatility in sickness absence rates, with sickness absence peaking at an annual rate of 5.7% in the second half of 2022. Sickness absence rates fell back for most of 2023, to 5.0%, but have picked up again over the last year, with the latest data, for the 12 months to September 2025 shows sickness rates at 5.2%. The difference between the sickness absence rate for the 12 months to September 2025, and the long-term average is 1.0 percentage points, the equivalent of having 12,200 fewer AfC FTE staff.

Figure A.42: Sickness absence rates in England, all staff, September 2015 to September 2025



Source: NHS England

83. Table A.14 shows average rates of sickness absence in **England**, by **staff group,** in the year to February 2020 (prior to the Covid-19 pandemic) and the year to September 2025. The staff groups with the highest rates of sickness absence in the year to September 2025 were support to ambulance staff (8.0%), hotel, property and estates staff (7.1%), support to doctors, nurses and midwives (7.1%), and ambulance staff (6.1%).

Table A.14: Rates of sickness absence, England, 12 month average to February 2020 and 12 month average to September 2025, by staff group %

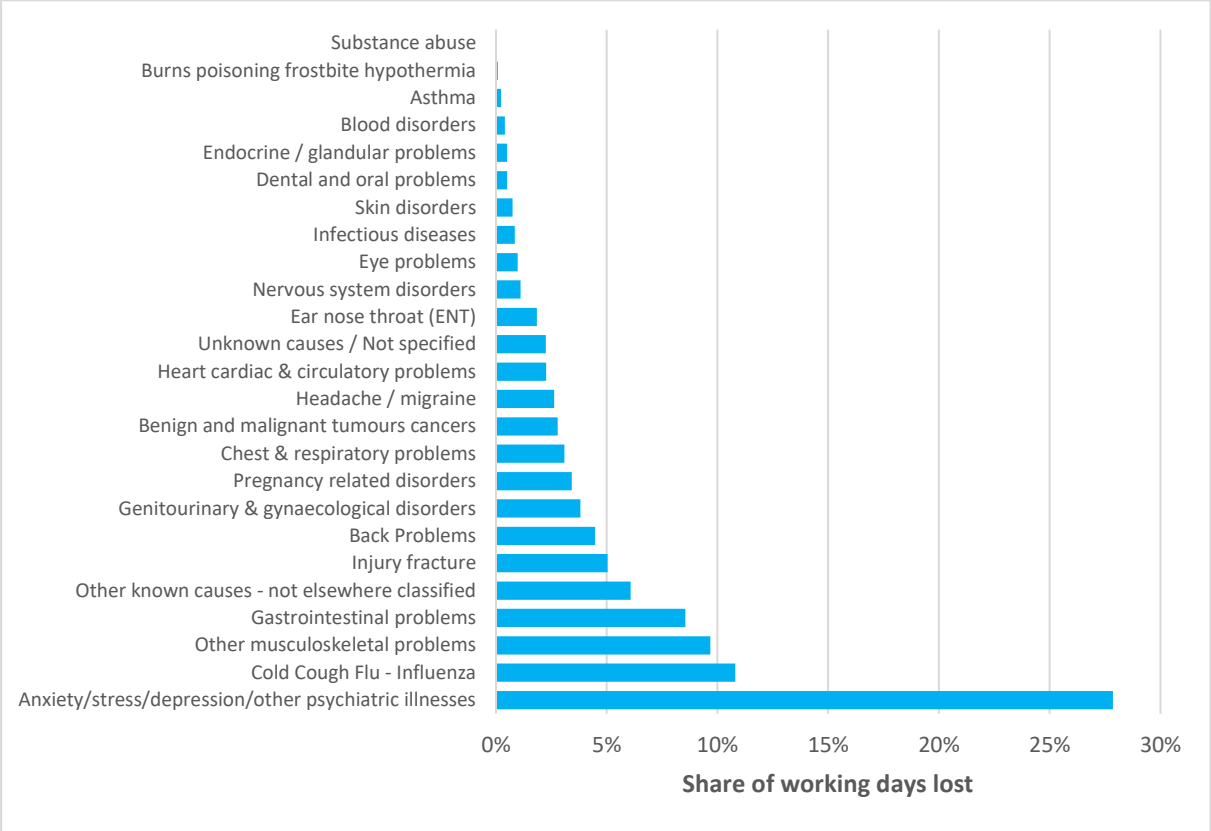
Staff group	12-month average to February 2020	12-month average to September 2025	Change between February 2020 and September 2025
	Percentage points		
All staff groups	4.4	5.2	0.8
Nurses & health visitors	4.6	5.6	1.0
Midwives	5.0	5.8	0.9
Ambulance staff	5.3	6.1	0.8
Scientific, therapeutic & technical staff	3.1	4.0	0.9
Support to clinical staff	5.9	6.9	1.0
Support to doctors, nurses & midwives	6.0	7.1	1.1
Support to ambulance staff	6.6	8.0	1.5
Support to ST&T staff	5.1	5.9	0.8
NHS infrastructure support	4.0	4.5	0.6
Senior managers	1.8	2.1	0.3
Managers	2.3	2.6	0.3
Central functions	3.6	4.0	0.4
Hotel, property & estates	6.0	7.1	1.1
Other staff or those with unknown classification	1.6	1.0	-0.6

Source: NHS England

84. The staff groups with the largest changes in sickness absence rates between the 12-months to February 2020 and the 12-months to September 2025 were support to ambulance staff (increase of 1.5 percentage points), support to doctors, nurses and midwives (1.1), and hotel, property and estates staff (1.1). The staff groups with the smallest changes in sickness absence rates over the period were managers (0.3 percentage points), and senior managers (0.3).

85. Figure A.43 shows the reasons for sickness absence in England, for AfC staff, in the 12 months to September 2025. The most common reason for sickness absence was ‘anxiety, stress, depression and other psychiatric problems’, accounting for 28% of all absence. The next most common reasons for sickness were ‘cold, cough, flu’ (11%), ‘other musculoskeletal problems’ (10%), ‘gastrointestinal problems’ (9%).

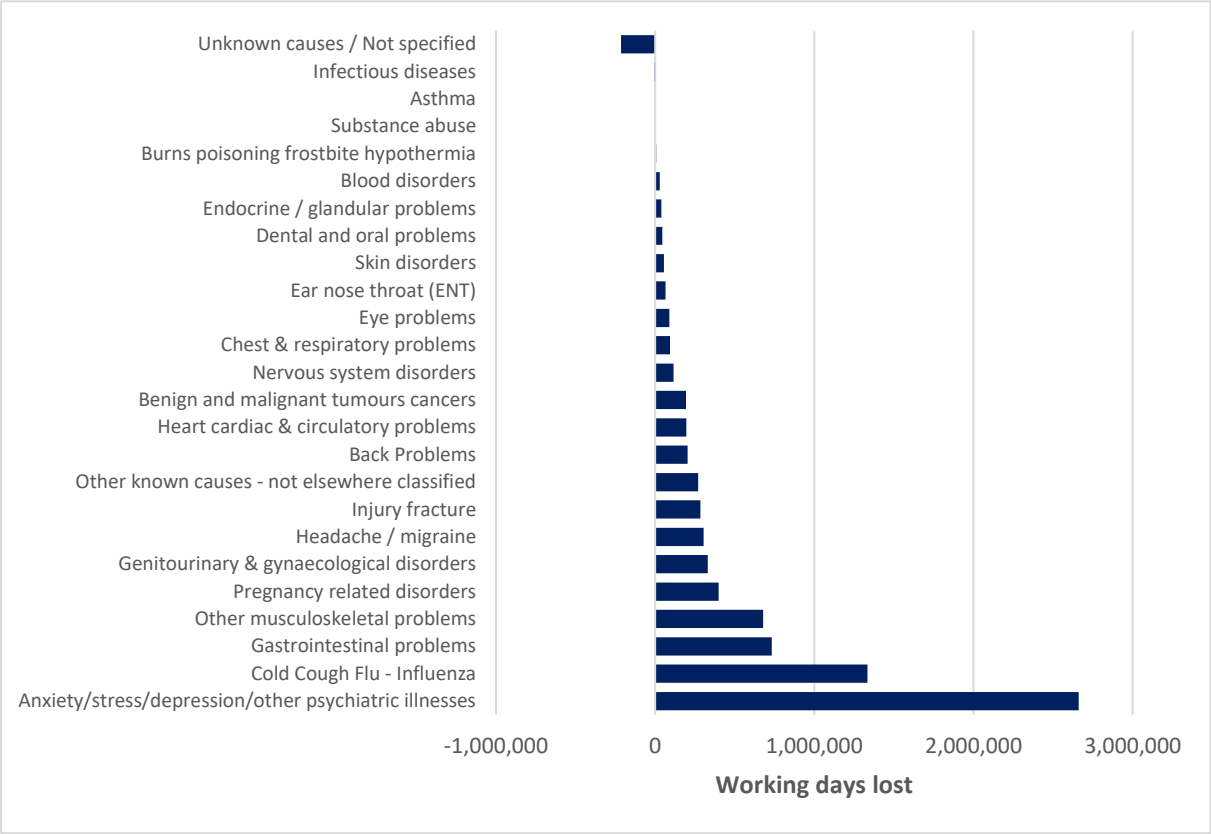
Figure A.43: Sickness absence days, by reason for absence, % of all sickness absence, England, 12 months to September 2025



Source: NHS England

86. In the 12 months to September 2025, there were 26.6 million AfC staff days lost to sickness absence, an increase of 7.9 million, from 18.7 million in the 12 months to March 2020. Figure A.44 shows that half of the extra sickness absence was related to 'anxiety, stress, depression and other psychiatric problems' (2.7 million days), and 'cold, cough, flu' (1.3 million days).

Figure A.44: Change in the number of sickness absence days between 12 months to March 2020 and 12 months to September 2025, by reason for absence, England, AfC staff

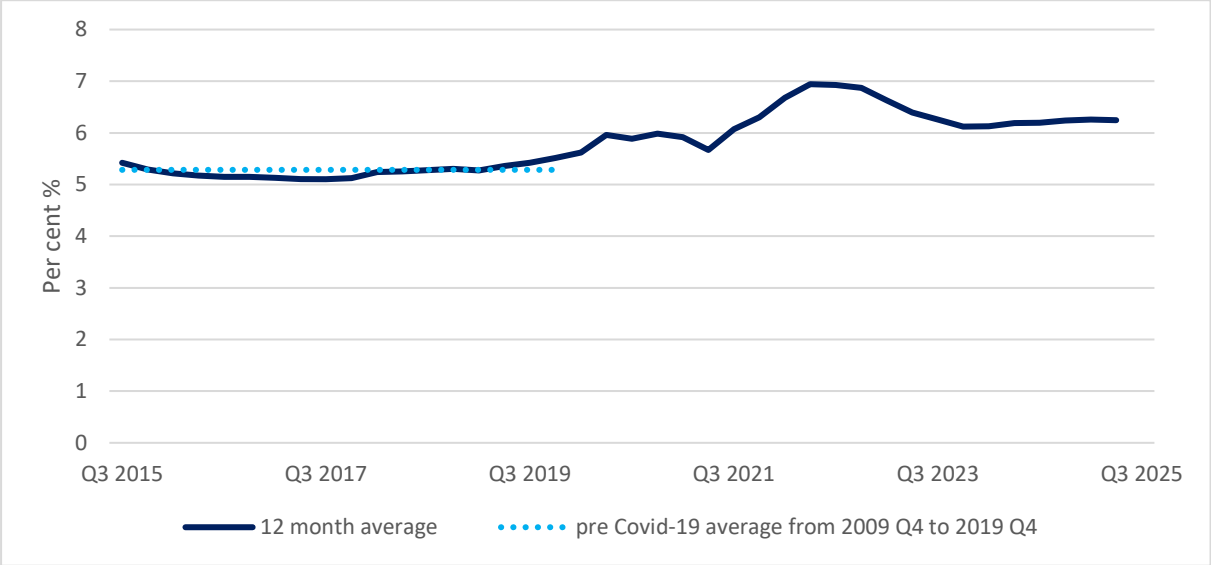


Source: NHS England

87. Figure A.45 shows sickness absence rates in **Wales** for staff as a whole, between September 2015 and June 2025. Between 2010 and February 2020 (prior to the Covid-19 pandemic) monthly sickness absence rates fluctuated in a narrow range, between 5% and 6%, with a 12-month average around 5.3%. Since early 2020 there has been more volatility in sickness absence rates, with spikes in absence in the spring of 2020 and the winter of 2020/2021, followed by periods when sickness absence rates dropped back to 5%. However, following a further spike in sickness absence in the winter of 2021/2022 absence rates remained above 6% every month between June 2021 and March 2023.

88. In the 12 months to June 2025, the monthly average sickness absence rate was 6.3%, down from a peak of 6.9% in the year to June 2022. The difference between the sickness absence rate for the year to June 2025, and the long-term average is 1.0 percentage points, the equivalent of having 870 fewer AfC FTE staff in Wales.

Figure A.45: Sickness absence rates in Wales, all staff, September 2015 to June 2025



Source: Stats Wales

89. Table A.15 shows average rates of sickness absence in **Wales**, by **staff group,** in the year to March 2020 (the 12 months prior to the Covid-19 pandemic) and the year to June 2025. The staff groups with the highest rates of sickness absence in the year to June 2025 were healthcare assistants and support workers (9.5%), ambulance staff (8.1%), and nursing, midwifery and health visiting staff (7.7%).

Table A.15: Rates of sickness absence, Wales, 12 month average to March 2020 and 12 month average to June 2025, by staff group %

Staff group	12 month average to March 2020	12 month average to June 2025	Change between March 2020 and June 2025
	Percentage points		
All staff groups	5.6	6.3	0.7
Scientific, Therapeutic and Technical staff	4.4	4.9	0.5
Administration, Estates and General Payments staff	4.8	5.3	0.6
Nursing, Midwifery and Health Visiting staff	6.8	7.7	0.9
Ambulance staff	7.6	8.1	0.5
Healthcare Assistants and Support Workers	8.0	9.5	1.6

Source: Stats Wales

90. The staff groups with the largest changes in sickness absence rates between the year to March 2020 and the year to June 2025 were healthcare assistants and support workers (1.6 percentage points), and nursing, midwifery and health visiting staff (0.9). The staff groups with the smallest change in sickness absence rate over the period were scientific, therapeutic and technical staff (0.5 percentage points) and ambulance staff (0.5).

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

Regional and local variation and HCAS

91. The High-Cost Area Supplement (HCAS) allowance, also referred to as London Weighting, is a payment made to employees who work in London and the surrounding areas. The allowance is divided into three levels, Inner, Outer and Fringe (set out in Table A.16).

Table A.16 HCAS rates, from 1 April 2025

Area	Rate
Inner London	20% of basic salary, subject to a minimum payment of £5,609 and a maximum payment of £8,466
Outer London	15% of basic salary, subject to a minimum payment of £4,714 and a maximum payment of £5,941
Fringe	5% of basic salary, subject to a minimum payment of £1,303 and a maximum payment of £2,198

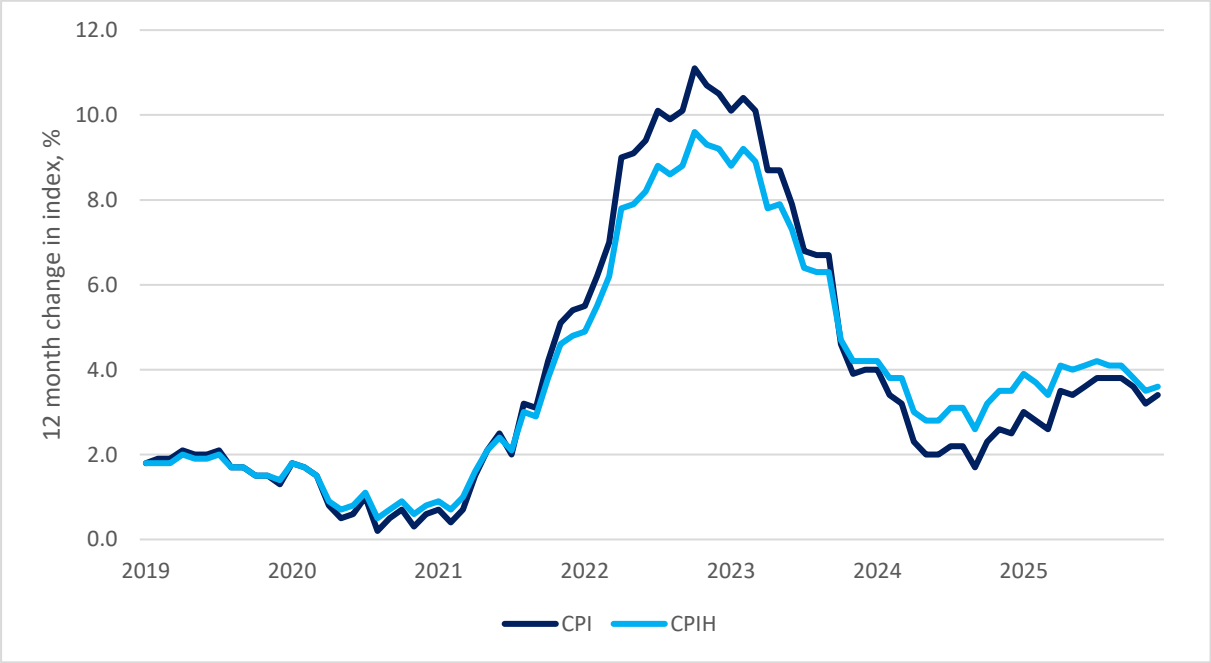
Source: OPRB calculations from NHS Employers data

The Government's inflation target and the economy

Consumer prices

92. The annual rate of inflation, as measured by Consumer Prices Index (CPI), was at 3.4% in December 2025, and 3.6% using the Consumer Prices Index including owner occupiers' housing costs (CPIH) (see Figure A.46) [76].

Figure A.46: Inflation, 12 month change, %, 2019 to 2025



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

93. In its November 2025 *Monetary Policy Report*, written before the November 2025 Budget, the Bank of England revised up its 2026 inflation forecast. The Bank's central projection is for CPI inflation to be 3.1% in the first quarter of 2026; 2.9% in the second quarter; 2.7% in the third quarter and 2.5% in the fourth quarter.

[76] The target set by the Government for the Monetary Policy Committee is to maintain inflation (measured by the Consumer Prices Index, CPI) at 2%.

CPIH (H for housing) is based on the CPI measure, plus owner occupiers' housing costs. These are the costs associated with owning, maintaining and living in one's own home and have a weight of 17.1% in the CPIH index. It uses 'rental equivalence', the rent paid for an equivalent house, as a proxy for the cost of housing services. The rental equivalence approach does not capture changes in asset value; rather it measures the change in price of housing services provided. CPIH also includes council tax which is excluded from the CPI, and has a weight of 2.8% in the index. Owner-occupier housing inflation was at 4.2% in December 2025, and council tax inflation was at 5.4%.

94. Following the November 2025 Budget, the OBR forecasts annual CPI inflation to fall from 3.5% in 2025 to 2.5% in 2026, compared with a forecast for 2026 of 2.1% in March 2025. It forecasted that CPI inflation will be 2.2% during the 2026/27 financial year.

Table A.17: Inflation forecasts

	Office for Budgetary Responsibility %	Bank of England central projection %
	November 2025	November 2025
	CPI	CPI
2026 Q1	3.2	3.1
2026 Q2	2.4	2.9
2026 Q3	2.3	2.7
2026 Q4	2.1	2.5
2026 average	2.5	2.8*
2026/27 financial year	2.2	2.6*

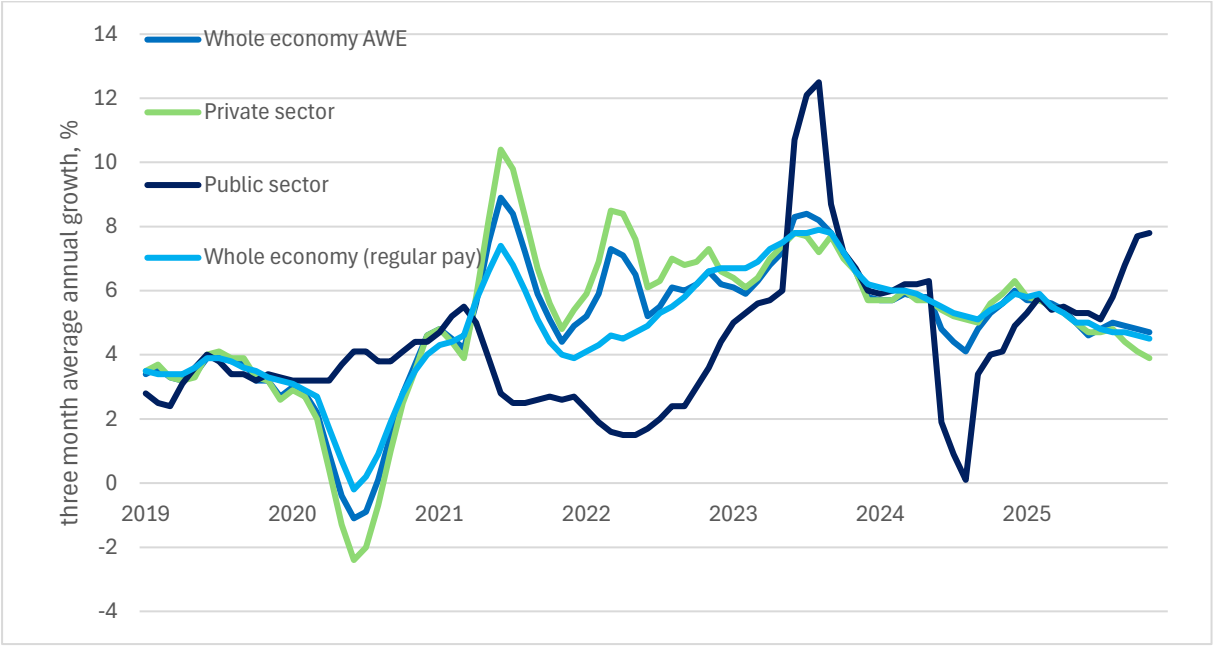
Note: OBR and Bank of England. * OPRB calculations

Earnings growth

95. Whole economy average weekly earnings growth was at 4.7% in the three months to November 2025. Regular earnings growth (i.e. excluding bonuses) was at 4.5% (see figure A.47).

96. Private sector average earnings growth (including bonus payments) was at 3.9% in the three months to November 2025, with regular earnings growth at 3.6%. Public sector average earning growth (including bonus payments) was at 7.8.% in the three months to November 2025, with regular earnings growth at 7.9%.

Figure A.47: Average weekly earnings growth, 2019 to 2025



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

97. In November 2025, the OBR forecast whole economy average weekly earnings growth of 5.2% in 2025, and 3.3% in 2026, around 1 percentage point higher than the forecasts in March 2025. It forecasted weekly earnings growth of 3.2% for the 2026/27 financial year. In November 2025, the Bank of England's expectation was for average weekly earnings (private sector regular pay) to be 3.5% higher in the final quarter of 2025 than a year earlier, and 3.2% higher in the final quarter of 2026 than a year earlier.

Pay settlements

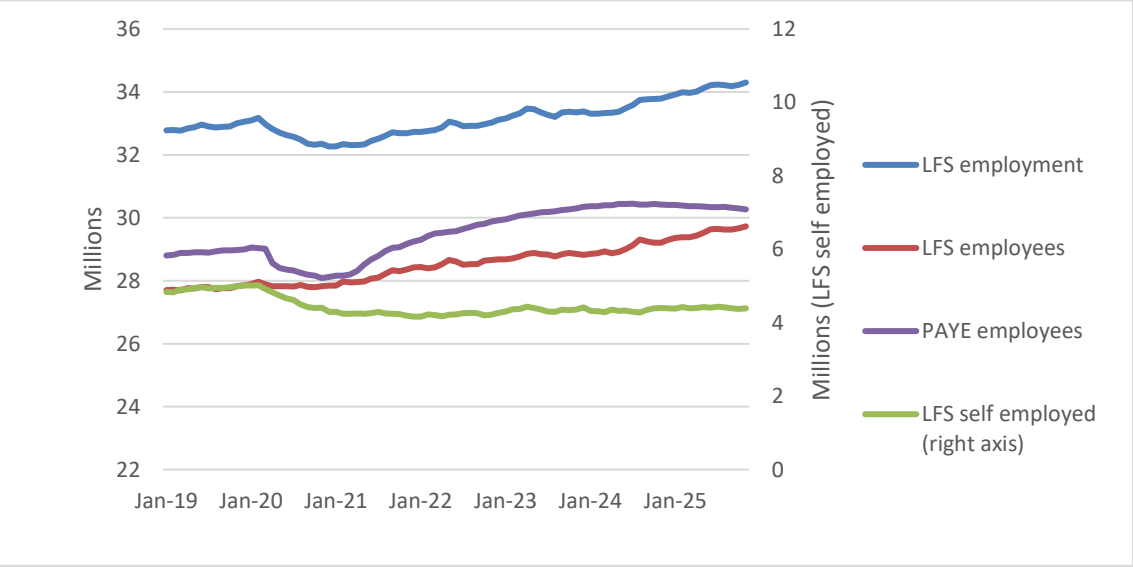
98. According to Brightmine data, the median pay settlement was 3% for the calendar year 2025[77]. Incomes Data Research's (IDR's) equivalent figure was 3.3%. Brightmine forecast the pay settlement median for the 2026 calendar year to be 3.0%[78], with IDR forecasting it to be between 3 and 3.5%[79]. The Bank of England Agents' summary, which describes business conditions, reported in December 2025 that early indications for pay settlements for 2026 were around 3½%[80].

The labour market

99. Pay as you earn real time information data indicate that the number of employees on payrolls in December 2025 was 30.2 million, down 43,000 over the month, 184,000 over the year, and up 1.2 million since the pre-pandemic peak in January 2020 (see Figure A.48).

100. According to the Labour Force Survey (LFS), the overall level of employment was 34.3 million in the three months to November 2025, up 513,000 over the year and 1,122,000 higher than the peak in the three months to February 2020. The number of employees is estimated to have increased by 1.8 million since February 2020, while self-employment is estimated to have fallen by 630,000 over the same period.

Figure A.48: Employment levels, Labour Force Survey (LFS) and payroll data, 2019 to 2025



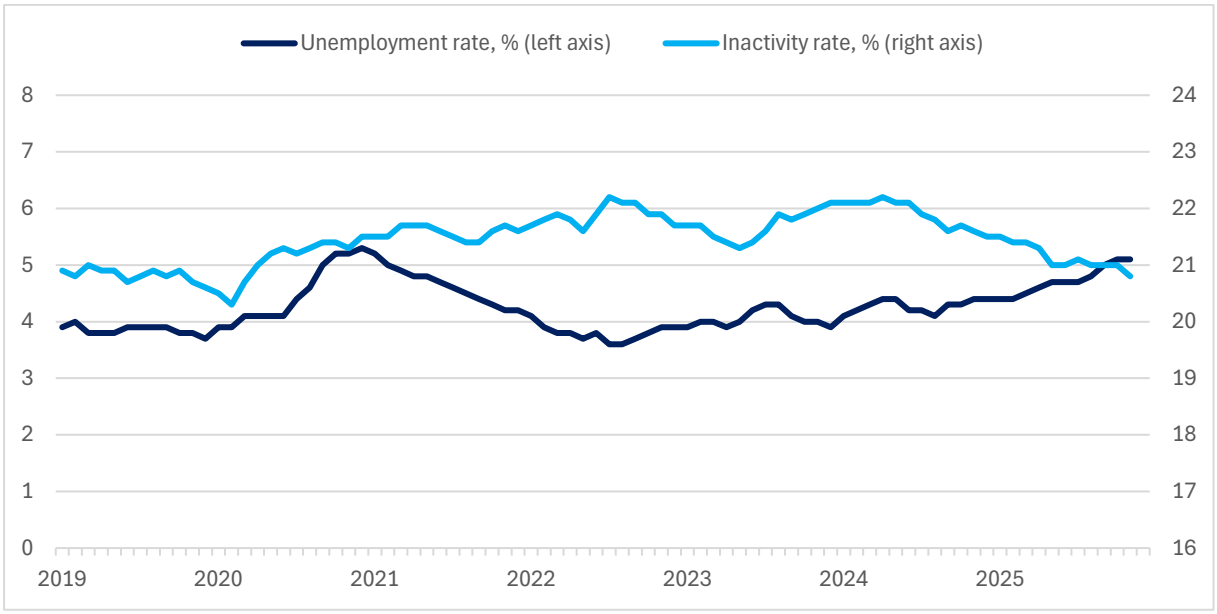
Source: ONS (MGRZ, MGRN, MGRQ); PAYE RTI data

101. The unemployment rate was at 5.1% in the three months to November 2025, up from 4.4% a year earlier (see Figure A.49). The unemployment level was estimated to have increased by 280,000 over the year, to 1.84 million.

[77] Forecasts for pay awards in 2025/2026 | Survey analysis | Tools | HR & Compliance Centre.co.uk
[78] Ibid.
[79] Steady outlook for pay in 2026
[80] Agents' summary of business conditions - December 2025 | Bank of England

102. Economic inactivity has fallen over the last year, to 20.8% (9.02 million) in the three months to November 2025, compared to 21.6% (9.31 million) a year earlier.

Figure A.49: Unemployment and inactivity rates, 2019 to 2025



Source: ONS, LFS (MGSX, LF2S)

AfC Earnings

Earnings growth

103. Table A.18 shows mean annual earnings, by staff group, in England, for the 12 months to October 2025, and the change from the 12 months to October 2024. By staff group, mean annual earnings range between £98,282 for senior managers and £24,970 for hotel, property and estates staff.

104. The share of overall earnings accounted for by non-basic pay varies substantially by staff group. The groups with the largest non-basic pay in overall earnings per person are ambulance staff (22% of total earnings), support to ambulance staff (21%), and hotel, property and estates staff (15%).

105. All staff groups saw changes in average earnings in the 12 months to October 2025, compared with the previous year, of between 1.5% (ambulance staff) and 7.1% (managers).

106. All groups saw an increase in average basic pay of between 4.0% (ambulance staff) and 7.2% (managers).

107. Most staff groups saw an increase in non-basic pay, of between 0.3% (ST&T staff) and 7.0% (central functions staff). However, the following staff groups saw a reduction in non-basic pay: ambulance staff (6.6%); and support to ambulance staff (4.8%).

Table A.18: Average basic pay and annual earnings per person, England, October 2025 and change from October 2024

	Average earnings		Basic pay per person		Non-basic pay per person		
Staff Group	**£**	**annual change**	**£**	**annual change**	**£**	**annual change**	**% of average earnings**
Nurses & health visitors	£42,119	5.1%	£37,525	5.2%	£4,594	3.7%	11%
Midwives	£40,381	4.3%	£35,314	4.4%	£5,067	3.8%	13%
Ambulance staff	£49,619	1.5%	£38,519	4.0%	£11,100	-6.6%	22%
Scientific, therapeutic & technical staff	£43,937	5.1%	£40,976	5.5%	£2,961	0.3%	7%
Support to clinical staff	£26,518	5.3%	£23,584	5.4%	£2,934	3.9%	11%
Support to doctors, nurses & midwives	£25,966	5.5%	£22,982	5.4%	£2,984	6.3%	11%
Support to ambulance staff	£32,345	2.5%	£25,700	4.6%	£6,645	-4.8%	21%
Support to ST&T staff	£26,623	5.4%	£24,936	5.4%	£1,688	4.1%	6%
NHS infrastructure support	£38,815	5.7%	£36,031	5.9%	£2,783	3.9%	7%
Senior managers	£99,282	6.3%	£95,150	6.6%	£4,132	1.4%	4%
Managers	£66,790	7.1%	£63,481	7.2%	£3,309	4.4%	5%
Central functions	£34,943	5.5%	£33,100	5.4%	£1,842	7.0%	5%
Hotel, property & estates	£24,970	4.4%	£21,218	4.9%	£3,753	1.3%	15%

Source: NHS England

108. As well as looking at increases in pay/earnings over the latest 12 months, analysis can be based on changes over longer periods of time. However, the nature of those comparisons are dependent on NHS pay/earnings measures, external price/earnings comparators, and the time periods over which comparisons are made. Figures A.50 to A.53 look at:

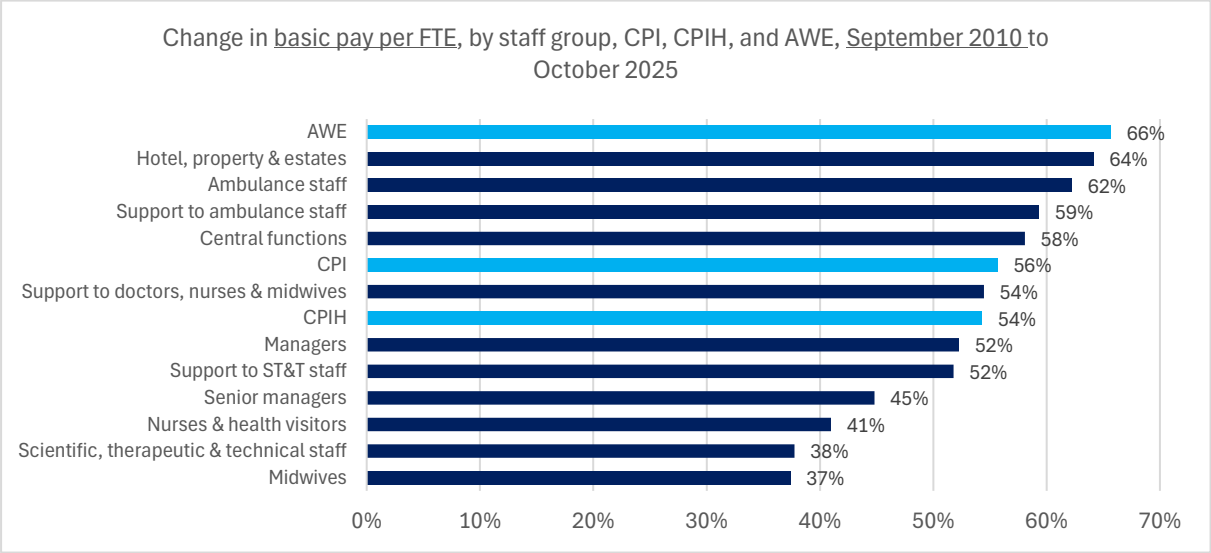
- changes in NHS pay/earnings – basic pay per FTE, earnings per head, basic pay per head;
- changes in CPI, CPIH and Average Weekly Earnings (AWE);
- using baselines of 2010 (Figure A.50, the furthest back the time series runs), 2015 (Figure A.51, covers the last decade), 2019 (Figure A.52, pre Covid-19), 2021 (Figure A.53, pre 2022/23 inflation spike).

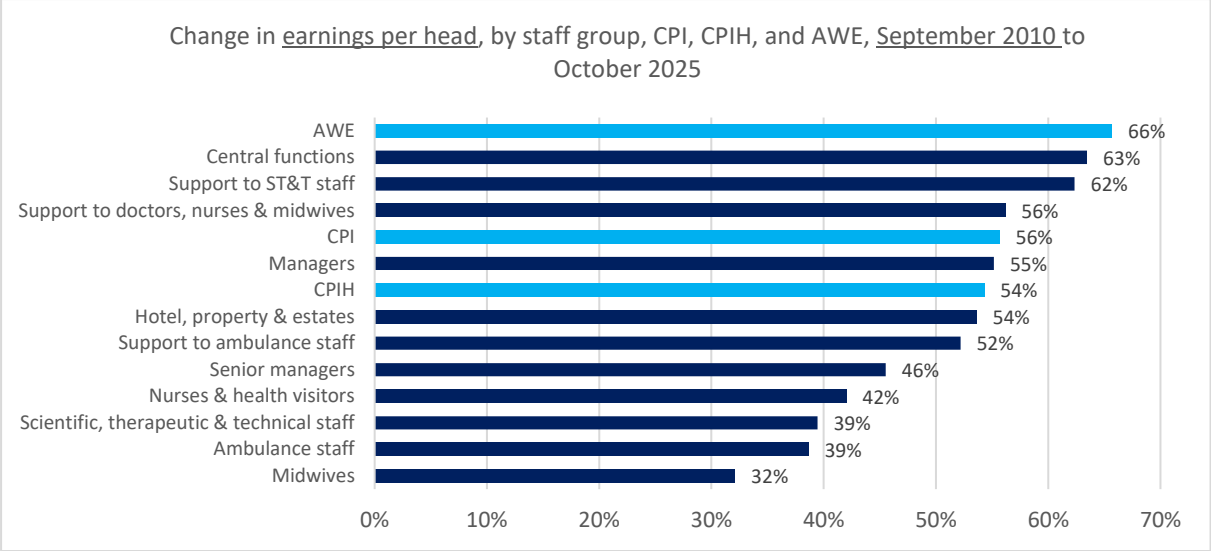
109. The figures show that staff groups with a greater share of lower paid staff compare relatively well compared with staff groups with relatively few lower paid staff. This will reflect band 1 being closed to new staff, relatively large increases to the lower pay points to reflect increases to the National Living Wage, and in some years, cash pay awards rather than percentage awards. Although changes in CPI and CPIH vary on a monthly basis, the charts show that over longer periods using CPI rather than CPIH, or vice versa, makes very little difference to the calculations. Both CPI and CPIH grew less quickly than AWE over each of the time periods.

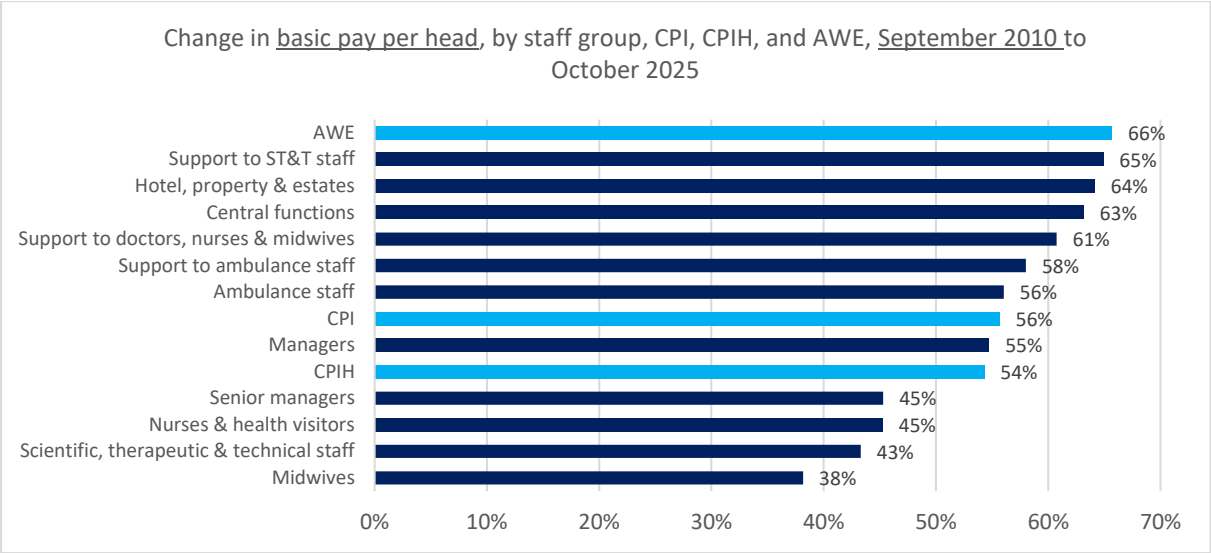
110. Figure A.50 (using 2010 as a baseline) – pay/earnings measures for support staff kept pace with inflation, but pay/earnings measures for professional groups did not keep pace with

inflation. In 2011/12 and 2012/13 there was a public sector pay freeze for everybody earning more than £21,000 per year, while those earning up to £21,000 had increases of £250 each year. In 2013/14 there was an award of 1%, and in 2024/15 a non-consolidated increase of 1% for those on the scale maximum.

Figure A.50: Changes in NHS pay/earnings, England, by staff group, compared with changes in prices and earnings, 2010 to 2025



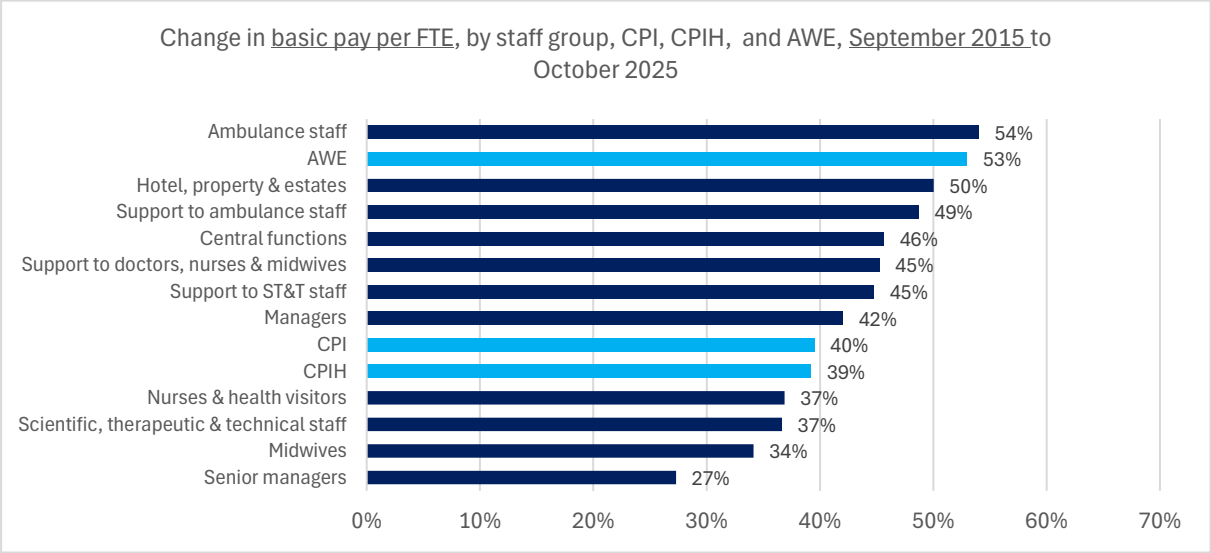


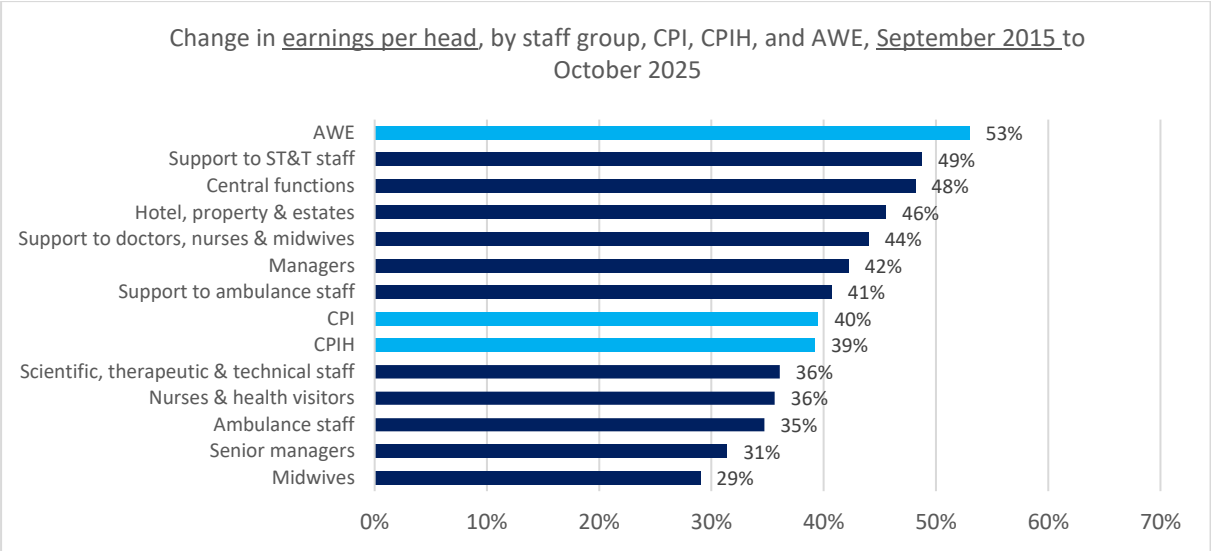


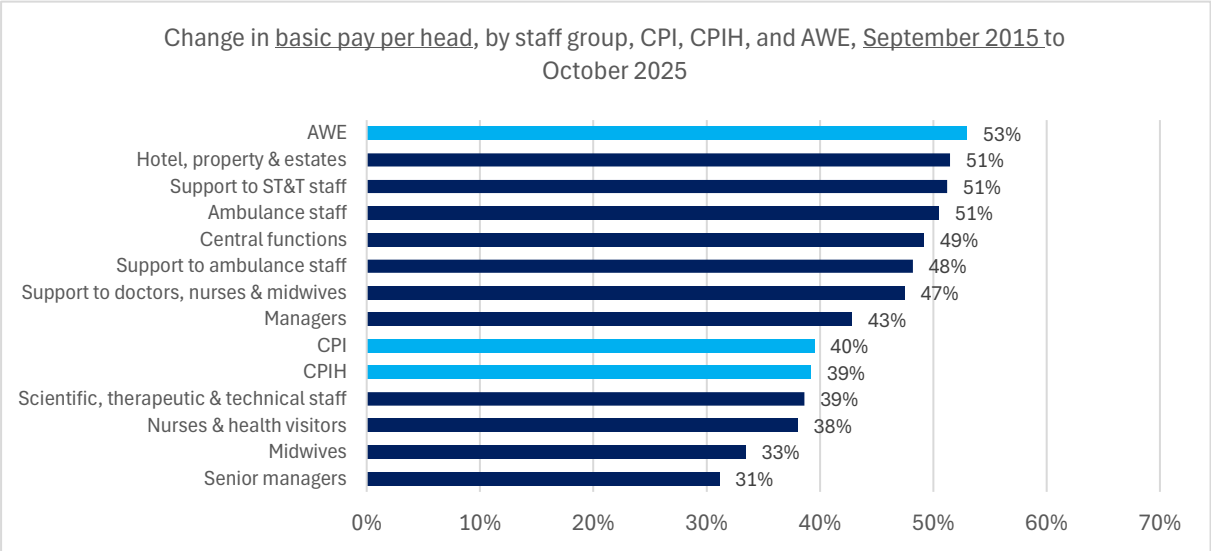
Source: OPRB calculations using NHS England and ONS data

111. Figure A.51 (using 2015 as a baseline) - pay/earnings measures for support staff grew faster than inflation, but pay/earnings measures for professional groups did not keep pace with inflation. A period where awards were usually 1%, were followed in 2018 by a three-year deal agreed by Government and the trades' unions, which removed pay points from the scales, allowing staff to move to the maximum more quickly and gave larger increases to the lower bands, and those below the band maximums.

Figure A.51: Changes in NHS pay/earnings, England, by staff group, compared with changes in prices and earnings, 2015 to 2025



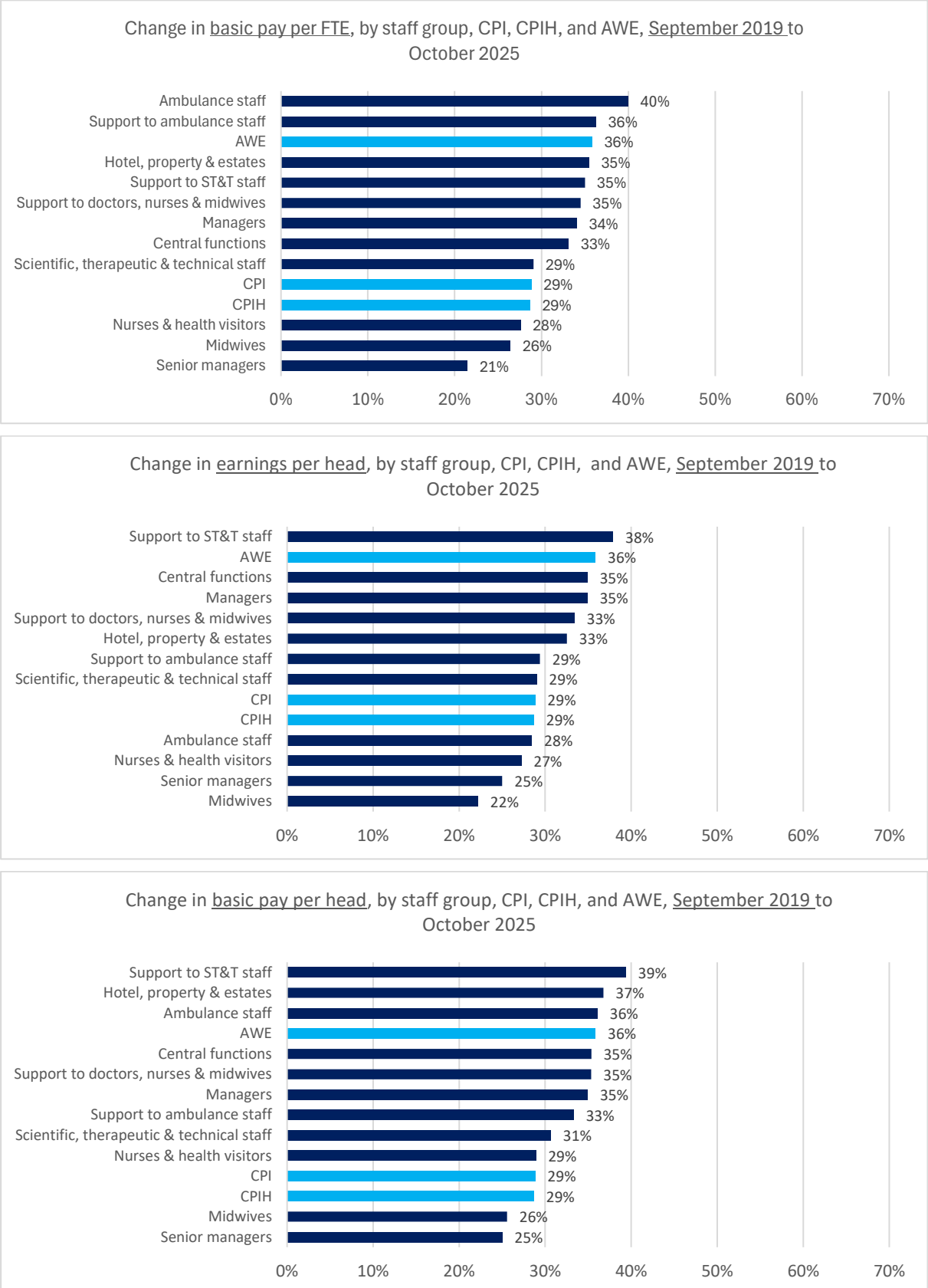




Source: OPRB calculations using NHS England and ONS data

112. Figure A.52 (using 2019 as a baseline) - pay/earnings measures for support staff grew faster than inflation, but pay/earnings measures for professional groups did not keep pace with inflation. The baseline is pre-Covid-19, so the data is not affected by short-term changes in 2020/21 and 2021/22 (both positive and negative).

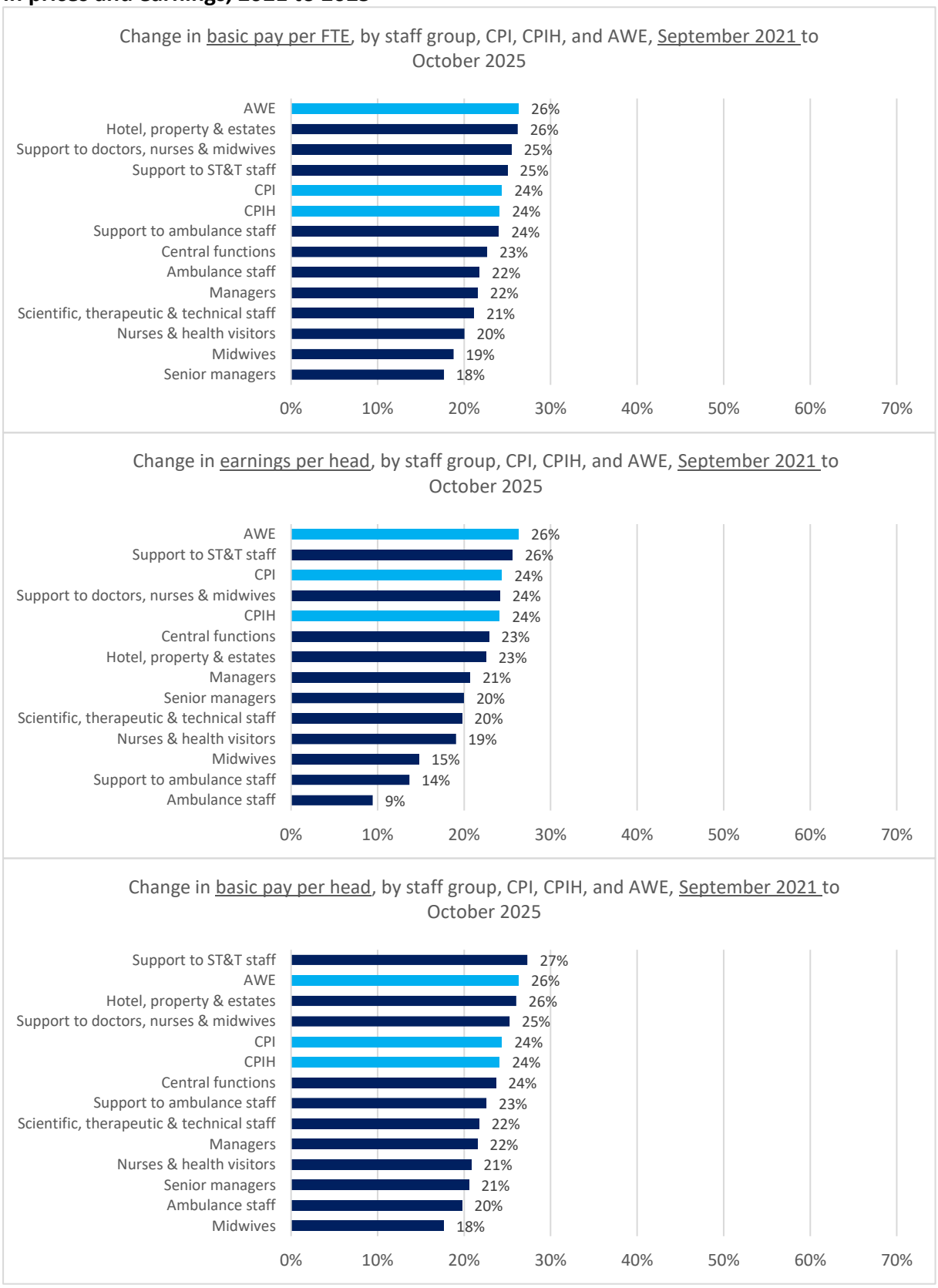
Figure A.52: Changes in NHS pay/earnings, England, by staff group, compared with changes in prices and earnings, 2019 to 2025



Source: OPRB calculations using NHS England and ONS data

113. Figure A.53 (using 2021 as a baseline) - pay/earnings measures for most staff groups did not keep pace with inflation. The baseline is set before the sharp increase in inflation, so the data includes the full extent of the price increases in 2022/23.

Figure A.53: Changes in NHS pay/earnings, England, by staff group, compared with changes in prices and earnings, 2021 to 2025

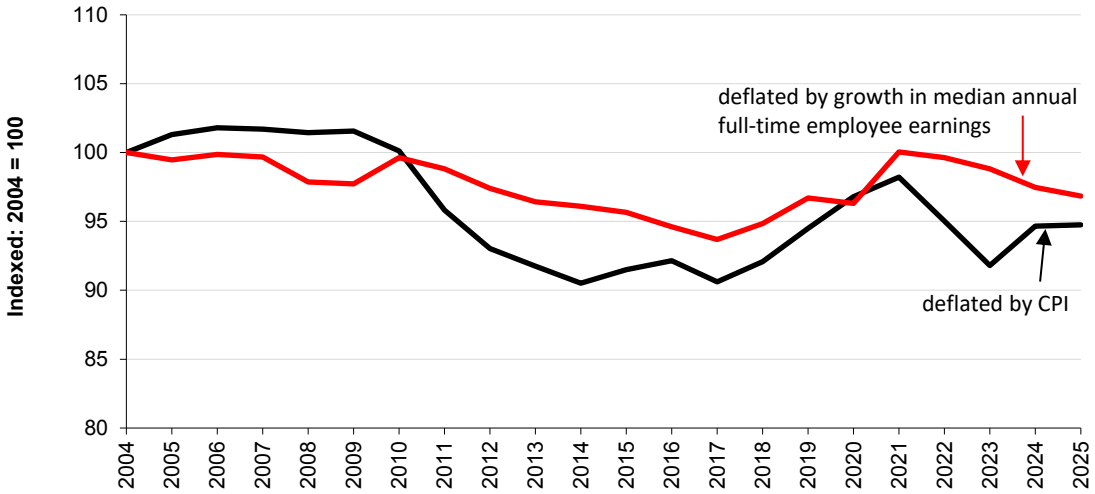


Source: OPRB calculations using NHS England and ONS data

114. Figure A.54 shows changes to the band 5 minimum pay point in England since the introduction of AfC in 2004, adjusted for CPI inflation (black line) and for earnings growth in the wider economy (red line). Following the introduction of AfC the band 5 minimum pay point in England maintained its value against both inflation and average earnings growth until 2009,

shortly after the financial crash. Between 2009 and 2017, the first point on the scale lost value compared to inflation as measured by CPI, and to a lesser extent compared to full-time employee earnings growth. The increase in value of the band 5 minimum contained in the 2018 AfC pay agreement meant that between 2017 and 2021 its value grew more quickly than CPI price inflation and median average earnings. Between 2021 and 2024 the value of the Band 5 minimum lost ground each year against median full-time employee earnings. Starting pay lost value against CPI inflation in 2022 and 2023 before gaining ground in 2024 when it increased by 5.5% against April CPI of 2.3%. In 2025 the band 5 minimum increased by 3.6%, slightly more than CPI in April 2025 (3.5%), but lost ground against median full-time employee earnings, which increased by 4.3% in 2025.

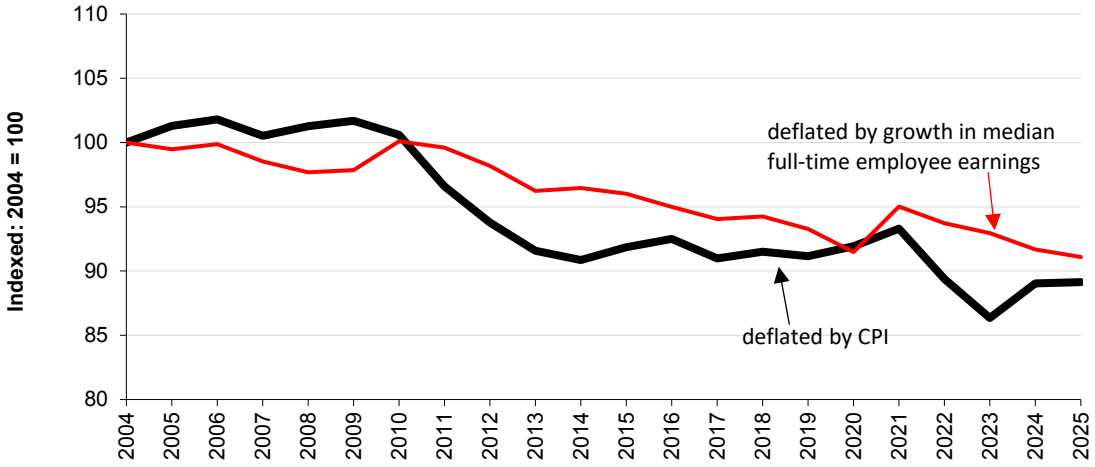
Figure A.54: AfC band 5 minimum, deflated by the growth in median average earnings and inflation, England, 2004 to 2025



Source: OPRB analysis of ONS data (Annual Survey of Hours and Earnings) (ASHE), CPI (D7G7) April each year

115. Figure A.55 shows changes to the band 5 maximum pay point in England since the introduction of AfC in 2004, adjusted for CPI inflation and for earnings growth in the wider economy. Following the introduction of AfC the pay point at the top of Band 5 maintained its value against inflation until 2009 and average earnings growth until 2010. However, between 2011 and 2017 the value of the top point of Band 5 increased by 4%, meaning that this point lost value compared with both inflation and earnings growth. The 2018 AfC pay agreement saw the Band 5 maximum increase by 3.0% in the first year of the deal and 1.7% in each of the second and third years. These increases meant that although the Band 5 maximum continued to lose ground against average earnings growth, it did maintain its value against CPI over the course of the agreement. Between 2021 and 2024 the value of the Band 5 maximum lost ground each year against median full-time employee earnings. It lost value against CPI inflation in 2022 and 2023 before gaining ground in 2024 when AfC pay increased by 5.5% against April CPI of 2.3%. In 2025 the band 5 maximum increased by 3.6%, slightly more than CPI in April 2025 (3.5%), but lost ground against median full-time employee earnings, which increased by 4.3% in 2025.

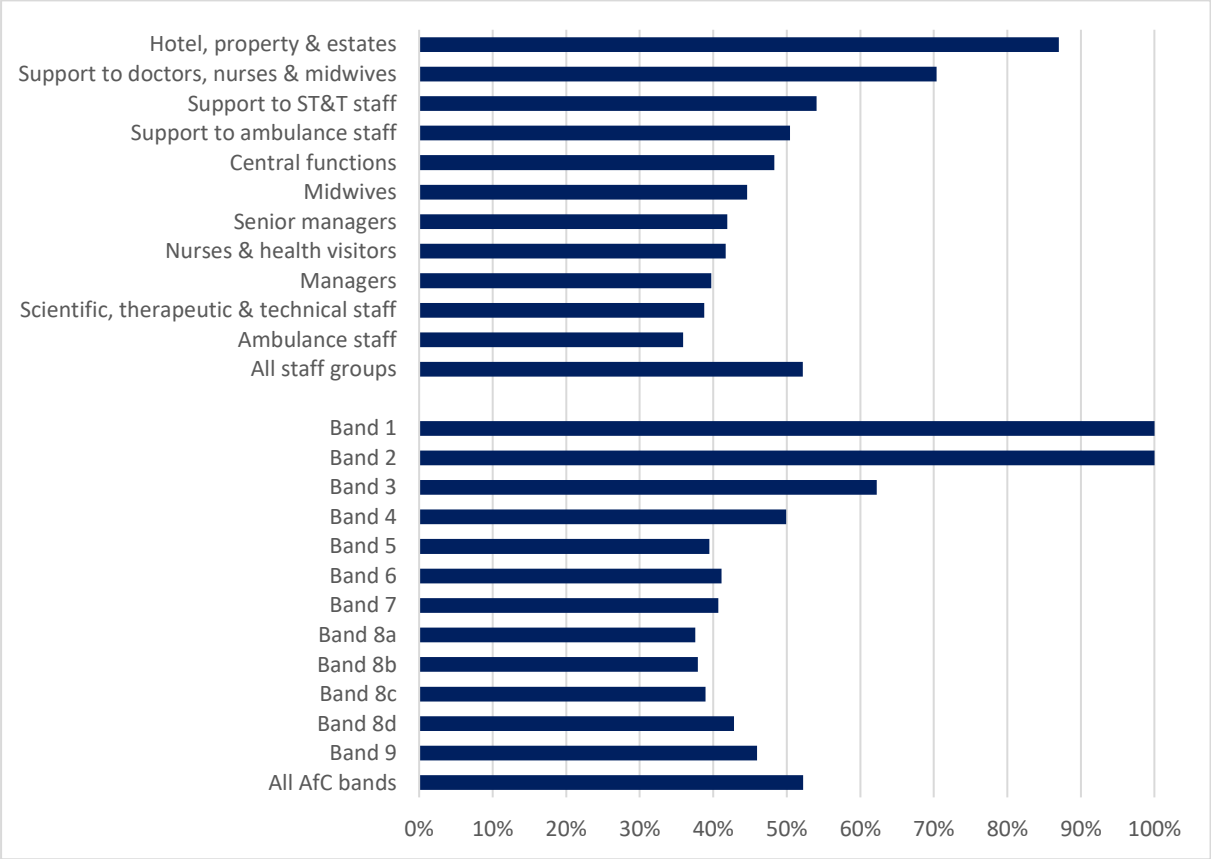
Figure A.55: AfC band 5 maximum, deflated by the growth in median average earnings and inflation, England, 2004 to 2025



Source: OPRB analysis of ONS data (Annual Survey of Hours and Earnings) (ASHE), CPI (D7G7) April each year

116. Figure A.56 shows that in England, at the end of March 2025, 52% of AfC staff were at the top of their pay band. The proportion varied across staff groups, between 36% of ambulance staff and 87% of hotel, property and estates staff. Other than Bands 1 and 2, which are both single pay points, the bands with the largest percentage of staff on the top of their pay band were Band 3 (62%) and Band 4 (50%), while the bands with the smallest percentage of staff on top of their pay band were Band 8a (38%), Band 8b (38%), Band 8c (39%), and Band 5 (39%).

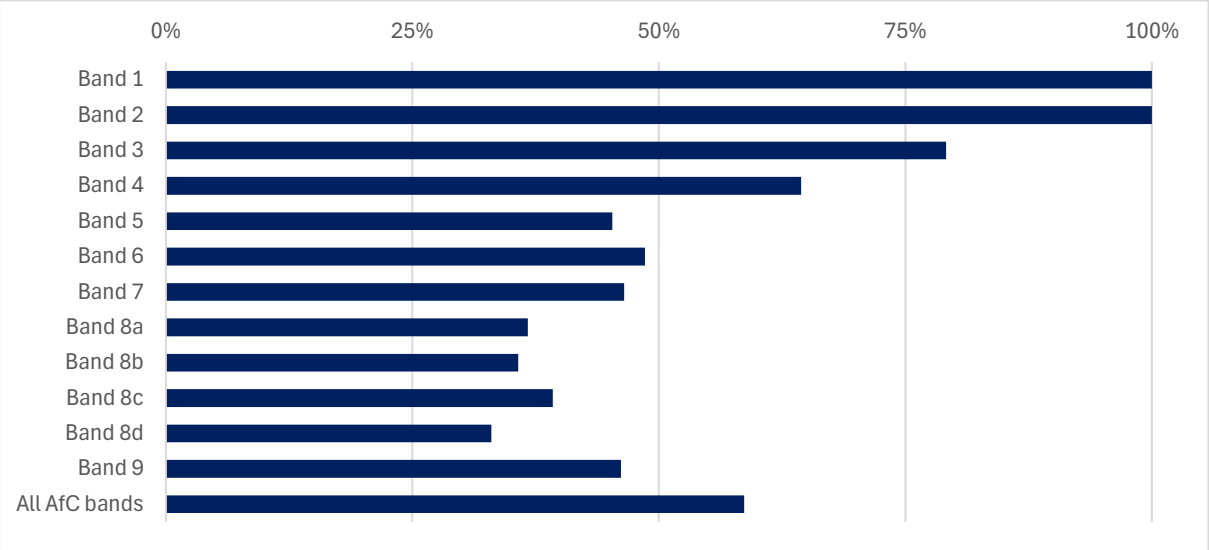
Figure A.56: Estimated share of staff (FTE) on top of band by staff group and band, March 2025, England



Source: DHSC

117. Figure A.57 shows that in Northern Ireland, at the end of March 2025, 59% of AfC staff were at the top of their pay band. Other than Bands 1 and 2, which are both single pay points, the bands with the largest percentage of staff on the top of their pay band were Band 3 (79%) and Band 4 (64%), while the bands with the smallest percentage of staff on top of their pay band were Band 8d (33%), Band 8b (36%), Band 8a (37%), and Band 8c (39%).

Figure A.57: Estimated share of staff (FTE) on top of band by band, March 2025, Northern Ireland



Source: Department of Health, Northern Ireland (written evidence, Table 44)

Pay and earnings by gender and ethnicity

118. In September 2025, NHS England published estimates of the differences in mean monthly basic pay per FTE by gender and ethnicity in the May of each year between 2016 and 2025[81]. The data covers mean monthly earnings per person for full-time staff only. Table A.19 shows gender pay gaps for staff in different ethnic groups in each AfC pay band, and shows that for almost all pay bands and different ethnic groups, mean monthly earnings of male staff are higher than for female staff.

[81] NHS Staff Earnings Estimates, June 2025 (including supplementary analysis on pay by ethnicity) - NHS England Digital

Table A.19: Differences in mean monthly basic pay per FTE, by gender and ethnicity, England, May 2025

	Gender pay gap (2024 figure in brackets)				
	Asian/Asian British	Black/African /Caribbean / Black British	White	Mixed/Multiple ethnic groups	Other ethnic groups
	Female/Male	Female/Male	Female/Male	Female/Male	Female/Male
Band 1	-11% (-4%)	-10% (-16%)	-1% (-2%)	Not available	Not available
Band 2	-2% (-2%)	-2% (-1%)	-3% (-2%)	-2% (-1%)	-3% (-2%)
Band 3	-3% (-3%)	-3% (-5%)	-3% (-4%)	-3% (-4%)	-3% (-3%)
Band 4	-2% (-1%)	-2% (-2%)	-5% (-4%)	-4% (-3%)	-3% (-4%)
Band 5	1% (1%)	0% (-1%)	-4% (-4%)	0% (-1%)	-1% (-2%)
Band 6	-2% (-2%)	-2% (-2%)	-5% (-6%)	-4% (-4%)	-2% (-4%)
Band 7	-2% (-1%)	-2% (-2%)	-3% (-4%)	-2% (-4%)	-2% (-3%)
Band 8a	-1% (-1%)	-1% (-1%)	-1% (-2%)	0% (-1%)	-2% (-2%)
Band 8b	-1% (-1%)	-1% (-1%)	-2% (-2%)	-3% (-3%)	-5% (-6%)
Band 8c	-1% (-1%)	-1% (-1%)	-2% (-2%)	-2% (-1%)	0% (-1%)
Band 8d	-1% (-3%)	0% (0%)	-2% (-2%)	-1% (-5%)	-1% (0%)
Band 9	-4% (-2%)	1% (-1%)	-1% (-1%)	-4% (-2%)	-10% (-19%)

Source: OPRB calculations using NHS England data

Pay comparisons: ASHE

119. The Annual Survey of Hours and Earnings (ASHE) has been used for a number of years to compare earnings for the human health and social work activities sector with employees in the public and private sector as well as to certain broad occupational groups. These sector and group earnings (median gross weekly pay) are shown in in Table A.20. In April 2025, compared with April 2024, median gross weekly pay for full-time employees in the human health and social work activities sector increased by 5.5%, compared with 5.3% across the economy as a whole, 5.3% across the public sector and 5.4% across the private sector. Over a longer period, between 2019 and 2025, median gross weekly pay in the human health and social work activities sector increased by 30%, compared with 31% across the economy as a whole, 28% across the public sector and 32% across the private sector.

120. Table A.20 also shows earnings growth in some broad occupational groups. In 2025, compared with 2024, median gross weekly pay increased by: 5.5% for professional occupations; 5.5% for associate professional and technical occupations; 5.4% for administrative and secretarial occupations; 4.3% for skilled trades occupations; and 7.1% for caring, leisure and other service occupations. Over a longer period, between 2019 and 2025, median gross weekly pay increased by: 24% for professional occupations; 19% for associate professional and technical occupations; 30% for administrative and secretarial occupations; 30% for skilled trades occupations; and 42% for caring, leisure and other service occupations. Despite the relatively large increases in earnings for caring, leisure and other service occupations, weekly earnings for these occupations remain lower than those for other occupations listed in the table.

Table A.20: Change in median gross weekly pay for full time employees at adult rates, 2019 to 2025, April each year, United Kingdom

	Median gross weekly pay (change on previous year)							
	2019	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**Change 2019 to 2025**
Human health and social work activities sector	£552 (4.3%)	£563 (2.0%)	£575 (2.0%)	£613 (6.6%)	£647 (5.5%)	£680 (5.2%)	£718 (5.5%)	30%
All employees	£585 (3.0%)	£586 (0.1%)	£610 (4.1%)	£642 (5.2%)	£687 (7.0%)	£728 (6.0%)	£767 (5.3%)	31%
Public sector	£632 (3.2%)	£648 (2.5%)	£664 (2.5%)	£697 (4.9%)	£727 (4.4%)	£767 (5.4%)	£808 (5.3%)	28%
Private sector	£571 (4.1%)	£566 (-0.8%)	£585 (3.4%)	£622 (6.3%)	£672 (8.0%)	£714 (6.3%)	£752 (5.4%)	32%
Professional occupations [1]	£769 (3.2%)	£777 (1.1%)	£794 (2.1%)	£811 (2.2%)	£862 (6.3%)	£907 (5.1%)	£956 (5.5%)	24%
Associate professional and technical occupations [2]	£624 (0.8%)	£612 (-1.9%)	£603 (-1.6%)	£633 (5.1%)	£667 (5.3%)	£702 (5.2%)	£741 (5.5%)	19%
Administrative and secretarial occupations	£457 (2.7%)	£461 (0.8%)	£479 (4.1%)	£499 (4.0%)	£534 (7.1%)	£565 (5.9%)	£596 (5.4%)	30%
Skilled trades occupations	£541 (3.3%)	£506 (-6.5%)	£551 (8.9%)	£590 (7.2%)	£631 (6.8%)	£677 (7.3%)	£706 (4.3%)	30%
Caring, leisure and other service occupations	£392 (5.0%)	£404 (3.0%)	£414 (2.6%)	£442 (6.7%)	£483 (9.5%)	£521 (7.7%)	£558 (7.1%)	42%

Source: ONS (Annual Survey of Hours and Earnings)

Notes:

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

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

Pay comparisons: Longitudinal Education Outcomes (LEO)

121. Data from the Longitudinal Education Outcomes (LEO) data set are published each year by the Department for Education (DfE) and track the employment and earnings outcomes of UK-domiciled first-degree higher education (HE) graduates from: HE institutions in the United Kingdom; Further Education Colleges; and Alternative Providers. The latest data is for the tax year 2022/23 and is broken down by subject studied. The data covers graduate earnings and employment by subject: one; three; five; and, ten years after graduation (YAG), for those studying: nursing and midwifery; medical sciences[82]; pharmacology, toxicology and pharmacy; allied health subjects[83]; and health and social care[84]. The figures for each group include the earnings of both full and part time workers, and is not adjusted for geography, age or other factors. It also includes the earnings of those working in areas unrelated to their degree subject, for example someone with a nursing degree working outside the health sector.

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

122. Table A.21 shows that one year after graduation median annual gross earnings of those who studied the following subjects were higher than the median for graduates as a whole: nursing and midwifery (27% higher than the median); pharmacology, toxicology and pharmacy (10%); allied health subjects (6%); and medical sciences (4%). Median annual gross earnings for those who studied health and social care subjects were 6% below median earnings for graduates as a whole. However, Table A.21 also shows that the longer the time since graduation, the relative position of median earnings for nursing and midwifery, allied health subjects and health and social care subjects worsens when compared against median earnings for graduates as a whole. Ten years after graduation, median earnings of those who studied nursing and midwifery were 2% below the overall graduate median, while median earnings for allied health and health and social care graduates were 10-16% below the overall graduate median. Median earnings for medical science and pharmacology, toxicology and pharmacy graduates better maintained their relative value and were still 15-17% higher than the overall graduate median.

123. Charts showing earnings, at the lower quartile, median and upper quartile, in 2022/23, by subject studied one, five, and ten YAG are at Figures A.58 to A.60.

Table A.21: Difference between median earnings by subject, compared with overall graduate median, by years after graduation (YAG), %, 2022/23

	1 year	3 years	5 years	10 years
Nursing and midwifery	27%	18%	9%	-2%
Medical sciences	4%	23%	23%	17%
Pharmacology, toxicology and pharmacy	10%	21%	25%	15%
Allied health	6%	6%	2%	-10%
Health and social care	-6%	-4%	-11%	-16%

Source: OPRB analysis of LEO data set

124. Table A.22 shows median earnings for those who studied health related subjects, for a given number of years after graduation, relative to median earnings for graduates as a whole, after the same number of years since graduation, between 2016/17 and 2022/23. In 2020/21 median earnings for those who studied health related subjects, for a given number of years after graduation, improved relative to median earnings for graduates as a whole, but this improvement has been reversed in 2021/22 and 2022/23.

Table A.22: Difference between median earnings for graduates of health related subjects and overall graduate median, by years after graduation (YAG), %, 2016/17 to 2022/23

	Nursing and midwifery				Medical sciences			
Tax year	**1 YAG**	**3 YAG**	**5 YAG**	**10 YAG**	**1 YAG**	**3 YAG**	**5 YAG**	**10 YAG**
2016/17	30%	17%	8%	0%	20%	20%	19%	12%
2017/18	29%	16%	8%	-2%	20%	19%	17%	12%
2018/19	30%	13%	5%	-5%	18%	18%	17%	11%
2019/20	29%	18%	8%	-1%	19%	23%	20%	14%
2020/21	40%	23%	10%	0%	25%	26%	23%	19%
2021/22	32%	21%	10%	0%	10%	25%	24%	20%
2022/23	27%	18%	9%	-2%	4%	23%	23%	17%

	Pharmacology, toxicology, pharmacy				Allied Health			
Tax year	**1 YAG**	**3 YAG**	**5 YAG**	**10 YAG**	**1 YAG**	**3 YAG**	**5 YAG**	**10 YAG**
2016/17	20%	29%	31%	5%	6%	0%	-4%	-12%
2017/18	18%	25%	24%	11%	5%	2%	-3%	-13%
2018/19	11%	30%	19%	14%	5%	3%	-4%	-13%
2019/20	13%	23%	23%	14%	7%	4%	-1%	-14%
2020/21	21%	29%	31%	19%	10%	9%	3%	-10%
2021/22	19%	35%	27%	19%	10%	10%	3%	-10%
2022/23	10%	21%	25%	15%	6%	6%	2%	-10%

	Health and social care			
Tax year	**1 YAG**	**3 YAG**	**5 YAG**	**10 YAG**
2016/17	2%	-7%	-13%	-11%
2017/18	1%	-6%	-9%	-9%
2018/19	3%	-4%	-11%	-11%
2019/20	3%	-4%	-10%	-10%
2020/21	8%	-2%	-8%	-11%
2021/22	-3%	-2%	-10%	-16%
2022/23	-6%	-4%	-11%	-16%

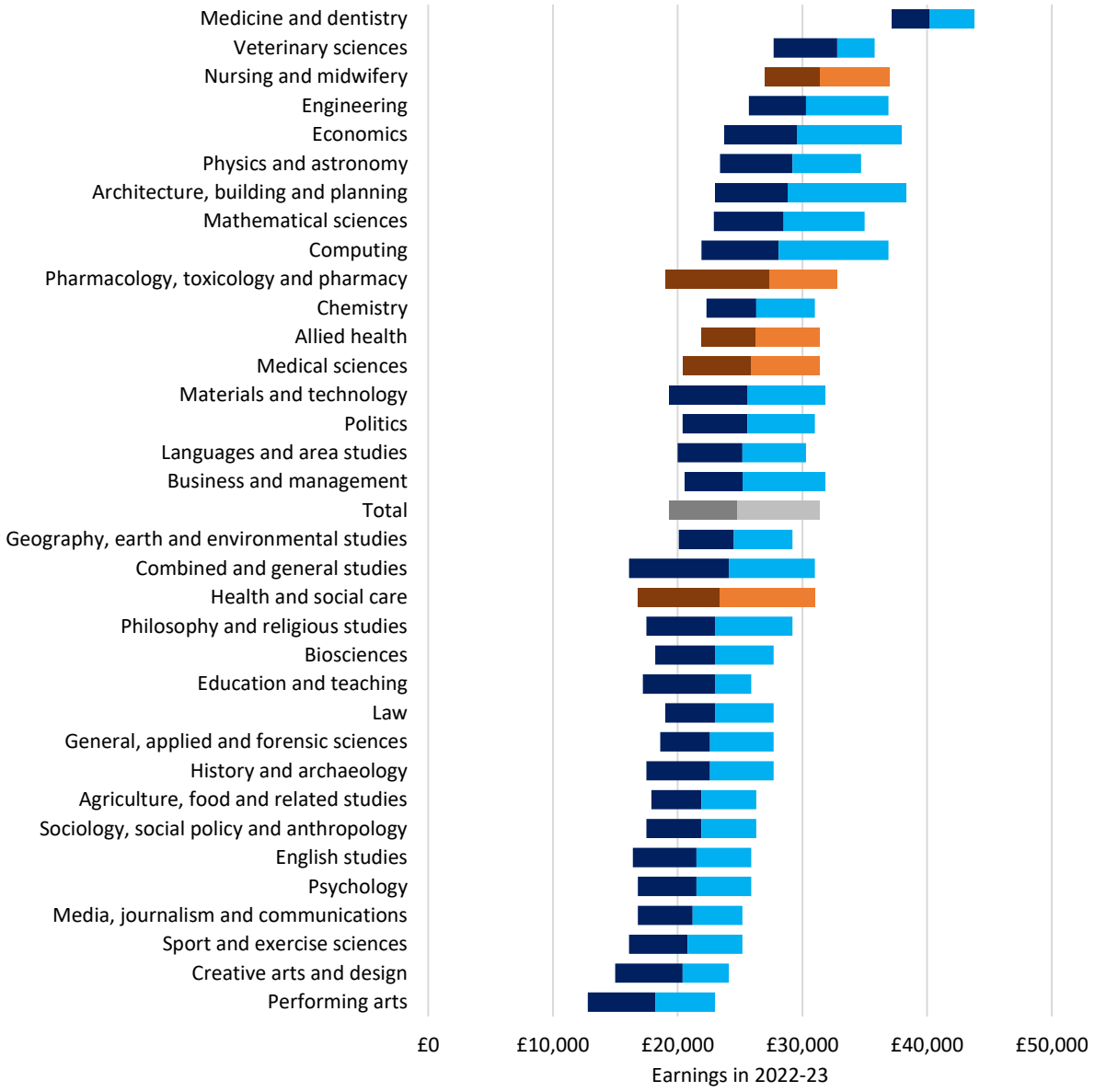
Source: OME analysis of LEO dataset

125. Figure A.58 shows median earnings one year after graduation. Only those who studied: medicine and dentistry and veterinary sciences had higher median earnings than those who studied nursing or midwifery. Median earnings of those who studied: medical sciences; pharmacology, toxicology and pharmacy; and allied health subjects were also above the median for graduates as a whole. Median earnings for those who studied subjects related to health and social care, were below median earnings for graduates as a whole.

126. Figure A.59 shows that median earnings, five years after graduation, for those who studied pharmacology, toxicology and pharmacy, and medical sciences were still considerably above median earnings for graduates as a whole. For those who studied nursing or midwifery, median earnings were still above the median for graduates as a whole, but by less than they had been one year after graduation. Median earnings for those who had studied allied health subjects were just above the overall graduate median, while median earnings for those who studied subjects related to health and social care was still below the median for graduates as a whole.

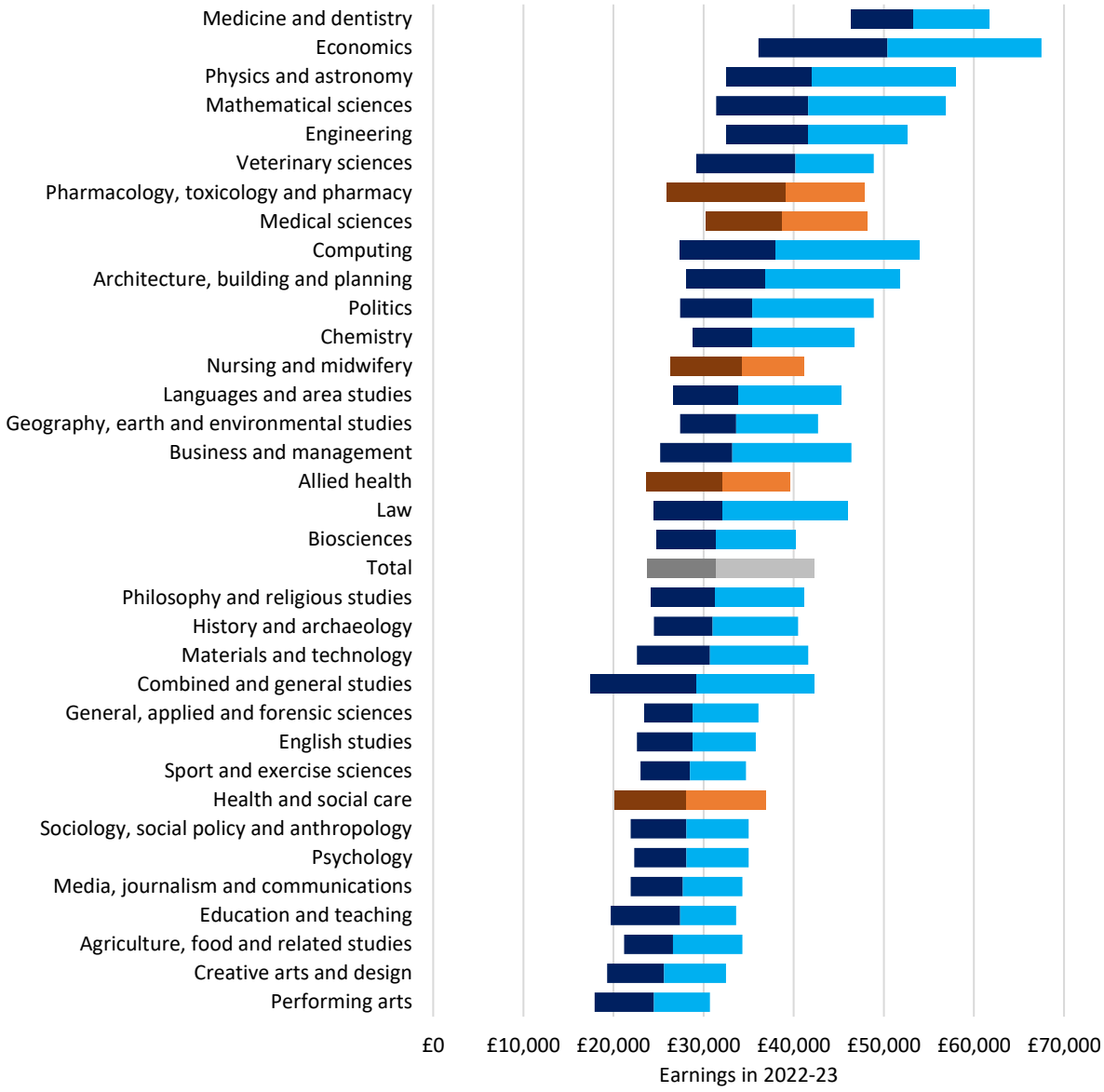
127. Figure A.60 shows that median earnings, ten years after graduation, for those who studied pharmacology, toxicology and pharmacy, and medical sciences were still above median earnings for graduates as a whole. However, median earnings for those who studied nursing or midwifery, and allied health subjects fell below the overall graduate median, while those who studied subjects related to health and social care remained below the overall graduate median.

Figure A.58: Annual gross earnings one year after graduation (2020/21 cohort), median £



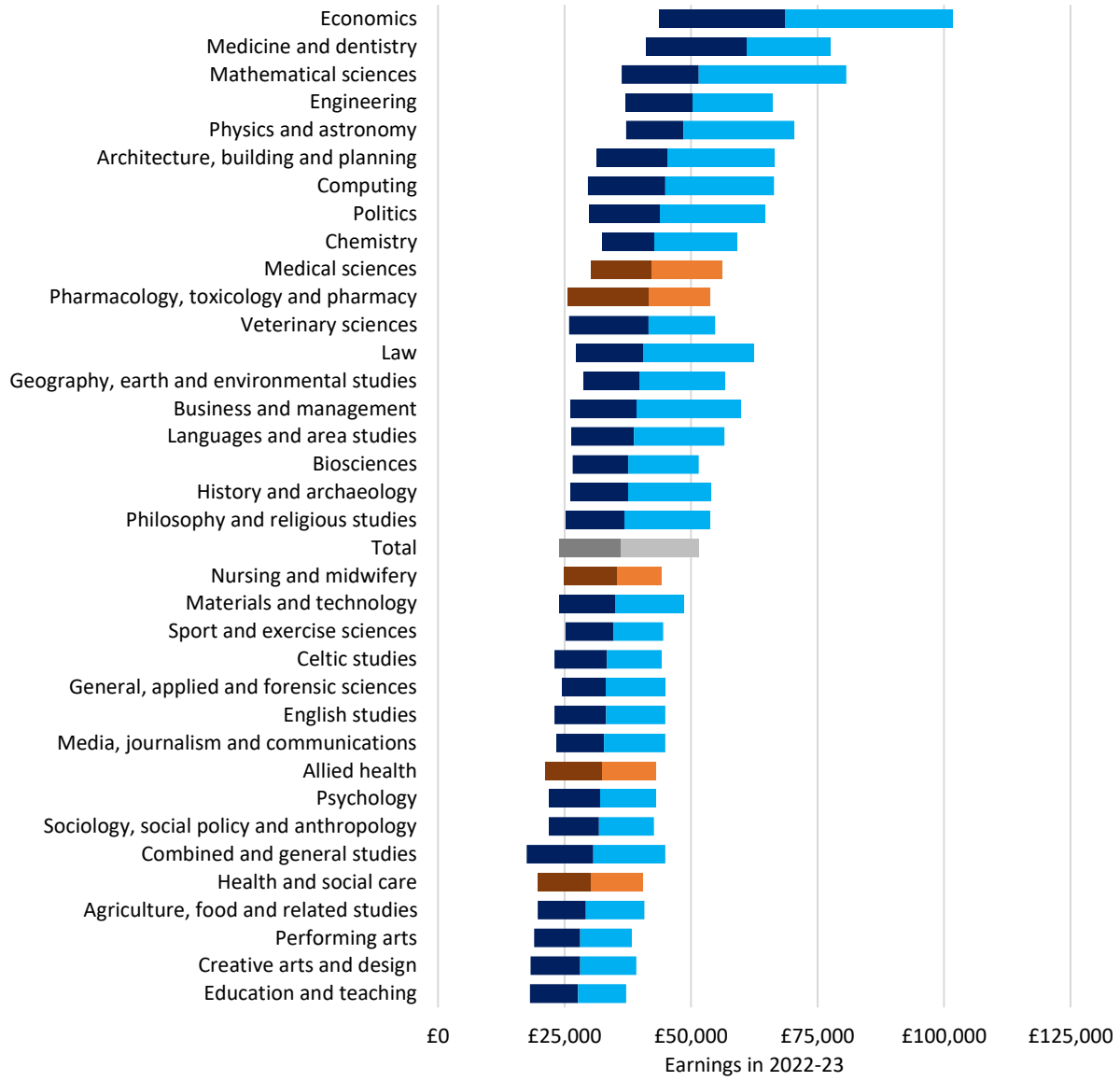
Source: OPRB analysis of LEO dataset

Figure A.59 Annual gross earnings five years after graduation (2016/17 cohort), median £



Source: OPRB analysis of LEO dataset

Figure A.60: Annual gross earnings ten years after graduation (2011/12 cohort), median £



Source: OPRB analysis of LEO dataset

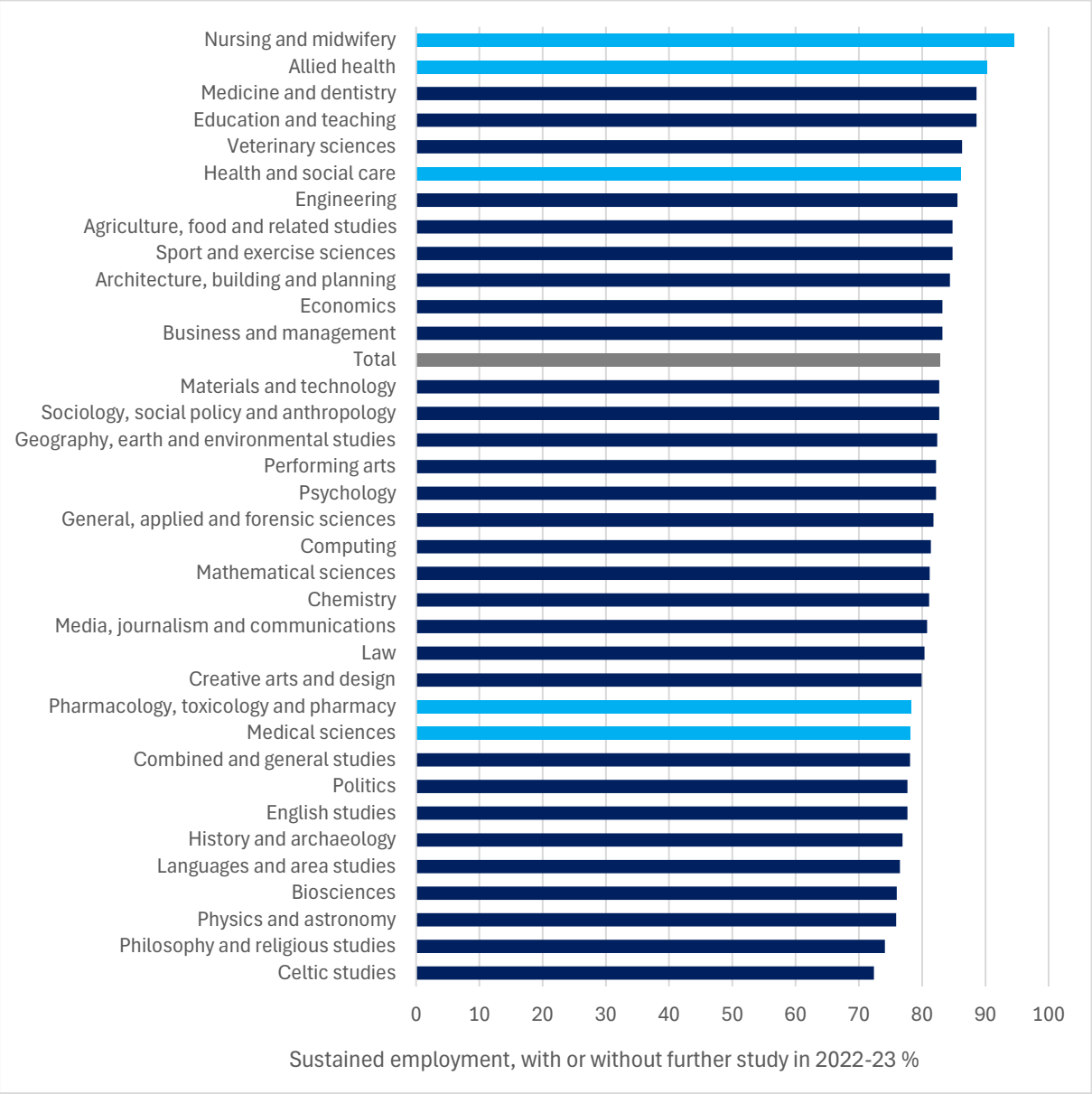
128. Figure A.61 shows, for 2022/23, the percentage of graduates in sustained employment, by subject studied, one year after graduation. 95% of nursing and midwifery graduates in that cohort were in sustained employment, a greater percentage than for any other subject studied. The percentage of those in employment who studied health and social care (86%) and allied health subjects (90%) were greater than the percentage of all graduates in this cohort (83%). The percentage of those who studied medical sciences (78%) and pharmacology, toxicology and pharmacy (78%) were below the overall average.

129. Figure A.62 shows, for 2022/23, the percentage of graduates in sustained employment, by subject studied, five years after graduation. 92% of nursing and midwifery graduates in that cohort were in sustained employment, a greater percentage than for any other subject studied. The percentage of those in employment who studied health and social care (89%), allied health subjects (88%), and medical sciences (88%), were greater than the percentage of all graduates in this cohort (87%), while the percentage of those in employment who studied pharmacology, toxicology and pharmacy (86%), was slightly below the overall average.

130. Figure A.63 shows, for 2022/23, the percentage of graduates in sustained employment, by subject studied, ten years after graduation. 89% of nursing and midwifery graduates in that

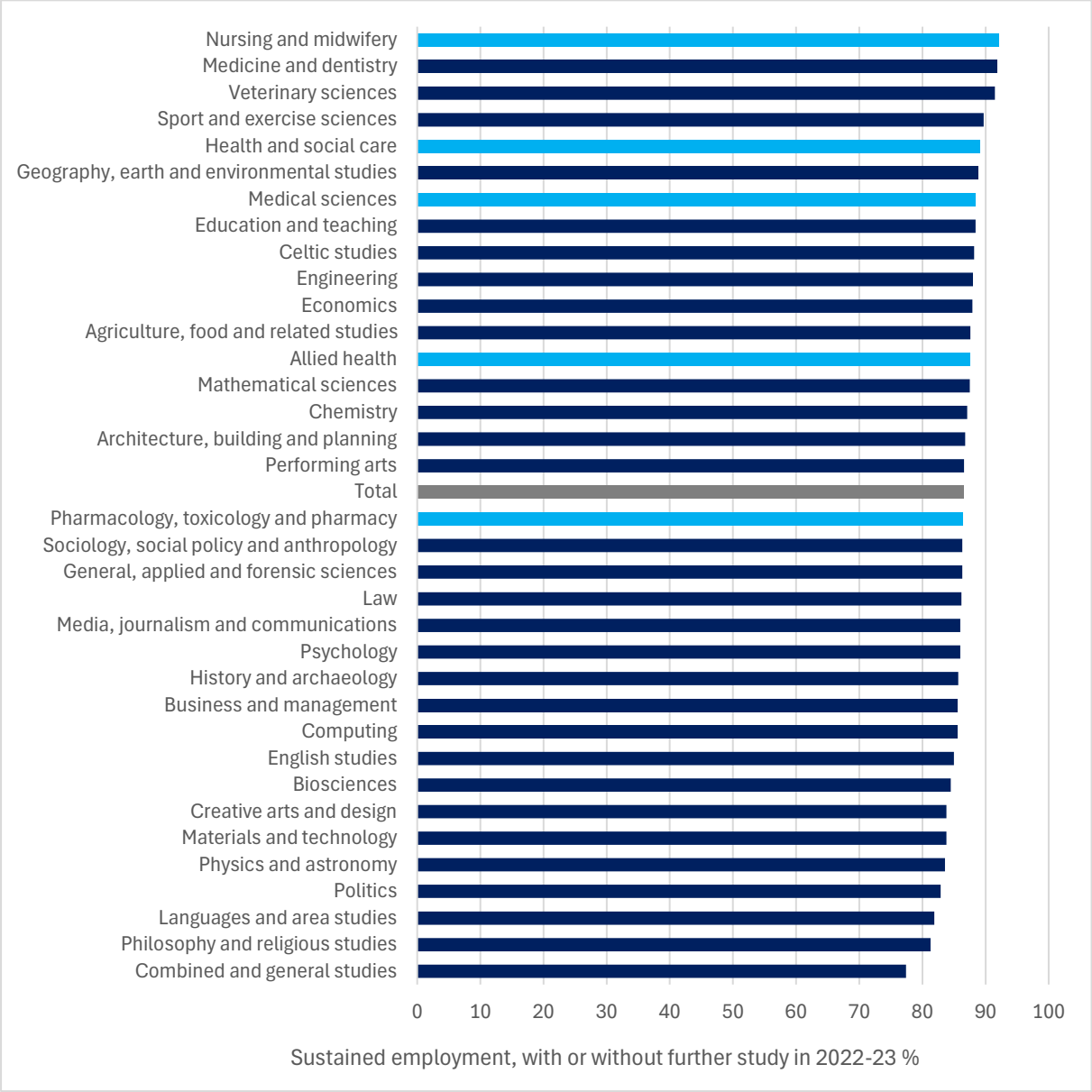
cohort were in sustained employment, a greater percentage than for any other subject studied, except for veterinary sciences and sport and exercise sciences (both also 89%). The percentages of those in employment who studied allied health subjects (86%), medical sciences (88%), health and social care (87%), pharmacology, toxicology and pharmacy (85%), were at least as large as the percentage of all graduates in this cohort (85%).

Figure A.61: Percentage of graduates in employment, by subject studied, one year after graduation (2020/21 cohort)



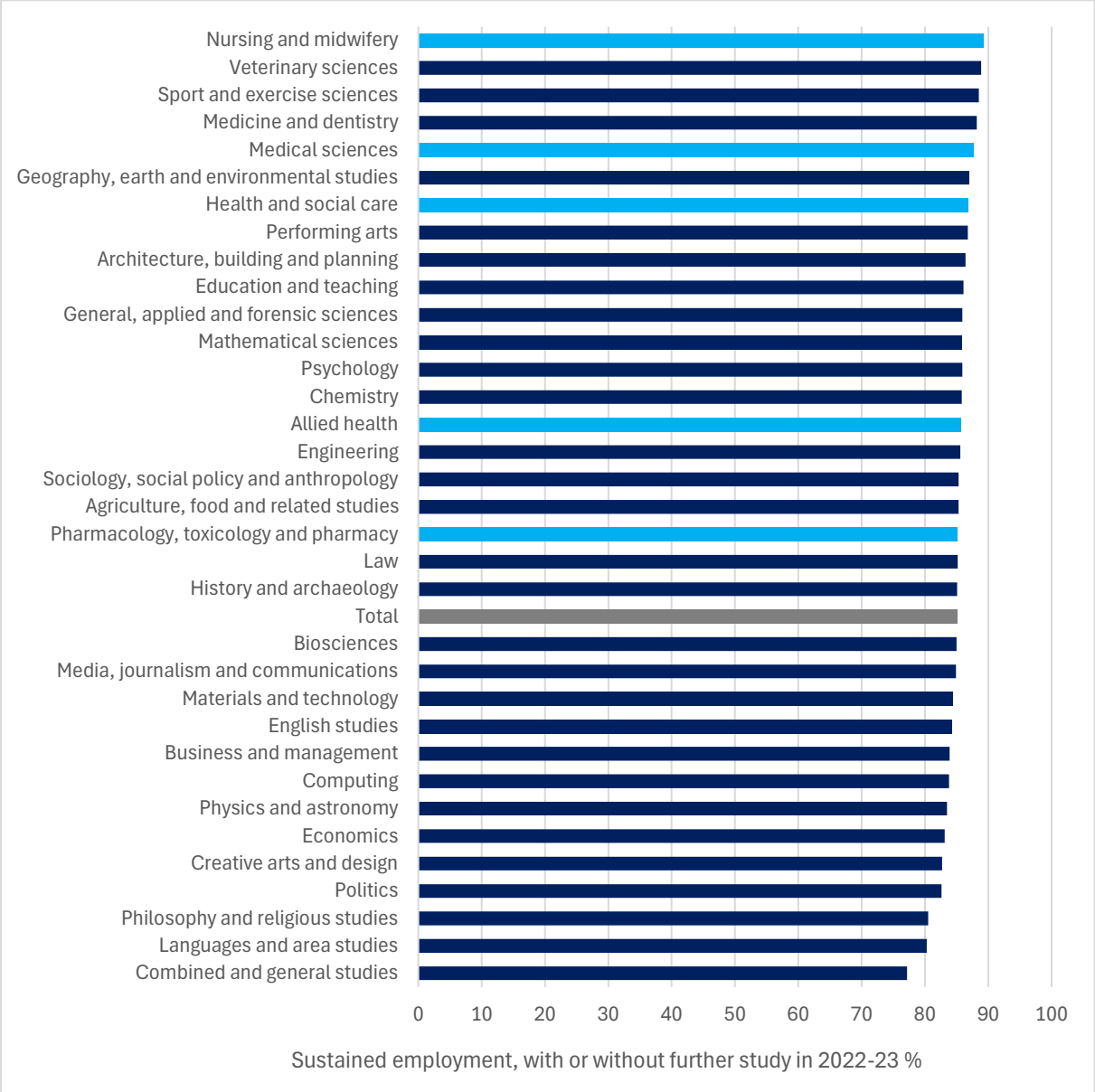
Source: OPRB analysis of LEO dataset

Figure A.62: Percentage of graduates in employment, by subject studied, five years after graduation (2016/17 cohort)



Source: OPRB analysis of LEO dataset

Figure A.63: Percentage of graduates in employment, by subject studied, ten years after graduation (2011/12 cohort)



Source: OME analysis of LEO dataset

National Living Wage (NLW)

131. Table A.23 shows changes in the NLW and the Living Wage Foundation Real Living Wage since 2017. Following the implementation of the 2025/26 award in England, the salaries attached to the lowest points on the AfC scale (Bands 1 and 2) equated to an hourly rate of £12.51. With effect from 1 April 2026, the NLW will increase to £12.71 per hour. Between 2017 and 2025 the NLW increased by 63%, while the Living Wage Foundation Real Living Wage increased by 49%. Over the same period, the lowest hourly rate of pay in the NHS increased by 59%, as the Band 1 rate was increased to match that of the Band 2 minimum as part of the 2018 AfC agreement, and in 2023 the lowest Band 2 pay point was increased to match the value of the highest Band 2 pay point.

Table A.23: National Living Wage and the Living Wage Foundation real Living Wage rates per hour, in place at April, 2017 to 2026

	National Living Wage (NLW)		Living Wage Foundation Real Living Wage (LWFRLW)		Agenda for Change pay minimum (England)			
Year	£ per hour	change from previous year	£ per hour	change from previous year	£	£ per hour	change from previous year	relative to NLW
2017	7.50		8.45		15,404	7.88		5%
2018	7.83	4.4%	8.75	3.6%	17,460	8.93	13.3%	14%
2019	8.21	4.9%	9.00	2.9%	17,652	9.03	1.1%	10%
2020	8.72	6.2%	9.30	3.3%	18,005	9.21	2.0%	6%
2021	8.91	2.2%	9.50	2.2%	18,546	9.49	3.0%	6%
2022	9.50	6.6%	9.90	4.2%	20,270	10.37	9.3%	9%
2023	10.42	9.7%	10.90	10.1%	22,383	11.45	10.4%	10%
2024	11.44	9.8%	12.00	10.1%	23,615	12.08	5.5%	6%
2025	12.21	6.7%	12.60	5.0%	24,465	12.51	3.6%	2%
2026	12.71	4.1%	13.45	6.7%				
Change 2017-2025		**63%**		**49%**	**59%**			

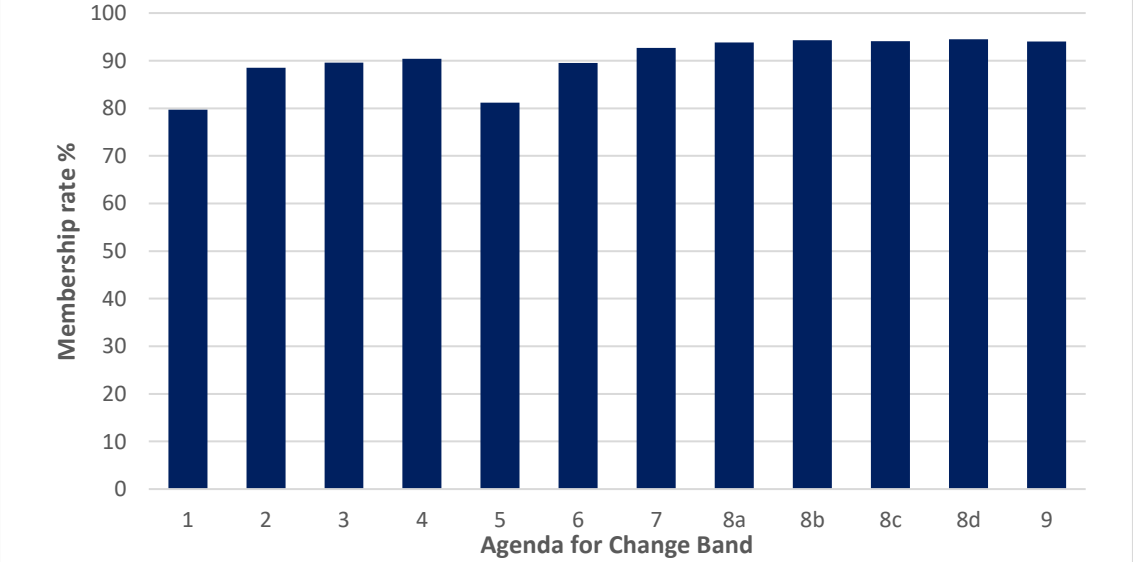
Source: Low Pay Commission, Living Wage Foundation, NHS Employers

Total reward

Pensions

132. The DHSC said that in June 2025, 88.6% of non-medical (AfC) staff were members of the NHS pension scheme. Figure A.64 shows that membership varies by band. Broadly speaking staff in the higher bands were more likely to be scheme members than those in lower bands. Between 92.7% and 94.5% of staff between Bands 7 and 9 were pension scheme members, 88.5-90.4% of staff in Bands 2-4 and Band 6 were scheme members, while just 79.7% of Band 1 staff (which is not open to new staff) and 81.2% of Band 5 staff were members.

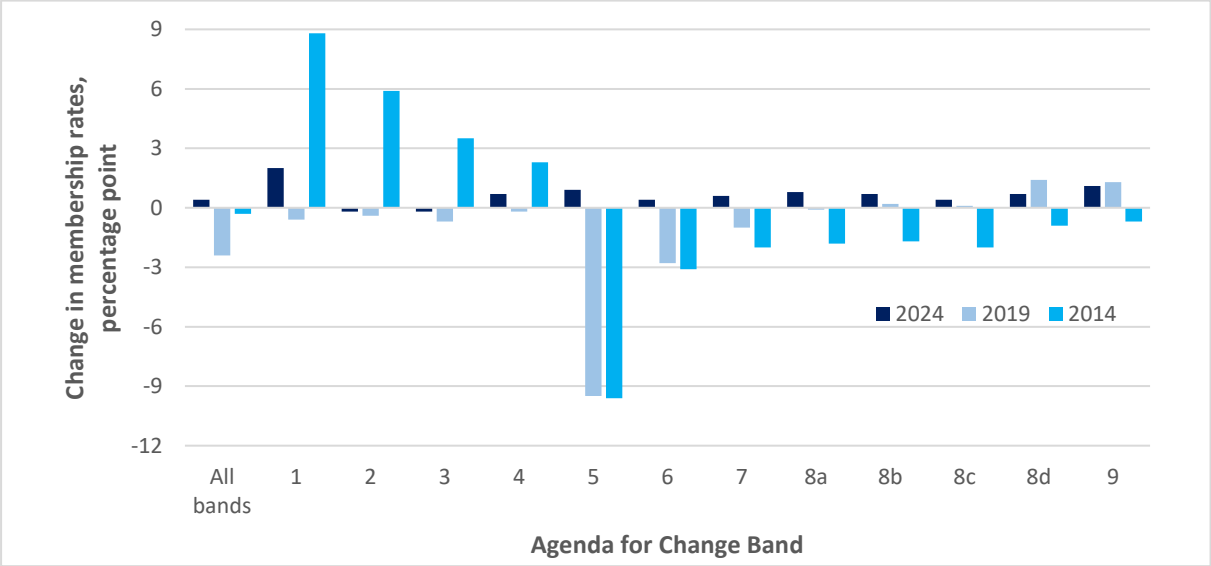
Figure A.64: NHS pension scheme membership, by AfC band, June 2025, England



Source: DHSC

133. Figure A.65 shows changes in the membership rate of the NHS pension scheme by AfC band, between 2025, and each of 2024, 2019 and 2014. Across all bands, membership fell by 0.3 percentage points between 2014 and 2025, fell by 2.4 percentage points between 2019 and 2025 but increased by 0.4 percentage points between 2024 and 2025.

Figure A.65: Change in NHS pension scheme membership rate, by AfC band, between June 2025 and: 2024; 2019; and 2014, England



Source: OPRB calculations using DHSC data

134. Between 2014 and 2025, membership rates increased for those in Bands 1 to 4 but decreased for those in Bands 5 to 9. Over that period the largest percentage point increases in membership rates were for those in Bands 1 and 2. Despite the increase in membership rate over the period at Band 1, the membership rate for staff at that Band remained lower than that for other Bands. The largest fall in membership rates between 2014 and 2025 was for those in Band 5, by almost 10 percentage points. More recently, between 2024 and 2025, the overall membership rate increased by 0.4 percentage points, with a fall in membership rates at Bands 2 and 3 more than offset by falls in membership rates at other Bands.

Table A.24: NHS pension scheme membership, AfC band 5, June 2025, by pay point and nationality, England

Pay point	Years experience	United Kingdom	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+ years	90%	85%	65%	85%
All points		91%	85%	60%	81%

Source: DHSC

135. Table A.24 shows that in June 2025, 91% of Band 5 staff with British nationality were pension scheme members, similar to the share across the NHS as a whole, 85% of EU staff were scheme members, while just 60% of those from the rest of the world were scheme members. The membership rate was lowest amongst Band 5 staff from the rest of the world with two to four years' experience. 46% of this group were members of the scheme.

AfC pay structure

136. The pay scales for England and Northern Ireland and Wales and the associated differences between pay points are as below. The pay points in Wales are 1.5% above those of England and Northern Ireland, so in general the differentials are the same (Table A.25). The smallest differentials are between Band 2 and 3 (1.9%) and Band 7 and 8a (1.8%).

Table A.25: AfC pay banding, 2025/26, in England, Northern Ireland and Wales and the associated differentials

	England and Northern Ireland			Wales		
Band/pay point	**Salary (FTE)**	**Salary (hourly)**	**Differential to next point**	**Salary (FTE)**	**Salary (hourly)**	**Differential to next point**
Band 1	£24,465	£12.51	0.0%	£24,833	£12.70	0.0%
Band 2 (entry step)	£24,465	£12.51	0.0%	£24,833	£12.70	0.0%
Band 2 (top step)	£24,465	£12.51	1.9%	£24,833	£12.70	1.9%
Band 3 (entry step)	£24,937	£12.75	6.7%	£25,313	£12.94	6.7%
Band 3 (top step)	£26,598	£13.60	3.3%	£26,999	£13.81	3.3%
Band 4 (entry point)	£27,485	£14.06	9.7%	£27,898	£14.27	9.7%
Band 4 (top point)	£30,162	£15.43	2.9%	£30,615	£15.66	2.9%
Band 5 (entry step)	£31,049	£15.88	7.9%	£31,516	£16.12	7.9%
Band 5 (intermediate step)	£33,487	£17.13	12.9%	£33,992	£17.39	12.9%
Band 5 (top step)	£37,796	£19.33	2.3%	£38,364	£19.63	2.3%
Band 6 (entry step)	£38,682	£19.78	5.5%	£39,263	£20.08	5.5%
Band 6 (intermediate step)	£40,823	£20.88	14.1%	£41,437	£21.19	14.1%
Band 6 (top step)	£46,580	£23.82	2.6%	£47,280	£24.18	2.6%
Band 7 (entry step)	£47,810	£24.45	5.2%	£48,527	£24.82	5.2%
Band 7 (intermediate step)	£50,273	£25.71	8.8%	£51,028	£26.10	8.8%
Band 7 (top step)	£54,710	£27.98	1.8%	£55,532	£28.40	1.8%
Band 8a (entry step)	£55,690	£28.48	5.0%	£56,514	£28.91	5.0%
Band 8a (intermediate step)	£58,487	£29.91	7.2%	£59,358	£30.36	7.2%
Band 8a (top step)	£62,682	£32.06	2.8%	£63,623	£32.54	2.8%
Band 8b (entry step)	£64,455	£32.96	6.5%	£65,424	£33.46	6.5%
Band 8b (intermediate step)	£68,631	£35.10	9.1%	£69,653	£35.62	9.1%
Band 8b (top step)	£74,896	£38.30	2.8%	£76,021	£38.87	2.8%
Band 8c (entry step)	£76,965	£39.36	6.1%	£78,120	£39.95	6.1%
Band 8c (intermediate step)	£81,652	£41.76	8.6%	£82,876	£42.39	8.6%
Band 8c (top step)	£88,682	£45.35	3.0%	£90,013	£46.03	3.0%
Band 8d (entry step)	£91,342	£46.71	6.1%	£92,713	£47.41	6.1%
Band 8d (intermediate step)	£96,941	£49.58	8.7%	£98,395	£50.32	8.7%
Band 8d (top step)	£105,337	£53.87	3.6%	£106,919	£54.68	3.6%
Band 9 (entry step)	£109,179	£55.84	6.0%	£110,818	£56.68	6.0%
Band 9 (intermediate step)	£115,763	£59.20	8.5%	£117,499	£60.09	8.5%
Band 9 (top step)	£125,637	£64.25		£127,523	£65.21	

Source: OPRB

Appendix B Remit Letter from the Secretary of State for Health and Social Care

Department of Health & Social Care

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

39 Victoria Street
London
SW1H 0EU

22 July 2025

Dear Mr Boyle,

RE: NHSPRB Remit Letter

I would firstly like to offer my thanks, on behalf of the government, to you and the members of the NHS Pay Review Body (NHSPRB) for your work over the past year on the 2025 to 2026 report. I appreciate the independent, expert advice and valuable contribution that the NHSPRB makes.

I would also like to take this opportunity to thank you personally for extending your interim role for a further year.

I write to you now to formally commence the 2026 to 2027 pay round.

Since you submitted your 2025 to 2026 report, my department has been working closely with trade unions and employers to progress important issues relating to the Agenda for Change (AfC) workforce. Most significantly, I was pleased to accept 36 out of the 37 non-pay recommendations that were generated from the 2023 AfC deal to support the NHS workforce. The measures we are taking forward include supporting local organisations to implement the NHS Job Evaluation Scheme correctly and consistently, and to support the career progression of nurses.

I have also committed to providing the NHS Staff Council with a funded pay structure mandate. We have begun engaging with the NHS Staff Council on this matter and have set out an expectation that the resulting changes will be implemented in 2026 to 2027. We will of course ensure that members of the NHSPRB are kept up to date with the progress of this work.

On 3 July we published our 10 Year Health Plan for England: fit for the future. This plan seeks to make 3 big shifts from hospital to community, sickness to prevention, and analogue to digital, and sets the context for the pay round. A valued, motivated and skilled NHS workforce is essential to delivering our plan, which is why we will publish a 10 Year Workforce Plan to create a more empowered workforce ready to deliver a transformed service.

We were pleased to be able to accept your recommendations for 2025 to 2026 pay awards. However, it came in above the figures we set out as affordable within evidence. Over the past few months, we have identified how extra funds will be freed up by cutting duplication and waste, and through abolishing NHS England, and

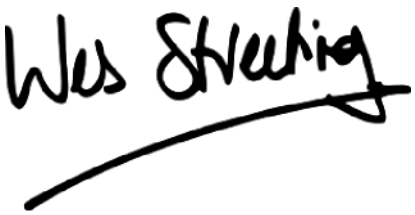
reshaping and reducing Integrated Care Board (ICB) costs by 50% to empower NHS staff and deliver better care for patients. As the Spending Review confirmed, all pay must be funded from departmental budgets and there will be no additional funding available for pay settlements. My department's evidence will set out the funds available to the Department of Health and Social Care (DHSC) for 2026 to 2027, following the Spending Review last month, as well as the recruitment and retention context alongside, earnings data and our plan for building an NHS fit for the future.

We know that public sector workers delivering our vital public services deserve timely pay awards. We announced 2025 to 2026 pay awards 2 months earlier than last year and remain committed to bringing 2026 to 2027 pay announcements forwards further. That is why we are launching this pay round 2 months earlier than the previous pay round, I would be grateful if you could support an earlier pay announcement by submitting your report at the earliest point that allows you to give due consideration to the relevant evidence. I recognise that changing the timeline from recent years will present challenges for you, but I am sure you also share the government's belief in the importance of returning to more timely annual pay processes. To enable you to submit your report earlier, our department will aim to cooperate with all your deadlines and bring the evidence process forward.

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

I would like to thank you again for your and the review body's invaluable contribution to the pay round and look forward to receiving your report for 2026 to 2027 in due course.

Yours sincerely,



RT HON WES STREETING MP

Appendix C Remit Letter from the Minister of Health (Northern Ireland)

FROM THE MINISTER OF HEALTH

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

Stephen Boyle
Interim Chair of NHS Pay Review Body
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8JX

By email: Alex.Ryder@businessandtrade.gov.uk

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

Our Ref: SUB-0432-2025

Date: 29 July 2025

Dear Stephen

NHSPRB 2024/25 PAY ROUND

I am writing to formally commence the 2026/27 pay round for Agenda for Change (AfC) staff in Northern Ireland and provide you with an update on the implementation of the 2025/26 pay award in Northern Ireland. I wish to begin by thanking the NHS Pay Review Body for its invaluable work on the 2025/26 pay round and the recommendations contained therein. I have accepted the recommendations of the Review Body

I want to state my commitment to implementing this year's pay award in full, and to doing so as promptly as possible. Due to the Department not being in a position to afford the full pay award, I have issued a Ministerial Direction for immediate implementation of the pay awards for all HSC staff in 25/26 in full. This is currently with the Northern Ireland Executive for consideration. I also met with Agenda for Change Trade Unions in June to discuss the current position regarding implementation of the 2025/26 recommendations. My department remains committed to ongoing engagement with unions as this process continues.

Appropriate reward and recognition for our staff is clearly an important part of demonstrating that we value the work that they undertake. Therefore, my aim is to move towards having the pay award in Northern Ireland paid to a similar timescale as in England. However, there is a need to recognise the challenge my department faces in relation to our budget. Issuing

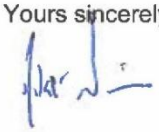
the Ministerial Direction is only the first step in moving forward with pay. We need to find significant additional funding in order to proceed with implementation of the award. I will continue to make the case, to Executive colleagues, for additional financial allocations that would allow me to implement a pay award in line with the recommendations from NHSPRB for 25/26. I will also be looking more closely at how we can approach supporting NHS Staff council in taking forward the funded mandate provided to NHS Staff Council by England to address structural reform in relation to pay for 2026/27.

Similar to the statement made by the Secretary of State for Health and Social Care in England my department's evidence will set out the funds available to the Department of Health in Northern Ireland for 2026/27 as well as the recruitment and retention context, earnings data and our plan for building a HSC fit for the future.

In line with the approach taken by the Department of Health and Social Care, my department will also seek to work collaboratively with you to meet your timelines and bring forward the provision of evidence. This will help to support the aim of enabling earlier pay announcements.

I would therefore welcome your pay recommendations for health and social care staff in Northern Ireland for 2026/27. The Department will, of course, keep you updated in regard to any progress made in respect of 2025/26 awards.

Yours sincerely



Mike Nesbitt MLA
Minister of Health

Appendix D Remit Letter from the Cabinet Secretary for Health and Social Care (Wales)

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

Llywodraeth Cymru
Welsh Government

Our ref: MA/JMHSC/1433/25
Stephen Boyle,
Chair of NHS Pay Review Body
1st Floor, 10 Victoria Street
London
SW1H 0NB
United Kingdom

NHSPRB@Businessandtrade.gov.uk

23 July 2025

Dear Stephen,

I am writing to formally commence the 2026-27 pay round for Agenda for Change staff in Wales.

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

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

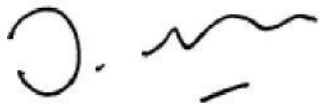
Therefore, I would like to receive your advice and recommendations as soon as possible to ensure that payment of any award to our dedicated NHS workforce is not unduly delayed past April 2026.

Canolfan Cyswllt Cyntaf / First Point of Contact Centre:
0300 0604400
Gohebiaeth.Jeremy.Miles@llyw.cymru
Correspondence.Jeremy.Miles@gov.wales

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1SN

Whilst I am aware that the timetable for your reports is being brought forward taking April timeframe into account, which is only right and necessary, this means they likely to be received within our pre-election period. I would still like to receive the reports as early as possible so these can be considered and responded to as soon as Welsh Ministers are able to do so.

Yours sincerely,



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

E03545983
978-1-5286-6228-4