



Department
of Health &
Social Care

The Department of Health Social Care and NHS England joint written evidence to the Senior Salaries Review Body (SSRB) for the 2027 to 2028 pay round

Published 19 October 2026

Contents

Chapter 1: executive summary	3
Chapter 2: NHS finances	6
Chapter 3: very senior managers (VSMs).....	18
Chapter 4: executive senior managers (ESMs)	34
Chapter 5: labour market context and high-income comparators	37
Chapter 6: total reward and NHS pensions.....	41

Chapter 1: executive summary

This document is the government's written evidence to the Senior Salaries Review Body (SSRB), submitted in response to the SSRB's call for evidence. It has been developed jointly between the Department of Health and Social Care (DHSC) and NHS England.

In July, the government remitted the SSRB to provide recommendations for the 2027 to 2028 pay award for very senior managers (VSMs) and executive and senior managers (ESMs). The SSRB responded and asked DHSC to provide evidence on all aspects of its terms of reference as well as on a number of additional points of interest. These include:

- evidence on how the last pay award was implemented by trusts and arm's length bodies (ALBs), including timing of payment (and whether ESMs received a consolidated award)
- how the new VSM pay framework is taking effect, and any impacts it appears to be having, including any early data and qualitative evidence on attractiveness of vacancies to applicants
- an update on the withdrawal of the ESM pay framework and delivery of training to Remuneration Committee (RemCo) chairs
- if available, updated corporate data on vacancies for each quarter
- any data covering recent years on the use of the central pay case approval procedure

Once SSRB has finished collecting evidence for this pay round, they will write a report as usual, including recommendations for VSM and ESMs pay uplifts for the 2027 to 2028 financial year.

For the 2026 to 2027 pay round, the SSRB made 3 recommendations. Firstly, they recommended a 3% uplift for ESMs and VSMs in the NHS in England. After careful consideration, government formally accepted this headline pay uplift recommendation on 21 May 2026

Secondly, the SSRB recommended again that the ESM pay framework should be withdrawn. The government has accepted this recommendation in principle, noting that any changes to ESM pay-setting and reward will need to be carefully sequenced and considered within the context of NHS England and DHSC coming together into one organisation.

Thirdly, the SSRB recommended that DHSC arranges delivery of training and knowledge sharing for remuneration committees and chief people officers on applying the VSM pay

framework and performance award principles, including on the scope to ensure posts are financially attractive to individuals near the top of the Agenda for Change (AfC) pay scale. The government has accepted this recommendation but within a longer timeframe than envisaged by the SSRB to allow sufficient stakeholder engagement in the design and delivery of the training.

This chapter sets out the wider context for DHSC's evidence for the 2027 to 2028 pay round and provides a brief overview of the evidence itself. Our evidence recognises the progress made over the past year, including improvements in access to NHS services, signs of recovering public confidence in the NHS, and the delivery of reform and pay awards within departmental budgets without recourse to the reserve. However, significant financial and workforce challenges remain, and further progress will require continued productivity gains and careful prioritisation of public finances.

Our evidence provides information on the government's approach to the pay and reward of NHS VSMs in provider trusts (NHS trusts and NHS foundations trusts) and integrated care boards (ICBs) and ESMs within DHSC arm's length bodies (ALBs).

Following positive feedback from SSRB on the structure of our evidence last year, we have taken a very similar approach to the chapters and sequence in this year's evidence. The contents are summarised below.

Chapter 2 covers finance and describes the financial context within which NHS pay awards will need to be met.

Chapter 3 sets out the policy context for VSMs including the operation of the NHS VSM pay framework, early implementation experience, and the developing evidence base on workforce, earnings, recruitment and retention for this workforce.

Chapter 4 considers the ESM pay framework, performance related pay and data collection.

Chapter 5 looks at Labour market context and high-income comparators

Chapter 6 covers the overall reward package and pensions

The NHS workforce

An engaged workforce is central to delivering the government's objectives for the NHS. Pay is an integral part of this, and it is vital that how we reward the workforce reflects the challenges they face and the responsibilities they carry and to set higher standards for senior leaders with pay tied to performance for senior managers.

Evidence approach

This evidence has been jointly developed by DHSC and NHS England. This approach ensures a single, coherent, set of evidence is provided to SSRB during the ongoing organisational transformation programme. This is the same approach taken for our joint evidence last year.

As with last year, rather than including the relevant data in this document in all cases, we will usually reference data in the accompanying data pack. As always, we will provide our own narrative and interpretation, signalling clearly where data pack figures, or publicly available data sources, are being referenced. Note, where we use the date format '2027 to 2028' we are referencing the financial year, unless otherwise stated.

We look forward to receiving SSRB's report in 2027.

Chapter 2: NHS finances

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

Pay awards above what is considered affordable within the spending review (SR) settlement will require further tough national and local re-prioritisation of the decisions already made through the planning process and would impact on the speed and delivery of the 10 Year Health Plan. To set a balanced budget post SR, we have made significant prioritisation decisions across both DHSC and NHS England. The productivity and efficiency section sets out the significant ask on both ICBs and NHS trusts in relation to productivity and efficiency, alongside pay and non-pay pressures, given unplanned events such as industrial action, which directly impact the scale of the challenge.

For the 2025 to 2026 and 2026 and 2027 pay uplifts, funding was found from within DHSC budgets through decisions on reprioritisation, the dissolution of NHS England, and reshaping and reducing ICB costs. Further pay awards above what is considered affordable will require difficult government trade-offs within existing DHSC budgets, including a reduction in ambitions for service or performance improvement.

Under the 2025 SR, NHS funding will rise by an average of 3% in real terms annually and the NHS is expected to deliver ambitious productivity targets of 2% per year equating to £17 billion in savings. The departmental financial plan for 2027 to 2028 is based on the successful delivery of the 2% productivity target, alongside managing a wide range of material financial risks.

Economic context

Headline Consumer Prices Index (CPI) inflation has risen to 3.1% in August 2026 with core inflation ((excluding energy, food, alcohol and tobacco) reaching 2.6%. While CPI remains below its recent peak of 3.8% in September 2025 it has increased from 2.6% in June 2026 as higher energy prices have begun feeding through to household bills.

The Bank of England's July Monetary Policy Report (MPR) projection expects inflation will rise further in the near term - global pressures, particularly higher energy prices, mean that risks to the inflation outlook remain tilted to the upside with the potential to feed through to the domestic economy and generate second-round effects in price and wage setting.

The unemployment rate has risen fallen back slightly, reaching 4.9% in the 3 months to July 2026. The latest indicators suggest that the labour market remains slack. HMRC Real Time Information data show employee numbers have fallen on the year for 17 consecutive

months to July 2026, while vacancies have continued to decline over the past twelve months.

Private sector regular pay growth has continued to fall and was 2.9% in the 3 months to July 2026. Private sector regular wage growth has now been below public sector regular pay growth (currently 6.3%) for 17 consecutive months although this is partly impacted by the timing of public sector pay awards.

Data on pay settlements are more limited but provide a more direct comparator for PRB recommendations as they remove the impact of compositional changes in the labour force or changes to working patterns which have historically been a factor in higher earnings growth. The Bank of England's Agents' survey reports average pay settlements of 3.6% for 2026, lower than the average settlement of 4.0% in 2025, while the Brightmine survey indicates businesses are reporting average settlements of 3.0% for 2027.

Funding growth

Table 1: mandate funding for NHS England

Year	NHS England revenue departmental expenditure limits (RDEL), excluding ringfence (RF) (cash) £ billion	NHS England capital departmental expenditure limits (CDEL), excluding ringfence (RF) (cash) £ billion
2023 to 2024	171.036	0.439
2024 to 2025	186.838	0.626
2025 to 2026	198.095	0.768
2026 to 2027	205.235	0.852

Source: [2026 to 2027 financial directions to NHS England](#)

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

Financial position of the NHS

In the Spending Review 2025 (SR25) to Parliament, the NHS England Revenue Departmental Expenditure Limit (RDEL) budget rose to £195.6 billion in 2025 to 2026 and

is set to rise to £226 billion in 2028 to 2029. The 2025 to 2026 Financial Performance Report shows the NHS ended the year with a £70 million underspend at a national level. Against the total NHS budget, the £70 million underspend was minimal and broadly reflects a breakeven position. However, local systems reported combined overspends of £563 million. The national position was balanced only after these pressures were managed, including through deficit support. Material risks remain from the cost of managing industrial action, implementing planned restructuring and headcount reductions and delivery of efficiency plans over 2027 and 2028.

Table 2: NHS providers RDEL breakdown

NHS Providers RDEL breakdown (£ million)	2023 to 2024	2024 to 2025	2025 to 2026
Gross deficit	1,606	1094	1408
Gross surplus	Minus 305	Minus 318	Minus 514
Reporting adjustment	12	0	23
NHS providers sector reported performance (SRP)	1,312	776	917
Plus additional RDEL adjustment	69	293	103
Net NHS providers resource departmental expenditure limit: non-ring-fenced. (RDEL NRF)	1,382	1070	1020

Table 2 shows the breakdown of funding provided to NHS providers since the 2023 to 2024 financial year, including preliminary outturn data for 2025 to 2026. The aggregate provider position shown here was a net deficit of £0.9 billion to £1 billion (depending on the technical measure). ICB underspends within systems offset some of this deficit, such that the net system overspend was a £563 million deficit, and other national offsets and savings resulted in the aggregate NHS position being £70 million underspend (as described above).

Share of resources going to pay

The growth rate in NHS trust and foundation trust provider sector (primary care services are not included in the growth rate) permanent and bank staff spend has exceeded the growth rate in overall NHS England funding in each of the past 3 financial years.

Given the SR settlement and funding allocated to the NHS already assumes a stretching productivity assumption of 2% as well as reductions in deficits, and performance improvements, any additional unfunded cost increases will manifest as trade-offs and delivery risks across service and workforce objectives.

Table 3 shows the proportion of funding consumed by NHS trust and foundation trust permanent and bank staff spend since the 2023 to 2024 financial year. This only covers staff working within hospital and community health services (HCHS) and excludes agency spend by these organisations.

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

Year	NHS England RDEL (£ billion)	NHS provider permanent and bank staff spend (£ billion)	% of spend on staff	Increase in total spend	Increase in provider permanent and bank staff spend
2023 to 2024	171.036	82.004	47.95%	7.95%	10.9%
2024 to 2025	184.873	89.823	48.59%	8.09%	9.53%
2025 to 2026	196.130	96.086	48.99%	6.09%	6.97%

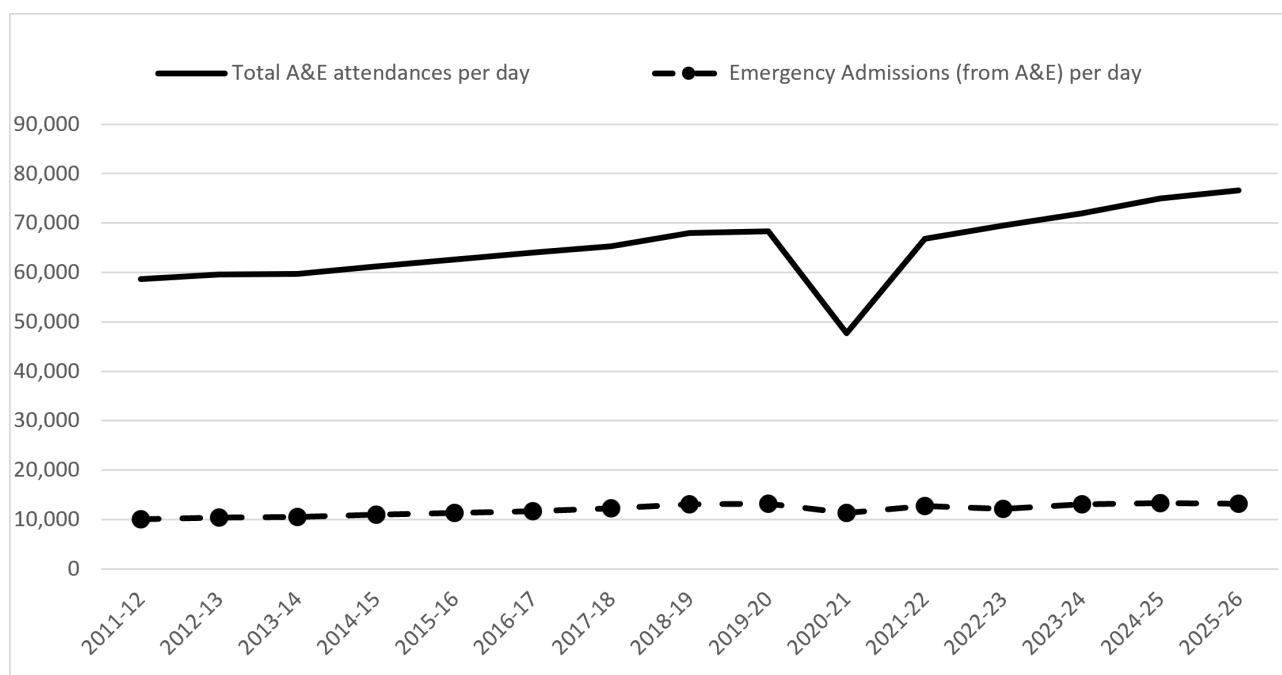
Notes:

- 2024 to 2025 and 2025 to 2026: NHS England RDEL figure excludes additional pensions funding (the further 3.1% employer contribution rate rise from 1 April 2024). NHS trust and foundation trust permanent and bank staff spend excludes a corresponding amount for additional pensions spend
- figures in the table are high-level estimates. Percentage increases may not match increases calculated from budget or spend figures as given in the table due to rounding
- Table 3 excludes agency expenditure from the NHS Provider Permanent and Bank Staff Spend column. However, agency spend remains included within the NHS England RDEL figure and has fallen substantially where agency costs made up 0.6% of the AfC pay bill in 2025 to 2026, down from 1.3% in 2024 to 2025, representing a cost reduction of approximately £568 million (0.7%)

Demand pressures

Demand pressures for emergency care is now above levels seen before the COVID-19 demand spike, with more accident and emergency (A&E) attendances. Similarly, demand for secondary mental health services has continued to increase. The average number of new referrals reached 453,930 per month in 2024 to 2025, representing a 15% increase compared with 2022 to 2023 levels and community service demand referrals have risen from 1.73 million in June 2025 to 1.83 million in June 2026 demonstrating a 5.7% increase.

Figure 1: total and emergency admissions per calendar day

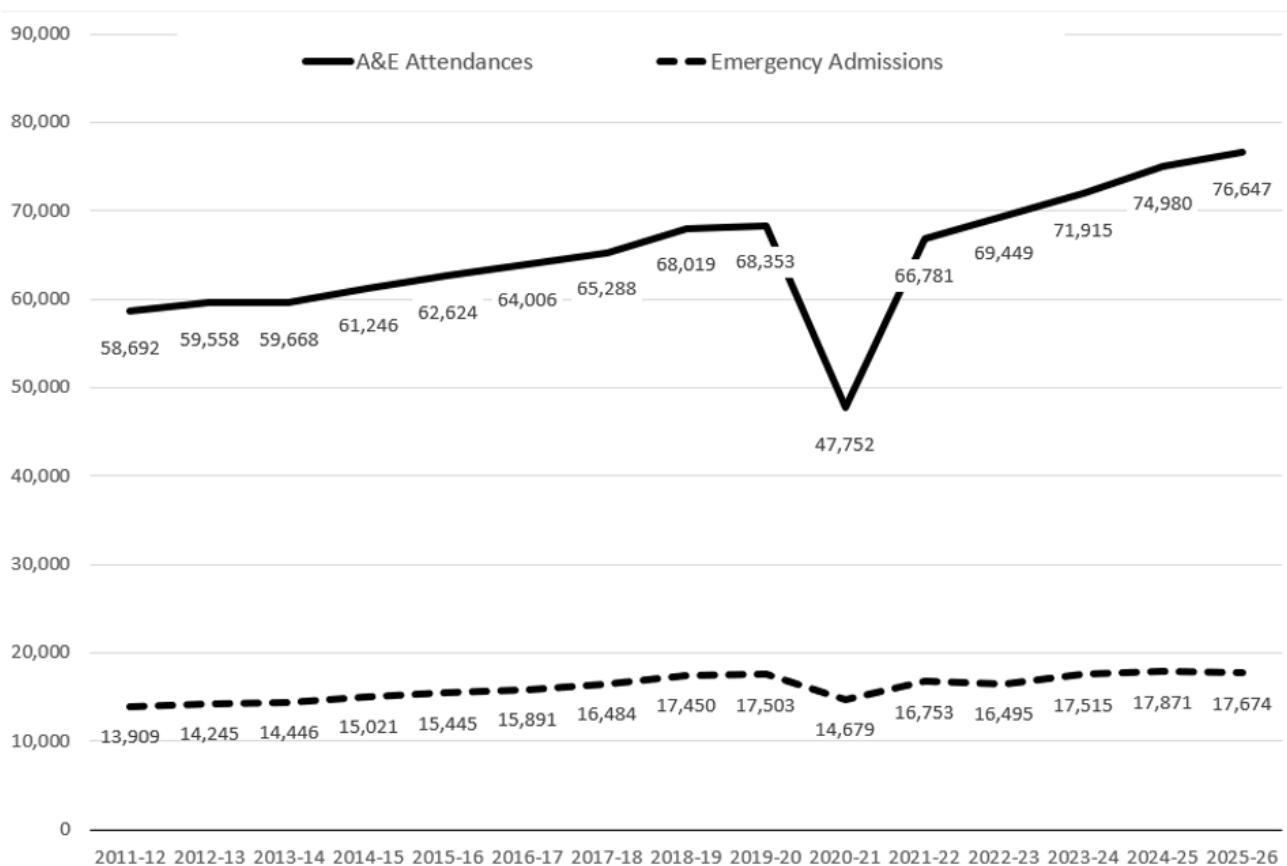


Source: [NHS England A&E attendances and emergency admissions](#)

Figure 1 shows the total attendances and emergency admissions to NHS England per calendar day between 2011 to 2012 and 2025 to 2026.

Between 2011 to 2012 and 2019 to 2020, both A&E attendances and emergency admissions increased steadily. In 2019 to 2020, there were an average of 68,353 A&E attendances and 13,167 emergency admissions per day. In 2025 to 2026, there were 76,647 A&E attendances and 13,202 emergency admissions per day. This equates to a 12.1% increase in A&E attendances, while emergency admissions via A&E grew more slowly demonstrating an increase of 0.3% between 2019 to 2020 and 2025 to 2026. However, changes to the recording of Same Day Emergency Care activity over this period has reduced recorded growth in emergency admissions.

Figure 2: people in contact with secondary mental health and learning disabilities services



Source: [NHS England Mental Health Services Monthly statistics](#)

Figure 2 shows the number of people with an open referral to any secondary mental health service between October 2023 and May 2026.

This shows a rise from 1.79 million people at the beginning of the period to 2.36 million in May 2026, showing a fairly consistent rise across the period. This equates to a 31.8% increase across the period.

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

Year	RTT estimated clock starts per working day	RTT total completed pathways and unreported removals per working day	Waiting list
2018 to 2019	82,231	81,272	4,345,467
2019 to 2020	79,712	79,552	4,386,297
2020 to 2021	55,824	53,595	4,950,297
2021 to 2022	74,916	69,322	6,365,772
2022 to 2023	79,511	75,665	7,331,186
2023 to 2024	82,163	81,332	7,538,830
2024 to 2025	82,440	82,913	7,418,598
2025 to 2026	84,925	86,160	7,106,135

Source: [NHS England consultant led referral to treatment statistics.](#)

Elective performance improvement

A central focus for the NHS is to deliver the NHS constitutional standard on the commitment for 92% of patients to wait no longer than 18 weeks from referral to consultant treatment, by March 2029. The size of the challenge to achieve this remains significant. The waiting list currently stands at 7.1 million (as of March 2026). This is down from 7.6 million in July 2024, but up from 4.5 million in July 2019 before the pandemic. At the end of June 2024, the start of the current parliament, 58.9% of waits were within the 18-week standard with over 300,000 patients waiting more than 52 weeks for elective treatment. The data for March 2026, the data has shown improvement with 65.3% of waits now within the 18-week standard, but this is a material improvement but remains significantly below the constitutional commitment of 92%.

The Elective Reform Plan, published in January 2025, outlines an ambitious package of reforms that the NHS is expected to deliver with national funding and support. It includes action to manage demand and transform outpatient services. This includes expanding advice and guidance and introducing a single point of access to support effective triage to the most appropriate next step for patients. We will also provide faster and more local diagnostics, implement more productive surgical pathways and improve patient experience.

The settlement includes £1.8 billion of additional funding, announced at Autumn Budget 2024, to support the delivery of 2 million extra operations, scans and appointments (equivalent to 40,000 per week) during this government's first year. The government reached and surpassed this target delivering 5.2 million additional appointments between July 2024 and June 2025.

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

Record levels of total patient referral to treatment (RTT) activity were seen in 2025 to 2026 which was driven by non-admitted activity. This meant monthly per working day RTT activity across 2025 to 2026 was above pre-pandemic levels, 9.8% higher than activity seen in 2019 to 2020.

Average elective demand growth pre-pandemic (between October 2016 and February 2020) was 2.1%. Demand returned to pre-pandemic levels in January 2023 and rebounded at a rate of 6.1% across 2022 to 2023. After slower growth across 2024 to 2025 (0.3%), the rate of demand growth has increased to 3.0% in 2025 to 2026. This is higher than the long-term trend seen before the pandemic at around 2% and includes mitigations from advice and guidance interventions.

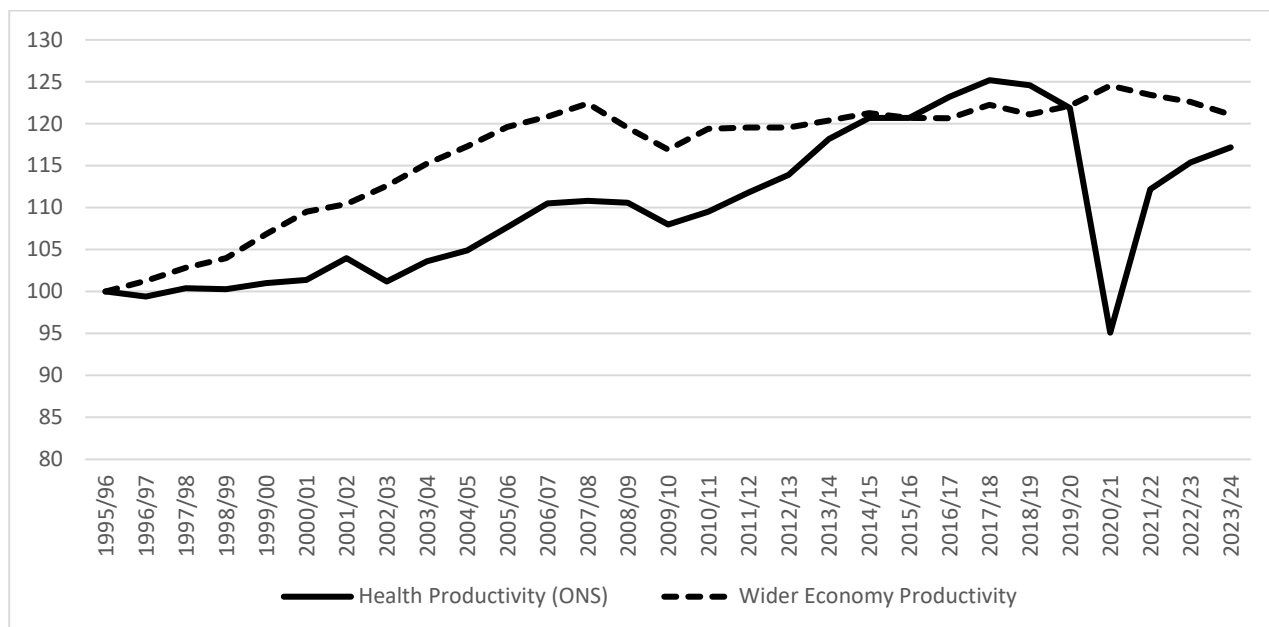
Calculating productivity in the NHS

The NHS has been set a target to deliver a 2% year-on-year productivity gain. This would return productivity to pre-pandemic levels by the end of this parliament. Research reported within the [10 Year Health Plan](#) has shown that reaching this level of productivity gain would reduce the long-term cost pressures facing the NHS by slowing the growth in health spending relative to the wider economy.

The Office for National Statistics (ONS) publishes annual estimates of productivity for public services, including healthcare. Between 1995 to 1996 and 2019 to 2020, healthcare productivity increased on average by 0.8% each year, with similar growth rates observed in the wider economy. Before the 2008 financial crisis, healthcare productivity initially declined in the early 2000s but recovered from the middle of the decade, averaging annual growth of around 1.4% as hospital activity, survival rates and overall efficiency caught up with earlier funding increases.

Figure 3: ONS annual estimates of productivity for public services, including healthcare

ONS England Health vs Wider Economy Multi Factor Productivity (index 1995 to 1996 = 100)



Sources: [Health Data from ONS Public service productivity estimates: healthcare, England, FY 2024](#) and [Wider Economy Data from ONS Multi-factor annual productivity, UK](#)

Figure 3 shows a 22% reduction in health productivity in 2020 to 2021. This was the result of both increased inputs (for example, staff capacity to cover the risk of surges in COVID-19 patients) and reductions in measured outputs (for example, fewer operations due to infection controls and limits on elective treatments). Infection control measures and lockdowns implemented during the COVID-19 pandemic delivered health benefits (for example fewer COVID-19 cases), but it is important to note that these benefits are not reflected in the usual measures of productivity. ONS has since reported a substantial recovery in productivity, with the 2023 to 2024 level estimated to be 4% below the 2019 to 2020 level.

These formal ONS estimates are currently only available to 2023 to 2024. However, NHS England now publishes monthly estimates of productivity at provider-level and these are recommended as the best available data on monthly productivity performance for the provider sector. These measures estimate that:

Acute productivity growth was 2.6% between 2024 to 2025 and 2025 to 2026 year to date (YTD).

- acute productivity growth has averaged 2.1% over the last 3 years (2023 to 2024, 2024 to 2025 and YTD 2025 to 2026)

- acute productivity growth was still 7 to 8% below the 2019 to 2020 level in 2024 to 2025 and was estimated to be 5 to 6% below the 2019 to 2020 level in 2025 to 2026
- productivity measures across all providers, including acute and non-acute, are less robust but do suggest higher growth in 2025 to 2026 (3.3%)

ONS's 2023 to 2024 versus 2019 to 2020 measure should not be compared with NHS England's 2025 to 2026 versus 2019 to 2020 measure as they measure different things. ONS has a wider scope and will therefore tend to show a smaller reduction versus 2019 to 2020.

NHS England data indicates the service is delivering against the SR25 commitment to achieve 2% annual productivity growth goal, (source: [NHS recovery continues with above target productivity growth](#)), which is well above the historic average; however, even where productivity is currently running above that level, these gains primarily support higher activity and service delivery within individual organisations rather than creating cash-releasing savings or headroom to absorb further pay pressures.

The focus now is on delivering further improvement through clinical and operational reform, workforce productivity, prevention, digital transformation, and reducing waste and unwarranted variation across the NHS.

It will also mean harnessing benefits from investment in technology and other digital tools. These investments will free up staff time, improve patient experience, and ensure the NHS is better equipped to meet future demand.

Affordability

SR25, published in June 2025, set departmental budgets for day-to-day spending until 2028 to 2029 based on the economic assumptions made at that time. The government has been clear in the SR that pay awards need to be funded in full from within these budgets and there will be no access to the reserve.

The government has allocated its SR funding to deliver on its commitments, including through setting multi-year planning guidance this allocated budgets to NHS ICBs already committing the majority of the SR settlement. The government is continuing to deliver its commitments on elective recovery, supported by increased activity levels this year, alongside wider service and performance objectives. Maintaining progress against these priorities will remain a key focus in 2027 to 2028.

DHSC is balancing these spending commitments across NHS England, its other Arm's Length Bodies (ALBs) and the core department, with an ambitious productivity assumption of 2% each year in the NHS which will be required to balance the settlement. DHSC have

developed financial and delivery plans that currently plan for a pay uplift of 2.4% without having to make trade-offs against headline government health commitments. Should the independent pay review bodies recommend an award above this level, we would need to consider whether and how this could be made affordable from within existing DHSC budgets. Accepting such an award would inevitably have an impact on healthcare delivery.

DHSC, along with the NHS, is already managing a wide set of material financial risks. These include the impact of higher inflation, energy costs, industrial action and reducing immigration health surcharge income. NHS pay is a significant material pressure where every 0.5% increase to pay costs is approximately £750m (equivalent of more than 89,000 hip or knee replacement operations). That's why anything above the pay plan outlined above will require difficult trade-offs for the government, particularly as most of the budget is already committed in ICB allocations.

These trade-offs could include a reduction in ambitions for service or performance improvement (for example, additional elective activity to reduce waiting lists or additional investment in digital and technology to support productivity improvements in future years).

The government has now overseen a series of difficult decisions to reform the health service. Over the last year, substantial workforce reductions have been delivered across both DHSC and NHS England as part of the commitment to reduce the size of the centre.

Chapter 3: very senior managers (VSMs)

This chapter sets out the policy context for VSMs, including the operation of the NHS VSM pay framework, early experience of implementation of the framework, and the developing evidence base on earnings, recruitment and retention for this workforce.

A VSM is an individual who holds an executive position on the board of an NHS trust, NHS foundation trust or ICB. The term also includes senior leaders below board level who report to the chief executive or another executive director and have substantial responsibility for the leadership, management and performance of the organisation.

VSMs hold some of the most senior leadership roles in the NHS and are central to delivering service improvement, financial sustainability, workforce reform and the wider ambitions set out for the health system. The evidence in this chapter therefore considers both the current pay and reward arrangements for this group and the policy issues that will inform further development of the framework over the coming years.

As of March 2026, there was a total VSM headcount of 3,517 and 3,164 Full Time Equivalent (FTEs) in trusts and ICBs. There has been a small decrease (around minus 3.5%) compared with the previous year during March 2025. More data can be found under the Workforce Numbers section, below.

VSM pay uplift

The government accepted the SSRB's recommendation of a 3% headline pay award for VSMs for the 2026 to 2027 financial year with published [pay ranges](#) also being uplifted by this amount meaning it benefits not just existing VSMs, following organisational processes, but also future and prospective VSMs

Implementation of the award is being taken forward in stages. The initial communication to employers confirmed the headline award but made clear that its implementation should only take place following the issuing of further guidance on eligibility. This is due to the need to confirm how NHS Oversight Framework segmentation, and arrangements for withholding the annual VSM pay award from eligible VSMs in organisations meeting defined performance criteria, will apply for the 2026 to 2027 award.

At the time of writing, those eligibility arrangements have yet to be finalised. Once confirmed, NHS providers' and ICBs' remuneration committees will be responsible for implementing VSM pay awards in accordance with the VSM pay framework. The arrangements will be shared with the SSRB ahead of the oral evidence session.

Where pay anomalies exist, for example where VSMs might earn less than staff they manage on AfC band 8d and 9, local remuneration committees remain responsible for

addressing these within the parameters of the framework and exercising their discretion appropriately.

NHS senior pay strategy

NHS senior pay policy forms part of the wider approach to strengthening senior leadership, accountability and capability across the NHS. The VSM pay framework provides the principal mechanism for setting pay for VSMs in NHS providers and ICBs, while the wider leadership development programme supports the pipeline, standards and accountability arrangements for senior leaders.

Further detail on the leadership reform agenda, including the 10 Year Health Plan, the launch of the NHS Leadership and Management Standards, the establishment of the NHS College for Leadership and Management, and the introduction of a barring mechanism for board directors, is set out later in this chapter.

NHS VSM pay framework

Implementation experience and early evidence

The [NHS VSM pay framework](#) was introduced in May 2025 to provide a nationally consistent approach to reward, while preserving appropriate local flexibility for recruitment, retention and organisational context.

While no formal evaluation has yet been undertaken, anecdotal feedback received by NHS England through pay case approvals activity and engagement with regional colleagues and chief people officers suggests that the framework is being implemented broadly as intended and is generally understood by employers. NHS England teams responsible for pay case approvals have also observed fewer cases being submitted outside the framework, which may indicate that organisations are increasingly operating within its parameters.

At this stage, available evidence does not indicate systemic issues with overall VSM pay levels. Early qualitative feedback suggests that pay levels are broadly considered appropriate for the roles concerned, although this evidence remains limited and largely anecdotal.

Consistent with the SSRB's 2026 report, we consider that it remains too early to draw firm conclusions on the framework's impact after one year. Significant elements, particularly the linkage between pay and organisational performance, require time for their effects to become evident. A phased evaluation over the first 3 years will therefore be undertaken to support a more robust assessment of outcomes.

Governance and accountability

Strategic oversight of VSM pay setting sits with DHSC. DHSC works with NHS England on implementation of the pay framework in practice. This approach will continue through the transition to a new single organisational structure.

The framework establishes clear national guidance while maintaining local accountability for pay setting for individual VSMs. Employing organisations remain responsible for VSM contracts and pay decisions within the framework, with a comply or explain requirement where deviations occur.

Pay and performance linkage

The VSM Pay Framework introduced a linkage between pay awards and organisational performance through reference to the NHS Oversight Framework (NOF). In 2025 to 2026, withholding of the annual pay award was applied on a targeted basis to a small number of the most challenged organisations in the Recovery Support Programme.

Withholding of the pay award applies at organisational level where the relevant criteria in the framework are met. The framework also permits some local flexibility through availability of the exceptional performance scheme and recruitment and retention premia. Evidence on the full impact of the pay-performance linkage is not yet available.

In their 2026 report, the SSRB raised concerns about the use of relative performance measures, the potential unintended consequences of league-table approaches, and the balance between individual and team-based reward. These concerns are recognised and will continue to be monitored as evidence develops.

ICB structural change and pay

Significant changes to the structure, scope and responsibilities of ICBs mean that the current population-based approach to VSM pay setting may no longer provide an appropriate basis for determining remuneration.

As ICBs are reconfigured, many are expected to move into higher population bands. This could result in pay increases that are driven by changes in population coverage rather than a proportionate increase in individual role scope, complexity and accountability. The government is considering steps to mitigate this.

Recruitment, retention and approvals

There is no evidence at this stage to indicate a systemic recruitment or retention issue linked to VSM pay levels. Early qualitative feedback suggests organisations are generally able to recruit within the framework pay ranges, although some challenges have been reported in specific circumstances, including recruitment to specialist roles. Anecdotal

feedback indicates that recruitment to VSM roles in rural areas, and to challenged trusts facing media scrutiny can be especially difficult. Some stakeholders have also raised concerns about the attractiveness of certain VSM roles for candidates moving from senior AfC posts. The framework includes flexibilities to support employers in addressing specific recruitment and retention challenges. Data on recruitment, attrition and applicant quality is not yet systematically available and will form part of the future evaluation programme.

By establishing nationally agreed pay ranges and governance arrangements, the framework delegates responsibility for routine pay decisions to NHS organisations, allowing Remuneration Committees to make appointments and pay decisions within defined parameters. Central approval is only required where proposals fall outside those parameters, reducing administrative burden while maintaining appropriate oversight of exceptional cases. Work has been undertaken to improve the timeliness and consistency of approval processes. Most pay cases are expected to be managed within the 4-week turnaround. Between April 2025 and July 2026, across all completed cases, including approved and rejected cases, the average decision time was 22.4 working days, equivalent to 4.5 working weeks. Among approved completed cases, the average decision time was 20.97 working days, or 4.19 working weeks. That is slightly above the 4 week approval window, although most documented approvals were completed within 4 weeks with a few especially complex cases extending the average turnaround time. Cases may take longer where information is incomplete, or the case is highly complex and requires ministerial approval.

Pay-setting principles and organisational challenge

The VSM pay framework is intended to balance national consistency with sufficient flexibility to reflect differences in role scope, organisational complexity and labour-market conditions. Nationally defined pay ranges and governance arrangements support fairness, transparency, affordability and value for money, while enabling employing organisations to take account of the responsibilities of individual posts, internal pay relativities and relevant recruitment and retention evidence.

The framework recognises that organisations facing significant operational, financial or quality challenges may find it harder to attract experienced leaders. It therefore allows relevant experience to be reflected in the spot salary and provides a challenged organisation recruitment premium for eligible new VSM appointments. The premium is a temporary, non-consolidated and non-pensionable payment of 15% of base pay, intended to support recruitment to the most demanding roles while maintaining affordability and accountability.

Evidence on the use and impact of these flexibilities is not yet systematically available. The planned evaluation will examine their effect on recruitment, retention and pay

outcomes, including their interaction with the framework's link between pay and organisational performance.

Evaluation and forward plan

A structured evaluation will be undertaken over the first 3 years of implementation. At present, key data gaps remain in relation to recruitment and retention metrics, the use of premia, exceptional performance schemes and allowances, and the distributional impacts of the pay-performance linkage.

Data collection is being strengthened over 2026 to 2027, including through workforce and pay systems. During this period, the focus will be on refining the pay-performance linkage and NOF methodology, implementing the revised withholding criteria, once confirmed, and delivering support for remuneration committees.

In 2027 to 2028, a fuller evaluation will be undertaken, including a review of recruitment and retention outcomes and consideration of whether wider framework changes are required, including in relation to structural issues.

As in previous cycles, NHS England has supplied a range of data and statistics for the VSM and ESM workforces which is available in the data pack which accompanies this evidence. For 2026 to 2027 the same definition is used as in previous years with the people most likely to be VSMs identified based on variables including job role, pay band and earnings level. We remain committed to improving the robustness of identification of very (and executive) senior managers.

Workforce numbers

Table 5 shows that as of March 2026 there were 2,846 staff identified as VSMs in NHS trusts (2,679 FTE) with a further 671 in ICBs (485 FTE) The number working in trusts was broadly similar to that reported last year (minus 1.5%), while the number in ICBs saw a reduction of around 13% following changes to organisational structures.

Table 5: VSM workforce in trusts and ICBs, headcount and full-time equivalent, March 2019 to March 2026

Month	Headcount - trusts	FTE - trusts	Headcount - ICBs	FTE - ICBs
March 2019	1,622	1,577	Not applicable	Not applicable
March 2020	1,768	1,722	Not applicable	Not applicable
March 2021	2,078	2,008	Not applicable	Not applicable
March 2022	2,178	2,089	Not applicable	Not applicable
March 2023	2,451	2,337	774	546
March 2024	2,721	2,581	844	589
March 2025	2,885	2,720	771	562
March 2026	2,846	2,679	671	485

Source: [NHS England workforce statistics](#)

An alternative definition, which only counts people in specified job roles, is shown in Table 6 for staff working in NHS trusts only. As with the lead definition, there was a small reduction (around minus 3%) in March 2026 compared with the previous year.

Table 6: Number of individuals, and full-time equivalents, working in specified board level roles in NHS trusts between March 2019 and March 2026

Month	NHS trusts - headcount	NHS trusts - full time equivalent
March 2019	1,605	1,566
March 2020	1,660	1,617
March 2021	1,697	1,651
March 2022	1,756	1,700
March 2023	1,780	1,719
March 2024	1,948	1,889
March 2025	1,960	1,902
March 2026	1,906	1,848

Source: NHS England workforce statistics

Overall, the headcount in NHS trusts saw a reduction in the number of VSMs for the first time since 2019, which may signal restraint due to financial prudence.

The ICB VSM headcount has also been declining since 2024 with a reduction from 844 in 2024 to 671 in 2026.

ALBs have seen the greatest fluctuations in VSM headcount over recent years, with a large increase from March 2024 to March 2025 (487 to 715). However, numbers are now on a downward trend with a headcount of 655 in March 2026 which may be a result of reductions in staff numbers as people leave and are not replaced due to organisational change (in the case of NHS England) or downsizing generally across the sector. Basic pay and total earnings figures have also dropped in the last 2 years within ALBs, from £118,876 basic pay and £125,494 total earnings in 2023 to 2024 falling to £103,125 and 106,486 respectively in 2025 to 2026. FTE earnings have remained steady, £136,532 in 2023 to 2024 and £138,426 in 2025 to 2026 (source: SSRB data pack 2027 to 2028 round and 2025 to 2026 round), suggesting that some VSMs in ALBs may have reduced their hours. Equally, it is worth mentioning that the data collection period has changed from July to June in previous years to April to March for this year's figures, so direct comparisons may not be accurate.

Workforce equalities and diversity

Data is available on the composition of the VSM workforce and how it is distributed across demographic groups, as shown in table 7.

The distribution of staff is shown to be broadly similar to previous years with:

- the gender split in trusts being almost exactly balanced, the same as last year, while there are slightly more females in ICBs. Although we note that the wider NHS workforce is around 75% female
- around 14% of VSMs in trusts (16% in ICBs) from non-white backgrounds, which is a slight increase from last year (13% trusts and 14% ICBs). Data from the [NHS Workforce Race Equality Standard \(WRES\) 2024 report for NHS trusts](#) shows that around 14% of VSMs in trusts (16% in ICBs) are from non-white backgrounds which is a slight increase from last year (13% trusts and 14% ICBs)
- the VSM workforce remaining older than the broader NHS workforce with around 45% of VSMs in trusts being between 45 and 54 and a further nearly 38% being between 55 and 64. The VSM workforce staff numbers data pack shows that the VSM workforce tends to have an older age profile compared to the rest of the NHS workforce average with around 45% of VSMs in trusts being between 45 and 54 and a further nearly 38% being between 55 and 64. This reflects the nature of these roles and that typically, these roles are occupied by individuals in the later stages of their careers

- the proportion of VSMs declaring themselves to be disabled is around 8%, broadly unchanged from last year and in line with the rest of the NHS workforce

Table 7: breakdown of VSMs by equality dimension, staff in NHS trusts and ICBs, March 2026 - headcount.

Demographic group	Demographic	Trusts	ICBs	Comparison of all staff in NHS trusts and core organisations
Gender	Female	50%	55%	75%
Gender	Male	50%	45%	25%
Age	Under 25	0%	0%	5%
Age	25 to 34	0%	1%	25%
Age	35 to 44	14%	15%	26%
Age	45 to 54	45%	43%	23%
Age	55 to 64	38%	37%	18%
Age	65 and over	3%	4%	3%
Disability	Yes	7%	9%	8%
Disability	No	79%	74%	82%
Disability	Unknown or not applicable	14%	17%	10%
Ethnicity	White	82%	77%	64%
Ethnicity	Ethnic Minorities	14%	16%	32%
Ethnicity	Unknown or not applicable	4%	8%	4%

Source: NHS England workforce statistics

Turnover

Turnover can be a useful way to measure recruitment and retention. In most cases a lower leaver rate would be preferred however, if there is organisational change or consolidation then we may see a temporary increase to leaver rates as the organisation adjusts to a new size.

Data provided in the data pack can be used to estimate the leaver rate for different types of organisations with the leaver rate being the number of leavers divided by the average workforce over the period. While leaver rates may appear slightly higher than last year, this is largely likely to reflect organisational change and downsizing rather than avoidable

leavers. Table 8 shows headcount and leavers rates in the 12-months to March 2026 in NHS trusts, ICBs and ALBs.

Table 8: estimated turnover for very senior managers in 12-months to March 2026, split by organisation type.

Measure	Trusts	ICBs	ALBs
March 25 headcount	2,885	771	715
March 2026 headcount	2,846	671	655
Leavers	299	117	90
Leaver rate	10.4%	16.2%	13.1%

Source: NHS England workforce statistics

It is noted that some of these 'leavers' will be people who have moved between organisations in different parts of the HCHS. For example, staff who might move from an ICB to a trust.

The Electronic Staff Record (ESR) collects some data on 'reasons for leaving' which provide an indication as to the cause of people leaving posts - table 9 shows the distribution of this data for NHS trusts, ICBs and ALBs. The proportion of people leaving with a reason for leaving relating to redundancy is higher than in previous years reflecting restructuring and redundancy programmes.

Table 9: distribution of 'Reasons for Leaving' for VSMs in 12-months to March 2026, split by organisation type and broad category or reason for leaving.

Measure	Trusts	ICBs	ALBs
Resignation	36%	32%	47%
Retirement	31%	18%	22%
Redundancy	17%	26%	17%
End of FTC	8%	16%	3%
Other	3%	0%	3%
Unknown	6%	7%	8%

Source: NHS England workforce statistics

Workforce earnings

Data provided in the data pack includes information on average pay and earnings for those identified as being in the VSM cohort. This includes basic pay and any additional earnings that staff might receive but does not include other aspects of the remuneration package such as pensions or redundancy payments for those no longer employed.

For those working in NHS trusts in the 12 months to March 2026, average earnings per person were over £157,000 with basic pay accounting for over 90% (£145,000) of this total. Compared to the 12 months to March 2025 this is an increase of just under 2%, slightly less than the pay award in 2025 to 2026 of 3.0%. This does not mean that eligible staff did not receive a pay award but may reflect changes to workforce composition or turnover.

Table 10: average pay and earnings for VSM workforce in the 12-months to March 2026 and comparison with the 12-months to March 2025

Earnings dimension	12-months to March 2026	12-months to March 2025	Change between 2025 and 2026
Basic pay per FTE	£153,986	£150,290	2.5%
Earnings per person	£157,997	£155,152	1.8%
Basic per person	£145,578	£142,420	2.2%
Non-basic per person	£12,419	£12,731	Minus 2.5%
% of total earnings not basic	7.9%	8.2%	Not applicable

Source: NHS England workforce statistics

There has been a small increase in the mean basic pay of VSMs (most notably chief executives) within ICBs and trusts. The ICB reconfiguration during 2025 reduced the number of Chief Executives overall as a consequence of creating a smaller number of larger ICB clusters. The increase in chief executive pay reflects that in some cases pay was increased modestly in line with the pay framework when ICBs clustered in advance of merger, as pay is based on the population size served by the ICB. Similarly in trusts, there have been a number of mergers which have resulted in a reduction in chief executives but a small increase in the average Chief Executive's pay, perhaps reflecting a trend towards larger group trust models.

Pay overlaps with other national contracts

NHS staff working in the secondary care sector work under different national contracts depending on their job role and level with non-medical staff working under NHS AfC and medical staff working under either consultant, SAS or resident doctor contracts depending on their level. Pay for these groups fall under the remit of the NHS Pay Review Body (NHS PRB) (non-medical) and Review Body on Doctors' and Dentists' Remuneration (DDRB) (medical).

Because of the different pay systems that are in place and the spectrum of seniority covered by the different contracts, there have been questions about the interaction between different contracts and the risk for pay overlaps which can impact staff incentives; for example, if someone working at the top of AfC pay range is considering whether to seek promotion to VSM level.

Table 11 shows the pay scale ranges in 2026 to 2027 for the contracts most at risk of overlapping against VSM pay ranges including the top of the AfC structure and the consultant contract. No detailed analysis has been undertaken to examine the significance of any potential pay overlaps on aspects of VSM recruitment, retention or performance. The introduction of the new VSM pay framework has set new benchmarks for pay and the similarity in pay awards has stabilised any overlaps

Table 11: pay scale minima and maxima of alternative contracts in 2026 to 2027

Contract	Grade	Pay scale minimum	Pay scale maximum
Consultant	2003 consultant	£113,565	£150,569
Specialist	2021 specialist	£104,401	£115,341
Agenda for Change	Band 8d	£94,356	£108,814
Agenda for Change	Band 9	£112,782	£129,783

Source: NHS Employers

Gender and ethnicity pay gaps

Data included in the data pack, and shown in table 12, provides information on the prevalence of 'pay gaps' for the VSM cohort which compare average pay and earnings for staff with different demographic characteristics.

When looking at the basic pay and earnings of those in the VSM grade, there is a consistent gender pay gap in trusts and ICBs. In ALBs, the pay gap fluctuates more over time, at times closing completely, however, in this submission it has widened again.

There is an ethnicity pay gap, on the basis of basic pay within the VSM grade. This ranges across ethnicities by approximately £1,800 basic pay per FTE in a monthly period in ICBs, and up to £1,400 in provider trusts. However, the extent to which different ethnicities are impacted change from organisation type to organisation type, and there is not one ethnicity consistently impacted across all organisation types. This may be as a result of the small sample sizes and changes in workforce composition from year to year.

Table 12: estimated gender pay gap (GPG) and ethnicity pay gap (EPG) for VSMs using basic pay per FTE in trusts, as of March 2026.

Grade	Ethnicity group	Gender pay gap: female to male	Ethnicity pay gap - female - relative to white	Ethnicity pay gap - male - relative to white
VSM	Asian or Asian British	2.7%	4.4%	2.7%
VSM	Black African, black British, or Caribbean	Minus 1.7%	4.6%	Minus 1.5%
VSM	Mixed or multiple ethnic groups	4.5%	Minus 2.8%	Minus 2.6%
VSM	White	4.4%	Not applicable	Not applicable
VSM	Other ethnic group	Not applicable	Not applicable	Minus 2.8%
VSM	Unknown	8.5%	0.7%	5.0%
Non-AfC	Asian or Asian British	Minus 0.9%	Minus 2.8%	2.0%
Non-AfC	Black African, black British, or Caribbean	Minus 3.7%	Minus 1.6%	0.5%
Non-AfC	Mixed or multiple ethnic groups	Not applicable	2.6%	Not applicable
Non-AfC	White	Minus 5.8%	Not applicable	Not applicable
Non-AfC	Other ethnic group	Not applicable	Minus 9.4%	Not applicable
Non-AfC	Unknown	Minus 4.1%	Minus 0.4%	1.2%

The data set includes 'Non AfC' staff which are all staff who meet the definition used for SSRB. For example, staff in eligible job roles earning over the VSM threshold, but not on AfC terms and conditions.

Morale and motivation: NHS Staff Survey

The SSRB has previously requested further evidence on morale and motivation among VSMs, as robust data on this important aspect of its remit has not previously been available.

Since the 2023 NHS Staff Survey, it has been possible to link data from the staff survey to data from the ESR to provide information on how members of the VSM cohort responded to the staff survey providing some detail on morale and motivation.

When reviewing this data, we would caution against making comparisons with staff survey outcomes for other sections of the workforce. VSM roles are, by definition, very different to other roles in the service, with different functions and pay as well as levels of responsibility and autonomy and so it is expected that they would have different staff survey outcomes. Now that we have 3 years of data, we may however be able to see if there have been any changes within the cohort on key metrics.

Some of the key results and trends identified are

- across categories scores for the VSM cohort are generally positive with scores across domains (including morale, engagement and flexibility) being some of the best across NHS workforces
- scores indicate that VSMs have substantial control over how they work with high scores for flexibility, involvement and ability to decide how they do work. Research shows that staff with control over their work, and how they do it, are more likely to be content
- over 85% of staff reported being at least satisfied with their pay. This has increased slightly (2 percentage point) over the past 2 years
- under 1 in 5 VSM staff report they will look to leave their current organisation in the next 12 months. While 60% of professional health staff indicated they may be considering moving, the most likely destination was another role in healthcare, followed by retirement, moving to another role outside of healthcare or taking a role inside healthcare but outside of the NHS

While more caution should be used when evaluating data at more granular level due to the impact of smaller sample sizes there may be differences between cohorts that are worth drawing out:

- pay satisfaction for all groups is high (over 80% satisfied) but is higher for white staff (86%) versus other staff (80%) and is slightly lower in London compared to other regions (rising to over 90% in the North East and Yorkshire)

- measures of engagement and morale were slightly higher for males compared to females

By job role there may be some indication of correlation with seniority with chief executives and deputy chief executives having some of the most positive scores while Nursing Directors had some of the least positive outcomes.

Leadership development

Leadership development is relevant to the SSRB's consideration of VSM pay because senior reward is only one part of the wider offer required to attract, retain and deploy effective senior NHS leaders. The VSM pay framework provides the pay and reward architecture, while the leadership development programme is intended to strengthen standards, capability, accountability and the pipeline into senior and board-level roles.

Delivering world class, inclusive leadership in the NHS

The 10 Year Health Plan set an ambition for the NHS to have world-class leadership and management. This reflects the central role that senior leaders will play in delivering the Plan's 3 shifts: from hospital to home, from analogue to digital, and from treatment to prevention.

As the NHS moves towards a new operating model, to deliver a more diverse and devolved health service with greater local autonomy and clearer accountability, senior leaders will need to combine system leadership, local partnership-building, innovation, financial grip and operational delivery. They will also need to lead anchor institutions within their communities, supporting wider social and economic outcomes alongside improvements in health outcomes.

Leadership standards, accountability and regulation

The new NHS Leadership and Management Framework was published on 6 July 2026. The framework, which has been developed in response to the Messenger review, sets out a code of practice, standards, competencies and a national curriculum for managers and leaders at all levels. The framework will be owned by the new NHS College of Leadership and Management and provides the foundation for future development, accreditation and appraisal arrangements.

The NHS Leadership and Management Framework will further reinforce inclusive, compassionate and accountable leadership and management behaviours, and support implementation of the recent Lord Mann Review recommendations.

NHS England published a new board member appraisal framework in April 2025. Wider appraisal reform is now being scoped and is also a commitment in the 10 Year Health Plan. The aim is to strengthen the link between standards, behaviours, objectives, development and performance, moving appraisal from a transactional process towards a more meaningful mechanism for improvement and accountability.

The government has also confirmed its intention to introduce statutory regulation for senior NHS leaders, covering board-level leaders and their direct reports. Legislative change will be brought forward within this Parliament to enable the Health and Care Professions Council to operate a statutory disbarring system for senior NHS leaders whose conduct is unacceptable, preventing them from working in senior leadership positions in the NHS again. The introduction of statutory regulation is part of a wider programme to professionalise NHS leadership and management and strengthen consistent accountability by creating a mechanism for removing leaders who commit serious misconduct.

NHS College of Leadership and Management

Work is also progressing at pace on establishing the NHS College of Leadership and Management. The appointments of the chair and interim chief executive have been confirmed, and the college is now undertaking a national stakeholder engagement phase to test and refine its emerging offer and operating model to inform the development of its initial business plan. The college is a clear response to the ambition in the 10 Year Health Plan for world-class leadership and management, and to the need for a more coherent, consistent and modern approach to developing the people who lead services, manage resources and deliver change across the NHS. It will provide a single national home for leadership, management and talent development, bringing together standards, curriculum, development, talent management, evidence and evaluation.

The college will provide the national delivery mechanism for many of the leadership and management commitments in the 10 Year Health Plan. Working with regions, employers and professional partners, it will coordinate a coherent, consistent and multi-professional development offer for the service, with clearer career pathways and stronger support for leaders and managers at every stage of their careers. This will help professionalise NHS management, strengthen pipelines into senior and board-level roles, and ensure leaders and managers are better equipped to deliver improved productivity, operational performance, staff experience and patient outcomes. The expectations placed on senior leaders are increasing, and the reforms now underway are intended to ensure that those leaders are better developed, better supported and deployed where they can have greatest impact.

Messenger Review update

Delivery of the Messenger Review remains central to the leadership reform agenda. Good progress has been made this year across its recommendations, with the main areas of delivery summarised below.

Recommendation 1: targeted interventions on collaborative leadership and organisational values. A new national induction resource was launched in March 2025. Delivery of the national leadership development programme continues, with content due to be refreshed in 2026 to 2027 to align with the new leadership and management and leadership standards and curriculum.

Recommendation 2: positive equality, diversity and inclusion action. The NHS Equality, Diversity, and Inclusion (EDI) Improvement Plan was published in June 2023 and set out high-impact actions for NHS organisations. Progress is being reviewed, with continued support to organisations to embed EDI locally. The forthcoming Leadership and Management Framework will further reinforce inclusive, compassionate and accountable leadership behaviours, and support implementation of the recent Lord Mann Review recommendations.

Recommendation 3: consistent management standards delivered through accredited training. The new Leadership and Management Framework published on 6 July 2026 sets out a code of practice, standards, competencies and a national curriculum for managers and leaders at all levels. The framework will be owned by the new NHS College of Leadership and Management and provides the foundation for future development, accreditation and appraisal arrangements.

Recommendation 4: a simplified, standard appraisal system for the NHS. NHS England published a new board member appraisal framework in April 2025. Wider appraisal reform is now being scoped and is also a commitment in the 10 Year Health Plan. The aim is to strengthen the link between standards, behaviours, objectives, development and performance, moving appraisal from a transactional process towards a more meaningful mechanism for improvement and accountability.

Recommendation 5: a new career and talent management function for managers. National talent programmes are already in place for aspiring chief executives, executive directors and chairs. From 2026 to 2027, the college is expected to implement a system-owned approach to identifying and assessing board-level talent, starting with chief executives before expanding to other board-level roles. Working with regions and professions, this is intended to provide a more coherent national framework for talent management across the NHS.

Recommendation 6: more effective recruitment and development of non-executive directors (NEDs). Work is progressing on attracting and developing non-executive talent. A

media campaign to attract first-time NHS NEDs was launched on 9 July 2026 and is part of the college's launch offer, alongside further work on induction and development. This is particularly important in a more devolved NHS operating model, where the quality of board challenge, assurance and local accountability will be increasingly significant.

Recommendation 7: encouraging top talent into challenged parts of the system. The VSM Pay Framework was published in May 2025 and includes incentives to attract leaders to the most challenging roles and organisations. Further work is ongoing between national and regional teams to strengthen talent pools and identify leaders able to support those systems and organisations. The college will help provide a more systematic route to identifying, preparing and deploying talented leaders into the most complex roles.

Chapter 4: executive senior managers (ESMs)

This chapter outlines the policy context for Executive Senior Managers (ESMs), including the purpose of the ESM pay framework, recent pay awards, and DHSC's agreement in principle to withdraw the framework. It also highlights the need for any changes to be carefully sequenced and considered alongside the broader implications of the legal transfer of NHS England staff into DHSC.

An ESM is defined as someone who holds an executive position in one of DHSC's ALBs, or someone who, although not a board member, holds a senior position typically reporting directly to the chief executive. DHSC's ALBs such as NHS Blood and Transplant or the Care Quality Commission appoint their most senior managers to ESM roles, which use a different pay framework to VSMs.

Consolidated ESM annual pay awards 2025 to 2026 and 2026 to 2027

The remuneration and annual performance-related pay of ALB CEOs and their executive directors paid under the terms of the ESM Pay Framework is determined by the DHSC Remuneration, Exits and Governance Committee (REGC). The Committee operates within the guidance and delegations for senior salaries set by the Cabinet Office and HMT.

For the 2025 to 2026 pay round, DHSC confirmed that a consolidated increase of 3.25% from 1 April 2025 should be paid to all ESMs.

For the 2026 to 2027 pay round, DHSC accepted the SSRB headline pay recommendation for a 3% uplift for all ESMs. We can confirm that a consolidated increase of 3% from 1 April 2026 will be paid to all ESMs. This was communicated to ALBs in June 2026, alongside confirmation that the funding for any uplifts would need to come from existing ALB budgets.

The annual pay awards for ESMs have again been consolidated this year, reflecting DHSC's acceptance that the ESM Pay Framework is outdated and should be removed.

Considerations for the ESM pay framework

In 2024 the SSRB commented that the ESM Pay Framework is outdated, and steps should be taken to provide greater alignment with the VSM Pay Framework. In the 2 most recent reports, the SSRB went further to recommend that the ESM Pay Framework should be withdrawn.

The most recent SSRB recommendation to withdraw the ESM pay Framework has been accepted in principle by DHSC. However, given the planned integration of NHS England into DHSC, it is not considered feasible to begin work to withdraw and replace the framework ahead of April 2027. Any changes to ESM pay-setting and reward will need to be carefully sequenced and considered alongside the wider impacts of the legal transfer of NHS England, including future reward strategy options.

Given that over 80% of ESM roles across DHSC's ALBs sit within NHS England, it would be premature to make changes to the ESM Pay Framework until the implications of the transfer for these roles, including their future grading and organisational context, are better understood. This remains subject to legal processes including trade union negotiations and will need to be considered alongside the DHSC's broader work on its future reward strategy. As such, this chapter does not include any update on the removal of the ESM Framework at this stage, as this would risk pre-empting the outcomes of the transformation programme. However, we will seek to provide a further update on this to SSRB at oral evidence.

ESM performance related pay

The DHSC REGC approved the use of non-consolidated performance-related pay (NCPRP) in ALBs. Historically, NCPRPs are only made to top performers.

For the 2026 to 2027 pay round (recognising performance to the end of 2025 to 2026), the DHSC REGC agreed that:

- there should be no formal restriction on the percentage of ESMs who could be given an award. However, they still expected to see differentiation in performance and a spread of performance ratings
- if an ALB proposed to pay awards to more than 20% of ESMs, a business case had to be submitted to the DHSC REGC

- individuals could receive a non-consolidated award of up to but no more than 5% of their reckonable pay (the exception to this being if a higher percentage had been agreed previously as part of a total remuneration package approved by DHSC Remuneration Committee and Ministers and, where appropriate, HMT in addition
- any money spent on NCPRP must come from existing budgets

ESM data collection

The transformation and integration of DHSC and NHS England provides an opportunity to take a broader, more strategic view of executive reward. Rather than undertaking a standalone ESM and ALB data collection exercise, work is being focused on the future reward strategy for the new department and the governance and assurance arrangements that will be needed to oversee executive pay across the wider health system.

Chapter 5: labour market context and high-income comparators

When determining the appropriate pay level for any group it is important to consider the wider economic and labour market context which will influence the judgement.

For senior leadership roles, this includes an assessment of general economic conditions which impact all staff and a consideration of factors which may influence conditions at the top of the income distribution.

Core economic context

The NHS operates as part of the wider labour market and so it is important to understand broader economic conditions and the wider context for this pay round alongside all of the other factors within the SSRB remit including, morale and motivation, recruitment and retention and total reward. Generally, greater emphasis is placed on forecasts for 2027 to 2028, as that is the pay period under consideration.

Data on earnings growth and pay settlements help us to understand pay in the wider economy and how different NHS pay awards might impact comparisons against wider labour markets. These are 2 different measures, with 'pay settlements' measuring the outcome, or expected outcome, of annual pay setting processes (and is most like the pay review body recommendation), while data on 'average earnings' also includes the impact of any changes to workforce composition or pay drift. This can mean that earnings grow at a different pace to pay settlements, as we have seen this year in the NHS.

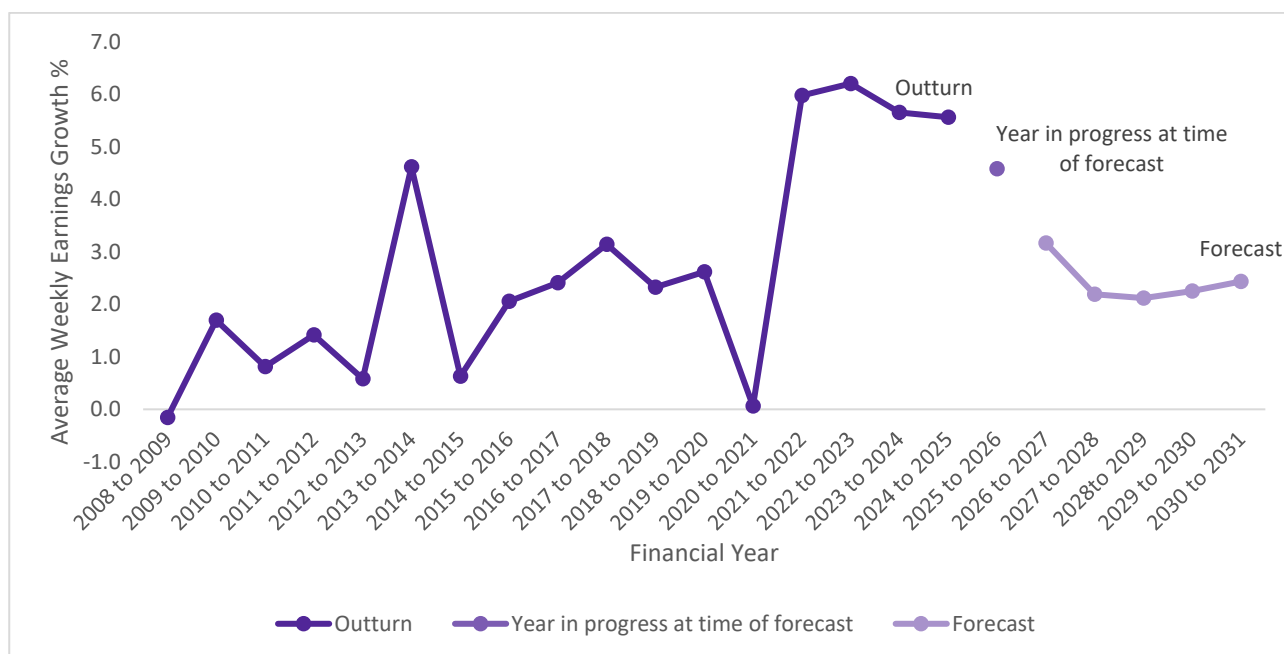
While there are no official statistics on pay settlements, several organisations undertake surveys which can provide an indication of current conditions:

- [data covering UK pay trends from Brightmine](#) shows a median pay settlement of 3.2% in the 3 months to June 2026 and the forecast for the rest of 2026 is also 3.0%
- [pay trend data from Incomes Data Research](#) also states the median pay increase in the private sector was at 3.5% for the 3 months to April 2026, with around half of all settlements being between 3% and 3.99%
- the latest [Bank of England Agents' summary of business conditions](#) showed a median pay award of 3.5% in 2026, with around 80% of firms having completed pay setting for this year. They did however note conflicting pressures for future pay rounds with the risk of higher inflation being offset by concerns around a looser labour market and weaker demand outlook

Through the rest of this review period, it will be important to monitor evolving conditions including the extent to which higher inflation occurs and the resulting impact on economic conditions and pay setting.

The ONS publish data on [Average Weekly Earnings \(AWE\)](#) for different sectors of the economy. While this can provide useful information on general trends, it is recognised that this is a broader measure than pay settlements and can be impacted by things like changes to workforce composition or pay drift (for example, an increase in average earnings could be seen by a reduction in jobs at the bottom of the income distribution, but this would be a purely compositional effect).

Figure 4: Average weekly earnings growth outturn and forecasts from Spring 2026 OBR forecast since 2008 to 2009



Source: [Office for National Statistics](#)

The [Office for Budget Responsibility \(OBR\)](#) forecast, shown in figure 4, made alongside the Spring Statement in March 2026, before the impact of events in the Middle East, forecast earnings growth in 2027 to 2028 would be around 2.2%, which would be down from 3.2% in 2026 to 2027. In comparison, in April the [Bank of England's Monetary Policy Report](#) forecast average weekly earnings growth to be at least 2.7% in 2027 to 2028, down from 3.9% in 2026 to 2027.

Wider economy pay settlements and earnings growth, partly driven by inflation, are more useful indicators for aligning NHS pay with relevant labour market comparators, alongside the SSRB's broader remit on morale, recruitment and retention.

The [Bank of England's Monetary Policy Report](#) in July forecasted CPI in 2027 to 2028 would be around 2.4% after averaging 3.0% in 2026 to 2027, but with the Bank of England recognising considerable uncertainty and with risks that skew more to the upside (meaning higher inflation). This is higher than the previous OBR forecast in March made before the start of the Iran conflict.

Whilst the importance and impact of high inflation for individuals is understood, there are concerns about it being a primary indicator in pay setting, as inflation is driven by a number of complex global and national factors, which inevitably raises the cost of living.

Increasing the pay of everyone in the country in-line with inflation would not alter these supply pressures and would be expected to fuel further inflation. Limiting such inflation-matching pay rises to the public sector, NHS or specific workforces would be unfair and would be expected to still be inflationary to the detriment of purchasing power across the country.

The SSRB will want to consider the most recent data and information at the time they are conducting deliberations and there is a higher-than-normal degree of uncertainty due to global conditions.

High-income professions and comparisons

1. Income distribution

As part of its earnings publication, the [ONS Earnings and employment seasonally adjusted data set](#) produces data on earnings growth across the earnings distribution. Because VSMs are at the upper end of the income distribution, growth at this part of the distribution is particularly interesting.

Table 13 shows how the rate of pay growth varies across the income distribution with those on lower pay experiencing a quicker rate of growth than those with higher salaries further up the income distribution. For example, average pay for someone at the lower quartile, on about £18,000 per year, has increased by around 5.7%, while someone at the 90th percentile, on about £70,000 per year, has increased by around 3.3% This is consistent with increases to the National Living Wage (NLW), resulting from policy decisions to increase the relative value of the NLW while there have been smaller increases further up the earnings distribution. This is contributing to wage compression, where pay differentials are not maintained in full, which comes as a natural result of this NLW policy.

Average earnings for the VSM cohort sit at the very top per cent of the UK income distribution where earnings growth has been lower.

Table 13 shows how pay growth has varied across the pay distribution. This shows if pay has grown evenly across the workforce or whether some groups have benefited more than others.

Faster growth at the lower end of the distribution, as seen this year, suggests pay gains have been concentrated among lower-paid employees. This is consistent with policy to increase the relative value of the NLW and contributes to wage compression where pay differentials are not maintained in full.

Table 13: average earnings growth across the UK income distribution by percentile, latest 12-month period

	10th percentile	25th percentile	Median	75th percentile	90th percentile	95th percentile
Monthly pay in March 2026	876	1,563	2,599	3,928	5,868	7,861
Growth in pay over the past 12-months	6.4%	5.7%	4.8%	4.1%	3.3%	2.5%

Source: [Office for National Statistics, Real-Time Information - Seasonally Adjusted](#)

2. Earnings percentiles analysis

The [Annual Survey of Hours and Earnings](#) (ASHE) collects detailed information on pay through time and for more detailed sectors of the workforce. It can be used to see how NHS pay compares against different parts of the wider economy, or to see how the place of NHS staff within the income distribution has changed.

This 'earnings percentiles' analysis estimates where average pay for different NHS staff compares against the wider economy and shows how the relative position of NHS pay has changed over time. Theory suggests this is likely to be more relevant to recruitment and retention than inflation alone because it reflects how NHS pay is changing relative to wider labour market conditions and opportunities, which are more likely to influence individual career decisions. We estimate that the minimum pay threshold used to define VSMs in this analysis would place them in the top 3% of the income distribution, while the average pay figure, of over £157,000, is estimated as being in the top 2% of the income distribution and the position of VSMs within the broader income distribution has been maintained.

Chapter 6: total reward and NHS pensions

Pay makes up one part of the overall reward package, and while important, there are other benefits which have both financial and non-financial value and impact the motivation, recruitment and retention of VSMs and ESMs, and should therefore be considered by the SSRB.

The total reward package in the NHS is generous. While arrangements for VSMs and ESMs are for employers to decide locally, terms and conditions are, in many cases, broadly similar to those offered under Agenda for Change. These benefits are above the statutory minimum and exceed those offered in other sectors. VSMs may also benefit from local arrangements, such as car and relocation allowances.

ESMs within the ALBs may also benefit from flexible and hybrid working conditions, including the ability to work from home, allowances and performance-related pay. Comparisons with the wider labour market should not just be limited to pay but include the full reward package. The SSRB has previously found that these additional benefits, in general, are competitive.

NHS Pension Scheme

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

There are 2 NHS Pension Schemes. A legacy scheme, which includes the 1995 and 2008 sections, and the 2015 scheme. Both are defined benefit schemes, but they have some key differences, as shown in table 14; the way benefits are calculated, the normal pension ages and the accrual rates. The legacy scheme is now closed to new members and all NHS staff who joined the Pension Scheme since 1 April 2022 are automatically enrolled in the 2015 scheme.

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

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

DHSC keeps the rules of the pension scheme under review to ensure it continues to help the NHS attract and retain the VSMs and ESMs needed to deliver high quality care for patients.

NHS Pension Scheme membership

We continue to monitor scheme members rates through ESR. Table 15 demonstrates changes to the estimated scheme participation rate over the past year. This shows that member rates have increased overall by 2 percentage points.

Table 15: estimated NHS Pension Scheme membership rates by salary range, March 2026 and comparison with March 2025

Salary range	Size of cohort sample	Estimated membership rate in March 2026	Estimated change in membership between March 2025 and March 2026
Under £125,000	540	87%	Minus 2 percentage points
£125,000 to £150,000	2,200	90%	Plus 1 percentage point
£150,00 to £175,000	870	89%	Plus 4 percentage points
£175,000 to £200,000	410	85%	Plus 6 percentage points
Over £200,000	370	74%	Plus 5 percentage points
Total	4,380	88%	Plus 2 percentage points

Source: DHSC analysis of electronic staff record

Retirement options

VSMs and ESMs who wish to retire earlier than their normal pension age (NPA) have the option of taking voluntary early retirement which allows staff to fully retire up to 10 years earlier than their NPA (subject to Normal Minimum Pension Age legislation), although their pension will be actuarially reduced (by around 5% per year), to account for the fact that it is being paid earlier and therefore for longer.

The generosity of the accrual model, potentially combined with retirement flexibilities, enable ESM and VSM members to take early retirement, with an actuarial reduction, before the NPA in the scheme and still receive a good value pension relative to the

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

ESMs and VSMs also have the option, with the agreement of employers, to take partial retirement or retire and return. These flexibilities allow members to claim their pension when it is most valuable to them but don't require them to leave or change their job. As well as supporting VSMs and ESMs with their work-life balance later in their careers, partial retirement may also support NHS employers, by allowing them to retain experienced members of staff.

Communicating the package

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

All NHS Pension Scheme members also receive an Annual Benefit Statement (ABS) every August, which shows the current value of their scheme benefits. For the period 17 August 2025 to 25 April 2026 there were 3,124,205 statements available, with 953,961 views. By comparison, on 25 July 2025 there were 3,073,848 statements available, with 1,091,850 views.

The NHS Pension Scheme is committed to complying with pensions dashboards legislation and supporting the objectives of the Pensions Dashboards Programme (PDP). The Scheme has successfully connected to the dashboards ecosystem and continues to work with the PDP and The Pensions Regulator to meet its regulatory obligations.

The MoneyHelper Pensions Dashboard, delivered by PDP, is designed to let people find and view all their pension information in one place online. It is expected to be available to the public during the 2027 to 2028 financial year. It aims to make pension information easier to access and help people better plan for their retirement.

The My NHS Pension member portal is available to all NHS Pension members. Access to the portal requires registration either through invite or contacting the Scheme. Registered members can access information about their Pension benefits and self-serve some administrative tasks, for example, managing Pension Nominations or viewing a pension payslip or P60.

© Crown copyright 2026

www.gov.uk/dhsc

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

