



Department
of Health &
Social Care

The Department of Health and Social Care and NHS England joint written evidence to the NHS Pay Review Body for the 2027 to 2028 pay round

Published 19 October 2026

Contents

Chapter 1: introduction.....	3
Chapter 2: NHS finances	6
Chapter 3: workforce planning and development.....	17
Chapter 4: staff experience	28
Chapter 5: remit groups	36
Chapter 6: earnings and pay comparators.....	49
Chapter 7: total reward	64

Chapter 1: introduction

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

For the 2026 to 2027 pay round, the NHSPRB recommended a headline pay uplift of 3.3% for all pay points on the Agenda for Change (AfC) pay scale in England and Wales. The government accepted this recommendation, and the new pay rates took effect on 1 April 2026.

In July, the government remitted the NHSPRB to provide recommendations for the 2027 to 2028 pay award for the AfC workforce. The remit letter was issued earlier than in previous years as part of the government's commitment to a more timely annual pay process and ensuring that staff receive pay awards as close as possible to the start of the financial year.

Once it has finished collecting evidence for this pay round, the NHSPRB will write a report as usual, including recommendations for AfC workforce headline pay uplifts for the 2027 to 2028 financial year.

This chapter provides the context for the DHSCs evidence to the NHSPRB for the 2027 to 2028 pay round, as well as a brief overview of the evidence itself. This 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.

Pay structure mandate

In line with recommendations from the NHSPRB in 2024 and 2025, the governments in England, Wales and Northern Ireland jointly provided the NHS Staff Council with a funded mandate to begin to resolve outstanding concerns with the AfC pay structure. This mandate was provided to the NHS Staff Council in March 2026.

The mandate covers pay structure changes for 2026 to 2027, with any changes being backdated to 1 April 2026. The mandate also provides the option to explore pay structure changes over more than one year (up to a maximum of 3 years). If multi-year agreements for pay structure changes are considered, the mandate states that governments would be open to exploring the inclusion of headline pay for 2027 to 2028 and 2028 to 2029.

The NHS Staff Council's negotiations are ongoing at the time of submitting this written evidence. The government will work with the NHS Staff Council to ensure that the NHSPRB is kept updated of developments and any agreements that are made.

This document

Following positive feedback from NHSPRB 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.

In its call for evidence NHSPRB particularly welcomed evidence focusing on:

- the NHS's overarching strategy to put patients at the centre of everything it does and the mechanisms for delivering this
- the need to recruit, retain and motivate suitably able and qualified staff
- regional and local variations in labour markets and their effects on the recruitment and retention of staff
- the funds available to governments as set out in departmental expenditure limits

There is evidence provided for each of these areas across the chapters in this document.

Chapter 2 provides an overview of the economic context and government and NHS finances. This year's Spending Review (SR) confirmed that pay awards must be funded from departmental budgets with no additional funding available for pay settlements. Pay awards above the level considered affordable within the SR settlement would require further difficult national and local re-prioritisation, that would affect delivery of the 10 Year Health Plan.

Chapter 3 outlines the direction of travel set out by the 10 Year Health Plan and current programmes relating to training, education, and international recruitment. The government will set out the action we will take to create a workforce ready to deliver the transformed service set out in the 10 Year Health Plan.

Chapter 4 examines staff experience and wellbeing across the NHS. It highlights both the challenges facing staff and the steps being taken to improve workplace culture, morale, and motivate suitably able and qualified staff.

Chapter 5 examines the important features of the workforce this year. While vacancy rates and turnover have generally improved, and workforce numbers have grown across many

professions, the chapter highlights continuing challenges in recruitment, retention and workforce supply that vary significantly between staff groups.

Chapter 6 considers earnings, labour market conditions and wider pay comparators relevant to the AfC workforce. It examines how NHS pay compares with that in the wider economy, explores evidence on recruitment and labour market competitiveness, and highlights the impact of workforce composition, pay progression and wider economic conditions on earnings.

Finally, chapter 7 describes the total reward package that NHS staff receive which is above the statutory minimum and typically exceeds that offered in other sectors.

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 the NHSPRB 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 NHSPRB's report in 2027.

Chapter 2: NHS finances

This chapter outlines the financial landscape within which NHS pay awards will need to be funded, 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 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 integrated care boards (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 to 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 SR 2025, 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 predicated 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 and 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 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 12 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). Integrated care board (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 2025 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%

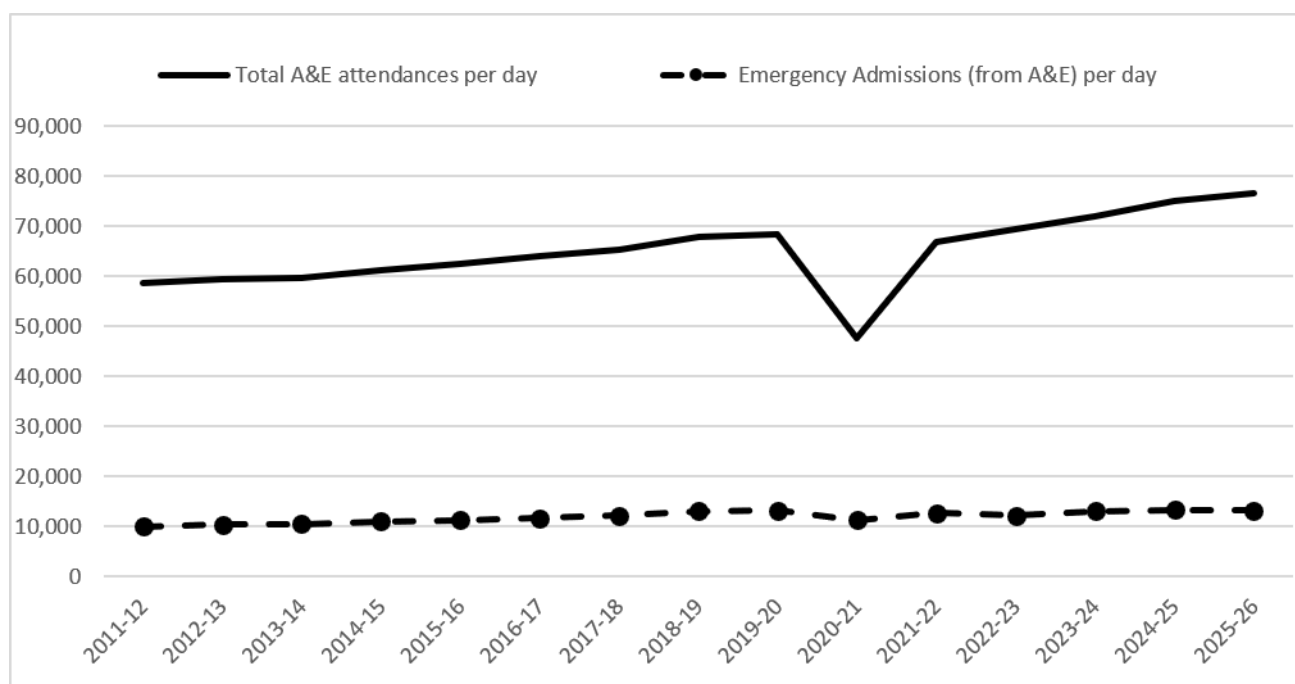
Notes:

- 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. This represents 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

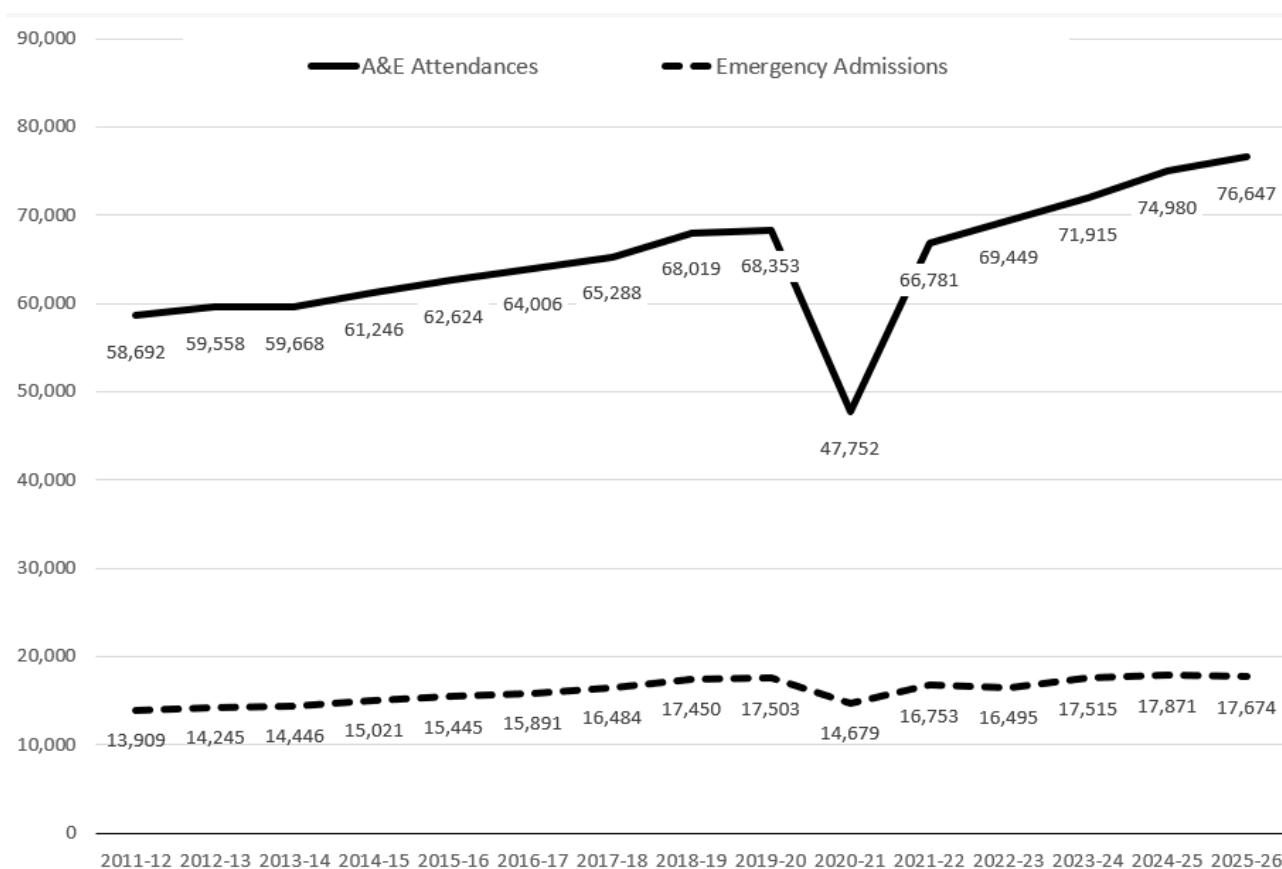


Source: [NHS England A&E attendances and emergency admissions](#)

Figure 1 shows the total attendances and emergency admissions 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 consistent rise. This equates to a 31.8% increase across the period.

Table 4: 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, in order to deliver the NHS constitutional standard, is a central focus for the NHS to deliver 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 stands at 7.37 million (as of August 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, has shown improvement with 65.3% of waits now within the 18-week standard. 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 SR 2025 settlement includes £1.8 billion of additional funding, announced in the 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 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.

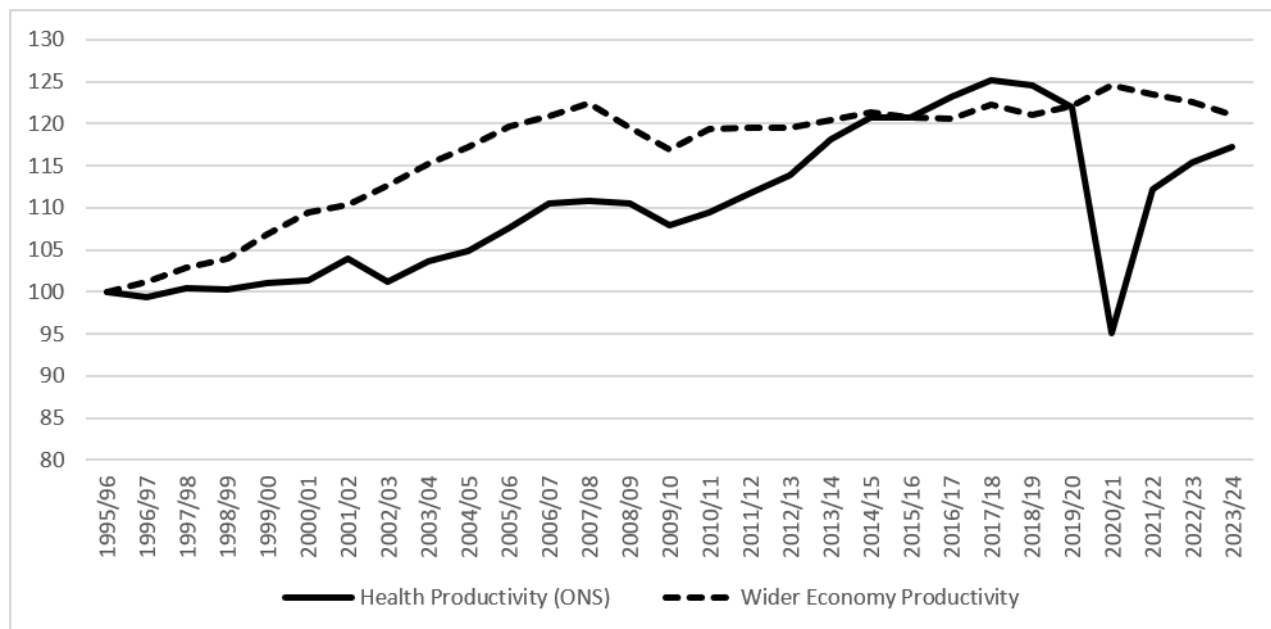
Calculating productivity in the NHS

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.

ONS annual estimates of productivity for public services, including healthcare. England health versus wider economy multi-factor productivity.

Figure 3 shows multi-factor healthcare productivity comparison with wider economy (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 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 SR 2025 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: workforce planning and development

This chapter sets out the government's reformed approach to workforce planning as a means of delivering the 10 Year Health Plan's new model of care, Fit for the Future NHS. The chapter provides information relevant to the requirement for NHSPRB to consider the need to recruit, retain and motivate suitably able and qualified staff, as laid out in its terms of reference. It provides an overview of recent trends in workforce growth, recruitment and retention for AfC staff, with changes in vacancy rates, overall AfC leaver rates and variation across staff groups, regions and settings. It describes how future workforce strategy will support a more sustainable workforce through improved productivity, retention and domestic supply.

This chapter also sets out the government's approach to education and training, including reforms to training pathways, alongside our ambition to reduce reliance on international recruitment over time and move to more socially responsible recruitment pipelines. The chapter also covers the role and importance of leadership and workforce development in supporting service delivery and transformation.

Non-medical workforce - health and community health services (HCHS)

Decisions around workforce growth are made by employers (mainly NHS trusts) balancing demand and quality factors alongside improvements in ways of working and available investment.

This section describes the trends in the numbers of NHS staff employed on AfC terms by NHS provider trusts, integrated care boards and in a range of central support organisations. It sets out a high-level picture of the staffing position, covering key issues with regards to patterns of recruitment and retention. It does not seek to replicate all regularly published data that is linked in the accompanying data pack.

By March 2026, there were over 1.40 million AfC staff employed across NHS trusts, integrated care boards and in central support organisations, the equivalent of over 1.24 million full time equivalents (FTE) (source: [NHS workforce statistics](#)). In March 2026 the AfC workforce comprised:

- almost 374,000 FTE nurses and health visitors
- over 25,000 FTE midwives
- over 23,000 FTE paramedics
- almost 184,000 scientific, therapeutic and technical (STT) staff

- over 404,000 FTE clinical support staff
- almost 234,000 staff in NHS infrastructure roles (including managers, estates staff and back-office functions)

The period April 2019 to March 2024 saw strong growth in the AfC workforce with an average increase of 4.2% per year. Workforce growth has though slowed significantly in the past 2 years. Growth in the year to March 2025 had slowed to 2.2% and the year to March 2026 saw no growth in the AfC workforce, with total FTE staffing numbers falling by 0.3% over the year. Annual growth is therefore now well below the longer-run average since 2010 of 1.9% per year.

The slowdown in workforce growth has not been consistent across staffing groups in 2025 to 2026, with the NHS having seen significant reductions in clinical support staff (down 2.3%) and NHS infrastructure staff (down 2.6%) Professionally qualified staffing groups such as paramedics (5.6%), midwives (2.6%) and straight to test (STT) staff (2.9%) increased at above the average annual increase, but the nursing and health visitor workforce slowed to 1.2% growth.

Annual leaver rates for AfC staff employed by NHS trusts and integrated care boards have remained broadly flat for the past 24 months with a 9.1% leaver rate in the year to March 2026. The rate has remained lower than the level seen pre-pandemic. Leaver rates reflect staff leaving the NHS trust or ICB sector and so include those leaving to work in GP settings or elsewhere in the health and care sector. Part of the variation in leaver rates between professions reflects how much activity is delivered by non-NHS providers outside of the NHS. Further detail on individual professions' leaver rates can be found in chapter 5.

Vacancy rates in NHS trusts have fallen, driven both by recent recruitment levels but also as workforce plans are adjusted to the current financial position of trusts (source: [NHS Vacancy Statistics \(and previous NHS Vacancies Survey\)](#)). It is not clear what the 'natural' level of vacancies would be as people also move between roles (churn), sectors, or retire. The headline vacancy rate for non-medical staff working in NHS trusts (6.8% as at March 2026 compared to 8.2% in March 2019) continues to mask significant variation between staff groups, trust types and regions. Mental health trusts continue to report the highest vacancy rates.

For registered nurses the vacancy rate as of March 2026 was 5.0%, and there remain relatively high vacancy rates in mental health trusts (8.3%) and much lower vacancy rates in acute trusts (4.4%). The North East and Yorkshire region holds much lower registered nursing vacancy rates (3.5%) than London (6.5%).

The reasons staff choose to leave NHS employment are complex and often difficult on which to obtain clear information on. While NHS workforce data do capture broad reasons

for leaving, it does not explain the multiple, more detailed, factors that can be behind a decision to leave NHS employment. The wider labour market differs for different professional groups so we would not expect the reasons for all professionals to be the same and there is no single measure that can tell us why people leave. NHS England published data on reasons for staff leaving reflects the mechanism behind how people leave the NHS (for example, resignation, end of fixed term contract) rather than necessarily their motivation for leaving (source: [NHS workforce statistics](#)).

The Nursing and Midwifery Council (NMC) publishes annual findings from a survey of staff leaving its register, including motivations for leaving (source: [The Nursing and Midwifery Council Registration data reports](#)). This shows that retirement continues to be the leading reason, whilst wellness related reasons are also prominent. Longitudinal Educational Outcomes (LEO) shows nurses tend not to leave for higher wages. UK nursing and midwifery graduates who remain in the healthcare sector 5 years after graduation have a slightly higher median salary than those working in different sectors. Despite lower rates of staff leaving, and notwithstanding the discussion of productivity above, there remain signs that the workforce is feeling stretched (source: [National results across the NHS in England | NHS Staff Survey](#)). Sickness absence rates in the NHS (source: [NHS Sickness Absence Rates](#)) remain above pre pandemic levels despite UK wide rates falling to below these (source: [Sickness absence in the UK labour market, ONS](#)).

Recruitment to entry-level roles

Recruitment to entry-level roles across the NHS continues to be influenced by a complex interaction of workforce demand, labour market conditions, and growing financial pressures facing employers. While recruitment activity remains substantial across many occupational groups, emerging evidence suggests that workforce supply may be beginning to align more closely with demand in certain professions. The alignment of workforce supply and demand can be seen particularly where targeted recruitment initiatives and expanded training pathways have strengthened candidate pipelines.

The Get Britain Working policy ambition is a flagship initiative supported by the government by programmes such as Widening Access Demonstrators (WAD), delivered through ICBs in partnership between NHS England and DHSC. The aim of the WAD programme is to support economically inactive individuals from working class communities disproportionately affected by unemployment into roles in health or social care. Each participating ICB established local demonstrator programmes, aimed at testing innovative approaches in their roles as local anchor institutions and major local employers. The expectation is for ICBs to mobilise a wide range of new and existing partners across their local areas to deliver high-quality and targeted pre-employment programmes.

The first year of delivery surpassed all national targets with 1,850 programme participants against a target of 1,000. Evidence from the first year indicates that band 2 and band 3 health care support worker roles represented almost a quarter of the substantive employment secured by programme participants. The programme also supported individuals into a range of band 2 and band 3 administrative and clerical roles predominantly in primary and secondary care organisations.

Recent trends indicate that some organisations are now experiencing increased application volumes for selected entry-level posts, reflecting changing economic conditions. Despite these positive developments, recruitment outcomes remain uneven across regions, professions, and service settings. Areas with historically high vacancy rates, including some rural and coastal locations, continue to encounter difficulties in attracting and retaining suitable candidates.

Education and training

Education and training remain central to building a sustainable NHS workforce, supporting both growth in supply and the development of skills aligned to future service needs. Across workforce groups, evidence shows increasing learner demand and continued reform of training pathways, including expansion of clinical roles, independent prescribing, and more flexible entry routes. However, the translation of learner numbers into workforce capacity is constrained by placement availability, supervision and educator capacity, higher education institute (HEI) sustainability and variation in training quality. Ongoing reforms aligned to the 10 Year Health Plan for England are focused on improving training quality, strengthening early career support, and developing more adaptable, skills-based pathways to ensure staff are prepared to work effectively in evolving models of care.

International recruitment

We want to ensure the NHS has the right people, with the right skills, in the right places to deliver high-quality care for patients. We value the skill and dedication overseas staff bring, alongside having a clear focus on building a more sustainable domestic workforce.

In the year to September 2025, 31.6% of people joining the Nursing and Midwifery Council register in the UK for the first time had non-UK countries of training (source: Nursing and Midwifery Council registration data reports).

However, international recruitment has fallen sharply in recent years. This reflects many acute providers achieving relatively low vacancy rates (less than 5%), a relatively strong domestic graduate outturn and low leaver rates, which collectively reduces demand for internationally recruited staff. The 10 Year Health Plan policy direction (see next paragraph), wider current financial position of trusts and a reduction in centralised funding

to support international recruitment following the end of the 2019 to 2024 plus the [50,000 extra nurses programme](#) have also had an impact on international recruitment activity.

The 10 Year Health Plan set an ambition to reduce reliance on international recruitment to under 10% by 2035 by recruiting and retaining more homegrown staff, and prioritising UK medical graduates for training places. Alongside this, immigration policy is being reformed to build a sustainable workforce for the future.

Health and care worker visa data shows that across 2021 to 2023, the average annual number of health and care worker visas granted for nurses was 23,053. There has been a significant reduction since 2023, with 1,373 nurse visas granted in the year to Q1 2026, 94% fewer than average annual number across 2021 to 2023 (source: Sponsored work visas by occupation and industry', Home Office, available on [Immigration system statistics data tables](#)). This trend is reflected across healthcare occupations (excluding doctors and dentists) more broadly, where visa grants have also declined by 91% over the same period. Nurses make up a large share of health and care worker visa grants and are therefore indicative of wider patterns in international recruitment across the health workforce.

Following the April 2026 AfC pay uplift, entry-level band 3 roles now meet the minimum salary requirement of £25,000, providing greater clarity for employers and international staff, particularly at the point of visa renewal or switching. Salary thresholds are subject to periodic review, reflecting ongoing adjustments to the wider immigration system.

The Migration Advisory Committee reported in December 2025 on salary requirements across the Skilled Worker route, including the health and care worker visa (source: [Review of salary requirements](#)). The government is considering its recommendations as part of wider reforms. The government has also consulted on proposals for an 'earned settlement' model, linking access to settlement more closely to contribution, as part of a more selective and controlled migration system.

Taken together, these changes are expected to help moderate international inflows and support a longer-term shift towards a more domestically trained workforce, while maintaining access to essential skills.

The government continues to emphasise high ethical standards in international recruitment through the Code of Practice for International Recruitment, ensuring recruitment does not undermine health systems in other countries and that employers act responsibly.

NHS temporary staffing

The deployment of a flexible workforce is an important element of efficiently running the NHS. Flexible working allows the NHS to meet demand fluctuations without the need to

increase capacity above what would be required on a sustained basis. Staff can be drawn from internal staff banks or external agencies.

Measures were introduced in 2016 to curb NHS agency spending including price caps, the mandatory use of approved frameworks for procurement, and the requirement for all systems to stay within the specified annual expenditure ceilings for agency staff. These measures, which are regularly monitored for compliance and effectiveness, aim to reduce cost and give greater assurance of quality in temporary staff and ensure that bank and agency workers provide the same standard of patient safety and care continuity as permanent personnel. Performance metrics on agency usage are included in the NHS Oversight Framework and linked to improving NHS productivity growth levels, reinforcing compliance with the agency rules for NHS trusts and foundation trusts.

Total expenditure on AfC temporary staffing decreased by 16% (£912 million) in 2025 to 2026 compared to 2024 to 2025.

Bank staffing costs decreased by 7% (from £4,767 million to £4,423 million) in 2025 to 2026, and bank staff as a proportion of the overall AfC pay bill decreased by 0.7 percentage points, from 5.4% to 4.7%.

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%).

On aggregate for total agency spend, we have achieved a 43.2% reduction across 2025 to 2026 well in advance of the 30% reduction target with spending approximately £896 million less in 2025 to 2026 than 2024 to 2025.

This demonstrates trusts have exceeded the target set of reducing agency spending by at least 30% for the full year in 2025 to 2026. Agency spend is the lowest on record, on track to eliminate agency expenditure by 2029, as per the commitment in the 10 Year Health Plan. The NHS did not, however hit the aggregate bank reduction target of 10% with provisional data showing an approximately 5.2% reduction year on year; however, spend is approximately £338 million lower in 2025 to 2026 than in 2024 to 2025.

DHSC and NHS England's flexible staffing strategy supports NHS providers in reducing their agency staff bills and encouraging workers back into substantive and bank roles. Trusts are encouraged to develop and improve their strategy, procurement and commercial negotiation for temporary staffing.

Leadership

The 10 Year Health Plan sets an ambition for the NHS to have world-class leadership and management. Leadership has been a key enabler of the progress the service has

collectively achieved over the last year, as reflected in the 6 percentage point improvement in public satisfaction with the NHS reported in the 2025 British Social Attitudes Survey (source: [Public satisfaction with the NHS and social care in 2025 \(BSA\), The King's Fund](#)). As the NHS enters a new phase, with a more devolved operating model and greater local autonomy, leadership and management will continue to play a vital role in determining how services are delivered. Individually, NHS leaders and managers will need to navigate a rapidly changing environment - particularly as technologies such as AI reshape how people across the NHS will work - and drive the transformation these changes make possible. Leaders and managers across the NHS are not only responsible for delivering and improving services but also play a key role in leading anchor institutions within their communities, supporting wider social and economic objectives alongside improving health outcomes.

A key development in the last year has been the progress made with establishing the new NHS College of Leadership and Management, a 10 Year Health Plan commitment. The college was launched in July 2026, and the appointment of the college chair and interim chief executive have been confirmed. They will be engaging closely with stakeholders to inform the development of its 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 be the national delivery vehicle for the NHS's leadership and management reform agenda, translating commitments in the 10 Year Health Plan into consistent standards, development and talent interventions across the service. This includes implementation of the Leadership and Management Framework, published on 6 July 2026 in response to a key recommendation of the Messenger Review. For the first time this establishes a consistent set of professional standards, a code of practice and a core national development curriculum for NHS managers and leaders. More broadly, it will co-ordinate a coherent, consistent and multiprofessional leadership and management development offer, providing clear career pathways and supporting managers and leaders at every stage of their career to develop, progress and fulfil their potential.

In partnership with regions and professions, the college will also have an explicit role in supporting the development of talent pipelines to board level roles, including new processes for identifying and assessing readiness for these and the development of aspiring executives and clinical leaders.

New programmes in education and training

Advanced and enhanced practice

To support healthcare professionals to advance in their careers, NHS England will continue to develop advanced practice models for nurses, midwives, optometrists, pharmacy, and allied health professionals (AHPs). These are aligned to delivery of the 3 shifts and the ambitions of the 10 Year Health Plan including expansion in community, prevention and digitally enabled care. Advanced practitioners will continue to play an increasingly important leadership role across neighbourhood and system settings.

As reported last year, NHS England continues to develop a nationally inclusive training offer to support advanced practice across all disciplines. This aligned to the ambitions of the 10 Year Health Plan to expand career pathways and support delivery across priority settings, including community and digitally enabled care. Employer-sponsored pathways will remain central to building advanced practice capability in priority patient pathways. However, delivery confidence is currently moderate and variable across systems, as ongoing financial pressures continue to constrain providers' ability to create, release and backfill posts at scale, limiting growth in the pipeline. Without sustained investment and system capacity, there is a risk that expansion of advanced practice will not keep pace with 10 Year Health Plan ambitions on workforce growth, productivity and retention.

Similarly, guidance from the Centre for Advancing Practice supports the safe and effective implementation of advanced practice, including development at band 6 level. Guidance remains a key enabler of enhanced and advanced practice pathways, supporting workforce capability, professional development and retention across disciplines and will continue to underpin delivery as these roles expand in line with 10 Year Health Plan ambitions and the 3 shifts.

Clinical placements

Linked to educator capacity, we are also working to ensure the right number, spread distribution and quality of clinical placements with a clear shift towards community, primary care and digitally enabled settings in line with the government's 10 Year Health Plan for England. The Plan establishes that workforce training must reflect the move from hospital to community care and prepare staff for multidisciplinary, neighbourhood-based models of service delivery. Current work on clinical placement management builds on insights from the 2022 to 2023 discovery phase and subsequent stakeholder engagement and is being strengthened to support this transformation. NHS England is co-developing national principles to guide placement planning and delivery across all professions and settings, ensuring placements are aligned to future service models and equip learners with the skills required for prevention-focused, digitally enabled and community-based care. This includes improving placement capacity and flexibility through more diverse delivery

models, including greater use of community providers, multi-professional settings and innovative approaches such as simulation and blended learning. These more diverse delivery models are consistent with the Plan's ambition to modernise education and training and align placement activity to the right settings and workforce needs.

Education and training reform

Skills development

This work is continuing in line with 10 Year Health Plan ambitions, with ongoing collaboration across regulators and education partners to modernise curricula and better prepare the future workforce.

Small and vulnerable professions

Work is continuing to assess and mitigate the risks facing small and vulnerable professions, with a focus on strengthening sustainable domestic supply pipelines. This programme remains a key priority for NHS England, with ongoing identification and implementation of targeted interventions to support these critical professions. The programme will continue to evolve in line with wider workforce reform and 10 Year Health Plan ambitions.

As reported last year, these professions play a vital role in addressing patient pathway bottlenecks and supporting wider access to education, employment and life opportunities. This work continues, with ongoing support for apprenticeships, training pathways and co-ordinated placement models to sustain capacity and ensure the necessary case mix and quality of training.

Shortened courses

NHS England has supported the development of shortened training routes, including targeted programmes to strengthen workforce supply such as the midwifery shortened training pathway. This work continues, with ongoing collaboration with higher education institutions and regulators to review course length and expand flexible learning routes in line with technological developments and the shift towards lifelong learning, as set out in the 10 Year Health Plan.

Accreditation of prior learning

As set out previously, accreditation of prior learning (APL) supports more flexible and accelerated entry routes into health and care professions. This work continues, with ongoing efforts to expand APL pathways and increase uptake to support workforce supply and widen access to career opportunities.

Apprenticeships

Apprenticeships will continue to play an important role in delivering the ambitions set out in the 10 Year Health Plan for England. This includes the shift towards a new workforce model aligned to service reform and the wider objectives of widening participation, improving workforce diversity and recruiting more people from the communities the NHS serves. As earn-while-you-learn routes, apprenticeships provide an alternative to full-time higher education and support both new entrants to the workforce and the development of existing staff. They also enable education and training to be more closely aligned to service need, helping employers to develop staff who are prepared for practice in changing models of care.

The NHS remained the largest public sector employer of apprentices, supporting around 27,000 new apprenticeship starts each year (source: [Department for Education Apprenticeships and traineeships data](#)). In nursing, Registered Nurse Degree Apprentice starts have fluctuated in recent years across NHS and wider health and care employers, including the independent sector, primary care and social care. The government has announced funding for an additional 2,000 nursing apprenticeships over the next 3 years targeted to the areas of greatest need, beginning in this financial year. This funding will support delivery of the ambitions set out in the 10 Year Health Plan for England and strengthen the pipeline further, building on earlier expansion. Apprenticeships in the NHS function both as an entry route and a mechanism for workforce development. However, consistent with wider national evidence, employers frequently use apprenticeship funding to upskill existing staff rather than recruit wholly new entrants (sources: [Value for money, The apprenticeships programme, National Audit Office, 2019](#); [NHS England Apprenticeships Programme](#), and [Apprenticeships in the NHS, NHS Employers, 2025](#)). This progression route remains valuable, but increasing the number of external entrants through apprenticeships will be important if the NHS is to maximise the contribution of apprenticeships to future workforce growth.

Following the Department for Education's defunding of Level 7 apprenticeships via the apprenticeship levy, DHSC and NHS England are continuing to provide financial support to a defined number of apprentice starts over the Spending Review period. These are on the following 4 standards identified as the highest priority areas to support delivery of the 10 Year Health Plan: Advanced Clinical Practitioner, Specialist Community Public Health Nurse, District Nurse (Community Specialist Practice Qualification), Clinical Associate in Psychology and Population Health Intelligence Specialist.

Blended learning

Blended learning combines digital and face-to-face delivery, integrating online learning with classroom-based teaching and clinical skills development. It offers greater flexibility while maintaining alignment with professional and regulatory standards and is now used

across a range of undergraduate, postgraduate and continuing professional development programmes in healthcare. NHS England continues to strengthen its understanding of blended learning delivery and participation across healthcare education. Since the previous NHSPRB cycle, NHS England has enhanced its evidence base and analytical capability, including the development of a national dashboard to support analysis of learner characteristics and programme uptake across participating higher education institutions. In parallel, NHS England and DHSC have undertaken a series of evidence reviews and commissioned further work to identify best practice, alongside the barriers and enablers to wider adoption of blended learning approaches.

Chapter 4: staff experience

The 10 Year Health Plan set out clear ambitions to improve the experience of staff working in the NHS. Good staff experience is crucial to ensuring the continued recruitment and retention of staff in the NHS workforce and should therefore be taken into consideration by NHSPRB. This chapter outlines the progress made to date in achieving these ambitions. This includes the development and publication of the staff standards from 2026 to 2027 onwards.

Staff standards

The 10 Year Health Plan outlined plans to introduce a series of staff standards for modern employment. These were developed through close engagement with the Social Partnership Forum (SPF) to ensure they address the issues that matter most to staff.

The standards aim to ensure that there is greater consistency in staff experience across the NHS and that it is prioritised at board level. The NHS Staff Survey results for 2025 showed that there are still issues with levels of morale and staff engagement where there has not been significant improvement. We know there is much more to be done to shape workforce culture in the NHS.

The standards will be an important tool in addressing this and will complement existing initiatives, such as the People Promise, and provide a framework to measure the progress of employers. A key point of difference from what's gone before is that the standards are mandatory and will be measured, initially through the NHS Oversight Framework which includes a headline composite metric on delivery against the standards for 2026 to 2027. The standards have also been incorporated in the Provider Capability Assessment and in the next phase of work, we will look to ensure they are embedded in the Care Quality Commission's (CQC) frameworks and that there is more regular, quarterly reporting on progress. This all ensures much stronger board accountability for staff experience. There are 6 staff standards:

- health and wellbeing (prevention, occupational health and wellbeing support)
- effective line management (ensuring appropriate support for line managers)
- promoting flexible working
- preventing and reducing violence against staff
- championing sexual safety
- tackling racism

NHS staff survey

The NHS Staff Survey continues to be the primary source of data to provide actionable insight on employee experience. Scores across all People Promise elements and themes have remained similar to 2024, with none of these elements or theme scores showing an improvement for 2025 for AfC Staff.

Scores across all People Promise elements and themes have remained similar to 2024, with none of these elements or theme scores showing an improvement for 2025 for AfC Staff. 2 of these, 'We have a voice that counts' and 'staff engagement' have the lowest scores since 2021. 'We have a voice that counts' (6.74 in 2021 and 6.65 in 2025) and 'staff engagement' (6.85 in 2021 and 6.76 in 2025).

A total of 17 out of the 21 sub-scores have not improved since 2024. 'Diversity and equality' (8.40 in 2025 and 8.41 in 2024), 'Autonomy and control' (6.91 in 2025 and 6.96 in 2024), 'Raising concerns' (6.40 in 2025 and 6.48 in 2024), 'Motivation' (6.86 in 2025 and 6.96 in 2024), and 'Advocacy' (6.66 in 2025 and 6.79 in 2024) are at their lowest level over the 5 year period. 'Compassionate leadership', 'Appraisals', and 'Line management' have shown some improvement and are all at the highest levels over the same period.

Where reported employee experience is declining, as indicated in the latest engagement score it presents challenges in achieving the ambitions of the 10 Year Health Plan, which relies on a motivated, skilled and sustainable workforce to deliver neighbourhood care, reduce inequalities and improve productivity. However, the successful implementation of the Staff Standards offers a practical route to improving experience at scale. A new score in the NHS Oversight Framework has been developed, built from the results of relevant questions in the NHS Staff Survey, and aligned to the requirements of the new standards. This score informs an organisation's segmentation, and is helpful in identifying poor performance, tracking progress and supporting wider engagement with organisations. Through this, boards are encouraged to take greater accountability for the improvement of the experience of their people.

The engagement theme score for AfC staff groups has steadily decreased from 2019. In 2021 the score was 6.85 (out of 10) and in 2025 dropped to its lowest level at 6.76. There was a decrease in all sub scores (motivation, involvement and advocacy), with motivation and advocacy now at their lowest over the 5 year period and remaining below pre-Covid levels. The score for the People Promise element 'We are recognised and rewarded' decreased for AfC staff groups from 5.99 in 2024 to 5.96 in 2025, with variances across occupational groups.

The percentage of AfC staff satisfied with their level of pay remained at 30.94% (unchanged from 2024) and is below the 2021 score of 31.41%. In 2025, fewer staff (53.41%) felt that their work was recognised compared to 2024 (54.40%). Similarly, fewer

staff (43.13%) in 2025 felt like their work was valued compared to 2024 (44.74%). In terms of staff groups, satisfaction with pay among nursing and healthcare assistants increased to 20.78% (2025) from 19.27% (2024) and ambulance staff (25.23% in 2025 to 25.70% in 2024). There was also an increase in satisfaction with pay for registered nurses and midwives increasing to 27.71% in 2025 from 27.10 in 2024. However, satisfaction with pay is lower in staff recruited from outside the UK (24.27%) although this is an increase on 2024 (23.55%).

Significant work is underway across systems to strengthen employee experience, building on national tools such as the Staff Experience Assessment Tool and a suite of national initiatives supported through the [Retention hub: looking after our people](#) webpages. The Staff Survey also helps individual trusts to maintain and deliver ongoing action plans in accordance with the requirements of the NHS Standard Contract. This work is being progressed in recognition of the complex strategic, operational and cultural factors that continue to shape staff experience across the NHS. Organisations are held to account for progress through the National Oversight System, which monitors performance against key indicators, including the employee engagement theme score alongside the new staff standards.

National quarterly pulse survey

The [National Quarterly Pulse Survey \(NQPS\)](#) became mandatory for all trusts in April 2022. Since then, it has consistently gathered around 100,000 responses per quarter which supports the survey's data reliability and validity. NQPS collates staff engagement data at an aggregated level for all staff. It does not require trusts to collate and submit any demographic information; therefore, it cannot be segregated to distinguish between medical and non-medical staff returns.

Staff engagement shows an overall downward trend, falling from 6.64 in Q1 2022 to 2023 to 6.39 in Q2 2026 to 2027 (on a scale of 0 to 10 where 10 is the highest, most positive score). After peaking at 6.67 in Q2 2023 to 2024, scores declined, briefly stabilised around 6.46 to 6.47, then dropped in the latest quarter. Latest participation was 97,352 responses, up from 90,048 in the previous quarter. All sub-theme scores (Motivation, Involvement and advocacy) decreased in Q2 2026 to 2027, the biggest decline is in advocacy scores from 6.42 in quarter 1 to 6.31 in quarter 2 2026 to 2027). Since the introduction of the NQPS in April 2022 the highest recorded staff engagement score was 6.67 (quarter 2 2023 to 2024), whereas the lowest was 6.39 (quarter 2 2026 to 2027).

Retention

Alongside development of the staff standards, significant work has continued to strengthen the staff experience through targeted, evidence-based interventions focused on factors

known to influence staff experience and retention. These include flexible working, career development, staff engagement and health and wellbeing.

Evidence from the People Promise Exemplar programme demonstrated that organisations implementing multiple interventions achieved greater improvements in retention, staff engagement and morale. The most effective approaches combined initiatives such as flexible working, e-rostering and local listening activities, supported by strong organisational leadership.

While workforce retention has improved overall (see chapter 4), challenges remain for some staff groups and career stages, particularly among those in the early years of employment. This indicates that transition into practice and progression through the early stages of a career remain important areas of focus for retention activity.

To address this, work is underway to strengthen support for newly qualified staff through a nationally consistent approach to early career support. This includes implementation of the Newly Qualified Health Registrants (NQHR) Commitment, which promotes system-wide accountability for transition support, and work to improve consistency of preceptorship and early career development offers across professions. Activity is focused on improving transition into practice, supporting career development beyond the first year of employment, and reducing avoidable early attrition, aligned to the commitments set out in the 10 Year Health Plan.

Retention trends should also be considered alongside wider workforce indicators. Workforce behaviour is influenced by a range of factors beyond staff experience, including workload, organisational change, financial pressures, labour market conditions and workforce mobility. As a result, improvements in retention should be interpreted within the wider context of workforce sustainability.

Health and wellbeing

Published sickness absence data indicates that there are still challenges, with sickness absence levels across all NHS staff now higher in March 2026 at 5.11% compared to a pre-pandemic level of 4.05% in March 2018. Mental health and musculoskeletal conditions remain the most prominent reasons for sickness absence with variance across the system with ambulance, nursing and midwifery, support to clinical and medical, and estates and support staff reporting the highest levels of sickness absence.

The results from the 2025 NHS Staff Survey indicate that staff perceptions toward their health and wellbeing remain largely unchanged, whereas the overall 'we are safe and healthy' score decreased by 0.05% between 2024 and 2025. The survey results have shown a decline with 54.08% of staff saying their organisation takes positive action on health and wellbeing compared to 57.05% in 2024. More than half of the staff responding

to the survey (56.01%) went into work despite not feeling well enough to perform their duties.

There has been a national focus on health and wellbeing through the development of staff standards and the planned development and investment in Staff Treatment Hubs. These will be regional treatment centres that focus on mental health and musculoskeletal problems faced by staff. NHS England and NHS Charities Together have worked in partnership to deliver the Workforce Wellbeing Programme to provide localised health and wellbeing support. The Growing Occupational Health and Wellbeing Together strategy continues to be delivered through the growth of integrated, multi-professional health and wellbeing services for all NHS staff at organisational level.

Through the 2026 to 2027 Medium Term Planning process, provider organisations have set out plans to reduce sickness absence and identify gaps and risks to delivery. Collectively, trust plans are forecasting a reduction in sickness absence over the period to March 2029, with all regions planning improvement.

The actions identified include stronger occupational health pathways, targeted mental health and musculoskeletal support, improved line management, wellbeing conversations and effective return-to-work processes. NHS England is also developing a National Sickness Absence Improvement Compendium to help organisations apply emerging evidence and learning alongside existing workforce health and wellbeing resources.

Flexible working

The staff survey results for 2025 have indicated an improvement in the 'We work flexibly' score from 6.05 in 2021 to 6.31 in 2024. In 2024, over half of respondents answered all 4 questions positively; 71.3% felt able to discuss flexible working openly with their manager, 57.7% were satisfied with available opportunities, 56.6% reported a good work-life balance, and 50.3% agreed their organisation supported them to achieve it.

The proportion of staff reporting in the NHS staff survey that they achieve a good work life balance increased from 2021 (52.00%) to 2024 (56.58%), stabilising in 2025 (56.63%). Furthermore, the proportion of staff who felt able to approach their immediate manager to discuss flexible working increased from 2021 (66.93%) to 2025 (71.75%). This suggests barriers to requesting flexible working are reducing.

Flexible working has become far more established since 2021 but reported access to it has plateaued more recently. Access remains inconsistent between staff groups and organisations with staff in community and mental health settings reporting a better experience than those in acute organisations, with the lowest levels reported in ambulance trusts.

To support the productivity benefits of flexible working, NHS England and DHSC have been working together on the development, and recent publication, of a series of staff standards, including one that will support organisations move to a 'flexible first' culture. In addition, NHS England has been supporting partners to develop guidance and tools facilitating both broad access to flexible working, and targeted support in the use of e-rostering to assist in the provision of flexible working access for frontline workers in 24 hours a day, 7 days a week services. They have also partnered with NHS Employers to create a flexible working campaign and support hub, to continue to raise awareness and support organisations to adopt the benefits of flexible working.

Violence, prevention and reduction

Violence against NHS staff remains a serious issue. The 2025 NHS Staff Survey shows that 14.47% of staff experienced physical violence from patients, service users, relatives, or the public in the previous year, the highest level in 3 years. Smaller proportions reported physical violence from managers (0.75%) and colleagues (1.80%). Additionally, 25.25% experienced harassment, bullying, or abuse from the public, and 9.26% reported discrimination, the highest recorded level.

Experiences of violence seriously damage staff wellbeing and retention, leading to trauma symptoms, emotional exhaustion, burnout, increased sickness absence and harm overall service delivery. Variations in reporting and data quality continue to limit a full understanding of the problem.

NHS England continues to work with DHSC and the Social Partnership Forum (SPF) to implement several non-pay recommendations from the 2023 AfC deal. These recommendations include mandating the implementation of the Violence Prevention and Reduction (VPR) Standard from April 2026 for all NHS trusts; supporting prevention, risk assessment, and response to incidents. Additional initiatives being developed include national Safe Working Practices guidance to support staff; a VPR Data Reporting Framework and a national pilot data collection on violent incidents, with findings expected later this year.

Finally, as mentioned above, a staff standard on violence prevention and reduction has also been developed and published. This standard sets out the role of employers in taking action to prevent violence and abuse and to ensure staff are to report incidences and receive timely support. The standards are mandatory and employers' performance against them will be assessed through the NHS Oversight Framework and wider assurance arrangements.

Looking ahead, we will focus on scaling up the pilot data collection, continuing development of the Regional Communities of Practice, and introducing civility and respect and VPR training as part of the reformed mandatory and statutory training package.

Equality, diversity and inclusion

In terms of career progression, the representation of Black and minority ethnic (BME) staff continues to improve across the workforce but the data shows that significant disparities remain. Only 49.6% of BME colleagues report feeling that their trust provides equal opportunities for progression or promotion, compared with 59.1% of White staff. This is reflected in senior leadership, where BME staff remain markedly underrepresented, holding 14.1% of senior and very senior roles compared with 82.9% held by White staff.

The [NHS Workforce Race Equality Standard \(WRES\) data](#) for 2025 showed that the percentage of staff experiencing harassment, bullying or abuse from other staff in the last 12 months was higher for Black and minority ethnic (BME) staff (24%) than for White staff (19%). Tackling incidents of violence, racism and sexual harassment in the workplace will form part of the new suite of staff standards, which were published this Summer 2026.

The [NHS equality, diversity and inclusion improvement plan](#) (EDI IP), published in June 2023, remains the key mechanism for strengthening equality, diversity and inclusion in the NHS. In 2026, a series of engagement events were held, which sought feedback from EDI leads and People Professionals on their experience of delivering the EDI Improvement Plan and to gain their insight as we shape the direction of travel for future developments in EDI.

As referred to earlier, a series of mandatory staff standards are now in place with one of the standards focussing on tackling racism. It sets the expectation that organisations should take sustained and meaningful action to prevent all instances of racism and discrimination in the NHS workplace. The standards are mandatory and employers' performance against them will be assessed through the NHS Oversight Framework and wider assurance arrangements.

These findings highlight the ongoing need for sustained targeted action to ensure fair and equitable career development for all colleagues. NHS England is continuing to partner with Henley Business School to deliver an EDI focussed Senior Leader Apprenticeship programme. The non-pay work generated by the 2023 AfC deal also included a workstream on supporting career progression for nurses. Through this, ethnic minority and internationally educated nurses should receive better and more consistent support for their career progression through 6-monthly career reviews and more consistent recognition of their overseas experience. A host of guidance on topics such as these is currently being produced for organisations by NHS Employers.

In October 2025, the then Prime Minister and Health Secretary asked Lord John Mann to conduct a rapid review into antisemitism and other forms of racism in the NHS following reported incidents of antisemitism from doctors revealing rising levels of racism and in the health system. Consequently, in June 2026 the recommendations from the Lord John

Mann review were accepted and work to implement these is now underway across NHS England and DHSC. NHS England wrote out to organisations immediately requesting that action was taken to tackle racism including antisemitism in the NHS.

In March 2026, a non-statutory [definition of anti-Muslim hostility](#) was announced by the government to provide clarity and consistency in understanding and responding to anti-Muslim hostility. The government is encouraging the adoption of this definition across the public, private and third sectors with NHS England requesting that NHS organisations also adopt this definition in their letter of 4 June 2026 (source: [Lord Mann Review](#)).

Gender and ethnicity pay gaps

The ONS reports the gender pay gap among full-time employees in the UK fell to 6.9% in April 2025, down from 7.1% the previous year. For part-time employees, women earned slightly more per hour than men, at minus 2.9%, a slight change from minus 3.0% in April 2024. The overall gender pay gap across all combined employee types stood at 12.8%, down slightly from 13.1% in 2024 (source: [Gender pay gap in the UK: 2025](#)).

In July 2025, the NHS Race and Health Observatory (RHO) commenced an independent review of ethnicity and progression pay gaps across the NHS. This set out to examine the current landscape of racial inequalities in career progression and pay within the NHS workforce. The findings of the review are due to be reported at the end of 2026.

The government consultation on the introduction of mandatory ethnicity and disability pay gap reporting closed in June 2025 with the government response published in March 2026. Legislation will be introduced in due course (when parliamentary time allows).

NHS England also publishes data on gender and ethnicity pay gaps specifically for NHS staff, which can be split in various ways including by staff group and grade. It shows that most of the differences in average basic pay between male and female staff can be explained by how staff are distributed across the workforce with males being overrepresented in senior roles while females are overrepresented in lower bands (source: [NHS Staff Earnings Estimates, April 2026 \(including supplementary analysis on pay by ethnicity\)](#)).

Chapter 5: remit groups

The AfC contract covers a wide variety of staff groups and professions, and this chapter explores the workforce picture for each of these in more detail. This includes nurses, midwives, allied health professionals (AHPs) and other AfC roles. These groups represent a diverse and complex workforce delivering care across a wide range of settings.

The chapter covers workforce trends across these groups, including changes in workforce size, composition and vacancy levels, as well as evidence on recruitment and retention. It also considers factors that have an impact on workforce sustainability, including education and training pipelines, workforce-specific leaver rates and the use of temporary staffing.

While the overall NHS workforce has increased in recent years, with growth in key professions and reductions in vacancy rates, challenges remain. Maintaining momentum on recruitment, improving retention and improving staff experience continue to be critical to ensuring a sustainable workforce.

Nursing and midwifery

As of September 2025, 666,652 professionals were registered with the Nursing and Midwifery Council (NMC) in England. Of those on the register, 88.4% are female and 34.7% from Black, Asian or other ethnic minority backgrounds. This represents a further increase in ethnic diversity compared with March 2025, when 657,882 professionals were registered and 33.9% were from Black, Asian or other ethnic minority backgrounds. Retirement remains the main reason for leaving the register, followed by physical and mental health (source: [NMC register mid-year report - September 2025](#)).

The NHS nursing and midwifery workforce has continued to grow, with both professions now at record levels. The nursing workforce increased by 4,434 FTE over the last year to 373,883 FTE in March 2026, while the midwifery workforce grew by 649 FTE to 25,638 FTE. Vacancy levels have also improved. Nursing vacancies have fallen by over 19,000 FTE since April 2022, with around 22,000 FTE posts unfilled in latest data, while midwifery vacancies reduced to around 800 FTE in March 2026, down from a peak of around 3,400 FTE in August 2022 (source: data pack, sheets NN1 and NN2).

These indicators point to a stronger workforce than in recent years, although decisions on workforce growth remain locally determined by employers. NHS operational planning suggests nursing workforce growth is expected to slow over the next 3 years, reflecting changes in ways of working, tighter financial constraints and competing service priorities. The longer-term picture is being considered as part of the 10 Year Workforce Plan.

Education and training recruitment indicators show a mixed picture. Undergraduate nursing unique applicants in England totalled 38,575 in 2025, a 1% increase compared

with 2024 and a 10% increase compared to 2019. Midwifery applicants reached 7,750 in 2025, a slight increase of 1% compared with 2024, but 5% below 2019 (source: [UCAS Undergraduate end of cycle data resources 2025](#)). Applicant demographics continue to shift, with increases among applicants aged under 20 (an increase of 7% for nursing and 4% for midwifery in 2025 on the previous year) and declines among those aged 20 and over (nursing and midwifery each saw a decrease of 4%). This may have implications for widening participation, mature entrants and the resilience of domestic supply over the longer term. Nursing and midwifery application trends showed modest improvement between 2024 and 2025, driven primarily by younger applicants.

Nursing applicants increased by 0.7% and accepted applicants by a similar proportion, with the accepted applicant rate remaining stable at 54.6%. Growth was concentrated among applicants aged under 21, while both applicants and accepted applicants aged 21 and over continued to decline. Midwifery applications also increased slightly (+0.5%), reflecting growth among under-21 applicants which was partly offset by a reduction in applicants aged 21 and over. Across both professions, recent growth has therefore been driven by younger applicants, while participation among older age groups continues to weaken.

There has been a decline in applications to Learning Disability Nursing programmes by UK providers since the peak observed in 2021. Applications fell from 3,530 in 2021 to 2,090 in 2025. Accepted applicants also declined, falling from 845 in 2021, to 540 in 2024 and 470 in 2025 (source: [UCAS Undergraduate end of cycle data resources 2025](#)). The downward trends indicate continued challenges in attracting entrants to Learning Disability Nursing programmes. A national Learning Disability Nurse education and training Expert Advisory Group has been established to oversee an action plan focused on improving attraction into the profession.

More widely, a professional narrative for nursing and a suite of profession-specific resources, for use at careers events, will be published in 2026 to 2027 to best position nursing within a competitive labour market. Placement capacity will shift from predominantly acute settings towards community, primary care and other environments. Our 2026 to 2027 written evidence submission noted that around 80% of nursing placements were hospital-based, underlining the importance of expanding placement opportunities. This will expose learners earlier to neighbourhood health models, in line with the 10 Year Health Plan, and develop skills needed for the future.

Retention indicators have improved since the peak pressures experienced in 2022. The registered nurse leaver rate in March 2026 was 7.9%, (with the average across all AfC staff groups at 9.1%) down from 8.1% in March 2025 and 10.3% in March 2022. The registered midwifery leaver rate in March 2026 was 9.2%, marginally up from 9.1% in March 2025 but an improvement from 9.5% in March 2024 and 12.1% in March 2022 (source: [NHS Workforce Statistics Turnover data tables, March 2026](#)). This improved

position since 2022 has been supported by national programmes and interventions, including investment for trusts to employ retention leads in each maternity unit. To support further improvements, the government announced in February 2026 a commitment to actions to deliver [a fairer deal for nurses](#), including ensuring nurses are paid correctly for the work they are asked to do. This includes developing a single national nursing preceptorship to create a national framework to support newly qualified nurses and is supporting an employer-led review of all band 5 nursing roles employed directly by NHS trusts, to ensure their pay and job descriptions better reflect their work.

Reliance on temporary staffing has also reduced. Agency nurse utilisation fell from an average of around 8,700 FTE per month in 2024 to 2025 to around 4,500 FTE per month in 2025 to 2026. Over the same period monthly bank staffing reduced from around 30,300 FTE to around 28,000 FTE. Taken together, reduced vacancy levels, lower leaver rates and decreased temporary staffing suggest improving workforce stability across nursing and midwifery (source: PRB data pack).

Transition into employment remains a key issue for newly qualified nurses and midwives, who continue to report inconsistent access to substantive NHS roles both within and outside the NHS. As part of the government's Graduate Guarantee, NHS England reprioritised £8 million of non-recurrent funding for 2025 to 2026 to support the temporary conversion of vacant maternity support worker posts to band 5 registered midwifery roles, creating opportunities for newly qualified staff (source: [Job boost for newly qualified nurses and midwives](#)).

NHS England is further supporting implementation through a series of measures. These include a Student Hub offering guidance and resources; a student movement dashboard to help regional NHS England teams, universities and employers understand graduate numbers, historic staff turnover and vacancies; and targeted recruitment support including updated job descriptions and early career development pathways. NHS England is monitoring future nursing and midwifery student numbers and is exploring what more we can do to support new graduates.

Despite improvements in headline workforce indicators, motivation and confidence may be affected by continued service pressure, workload and uncertainty around employment opportunities for some newly qualified staff. Learners also continue to report high levels of stress and burnout, often linked to workload, placement quality and support from practice staff. These pressures are relevant to the attractiveness of nursing and midwifery careers, student retention and early career experience. Maternity services continue to face pressure. National investigations indicate workforce and staffing capacity pressures, alongside wider system factors, affect the consistency and safety of care and the experience of both service users and staff (source: [Independent Investigation into Maternity and Neonatal Services in England](#)). These pressures are likely to continue to have implications for the current midwifery workforce.

Allied health professionals (AHPs)

The AHP workforce continued to grow between March 2025 and March 2026, increasing from 115,036 to 118,486 WTE (129,580 to 133,183 headcount) (source: NHS hospital and community health services (HCHS) monthly workforce statistics March 2026). Vacancy pressures eased across most AHP professions between March 2025 and March 2026 to 4.8% from 6.6% the previous year (source: data pack, sheet AHP1).

Vacancy rates fell in art, music and dramatherapy (10.2% to 6.0%), prosthetics and orthotics (4.1% to 0.3%) and podiatry (13.1% to 10.3%). Orthoptics was the main exception, rising from 2.0% to 5.4% (source: data pack, sheet AHP2). Similarly, qualified AHP temporary staffing fell by 800 FTE (19.9%), from 4,017 to 3,217. This was driven by a 780 FTE (50.6%) reduction in agency staffing, while bank staffing was broadly stable, decreasing by 20 FTE (0.8%) (source: data pack, sheet AHP3). While this represents a positive overall trend, workforce pressures remain uneven across professions and geographies, particularly where labour markets extend beyond the NHS, training pipelines are comparatively small, or recruitment challenges persist in rural and coastal areas.

NHS England continues to support AHP workforce sustainability through a range of national programmes focused on workforce supply, retention and career development. Key initiatives include implementation of the AHP Preceptorship Framework, development of a multi-professional quality mark, national placement guidance, the AHP Student Hub and the National AHP Learner Council. Targeted support for smaller and vulnerable professions aims to strengthen domestic education and training pathways, increase placement capacity and expand alternative routes into practice through initiatives such as Level 6 and Enhanced Clinical Practice apprenticeships. Workforce retention is further supported through return to practice programmes for Health and Care Professions Council (HCPC) registrants (227 AHPs), expansion of advanced and consultant-level career pathways, and development of alternative access routes where traditional education pipelines are vulnerable. Employers and integrated care systems are also supported through the AHP Workforce Toolkit, national webinars and funded resources to strengthen workforce planning, retention and service development. Wider workforce reforms associated with the 10 Year Health Plan are expected to support more flexible career pathways, skills development and progression across professional groups.

For the 12 months to March 2026, the published aggregate for the AHP workforce indicates a positive overall workforce position, with joiner rates exceeding leaver rates on both headcount and FTE measures. The headcount joiner rate was 10.2% compared with a leaver rate of 8.5%, with a stability index of 91.4%, while the equivalent FTE rates were 10.3% and 8.1% respectively, with a stability index of 91.8%. While these aggregate measures indicate continued workforce growth and retention overall, profession-level data show important variation. In Osteopathy, Orthoptics and Chiropody or Podiatry leaver rates exceed joiner rates on both measures. Speech and Language Therapy and Occupational

Therapy also have comparatively high turnover, although recruitment currently exceeds exits. Operating Theatres, Ambulance staff and diagnostic and therapeutic radiography show stronger retention, with relatively low leaver rates and stability generally above 92%. Prosthetics and Orthotics records exceptionally high recruitment relative to exits, indicating expansion or active replenishment, but its small workforce means rates may be volatile (source: data pack, sheets AHP4 and AHP5).

Retention pressures were most evident at band 4, where leaver rates (12.2% headcount; 12.1% FTE) were approximately double joiner rates (6.0% on both measures), contributing to lower workforce stability than at other bands. Band 5, which remains the principal entry point to the registered AHP workforce, demonstrated strong workforce growth, with joiner rates substantially exceeding leaver rates. However, stability remained at approximately 91%, indicating considerable workforce movement alongside expansion. Across bands 6 to 9, joiner rates remained below leaver rates, suggesting that losses among experienced and senior staff were not being fully replaced. Recruitment activity was particularly limited at the most senior grades, although conclusions regarding band 9 should be interpreted cautiously given the relatively small workforce size (source: data pack, sheets AHP4 and AHP5).

The 2025 National Education and Training Survey indicates continued improvement in learners' experiences of teaching and supervision. However, respondents also identified ongoing challenges relating to workload, clinical placement capacity, learning environments and facilities. Variation between professions remains evident, particularly among smaller AHP groups where workforce and educational infrastructure can be more limited (source: [National Education and Training Survey, 2025](#)). Professional equity, including equal pay for work of equal value and access to development, remains a concern. Wider developments, including nursing band 5 job evaluation and the graduate guarantee, may influence perceptions of relative career value. At the same time, supply to demand mismatches in paramedics and physiotherapy are contributing to emerging graduate unemployment, reinforcing the need to align education supply, employment opportunities and service demand.

Healthcare scientists

Healthcare science (HCS) supports NHS diagnostics in pathology, specialist therapeutic services and multiple pathways of care, including cancer, cardiovascular disease, and women's health. HCS contributes to reducing waiting times and is integral to the NHS 10 Year Health Plan, the Industrial Strategy Life Sciences Sector Plan, the Cancer Plan and wider reform. Across more than 50 scientific specialties, over the past 12 months to March scientist staff group grew from 31,315 in March 2025 to 32,260 in March 2026, an increase of 3.0%. Growth was highest in physical sciences and genomics and bioinformatics (both 3.7%), followed by physiological sciences (3.5%). Life sciences, representing around a

quarter of the combined healthcare science workforce, grew by 2.4%. Support roles grew by 1.3% to 23,255 staff. Consultant healthcare scientist numbers increased from 678 to 716, a rise of 5.6% (source: [NHS Workforce Statistics - March 2026](#)).

Senior workforce capacity remains an area of challenge within parts of the healthcare science workforce. Workforce data analysis indicates substantial variation in consultant-level capacity across specialisms, with some disciplines (for example, physiological sciences) having relatively limited senior clinical leadership and supervisory capacity compared to others (for example, physical sciences) (source: data pack, sheet HCS3). Career progression may be constrained by limited opportunities at senior levels, changes in the distribution of consultant-level posts, and concerns that some Fellowship of the Royal College of Pathologists (FRCPath) qualified clinical scientists are employed at grades below those that may be expected given their qualifications and responsibilities. These factors may have implications for retention, career development and perceived parity with other professions.

Education and training capacity remains a key workforce risk for healthcare science. Capacity constraints, inconsistent access to protected training time and gaps in pathway availability continue to affect some specialties. Financial and workforce pressures during 2025 to 2026 have reduced the ability of organisations to support training posts, while differences in funding arrangements compared with some other professional groups may discourage employer participation. These challenges are amplified by the small scale of many healthcare science programmes, with some specialties recruiting very small cohorts and others facing concerns about long-term viability. Limited awareness of healthcare science careers also constrains recruitment, increasing reliance on alternative entry routes and in-service training models. Recent education and training trends present a mixed picture. Several established programmes recorded reductions in uptake, including the Practitioner Training Programme, Scientist Training Programme, Echocardiography Training Programme and Higher Specialist Scientist Training. At the same time, apprenticeship pathways continued to grow, demonstrating their increasing contribution to workforce development. Maintaining a balanced mix of training routes will be important to support future workforce supply and reduce vulnerability within smaller specialist professions.

Overall workforce flows in HCS remain favourable, with joiner rates continuing to exceed leaver rates in the year to March 2026 on both headcount and FTE measures. The aggregate headcount joiner rate was 10.0% compared with a leaver rate of 8.9%, with a stability index of 91.0%, while the equivalent FTE rates were 9.9% and 8.4% respectively, with a stability index of 91.5%. However, these aggregate figures mask differing retention pressures across the HCS workforce. Clinical Bioinformatics and Clinical Engineering continue to experience workforce pressures associated with net outflows and lower workforce stability, while Blood Sciences and Cellular Sciences show relatively high levels of turnover. By contrast, Genetics, Infection Sciences, Medical Physics and Neurosensory

Sciences demonstrate stronger retention. The small and highly specialised nature of many healthcare science professions means that workforce losses can have a significant effect on service delivery, making sustained attention to retention, career development and succession planning essential.

During the 12 months to March 2026, bands 1 to 4 recorded the highest levels of workforce movement, with joiner rates exceeding leaver rates on both headcount and FTE measures, but with lower workforce stability than the HCS workforce overall. Turnover was particularly pronounced at bands 2 and 3, where workforce stability was weakest. Band 5 recorded strong net inflow and band 6 was broadly balanced. From band 7 onwards, however, joiner rates fell below leaver rates on both measures, suggesting recruitment is not fully offsetting losses among experienced and senior staff. While workforce stability remained high at bands 8c and 8d, recruitment activity at these grades was limited, and no joiners were recorded at band 9, although this should be interpreted cautiously given the small workforce size. The evidence suggests a need for targeted retention support at bands 2 to 3, alongside measures to strengthen progression, recruitment and retention pipelines into senior and specialist HCS roles (source: data pack, sheets HCS5 and HCS6). Over the period, vacancies fell by 168 FTE (8.3%), from 2,032 to 1,864, while the vacancy rate decreased from 6.6% to 5.8% (source: data pack, sheet HCS1).

Bank and agency staff continue to play a supplementary role within the healthcare science workforce. During 2025 to 2026, overall temporary staffing utilisation declined from 3.2% to 2.8% of the workforce, reflecting a substantial reduction in agency use alongside increased reliance on NHS bank staffing. Although bank staffing increased modestly, this was more than offset by a reduction in agency staffing, resulting in a 9.2% fall in total temporary staffing (from 912 to 828 FTE). This suggests reduced dependence on external temporary labour and greater use of internal workforce flexibility, although workforce pressures vary across specialties and local labour markets (source: data pack, sheet HCS2).

Career progression remains constrained. NHS England internal analysis indicates that among newly qualified clinical scientists entering the NHS at AfC band 7, 31% progressed to band 8a or above within 5 years across the 2015 to 2020 cohorts, compared with 49% of newly qualified biomedical scientists and HCS practitioners entering at AfC band 5 who progressed to band 6 or above. Progression varies by specialty, ranging from 44% in blood sciences to 10% in clinical engineering. Disparities persist between NHS and other employers (for example, [the Government Science and Engineering \(GSE\) career pathway](#)). Exit interview data indicate turnover is driven by both retirement and early-career voluntary resignation, suggesting ongoing structural retention challenges and the importance of progression and early career support (source: data pack, sheet HCS4).

Inconsistent professional regulation, with statutory and voluntary routes, creates risks for patient safety, workforce supply, progression and retention. HCS students and staff

continue to experience limited access to Travel and Dual Accommodation Expenses, the Learning Support Fund and employer placement tariffs, while continuing professional development funding is applied inconsistently. These factors may affect morale and perceptions of fairness and pay parity.

Medical associate professionals

Medical Associate Professions (MAPs) refer to a group of healthcare roles working alongside doctors within multidisciplinary teams to deliver medical care under the supervision of a senior clinician. These roles primarily included physician assistants (PAs, also known as physician associates), physician assistants in anaesthesia (PAAs, also known as anaesthesia associates or AAs), and surgical care practitioners (SCPs). The term reflected the previous government's approach to workforce skill mix within doctor-led models of care. Following the government's acceptance of all 18 recommendations from the [independent review of the physician associate and anaesthesia associate roles](#) including changes to role nomenclature, the term MAPs is no longer used. DHSC and NHS England are implementing the recommendations of the Leng Review, focusing on the safe deployment of PAs and PAAs across a range of clinical settings. PAs practise under the supervision of a named senior doctor, while PAAs work within anaesthesia teams under consultant anaesthetist supervision. In the UK, both professions are regulated by the General Medical Council (GMC).

NHS England workforce data indicates that in March 2026, there were approximately 1,774 FTE PAs in primary care and 1,497 FTE in secondary care, representing an 8% decrease compared to March 2025. In contrast, the AA workforce increased to around 143 FTE in secondary care, a 19% rise over the same period (sources: [Primary Care Workforce Quarterly Update, 31 March 2026](#) and NHS Workforce Statistics, March 2026).

Entry to PA and AA training is typically through a prior biomedical or life sciences degree, or through an existing registered health profession background, followed by a 2 year postgraduate training programme. Student AAs are employed by the organisations in which they train. NHS England commissions education and training for both professions through national funding arrangements. The GMC has approved 31 PA courses and 3 AA courses in England. Of these PA courses, 3 have closed and 13 are currently paused, predominately due to falling applications and uncertainty over employment prospects. There are currently no AA courses in England being delivered.

Ongoing debate regarding the PA role, employer uncertainty, and wider NHS financial constraints are contributing to reduced employment opportunities for newly qualified PAs. Emerging evidence suggests difficulties securing entry-level posts, particularly where supervision and structured preceptorship are required. Employer caution regarding role deployment, influenced in part by recent public commentary and campaigns from some

professional representative groups, may also be contributing to reduced recruitment opportunities. Through the implementation of the Leng Review recommendations we are seeking to address employer confidence and barriers to future employment.

Pharmacy

Pharmacy continues to undergo significant education and service reform, including changes to pharmacist initial education and training, expansion of independent prescribing, and development of pharmacist and pharmacy technician roles, particularly in primary care. These reforms support the objectives of the government's 10 Year Health Plan for England, but sustainable workforce growth will depend on education capacity, placement availability and supervision as well as learner numbers.

Pharmacist numbers increased from around 54,400 in 2023 to 2024 to 55,650 in 2024 to 2025 (plus 2.3%), while pharmacy technician registration rose from 21,695 in 2024 to 22,399 in 2025 (plus 3.2%). In primary care, pharmacist FTE increased from around 7,083 in 2024 to 7,303 in March 2025 (plus 3.1%), and pharmacy technician FTE rose from around 2,383 to 2,582 (plus 8.4%) (source: [General Pharmaceutical Council registers data](#)).

In community pharmacy total workforce FTE increased by 7% between 2024 and 2025, but pharmacist headcount fell by 10.2% (2,941 staff) and FTE by 8.0% (1,512 FTE). Pharmacist vacancy FTE fell by 15.4% (462 FTE), while pharmacy technician headcount increased by 28.5%, FTE by 32.4%, and vacancy FTE by 24% (264 FTE) (source: [Community Pharmacy Workforce Survey 2025](#)). Pharmacist joiners fell from 2,590 in 2023 to 2024 to 2,513 in 2024 to 2025 (minus 3.0%), while leavers increased from 1,039 to 1,264 (plus 21.7%). This suggests some weakening in net inflow, although joiners continued to exceed levels. Pharmacy technician joiners were broadly unchanged (1,553 to 1,555; plus 0.1%), while leavers fell from 917 to 845 (minus 7.9%), indicating modest improvement. Retention pressures are likely to vary by setting, reflecting competition between sectors, local recruitment challenges and demand for advanced clinical capability.

Accepted applicants to Master of Pharmacy (MPharm) programmes in the UK increased from 4,570 in 2024 to 5,240 in 2025 (plus 14.7%), with continued growth in Schools of Pharmacy accredited, or progressing through accreditation, by the General Pharmaceutical Council (source: [UCAS Undergraduate end of cycle data resources 2025](#)). The extent to which this growth translates into workforce supply will depend on placement capacity, teaching resource and the availability of supervision across sectors. In 2025 to 2026, the first foundation training year to use a fully centralised NHS England recruitment process for trainee pharmacists, 2,949 trainees were recruited in England (source: NHS England trainee onboarding data). Funding in 2026 will support training for approximately

1,600 pharmacy technicians, broadly similar to the previous year, with technician supply remaining broadly stable since 2021 and showing a modest recovery in 2024 and 2025.

The transition to the Foundation Trainee Pharmacist Programme in 2025 to 2026 gives NHS England delegated responsibility for trainee pharmacist places in England, including community pharmacy, alongside oversight of education quality. Since 2025, MPharm students have been eligible for clinical tariff funding for placements aligned to new learning outcomes and may access Travel and Dual Accommodation Expenses through the Learning Support Fund, though not other elements. Pharmacy technician education is also evolving, with proposals from the regulator to move training from Level 3 to Level 4, requiring changes to apprenticeship provision, employer capacity and supervision.

Reforms to pharmacist education incorporate independent prescribing into the 5-year training continuum, meaning pharmacists joining the register from summer 2026 will be independent prescribers. Community pharmacy independent prescriber FTE increased from 1,996 in 2024 to 2,456 in 2025 (plus 23%), although distribution remains uneven and independent prescribers remain a minority of the workforce. Legislative changes, including from June 2024 enabling pharmacy technicians in England to supply and administer medicines under Patient Group Directions, support fuller use of skill mix (source: Community Pharmacy Workforce Survey 2025). The 2025 National Education and Training Survey shows pharmacy learner experience remains positive and broadly stable, but with pressures on workload, wellbeing, supervision and teaching quality (source: National Education and Training Survey). Overall, continued growth will depend on employer readiness, placement capacity, educator and supervisor supply, early career support and effective conversion of education growth into substantive roles across settings.

Estates and facilities

The NHS Estates and Facilities Management (EFM) workforce comprises approximately 67,229 FTE staff (83,583 HC), representing 4.8% of the total NHS workforce. It supports the management of over 27.7 million square metres of estate, with annual occupancy costs of £14.0 billion and a maintenance backlog of £15.9 billion, including £3.5 billion assessed as high risk (source: [Estates Returns Information Collection](#)). The scale and complexity of the estate places pressure on workforce capacity, requiring targeted intervention to ensure delivery of infrastructure priorities.

National policy recognises the critical role of EFM in enabling productivity, patient safety and operational resilience. The [10 Year Infrastructure Strategy](#) emphasises the need for a skilled and sustainable workforce to deliver capital programmes and address backlog maintenance, while [Delivering productivity through the NHS Estate](#) highlights the contribution of estates and facilities to service efficiency.

However, workforce growth has slowed. Total FTE increased by 735 (plus 1.1%) between February 2025 and February 2026, driven by expansion in soft facilities roles such as cleaning and portering. In contrast, growth in technical and engineering roles has been modest, despite increased estate size and complexity. Between 2019 and 2025, the NHS estate expanded by approximately 0.8 million square metres, while the engineering and technical workforce grew by only around 0.7% per year, despite significant investment in apprenticeships and graduate pathways. Workforce modelling suggests that this rate of growth is unlikely to be sufficient to meet future engineering demand of 2% per year over the next decade. Recruitment and retention challenges further constrain this growth, with private sector salaries reported to be 29 to 45% higher for comparable engineering roles (source: see salary data in the accompanying data pack).

Demographic pressures intensify these challenges. 41% of the EFM workforce is aged 55 or over, nearly double the NHS average, creating a significant retirement risk over the next decade, while only 4% are under 25, highlighting a weak pipeline. With workforce demographics largely unchanged and sickness absence at 6.7% for 2026, these factors reduce workforce resilience and increase the risk of skills loss and recruitment pressures.

Despite 41% of organisations using Recruitment and Retention Premia (RRP), these payments have often been found to be insufficient to counteract private sector pay differentials and have not resolved long-standing recruitment and retention challenges. As a result, skills shortages remain widespread, with over 70% of trusts reporting gaps in critical mechanical and electrical roles (source: see accompanying RRP data in data pack).

In response to the NHSPRB's request for evidence on low pay, the EFM workforce provides a clear illustration, with around 74% of staff concentrated in AfC bands 2 and 3. Increases to the National Living Wage (NLW) have narrowed pay differentials, weakening incentives for progression and affecting retention. While joiner rates (11.6%) exceed leaver rates (9.6%), highlighting modest workforce growth, this reflects ongoing churn and reliance on recruitment rather than improved retention.

Collectively, these factors show the EFM workforce is under sustained pressure and is not being replenished at the pace required. The continued reliance on local approaches to RRP, a concern raised for a third consecutive year, has not delivered the scale or consistency of response needed to tackle workforce shortages in technical disciplines. There is significant concern about the need to address pay competitiveness and wider labour market pressures, strengthen recruitment and retention, and ensure the NHS can maintain the technical engineering capability for safe and compliant and services.

Digital, data and technology (DDaT) workforce

The NHS is increasingly dependent on the DDaT workforce; digital systems, automation and AI now underpin most clinical and operational processes (source: [NHS England, Digital Maturity Assessment 2024 to 2025](#)). Additionally, the 10 Year Health Plan commits to a shift from analogue to improve productivity gains. The 10 Year Health Plan shifts also require digital inter-connectivity capability. Achieving this depends on a workforce with the digital skills to design, build, maintain and optimise systems at scale.

The NHS currently faces a national digital skills gap, with shortages in architecture, cyber security, data engineering, software development, product management and IT operations. These shortages directly affect frontline performance, system resilience and the ability to adopt new technologies safely (sources: DDaT Census 2025 and [NHS England, Digital Maturity Assessment 2024 to 2025](#)).

Recruitment

The 2025 Digital Maturity Assessment found that over 90% of organisations report difficulty resourcing DDaT skills (source: NHS England, Digital Maturity Assessment 2024 to 2025).

Factors include the government announcement to expand digital skills across the public sector (source: [Skills England annual skills report and Sectoral Skills Needs Assessments 2026](#)), private sector salary growth (ONS Labour Market and Earnings Data, 2024) and a national shortage of mid-senior digital specialists across all industries (source: [Digital Skills Council and Department for Science Innovation, UK Digital Skills Gap Report 2024](#)).

Additionally, staff may feel that the 2004 AfC framework does not fully reflect modern DDaT roles, especially in contrast to the Civil Service DDaT Pay Framework, which introduced 12 to 18% pay enhancements for most DDaT roles in 2025 (source: [Civil Service Pay Remit Guidance 2025 to 2026](#)).

Retention

The DDaT workforce comprises approximately 35,000 staff, representing 2.5% of the NHS workforce, lower than comparable organisations which have DDaT workforces of 5%.

The vacancy rate varies between 7% and 8%. NHS England long-term workforce modelling indicates that demand for the DDaT workforce will grow by around 2% annually for the next 10 years, creating an estimated supply-demand gap of 11.6% that is expected to widen over time (NHS England Long-Term Workforce Modelling, 2026; NHS England WTE Modelling, ESR 2026).

Although no published leaver rate specifically exists for the DDaT workforce, published turnover statistics for March 2026 exist for the following workforces in which DDaT workforce will be a subset:

- senior managers: 9.4% (compared to 9.5% for all staff)
- managers: 8.9%
- central functions: 10.5%

These suggest turnover statistics are broadly comparable to the overall average, with central functions slightly higher.

Workforce pressures are compounded by increased requirements for digital capability and cyber security expertise at national, regional and provider levels. There is also growing reliance on data for operational, clinical and financial decision making, improving productivity, and supporting the safe adoption of AI and automation.

Service delivery

In addition to the structural and financial pressures affecting the wider NHS workforce, DDaT workforce capacity faces a number of specific challenges. Following the transition of Commissioning Support Unit (CSU) functions into NHS England, organisations will need to maintain continuity of digital, data and technology services while managing workforce integration, capability retention and new delivery arrangements.

Similarly, the draft model integrated care board (ICB) blueprint shifts digital responsibilities to providers or national organisations, increasing capability requirements ([NHS England, ICB Operating Model Blueprint, 2025 \(PDF, 334 KB\)](#)).

Insufficient DDaT capacity has direct consequences for frontline performance, patient safety, productivity, financial sustainability and transformation (Sources: [NHS England Digital Maturity Assessment 2024 to 2025](#) and [Impact statement: 10 Year Health Plan for England](#)).

Chapter 6: earnings and pay comparators

This chapter provides an assessment of pay and earnings for the non-medical workforce working under NHS terms and conditions. It includes the following sections:

- data on current pay and earnings for the HCHS workforce. This helps to set a baseline for the pay round
- data and evidence on current economic conditions and how they might be expected to evolve over the coming year
- a more detailed assessment of specific benchmarks and comparators which may have an impact on the standing of specific sections of the workforce. This helps us to understand if there are any specific challenges facing sections of the workforce which may require a more focussed pay response

It is observed that:

- in 2025 to 2026 AfC pay scales increased by 3.6% following acceptance of the pay recommendation, with most individual staff experiencing this increase. While average pay increased by more than the pay recommendation this reflects changes to workforce composition and how the workforce is distributed across the pay structure
- the position of non-medical staff in the UK income distribution has remained relatively constant over a prolonged period
- The value of healthcare degrees remains high. Nursing, midwifery and allied health degrees continue to offer one of the most reliable routes to high-value employment
- due to global events, the economic landscape remains more uncertain than usual, with potential implications for labour market conditions, earnings and prices. The Pay Review Body will therefore wish to consider the latest available data and forecasts as they emerge during the pay round

Pay and earnings for HCHS staff in 2025 to 2026

Almost all non-medical staff working in HCHS are employed under NHS Terms and Conditions using the AfC pay structure.

The AfC pay system is underpinned by the Job Evaluation Scheme (JES). The JES delivers equal pay for work of equal value by assessing the skills and responsibilities

required of a role, as set out in the job documentation. Through application of the scheme, each role is placed into one of 9 pay bands, with band 8 sub-divided into 4 levels.

Data on average pay and earnings for staff in HCHS is published by NHS England (source: [NHS Staff Earnings Estimates](#)).

The latest data runs to March 2026, the end of the 2025 to 2026 financial year, and is summarised in table 5. When interpreting these data, it is important to remember that:

- these data reflect the operation of the pay structure, including how staff are distributed across pay bands or the extent to which different roles might be required to undertake work during unsocial hours or complete additional work
- data on average pay and earnings is affected by any changes to workforce composition or usage over the period and may not be reflective of individual experience of the pay system. For instance, the average increase in pay may be higher (or lower) than the annual pay award, which in 2025 to 2026 was 3.6%, if there are changes to how staff are distributed across pay bands or points
- data to the end of March 2026 will include the full impact of the 2025 to 2026 pay award which increased all pay points by 3.6% but do not include the impact of the 2026 to 2027 pay award, to increase all pay points by 3.3%, which will be reflected in statistics over the coming year

Table 5: pay and earnings for non-medical staff working in NHS trusts and core organisations in the 12 months to March 2026 and comparison to the 12 months to March 2025.

Staff group	Average basic pay per FTE (£)	Growth in basic pay per FTE (%)	Average earnings per person (£)	Growth in earnings (%)
All non-medical staff	38,286	4.8%	37,259	4.7%
Nurses and health visitors	42,697	4.0%	42,880	4.4%
Qualified midwives	44,332	4.1%	41,021	4.0%
Qualified ambulance staff	42,445	4.3%	50,268	2.0%
Scientific, therapeutic and technical staff (STT)	47,982	4.9%	44,591	4.0%
Support to doctors, nurses and midwives	27,303	5.2%	26,441	4.8%
Support to ambulance staff	29,138	4.6%	32,940	3.3%
Support to STT	28,933	4.1%	27,188	4.5%
Senior managers	100,623	4.3%	101,488	3.9%
Managers	68,461	4.7%	68,976	4.6%
Central functions	37,803	4.2%	36,895	5.1%
Hotel, property and estates	26,634	4.8%	25,377	3.9%

Source: [NHS England Earnings Statistics](#)

Average earnings per person ranged from over £27,000 for support to scientific, therapeutic, and technical staff (STT) staff through to over £100,000 for Senior Managers. This highlights the breadth of staff within the AfC workforce from people whose pay is just above the NLW right through to those toward the top of the income distribution as well as the challenge of pay setting across a large and diverse range of staff across professions.

In addition to basic pay, NHS staff working under AfC may benefit from provisions that mean that staff who, for example, work during unsocial hours or complete additional hours receive additional or premium pay. On average, additional earnings add between 5% (senior managers) and 28% (ambulance staff) on top of basic pay reflecting the demands of those roles. For example, ambulance staff and support to ambulance staff have the highest proportion of 'additional earnings' as those services must always operate and often have overtime requirements.

Table 5 shows that the increase in average basic pay per full time equivalent (FTE and total earnings were markedly higher than the pay award. Additional analysis, as shown in table 6 using data from the data pack, can highlight some of the reasons why this is the case with changes to workforce composition, how staff are distributed across pay bands and points, helping drive this change.

Table 6: changes in the distribution of the AfC workforce by pay band and pay position, March 2025 to March 2026

Banding	March 2025 FTE	March 2025 % of workforce	March 2026 FTE	March 2026 % of workforce	Change
Band 1 to 4	469,320	38.7%	457,372	37.8%	Minus 0.9ppts
Of which band 2	135,905	11.2%	111,725	9.2%	Minus 2.0ppts
Of which band 3	210,201	17.3%	225,300	18.6%	Plus 1.3ppts
Bands 5 to 7	639,349	52.7%	648,361	53.6%	Plus 0.9ppts
Bands 8a plus	103,505	8.5%	104,615	8.6%	Plus 0.1ppts
Top of band	634,962	52.4%	667,782	55.2%	Plus 2.8ppts

Source: NHS England Workforce Statistics, March 2026

The proportion of staff in band 2 has reduced by around 2 percentage points (11% to 9% of AfC staff) while the proportion in band 3 has increased by around 1.3 percentage points. Much of this relates to pay banding changes following the outcome of job evaluation banding reviews amongst support staff especially healthcare assistants. This will increase average pay as there are a higher proportion of people in a higher band.

There has been a small reduction in the proportion of staff in bands 1 to 4 (down around one percentage point) while the proportion of staff in higher bands has increased by a similar amount. This will increase average pay as the average banding of the workforce increases.

The proportion of staff working at the top of their pay bands has increased by around 3 percentage points in the past year with over 55% of staff now working at the top of band. This shifts the workforce mix towards higher pay points and increases average pay. Similarly, a slowdown in workforce growth will lead to fewer people on lower pay points which also increases average pay.

The growth in additional earnings has generally been at or slightly below the growth in basic pay. One of the reasons for this in 2025 to 2026 was a reduction in overtime payments that contribute to additional earnings growing more slowly than basic pay.

Core economic context

The NHS operates as part of the wider labour market. Therefore, it is important to understand broader economic conditions and the wider context for this pay round alongside the other factors that are explored elsewhere within this evidence, including morale and motivation, recruitment and retention, and total reward. Greater emphasis has been 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 affect 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 similar to 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 has been the case this year in the NHS.

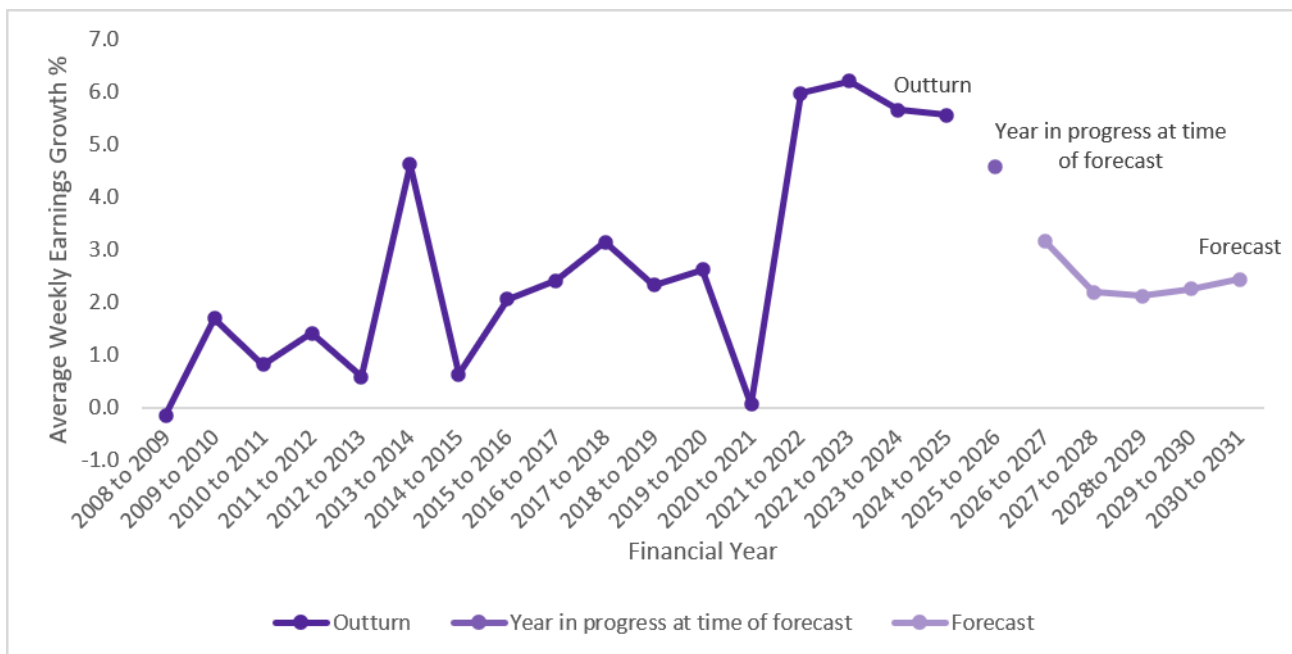
While there are no official statistics on pay settlements, several organisations undertake surveys which can provide an indication of current conditions. These include:

- [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 affected by things like changes to workforce composition or pay drift (for example an increase in average earnings 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 Office for Budget Responsibility (OBR) forecast since 2008 to 2009



Source: [Office for Budget Responsibility \(OBR\) Table 1.6 \(XLSX, 472KB\)](#) file containing March 2026 economic and fiscal outlook detailed forecast tables

The [economic and fiscal outlook March 2026](#) 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 July the [Bank of England's Monetary Policy Report, July 2026](#) forecast average private sector earnings growth of around 3.2% in 2027 to 2028 and 3.1% in 2028 to 2029.

Wider economy pay settlements and earnings growth, partly driven by inflation, are more useful indicators for aligning NHS pay with relevant labour market comparators; subject to any additional issues around morale, recruitment and retention as per the PRB's wider remit.

The Bank of England also forecasted in the July 2026 Monetary Policy Report that CPI in 2027 to 2028 would be around 2.4% after averaging 3.0% in 2026 to 2027, but with the BoE 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.

While 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 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.

We expect that the PRB 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.

Comparators and staff group analysis

1. Income distribution

Table 7 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 7: average earnings growth across the UK income distribution by percentile, latest 12-month period

Position in income distribution	10th percentile	25th percentile	Median	75th percentile	90th percentile	95th percentile
Growth in average pay over the last 12-months	6.4%	5.7%	4.8%	4.1%	3.3%	2.5%

Source: [ONS, Real-Time Information - Seasonally Adjusted](#)

2. The annual survey of hours and earnings (ASHE) - movement across the earnings distribution

The [Annual Survey of Hours and Earnings \(ASHE\)](#) collects detailed information on pay for more detailed sectors of the workforce and through time. 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. This is 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.

Table 8 estimates the position of different non-medical staff groups in the earnings distribution. We see that:

- percentiles are generally lower in 2025 compared to 2024 reflecting the expiry of non-consolidated payments to non-medical staff as part of the 2023 to 2024 pay agreement which artificially improved the position last year
- over the past 5 years, when pay has been determined by either pay review bodies with unconstrained remits or negotiated pay agreements there have been relatively small changes with most staff groups being in a similar position. However, some lower paid staff and support groups may have fallen slightly following large increases to the NLW which particularly benefit the wider economy and act to compress the wage distribution
- over a longer period where the position of some staff groups has fallen (for example, nurses and midwives) most of the reduction occurred between 2011 and 2020 which coincided with a period of pay restraint and tight public sector pay policies

Table 8: percentile position of non-medical staff groups within the UK earnings distribution, 2011 to 2025

Staff Group	2011	2015	2020	2023	2024	2025
Nurses and health visitors	70th percentile	69	65	65	67	64
Qualified midwives	71	69	65	63	64	62
Qualified ambulance staff	79	78	77	79	79	76
Scientific, therapeutic and technical staff	73	71	67	67	69	67
Support to doctors, nurses and midwives	37	37	33	31	34	31
Support to ambulance staff	51	51	50	50	51	47
Support to STT	37	36	33	33	36	33
Central functions	52	52	51	51	54	54
Hotel, property and estates	36	34	31	30	32	29
Senior managers	96	96	96	96	96	96
Managers	88	88	86	87	88	87

Sources: [Annual Survey of Hours and Earnings 2026](#) (ASHE) and [NHS England Earnings Statistics 2026](#)

When looking for reasons why the position of any staff group may have changed over time, analysis will generally be focussed on comparing earnings growth in the AfC workforce against the wider economy, of which one factor may be differences in pay awards for different parts of the public sector.

Table 9 compares recent pay awards over the past 5 years, for some of the main pay review bodies including NHSPRB, DDRB, and the review bodies for teachers (STRB), armed forces (AFPRB), and prison officers (PSPRB). This indicates that while all pay review bodies tend to operate in a relatively narrow range (reflecting general economic conditions) AfC has tended to be toward the lower end of the range.

Table 9: comparison of pay recommendations by pay review body, 2022 to 2023 to 2026 to 2027

Pay year	NHS PRB (AfC)	DDRB	STRB	AFPRB	PSPRB
2022 to 2023	£1,400 (min 4% in bands 1 to 7)	4.5%	5.0% to 8.9% (targeted by pay point)	3.75%	Minimum of 4% (plus targeted awards for lowest paid)
2023 to 2024	5.5% (negotiated agreement)	6% (additional £1,250 for resident doctors)	6.5%	5% + £1,000	5% to 7% (targeted by grade)
2024 to 2025	5.5%	6% (additional £1,000 for resident doctors)	5.5%	6%	5%
2025 to 2026	3.6%	4% (additional £750 for resident doctors)	4%	4.5%	4%
2026 to 2027	3.3%	3.5% (3.75% for dentists' contract uplift)	3.5%	3.6%	3.5%

Sources: NHS Pay Review Body, Doctors and Dentists Remuneration Body, School Teachers Pay Review Body, Armed Forces Pay Review Body and Police Service Pay Review Body

3. Longitudinal education outcomes of the graduate premium

The Department for Education (DfE) publishes data on [Longitudinal Education Outcomes](#) (LEO). These combine data from the education system with information from Department of Work and Pensions (DWP) and HM Revenue and Customs (HMRC) to track the earnings and employment outcomes of graduates and can be used to compare outcomes across subjects or providers.

This data can be used to show how outcomes for those with healthcare degrees compare to those from other courses and provide insight to the value offered by these courses.

Table 10 shows median earnings and employment outcomes for graduates of nursing and allied health courses over different time periods and a comparison to outcomes across all graduates. Rankings are out of 35 subject areas.

Table 10: graduate earnings and employment outcomes for nursing and midwifery and allied health professions graduates, 1 to 10 years after graduation

	1 year after graduation	3 years after graduation	5 years after graduation	10 years after graduation
Median earnings nursing and midwifery	£34,000	£35,900	£37,300	£38,400
Earnings rank nursing and midwifery (35 subject areas)	2	8	12	21
Proportion in employment or training nursing and midwifery	95.7%	94.3%	92.9%	90.9%
Median earnings allied health	£29,300	£33,300	£34,800	£35,900
Earnings rank allied health	9	11	17	23
Proportion in employment or training allied health	92.0%	90.4%	86.2%	87.7%
Median earnings for all graduates	£26,000	£29,600	£33,300	£38,800
Proportion in employment or training all graduates	87.7%	86.8%	85.9%	82.9%

Source: Longitudinal Education Outcomes, rankings cover 35 different subject areas

The data shows that:

- median earnings for nurses are above average for the first 5 years before falling below the average 10 years after graduation. The higher-than-average earnings in the early stages reflect the ability of most graduates of these courses to progress into 'graduate level' roles while for other subjects a higher proportion of individuals may not immediately obtain graduate level positions
- median earnings for graduates in the allied health professions follow a slightly different pattern with them being above average for the first 5 years after graduation before falling below average after 10 years. It should be noted that progress from AHP courses into the NHS is not as high as for nursing and midwifery
- data from the [Longitudinal Education Outcomes; Graduate Industry dashboard, Tax year 2023 to 2024](#) shows that most healthcare graduates go on to work in healthcare with around 88% of nursing graduates working in 'human health activities' 5 years after graduation. There is no suggestion that average earnings are being inflated by those working outside of healthcare

- employment outcomes for both nurses and AHPs are above average. The proportion of nursing graduates in sustained employment or training at all stages is above 90% and is consistently over 7 percentage points above the average for all graduates. AHPs are also above the average
- taken together, this highlights that both nursing and AHP qualifications offer a competitive earnings profile alongside strong employment prospects

4. Estimates of the long-term returns from nursing degrees

The Institute for Fiscal Studies has recently published new estimates of the [impact of undergraduate degrees on lifetime earnings](#), and this is another source which points to the long-term value of a nursing or allied health degree. This research is built around data from LEO, the Labour Force Survey (LFS), linked Higher Education Statistics Authority (HESA) and HMRC records, and focusses on the cohort of students who took GCSEs in 2002 and considers how variables such as subject, institution and prior attainment impact have an impact on long-term outcomes for the individual and the exchequer.

The report generally shows benefits to those undertaking degree level education, with graduates earning substantially more than non-graduates in their thirties and with earnings gaps expected to persist throughout their working lives.

Analysis shows women with lower prior attainment in their GCSEs who study nursing particularly benefit from their degrees with the IFS noting that nursing offers a reliable graduate premium through a regulated, structured-pay profession. This makes it a particularly strong proposition for women who would otherwise be lower in the earnings distribution - for this group Nursing is the subject with the highest expected returns.

5. Longitudinal pay - the employee experience of the pay system

Using data from the Electronic Staff Record (ESR) it is possible to track individual members of the workforce through time and see the impact of pay progression (moving to higher points within a given pay band) or promotion (moving to a higher pay band).

Table 11 show estimates of the distribution of total (annualised) pay increases for people employed in both 2016 and 2026 and is split according to an individual's staff group in 2016. The median increase over this period is around 4.8% per year (a total of 59.2%) The lower quartile increase, experienced by 25% of staff is around 3.4% per year which may cover staff who have been working at the top of their pay band throughout. Higher increases are possible for those who either progress within their current pay band or those who gain promotion to a higher band. For example, research from the Institute for Fiscal Studies showed that only around one third of nurses who were still working in the NHS were still at band 5 after 9 years. This trend was broadly similar for different time periods (source: [Progression of nurses within the NHS](#)).

Table 11: estimated average annual pay increases for HCHS staff employed in both March 2016 and March 2026

Staff group in 2016	Lower quartile (annual)	Lower quartile (total)	Median (annual)	Median (total)	Upper quartile (annual)	Upper quartile (total)
All non-medical staff	3.4%	40%	4.8%	59%	6.1%	81%
Nurses and health visitors	3.0%	34%	4.7%	58%	6.0%	79%
Qualified midwives	2.9%	34%	4.5%	55%	6.0%	79%
Qualified ambulance staff	5.1%	65%	5.6%	72%	7.1%	99%
Scientific, therapeutic and technical staff	3.0%	34%	4.6%	57%	6.4%	86%
Support to doctors, nurses and midwives	3.6%	42%	4.8%	59%	5.6%	73%
Support to ambulance staff	4.1%	50%	5.4%	70%	7.4%	103%
Support to STT	3.5%	41%	4.7%	59%	6.4%	87%
Central functions	3.8%	45%	5.2%	65%	7.1%	99%
Hotel, property and estates	4.2%	51%	4.8%	59%	4.9%	62%
Managers	3.6%	42%	4.8%	60%	6.4%	86%
Senior managers	3.0%	35%	4.5%	55%	5.9%	77%

Source: DHSC analysis of ESR

Pay structure challenges and specific issues

The previous section focused on specific parts of the workforce through the lens of the wider economy. This section concentrates on issues specific to the NHS and its pay structure.

As highlighted in the introduction, NHS Staff Council negotiations on changes to the AfC pay structure remain ongoing, and the outcome of these negotiations is not yet known.

Low pay policy and the National Living Wage (NLW)

A core issue for pay setting is where the bottom of the NHS pay scale should sit relative to the NLW. As of March 2026, just over 10% of the AfC workforce (about 140,000 people) were in bands 1 or 2 with a further 19% (about 260,000) staff in band 3

In recent years, developments to both the NHS pay scale and the NLW itself have raised the salience of this issue:

- as part of the 2023 AfC pay agreement all staff in bands 1 (which was closed to new entrants in 2018) and 2 have the same basic pay following the introduction of

a spot rate. This meant that pay for band 1 and the entry point of band 2 was brought up to match the top of band 2, which removed progression in band 2

- there has been government policy to increase the value of NLW with it reaching 66% of median hourly pay by 2024. Meeting this commitment required a series of higher than usual increases to NLW which were higher than those given to AfC staff. These have resulted in a lowering of the gap between the lower end of AfC and NLW as shown in Table 12. We highlight that this is primarily caused by an increase in the relative value of NLW rather than a reduction to AfC pay. Despite this, there is no clear evidence to suggest there are specific recruitment and retention challenges at the lower end of the pay scale

Table 12: comparison of AfC minimum pay and the NLW, 2022 to 2023 to 2026 to 2027

	2022 to 2023	2023 to 2024	2024 to 2025	2025 to 2026	2026 to 2027
AfC min	£20,270	£22,383	£23,615	£24,465	£25,272
AfC hourly	£10.37	£11.45	£12.08	£12.51	£12.92
NLW	£9.50	£10.42	£11.44	£12.21	£12.71
AfC premia	9.1%	9.9%	5.6%	2.5%	1.7%

Source: NHS Employers Pay Circulars, Low Pay Commission

As with other workforce groups, pay positioning relative to the NLW should be informed by recruitment and retention considerations, labour market comparisons, and the total reward package.

Following recommendations from NHSPRB in 2024 and 2025 to reform the AfC pay structure there are ongoing negotiations, of which one of the things being discussed is entry pay for AfC staff.

Impact on salary sacrifice participation

Salary sacrifice schemes are arrangements where staff can get the opportunity to gain a benefit in kind while agreeing to sacrifice a portion of their salary in exchange. These can offer substantial benefits to staff and reduce tax obligations. Examples of schemes include ones for car leasing, cycle to work or home electronics.

Continued participation in salary sacrifice schemes is dependent on pay not dropping below the National Minimum Wage (NMW). As previously noted, the gap between the National Minimum Wage and the bottom of the AfC system has reduced in recent years. This has left a smaller buffer which staff could use to participate in sacrifice schemes while remaining compliant with the National Minimum Wage. As a result, it has been necessary

for some staff, particularly in the lower bands or those participating in multiple schemes, to be removed from salary sacrifice schemes by their employer to ensure their pay does not fall below the NMW.

However, participation in salary sacrifice schemes is heavily dependent on salary sacrifice regulations for which HM Treasury is the lead. Rates of pay and pay uplifts alone are not the sole determinate for continued access to such schemes.

Reforms to the AfC pay structure continue and it is intended that the outcomes of these negotiations will address pay for the lowest earners and therefore mitigate the issues with salary sacrifice participation.

Chapter 7: total reward

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

The total reward package in the NHS includes a range of benefits that exceed the statutory minimum and those offered in other sectors. These include:

- a generous holiday allowance, in addition to public holidays, increasing with years of service (up to 33 days)
- sickness absence arrangements of up to 12 months of payment
- access to a defined benefit pension scheme with an employer contribution rate of 15.5%
- enhanced parental leave
- career progression support, learning and development

Labour market context

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

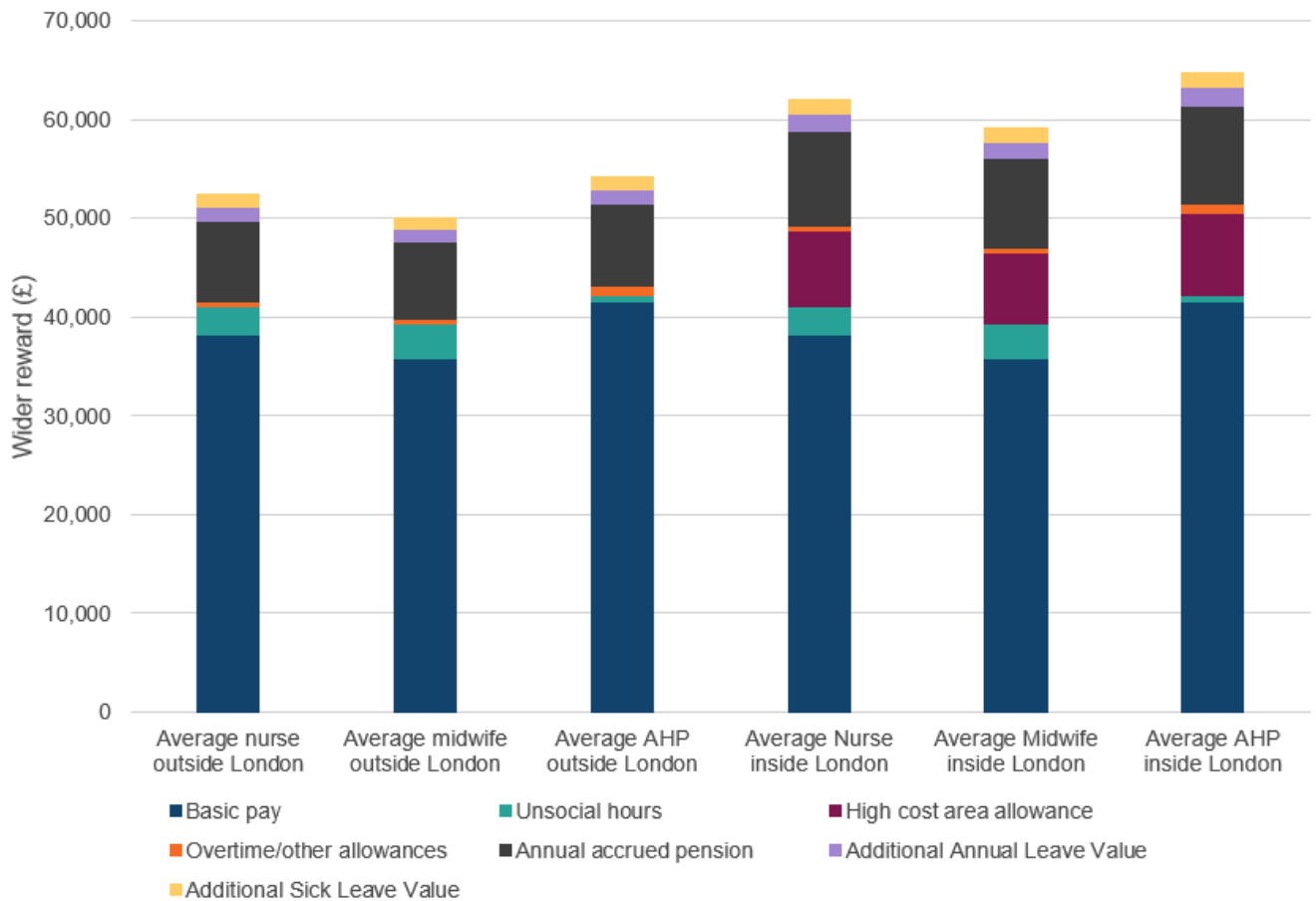
In the UK, employers are required to contribute a minimum of 3% to employee's pensions, and any additional contributions over the 3% are at the discretion of the individual employer. The statutory minimum holiday allowance is 28 days per year (including bank holidays) for full-time members of staff.

Measuring the value

DHSC commissions the Government Actuary's Department (GAD) to measure the value of the total reward package for a range of NHS roles, as shown in the analysis in figure 5.

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

Figure 5: wider reward packages for a range of NHS staff roles



The figure above shows the value of the wider reward package for NHS staff in different roles and outside or inside London for 2025 to 2026. It shows those in London receive a higher total reward, due to the high-cost area allowance.

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

Figure 6: analysis of the trend in wider reward over the period 2024 to 2025 to 2026 to 2027

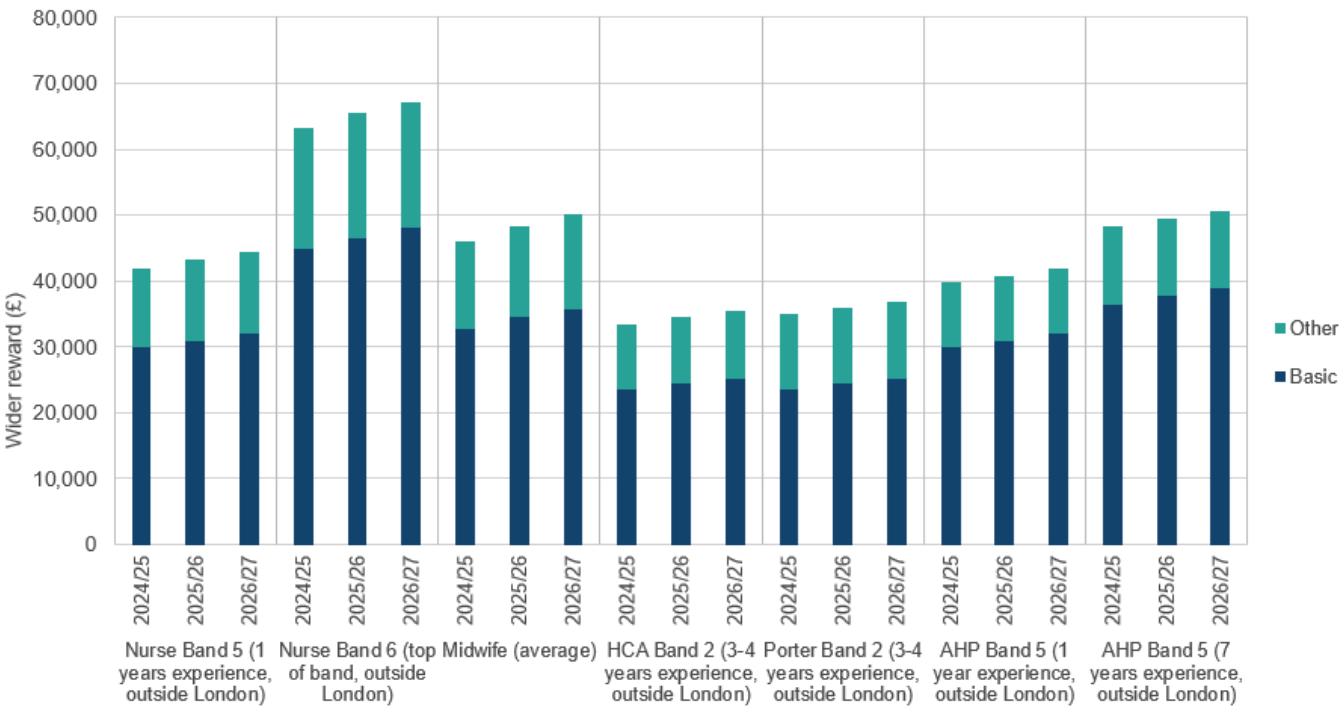


Figure 6 analysis shows the split of total reward packages between basic and other pay over the period 2024 to 2025 to 2026 to 2027. Please note, for an average midwife we are comparing average rewards at 30 June 2024, 31 March 2025 and 31 March 2026 with pay bands at 2024 to 2025, 2025 to 2026 and 2026 to 2027 for all other roles. We believe this will only cause a negligible difference for the purpose of comparison. This is consistent with the approach used in previous years and reflects the availability of the relevant data.

All NHS roles considered have experienced an increase in total reward in monetary terms over the past 3 years. Across all roles, at least 23% of total reward is made up of non-basic pay.

Figure 7: summary of increases in reward over the total period 2024 to 2025 and 2026 to 2027

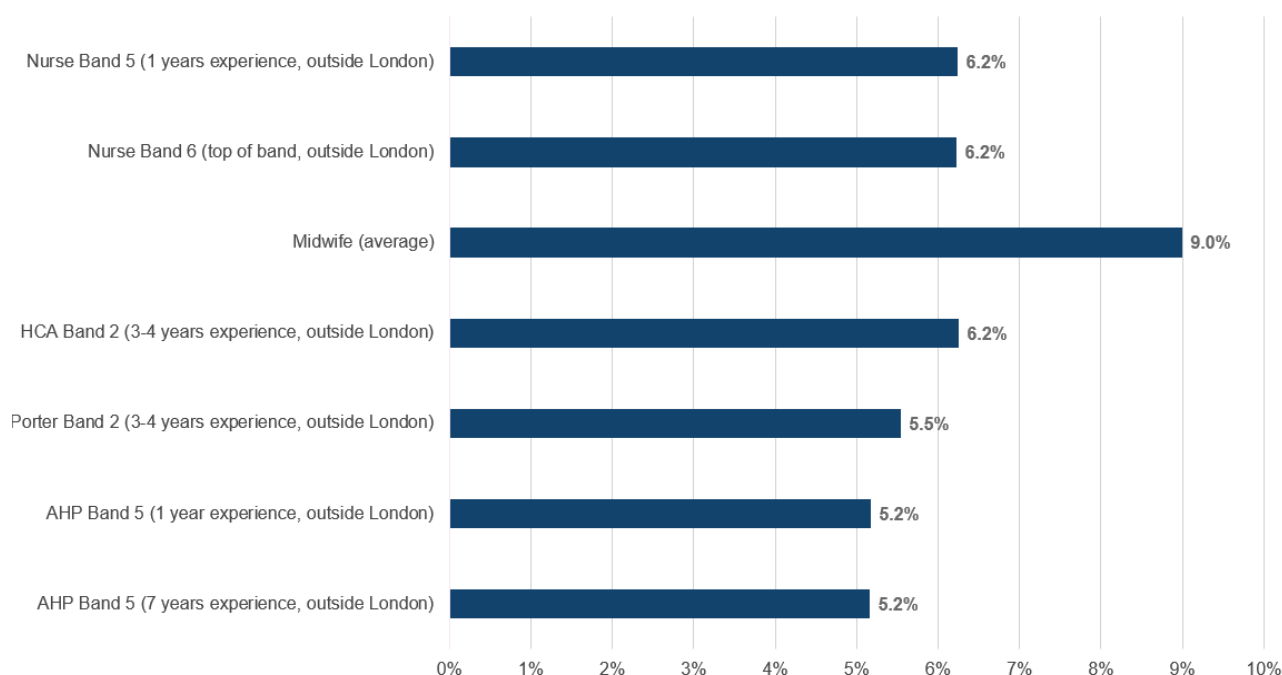


Figure 7 shows that total reward increased each year for all roles considered. Over the period, increases were at least 5.2%, with midwives seeing the largest rise, at 9%.

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 13; 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 NHS Pension Scheme since 1 April 2022 are automatically enrolled in the 2015 scheme.

Table 13: 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

NHS Pension Scheme contributions

Members and employers are required to pay towards the cost of benefits built up in the NHS Pension Scheme. Following a recent actuarial valuation and subject to consultation on updates to scheme regulations, from 1 April 2027 employers will contribute 15.5% of each member's pensionable earnings, plus a charge of 0.08% to fund the administration of the scheme. As a defined benefit scheme, the value of these benefits is determined by a member's earnings and length of service, rather than by the level of contributions alone. The change in the employer contribution rate does not alter the generosity of pension rights that staff build up. The valuation shows that those rights are now not expected to cost as much in the long-term, compared to the last valuation that led to the change in employer contribution rate in 2023.

DHSC reviewed member contributions in 2021 and introduced changes in October 2022 and April 2024. More information on these changes is available from the relevant consultation documents (source: [NHS Pension Scheme: proposed policy changes for April 2024 consultation outcome](#)). Following these changes, member contribution tier thresholds are updated automatically each April, in line with CPI from the previous September. If the AfC pay award in England is higher than this figure, the thresholds are updated again. This policy ensures that the tier thresholds remain up to date, and to reduce the likelihood of members moving into the next contribution tier solely as a result of receiving a nationally agreed pay award.

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

Table 14 shows the employee contribution rates to the NHS Pension Scheme, against different pensionable pay ranges.

Table 14: NHS Pension Scheme member contribution threshold structure (as of 1 April 2026)

Pensionable pay range	Contribution rate from 1 April 2026, based on actual annual pensionable pay
Up to £13,259	5.2%
£13,260 to £28,854	6.5%
£28,855 to £35,155	8.3%
£35,156 to £52,778	9.8%
£52,779 to £67,668	10.7%
£67,669 and above	12.5%

Pension projections

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

GAD has also estimated that a nurse who joins the NHS Pension Scheme in 2026 age 21 and works at AfC band 5 before retiring at age 65, can expect an annual pension of around £38,400 in today's monetary terms. A nurse who joins the NHS Pension Scheme in 2026 age 21 and progresses through AfC bands 5 and 6 before retiring at age 65 can expect an annual pension of around £44,000 in today's monetary terms. These estimates assume members remain in service and work full-time to retirement.

Table 15 sets out illustrative project pensions for members as above, as well as allowing for commutation where 20% of the pension is converted into a tax-free pension commencement lump sum (PCLS) at retirement.

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

Nurse band	No commutation: projected pension (per year)	Allowing for commutation: projected residual pension (per year)	Allowing for commutation: projected pension commencement lump sum (PCLS)
Nurse band 5	£38,400	£30,700	£92,100
Nurse band 5 or 6	£44,000	£35,200	£105,500

NHS Pension Scheme membership

We continue to monitor scheme membership rates through ESR. Table 16 shows the percentage of staff members, by staff group and AfC band, who were members of the scheme in March 2026 in comparison to March 2025.

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

Role	Mar 2026	One year change (percentage point (pp) change)
Nurses and health visitors	84.4%	1.7pp
Midwives	91.3%	0.6pp
Qualified ambulance staff	92.0%	0.4pp
Qualified scientific, therapeutic and technical staff	92.8%	1.1pp
Support to doctors, nurses and midwives	88.2%	Minus 0.4pp
Support to ambulance staff	90.8%	Minus 0.3pp
Support to scientific, therapeutic and technical staff	90.2%	0.1pp
Central functions	88.5%	0.6pp
Hotel, property and estates	86.9%	No change
Senior managers	92.7%	0.8pp
Managers	92.3%	0.7pp
Grand Total	88.1%	0.6pp

Table 17: NHS Pension Scheme membership for non-medical staff by band

Band	Mar 2026	One year change (percentage point (pp) change)
Band 1	78.6%	1pp
Band 2	87.5%	Minus 0.2pp
Band 3	88.2%	Minus 0.9pp
Band 4	89.9%	0.3pp
Band 5	80.8%	1.8pp
Band 6	89.1%	0.7pp
Band 7	92.7%	0.8pp
Band 8a	94.0%	0.9pp
Band 8b	94.4%	0.6pp
Band 8c	94.5%	0.7pp
Band 8d	94.6%	0.5pp
Band 9	94.4%	1.2pp

Overall membership rates remain high across the workforce, particularly in more senior bands. However, there is a noticeable dip at bands 1 and 5, where participation is lower.

Table 18: NHS Pension Scheme memberships for band 5 staff by pay step and nationality

Step	Pay point	Rest of world	One year change (rest of world)	UK	One year change (UK)
1	Entry	79.3%	3.2pp	93.8%	0.4pp
2	Entry	55.6%	7pp	90.5%	0.2pp
3	Intermediate	41.5%	4.1pp	89.0%	0.6pp
4	Intermediate	50.9%	8.3pp	89.0%	0.2pp
5	Top	55.4%	5.4pp	90.0%	1.1pp
6	Top	58.4%	7pp	89.3%	Minus 0.1pp
7	Top	58.9%	7.9pp	90.7%	0.7pp
8	Top	68.7%	3.7pp	91.5%	1.2pp

Table 17 shows that compared with last year, band 5 membership rates have increased across almost all pay steps, with the only exception being a marginal decline at step 6 on the top pay point. Increases are notably larger among staff from the rest of the world, whereas changes for UK staff are more modest, reflecting already high participation rates across all pay steps.

Data obtained from the ESR opt-out tool for February 2026 highlights the primary reasons for band 5 opt-outs being either a temporary opt-out due to other financial priorities (59%), and affordability (30%).

Retirement options

The scheme has a normal pension age (NPA) at which pension benefits are paid without adjustment. Members have the option of taking Voluntary Early Retirement which allows staff to fully retire up to 10 years earlier than their NPA (subject to Normal Minimum Pension Age legislation). If they choose to do this 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, enables 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.

Partial retirement was introduced for NHS staff in the 1995 Scheme on 1 October 2023 and allows NHS Pension Scheme members to draw down some or all of their pension while continuing to work and build up further pension, subject to a reduction in pensionable pay of at least 10%, being agreed with their employer. As well as supporting staff with their

work-life balance later in their careers, partial retirement also supports NHS employers, by allowing them to retain experienced members of staff who may otherwise retire.

As of 23 March 2026, there have been 39,518 completed applications for Partial Retirement Awards, with over £587 million being paid in annual benefits and over £2.9 billion in lump sums. The NHS Business Services Authority (NHSBSA) estimate that of the 39,518 completed applications, 16,307 (41.27%) were taken by nurses, 5,323 (13.47%) by doctors and dentists, and 17,888 (45.27%) by other staff groups, demonstrating the popularity of partial retirement.

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

Gender pensions gap

Work is being undertaken to assess the gender pension gap within the NHS Pension Scheme. Evidence suggests that the gap is smaller among members of the 2015 Scheme. This scheme has a career average design, which builds pension benefits more evenly over a member's working life and reduces the impact of differences in pay progression and working patterns.

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. In 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.

