Pay Review Body Evidence

October 2025

SoR
THE SOCIETY OF RADIOGRAPHERS

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NHS Pay Review Body (PRB) Written evidence September 2025

The Society of Radiographers (SoR), representing over 34,000 diagnostic imaging and radiotherapy professionals across the NHS, submits this evidence to the NHS PRB at a time of acute workforce crisis. Radiographers are central to patient care and to reducing diagnostic and treatment waiting times, yet continued pay erosion, poor working conditions, and hostile recruitment policies threaten service delivery and patient safety.

We are submitting evidence to the PRB to make the radiography case for improvements to pay and reward. We also make reference to important areas of wider workplace experience and culture which have a significant impact on professional recruitment, retention and progress. In several of these we acknowledge it is not within the PRBs expertise or remit to recommend specific solutions - although we argue the PRB can and should specifically acknowledge these challenges. Doing so would add positive encouragement towards the Government implementing solutions identified through the Social Partnership Forum and parallel workforce reform discussions between the members of Staff Council, including the SoR.

Key Issues

- **Pay Restoration:** NHS radiographers have experienced a devaluing of their pay and terms and conditions compared to the rest of the economy since 2008. For SoR members the pay gap is between 22% - 24%. In managerial grades the gap is even higher, between 26%-32%. The 2025–26 pay award of 3.6% widened the gap between NHS pay and average earnings, further undermining morale, recruitment, and retention.
- **Gender Pay and Pension Gaps:** Inequities persist, with Agenda for Change (AfC) staff—predominantly women—falling further behind groups such as doctors and dentists. The NHS pension scheme's gender gap is significantly higher than in comparable public sector schemes.
- **Pensions and Retention:** High opt-out rates, particularly among Band 5 staff and internationally trained recruits, undermine pensions as a cornerstone of NHS reward. Contribution rates are disproportionately high compared with other public sector schemes, worsening affordability and retention. Opt-out rates are especially high for those engaged through NHS Banks or agencies. Opt-out rates are also especially high in London, where member contributions are proportionately higher by grade because of London weighting. There is a link between groups with higher opt-out rates and the gender pension pay gap.
- **Workforce Crisis:** Vacancy rates remain critical—14.9% in diagnostics in England, 15.3% in Wales, and much higher in specialist areas. New graduates are struggling to secure posts due to short-term job freezes, risking long-term attrition. Demand for imaging and radiotherapy continues to rise faster than workforce supply. This prompts a need for the new Workforce strategy to sustain a credible long-term fully funded plan to continue to grow the radiography workforce at all levels, alongside imaging capacity, as a priority.
- **International Recruitment:** The Government's restrictive immigration policy will deter internationally trained radiographers, who currently make up nearly 30% of registrants and account for growth in registered radiographers since 2020. This threatens the NHS's ability to meet waiting list reduction and cancer treatment targets.
- **Specialist Shortages:** Sonographers and mammographers face vacancy rates of up to 48% in some regions, with widespread reliance on agency staff at unsustainable cost.
- **Leadership Roles:** Senior management posts (Bands 8a–9) are increasingly unattractive due to excessive workload and inadequate pay differentials, further undermining NHS service delivery. As radiography becomes ever more central to patient support, especially regarding reducing patient waiting times for diagnosis and early cancer treatment, developing more managers and leaders from radiography would have a wider benefit for the NHS. There need to be more and easier pathways for career progression for radiographers.

SoR Recommendations

1. **Immediate Significant Pay Award (2026–27)** to begin addressing pay restoration and prevent further workforce loss. Paying this early in 2026 will re-enforce support for and momentum around parallel pay and reward discussions between unions, employers and the Department of Health and Social Care (DHSC).
2. **Commitment to Full Pay Restoration by 2030**, as endorsed by the Trades Union Congress (TUC), with PRB oversight to prevent further erosion.
3. **Gender Equality Action:** Assess AfC pay awards to ensure they consistently narrow, rather than widen, gender pay and pension gaps.
4. **Pension Reform:** Recommend a review of contribution levels. Test awards against perceived inequities to reduce pension opt-outs and improve recruitment/retention.
5. **Support for New Professionals:** Encourage the need for structured preceptorships, fair starting pay, and incentives such as student loan write-offs or pension holidays.
6. **Investment in the Support Workforce:** Recommend job evaluation is used to address inconsistencies, especially at Bands 2 and 3. Demonstrate support for growing the radiography support workforce, recognising their roles as critical to service delivery. Support wider investment in extending career pathways options for the support workforce to progress their careers (e.g. more graduate apprenticeship posts).
7. **Positive International Recruitment Policy:** Recommend supporting incentives to attract and retain skilled overseas professionals.
8. **Targeted Support for Specialist Areas** (sonography, mammography): Highlight support for urgent pay reform and easier training pathways open to increase recruitment and retention. This can be funded by savings arising from containing agency or outsourcing costs, especially in sonography.
9. **Strengthening Leadership:** Highlight a need for fairer pay differentials and overtime recognition for managers to encourage progression into senior roles.

Conclusion

The NHS stands at a crossroads: pay erosion and underinvestment have left radiography in crisis. Without immediate and substantial pay action, alongside structural reform, the workforce will continue to shrink, waiting times will rise, and patient care will deteriorate. The PRB must use its independence to recommend urgent pay restoration and highlight systemic reforms needed to stabilise and grow the workforce.

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Director of Industrial Strategy
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Society of Radiographers

Introduction

The SoR is the professional body and trade union for all those working in diagnostic imaging and radiotherapy. The SoR represents over 34,000 members, most of whom work in the NHS across all 4 nations, at all grades across clinical imaging and radiotherapy.

Our members continue to be absolutely critical to delivering improved patient care and outcomes, but the workforce crisis, reported in our recent PRB evidence, continues unabated – indeed, it is being exacerbated rather than helped by some recent Government interventions, as detailed below. There is a critical and urgent need for action to end the workforce crisis. The PRB has been given some responsibility for making recommendations that calm the waters and support wider structural reinforcement of the AfC pay and reward structures. Our evidence sets out what we think these recommendations should include and why we think these are critical now and into the future.

Summary

The SoR is continuing to give evidence to the PRB. We are doing so because:

- We will continue to take every opportunity open to us to make the case for pay restoration and greater investment in all parts of clinical imaging and radiotherapy. The government is continuing to seek a recommendation from the PRB, and so we will take the opportunity to present the case for better pay and reward for our members.

- Although we agree the PRB should not try to solve the structural problems with pay, reward, and staffing levels at the root of the NHS workforce crisis, we think they can and should highlight some of the obvious problems. The PRB publicly recognising key issues and making recommendations that the Government support addressing these would support the parallel discussions taking place between NHS unions, employers, and the DHSC.

- Our members need a credible pay award that begins to address pay restoration. Whilst ideally parallel talks would identify all of the structural problems and secure both the resources and pathways to address these, we think progress will be difficult and slow. It is certainly extremely unlikely that substantial progress will be made by the pay award date of 1st April 2026. As such, the Government has requested the PRB to make a recommendation. To influence this, we are affording evidence to the PRB.

- The SoR has long-standing policy in support of using the PRB. We continue to see a potential long-term role for a PRB, assuming this is genuinely independent and both willing and capable

of making recommendations that a Government may find uncomfortable. This still feels like a model that can deliver long-term strategic progress for our members, whilst minimising the risk of industrial conflict more than direct negotiations with an elected Government pulled towards short-term political priorities.

We explain how the 2025-26 award widened the pay gap and has increased member frustration with their pay and reward, alongside their confidence in the new Government really being willing to tackle the NHS workforce crisis.

We explain how the challenges are evidenced against responsibilities on the Government and the PRB to close equal and gender pay gaps, including with reference to the NHS pension gender pay gap.

We also highlight why confidence in, and the perceived benefit of, the NHS pension scheme is being undermined. This is a combination of how it is perceived by some groups in relation to other pay pressures, and how it is being strategically applied for short-term gain (e.g. bank workers or outsourcing key processes via organisations like NHS Professionals). We argue that recruitment and retention become significantly more difficult if the relative value of the pension is reduced or perceived to be lost.

We re-emphasise concerns presented in recent PRB evidence about the causes and impact of the workforce crisis through the radiography lens – including the impact on patients and waiting lists from failing to invest in key groups of staff. These include:

- New Professionals and those in band 5
- The Radiography Support Workforce
- Sonographers and Mammographers
- Managers and Leaders

We particularly emphasise the critical risks from the Government's "hostile environment" policy towards recruiting and retaining internationally trained radiographers – highlighting how this would destroy any credible prospect of reducing diagnostic waiting times.

Consequently, we urge the PRB to make a recommendation that the Government make a significant pay award for all groups of staff in 2026-27, to at least start addressing full pay restoration.

We also invite the PRB to highlight a number of structural problems with the AfC pay system, with suggestions for priority areas for strategic reform to the Government to support the parallel discussions between Staff Council and the DHSC, which we are also an active party.

1. Why we are giving evidence

We will start our evidence by explaining why we are still here, presenting evidence when most other unions are choosing not to do so in 2026-27.

The NHS is currently parked at a crossroads – literally stalled between the publication of the new 10-year plan whilst awaiting directions towards the route to sustained credible reform, via an updated Long-Term Workforce Plan (LTWP).

There is widespread consensus across patients, staff, and the Government that a change of direction is urgently needed. Continuing as before would evidently lead to the NHS collapsing in on itself. We also know people don't want to travel far from or lose sight of our traditional NHS model. Rather than demolishing to start again, there is a strong desire from patients, staff, and politicians to stabilise and renovate existing NHS structures – so that they can once again provide a positive, safe, and desirable place to work and be treated. There is no confidence in relocation or any renovation that doesn't showcase the principles and values underpinning both the NHS and the AfC structures. Around all this, there is a consensus of purpose.

This extends to a shared collective sense of urgency to make the changes happen and work quickly – in part because of recognition that other players loom in the wings who are opposed to the NHS's founding principles and values. Likewise, there is an implicit recognition across employers, the Government, and unions that staff patience is close to breaking point. Turnout and feedback in our consultations on the 2025-26 award resonated this frustration. Our members need to see urgent evidence of positive change being realised – preferably to both their core pay and to their working environments.

The Government has so far offered little to no clear direction about how they'll support renovation of AfC structures, including modernisation of pay and reward. It is some relief that the Government is not trying to impose its own ideas and solutions, given that they have neither the technical knowledge, skills, nor expertise to deliver structural renovation of this scale and complexity. Instead, they are relying on Staff Council to lead, recognising the strengths within and across the Council – including the knowledge gained from having already repeatedly surveyed and mapped systemic structural flaws.

What we don't know is how willing the Government is to commit fully to the project and all of the necessary renovations, or, as the project owner, how much they are willing to invest once the Staff Council reaches consensus on the right solutions.

What is also clear is that we don't know how long it will take the Staff Council to reach a consensus around solutions, not least because their range of options needs to be guided by how much the owner (Government) is willing to spend on the renovation. As yet, no guidance on available resources is being presented by the Government.

Instead, we're seeing Government actions that, despite positive rhetoric about understanding the need for a new direction, in fact suggest there is still a strong pull towards continued chaos and collapse – for example, the mid-year requirement for huge spending cuts, with the inevitable side effect of job freezes (see more below), or the reactionary position towards future international recruitment.

This brings us to the PRB's role at this critical time. Most unions have decided not to participate in this year's PRB process. The majority view is that at this point:

- Primary importance should be given to reaching an agreement with the employers and the Government as the owners/funders.
- It is impossible to uncouple the costs of this and the need for ongoing pay awards.
- Governments are more likely to declare how much they can invest, over how long, and say how far they are willing to take the modernisation without interruption to the PRB.

The SoR would agree with much of this except the last point.

We know how much work needs to be done and how complicated the renovation work will be. Many of the identified issues have knock-on effects elsewhere in what are now hugely unstable structures. However, the NHS has to remain occupied and functioning whilst all the work is carried out. It would be naïve to pretend all of the Staff Side prioritise the same pieces. Some may potentially settle for only renovating their floor, or at least want to start and complete their pieces of the structure before moving on to other areas. Employers will also have different priorities that could conflict. Employers will also be especially cautious about committing resources they're not certain they'll have going forward – especially if blind decisions now impact their league table scoring and future resourcing in some unforeseeable way. In even recognising the urgency to get started on the structural reforms, there has to be a recognition that they will take time and care to get right.

The need for time and care will try various players' patience as well as the Government's courage and resolve. The SoR recognises how slow progress has been in addressing already identified structural concerns so far. We do not think there is any serious likelihood of significant outcomes being clear and ready to implement by April 2026. Our members' disappointment with the 2025-26 award has

also been recognised – especially around pay restoration. The 2026-27 award saw the gap between our member pay and average total pay growth across the whole economy since 2008 widen rather than close.

We don't believe we can, or should try to get well into 2026-27 without a basic pay award. Moreover, we think we need an early award in 2026 that will support the positive change of direction by reinforcing support for the longer-term structural repairs. Without a positive recommendation from a PRB, this seems, to us, to be highly unlikely to happen for April 2026.

Therefore, we believe there continues to be a useful role for the PRB in 2026-27. As a body, the Government publicly continues to hold up as a credible and independent voice; you've a duty to actively support this work by offering positive guidance and support around the areas identified as needing to be addressed. This is very definitely not to suggest the PRB should offer structural solutions. However, you are tasked by the Government to make recommendations around what needs fixing, and they are obliged to consider funding your recommendations. Whilst structural solutions are yet to emerge, it would be a missed opportunity not to continue to add weight in support of positive reforms.

Most importantly, whilst the Staff Council discussions continue, the PRB will have an opportunity to make the case for starting pay restoration now, and building this into longer-term funding models. This is a principle where there is widespread consensus. Pay restoration has to happen to stabilise any pay and reward structure. It is the rot that needs to be removed, or it will immediately undermine any renovation work. Starting to address pay restoration is the obvious and important recommendation any independent PRB should be making in 2026-27. Doing so could add important momentum to the discussions between Staff Council and Government, as well as encourage NHS staff to remain positive and patient whilst plans for their new NHS emerge.

Beyond 2025-26, we also see a long-term role for the PRB – albeit we would potentially welcome a long-term negotiated approach to finishing pay reform that could justify a pause, as we saw in 2018. Once the core tenets of what is needed are agreed and the Government commits to adequately funding these, it would be possible to collectively negotiate our way to a new starting point.

However, if and when the renovation work is safely completed, the structures will again need to be maintained, and lessons will need to be heeded about how we have ended up in such a critical position.

The SoR recognises that the Government is the single source of funding for reform to both basic pay and AfC structural repair and renovation. Part of the reason why the pay gap has arisen is that PRBs have repeatedly failed to assert any independence from the Government and too readily accepted imposed pay restraint. To our members, this looks like the PRB has endorsed the strategic failure to invest in maintaining a safe, modern, and sustainable AfC structure. We don't believe the PRB has worked well, if at all.

However, that doesn't mean we would have been more successful if we had been negotiating directly with various Governments between 2008 and now. Whilst the PRB has failed to assert the necessary level of independence over Government, the real blame for the underinvestment has to rest with Governments. Our members have seen their relative pay fall and general conditions worsen because of the Government's choices.

It would be a leap of faith to think it will not always be difficult to negotiate with any elected Government who will always have conflicting priorities that pull them towards decisions that have the most impact in the political short term. We also know that different pressures will emerge across the Staff Side, and the risk of ongoing industrial conflict between unions and the Government will be a constant, unless there is a safety valve provided by some (albeit genuinely independent) body to guide.

SoR members had long supported the principle of a PRB process, allowing us to influence the collective Staff Side discussion whilst highlighting the specific radiography case. Therefore, by submitting evidence this year, we are indicating our continued support for this principled position even whilst recognising that some work needs to be urgently undertaken aside from the traditional parameters of the PRB remit.

2. Impact of the 2025-26 Award

With the PRB process being brought forward and the payment of the 2025-26 award being delayed, albeit by less than in most recent years, it could be considered too early to judge the impact of the 2025-26 award on staff morale, recruitment, and retention.

However, by looking at the award against a number of economic and wider environmental factors, we can confidently assert it has at best amplified the concerns we raised in last year's evidence. In some issues, it has had a negative impact on recruitment, retention, and the staff morale of our members.

The 3.6% award was a relatively straightforward flat rate increase across most grades. The exception to this was at the lower end, where early payment and adjustments had to be made to accommodate legal requirements linked to the National Minimum Wage. This also further exposed weaknesses in salary sacrifice

options, especially impacting the lowest-paid NHS workforce. These requirements have amplified how low-paid these members are and how uncompetitive an employer the NHS still is. If there were merely another overall award barely matching Consumer Prices Index (CPI), this problem would recur in 2026-27, unless it can be resolved in structural discussions ahead of April 2026.

The award was oversold by the Government. It was presented as above inflation and showed a commitment to recognising the value of the NHS workforce. It was above the level they had said they wanted to pay in their evidence. However, in no way can the award be credibly described as fair, never mind generous.

Whilst there was little immediate appetite amongst members to oppose the award, our members' reaction in our consultation was marked by a resounding lack of enthusiasm. We know this was reflected across other AHP unions, with lower than usual turnouts to the consultation and a higher proportion of those responding in pay surveys saying they did not think it was an acceptable award. In England 60% voted yes, 40% voted no. In Wales 75% voted yes and 25% voted no.

As we have seen, its value has been overtaken by inflation, at 3.8% by the time it was implemented in England and Wales, and widely expected to continue to rise at least to or beyond 4% in this financial year. Whilst political opponents attribute much of rising inflation to the Government's increase in employer National Insurance (NI) contributions, we especially note reports from food retailers UK inflation rises by more than expected to 3.8%, largely driven by air fares - BBC News recognising much of the increase so far has been because of rising import costs linked to external factors such as climate issues or tariff uncertainty. These will continue, whilst the impact of the NI rises for employers may have been largely contained up until now, so it remains an ongoing inflationary risk.

Further, the relative value of the 3.6% has been undermined by it being lower than any recommended and made to other PRB groups (except for the senior salaries group). This may be because the NHS pay date is earlier, and an unhelpful side effect of the award being settled marginally earlier last year. One of the structural considerations should be whether all public sector awards are coordinated to a date midway through the year. This could also help stabilise marginal issues, such as those relating to the National Minimum Wage, if the increase for the following April was already known and could be factored into all the public sector awards. A settlement date in September or October could look forward more easily than back. Of course, any change would need to be covered by an award for an extended period up to the change of pay date.

In the meantime, the impact for NHS staff is that they've fallen further behind other public sector professionals. The issues we've raised previously regarding the relative competitiveness of NHS salaries have been amplified to the AfC workforce. The pay gap to the rest of the wider economy has grown, hugely undermining confidence in the new Government's messaging about valuing the NHS workforce.

Table 1 is an updated version of our Pay Restoration Tracker, presented in our recent PRB evidence submissions. It shows the changes to pay rates by AfC band since 2008. The final column shows how the change at the maxima of each band relates to corresponding changes in average total pay across the whole economy over the same period. When considering recruitment and retention, namely how competitive working in the NHS is to other choices, this figure is as important as CPI or any other inflation measure, as it measures how your pay and reward compares to those around you.

	2008			2025-06			Difference	Increased		% Difference		
Band	**Min**	**Mstart**	**Max**	**Min**	**Mstart**	**Max**	**Min**	**Mstart**	**Max**	**Min**	**Mstart**	**Max**
1	12517		13617	24465		24465	11948		10848	95		80
2	12922		15950	24465		24465	11543		8515	89		53
3	14834	16307	17732	24937		26598	10103		8866	68		50
4	17316	18385	20818	27485		30162	10169		9344	59		45
5	20225	21373	26123	31049	33487	37796	10824	12114	11673	53	57	45
6	24103	27191	32653	38682	40823	46580	14579	13632	13927	60	50	43
7	29091	33603	38352	47810	50273	54710	18719	16670	16358	64	50	43
8a	37106	39896	44527	55960	58487	62682	18854	18591	18155	51	47	41
8b	43221	46782	53432	64455	68631	74896	21234	21849	21464	49	47	40
8c	52007	55806	64118	76965	81652	88682	24958	25846	24564	48	46	38
8d	62337	66790	77179	91342	96941	105337	29005	30151	28158	47	45	36
9	73617	80883	93098	109179	115763	125637	35562	34880	32539	48	43	35

ADJUSTED TO 1st April 2025									
AWE:	Apr-08	£404			Total Pay	Apr-08	£432		
	Apr-23	£600	48.50%			Apr-23	£652		
	Apr-24	£640	6.70%	**Total = 58.4%**		Apr-24	£686	5.40%	**Total = 59%**
	Jul-24	£647	60%			Jul-24	£689	59%	
UPDATED	**May 25**	**£677**	**67.6 or 68%**			**May-25**	**£722**	**67%**	

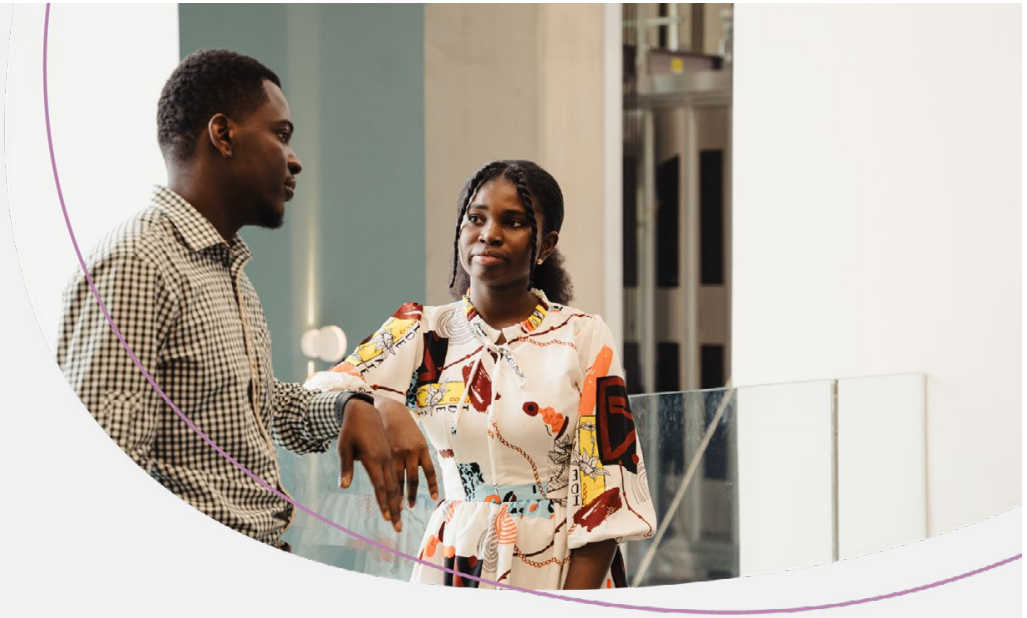
Source: [Average weekly earnings in Great Britain - Office for National Statistics]

The latest available figure at the time of writing is 67%. This means every active band in AfC has a relative pay gap of at least -14% since 2008. For most radiographers, the gap is -24% to -26%, or around 1/4. For someone aspiring to senior leadership, the relative drop in reward is approaching 1/3.

This is not credible or sustainable. NHS professionals will not trust or engage with anyone who says they value their contribution whilst continuing to propose headline pay awards that fail to start closing this gap. We understand the majority position that the PRB should be parked up for this year and that the Government should address this directly. However, there is a significant risk in no award being proposed whilst negotiations continue. This risk builds enormous additional pressure inside the negotiations.

As the Government has not stood down the PRB and they are still clearly expecting you to make recommendations, we believe it is essential you guide the Government by recommending an immediate award that starts to close the gap.

Further, the PRB should publicly support calls from a number of unions, including the SoR, for a commitment to fully close the pay gap by the end of this Parliament (July 2030). This was reflected in a motion passed unanimously at this year's TUC. Achieving this should be part of the PRB remit until 2030, along with preventing it from re-emerging over the rest of the 10-year plan and beyond.



3. Duty on the PRB to support Gender Pay Equality and close gender pay and pension gaps

As mentioned above, the 3.6% award turned out to be lower than any recommended and made to other PRB groups (except the senior salaries group). Our members are particularly aware that it was lower than the Review Body on Doctors' and Dentists' Remuneration (DDRB) recommendation for doctors and dentists (4%). Since the end of the pandemic, doctors and dentists have seen noticeable inroads into their pay gap. This is inevitably widening both the NHS gender pay gap and the NHS pension gender pay gap.

Any Government or PRB serious about its responsibility to address pay inequality should be concerned by those covered by the DDRB pulling even further ahead of AfC grades.

The gender pay differential goes deeper than changes to the headline rate, but consistently awarding groups with higher densities of men comparatively higher basic pay awards can only increase the gender pay gap. Whilst this continues, women members of the NHS workforce (including over 3/4 in the AfC bands) will view any wider rhetoric from the Chancellor, Ministers, or members of their PRB about wanting to promote gender equality with cynicism.

The NHS is the largest source of 'good and stable jobs' in many towns and one of the largest employers in most regions of England and Wales. For example, in the South West, the NHS employs more people than the population of Exeter. In the same way as improving basic pay can boost local and regional economic spending in the short to medium term, entrenching pension inequality will have a generation-long impact with wider, longer-term economic and social costs, embedding inequality.

Therefore, the NHS PRB should also make specific reference to AfC awards, catching up recent DDRB awards, and support for factoring into future awards, closing the NHS gender pay and gender pension gaps.

The NHS pension scheme gender gap is one with growing political concern and interest. The gender pension gap in the NHS scheme is 63% as opposed to 47% in the civil service and 29% in the Teachers' Pension Scheme. Any recommendations from the PRB (and other pay review bodies) should be coordinated and risk assessed by Ministers for their impact on pensions and the gender pension gap.

The pension reforms in 2015 can in part be justified by the evident inequalities built into the old final salary model. By design, final salary schemes rewarded multiple career promotions from which men benefited disproportionately. The reforms also aimed to flatten the impact of women comparatively losing out during periods of working part-time. By continuing to exclude overtime from pensionable pay in the NHS (an exception to most other public sector schemes where overtime is less frequent) whilst allowing all pay up to full-time equivalent levels to be pensionable, the new model is meant to be fairer and more equitable.

However, there are concerns that this may not be playing out as planned. The NHS pension scheme is continuing to see higher opt-out rates than ever before. These are disproportionately in AfC grades compared to those covered by the DDRB. They are also disproportionately highest amongst the lowest paid, Band 5 new professionals, and amongst those working on bank contracts – including the NHS-owned NHS Professionals company. These groups all have a significant gender imbalance.

The other group where this is evidenced is the internationally trained workforce, which we discuss more about below.

It really shouldn't be that surprising that these groups are disproportionately opting out, even setting aside evidence that employers and the NHS Professionals organisation are implicitly failing to promote scheme membership, especially to those on the Bank. Saving for a rainy day when it's pouring down now and you

can't afford an umbrella is a difficult choice to make. Trust in your employer and/or the Government to honour a pension promise is also undermined by memories of the conflict accompanying the reforms between 2013 and 2015 and recent administrative challenges, e.g. around McCloud implementation.

These issues have not had the attention needed. The NHS can't afford to shrug collective shoulders around this, not being surprised or considering pension inequality to be in the too difficult pile. Pensions are a critical part of the overall NHS pay and reward package. In the new scheme, someone who opts out for a period loses even more proportionately than in the old model, as their relative loss is literally compounded into their CARE pension.

Whilst the PRB remit does not and should not extend to fixing this, it does and should extend to highlighting the concern and the impact of continuing to ignore its impact on recruitment and retention.

4. Other problems with how the pension scheme is perceived

The PRB is not in a position to directly intervene to correct the pension problems identified here, but it is in a position to highlight and amplify this genuine concern to the Government by making recommendations about areas of the pension model that need to be considered as part of long-term structural reforms. Gender unfairness is only part of the side effects of pensions being an afterthought for NHS pay awards since the 2015 scheme was introduced. In a number of areas, we believe there is a perception that the scheme is either unfair and/or too expensive, and that this is likely already impacting opt-out rates.

High opt-out rates eventually start to undermine the viability of the scheme. If parts of the NHS workforce need significant additional support in retirement due to insufficient workplace pensions, as a consequence of even periods where they have opted out, then this also increases costs on the wider public purse and confidence in pensions generally. In the meantime, any perception that the NHS pension scheme is unaffordable and/or uncompetitive is bad for recruitment and retention.

The biggest challenge for the NHS scheme is that members all pay too much, relative to other public sector schemes. There is no obvious or evident justification in the benefits provided by the NHS scheme to explain and account for why the NHS workforce has to contribute so much more to the pension scheme than others in unfunded public sector defined benefit schemes.

Paying around £1 in every £10 of your earnings into a pension scheme is less of an issue if your earnings are such that you can view this as part of wider affordable savings for your retirement, but if your pay has consistently been devalued relative to the rest of the economy and you're struggling to cover basic costs every month this becomes harder to afford and so to justify. This is the position for almost all NHS band 5s after 2 years, given they'd need only £381 in

on-call, out of hours, or unsocial hours allowances to cross the 9.8% threshold. The vast majority of AHPs pay between 9.8% and 10.7%.

Latest NHS Business Services Authority (NHSBSA) data shared with the Scheme Advisory Board in September 2025, shows a national opt-out rate amongst Band 5s of 18.8%. Below we share our tracking of the impact on pay awards of a notional new professional radiographer entering their 3rd year in the NHS in Salford Home.co.uk: Salford Local Property Information. One of the pressures on their finances is whether they can afford to remain in the pension scheme. It's plausible they could be persuaded by a sales pitch around the value of the pension scheme in 4 ½ decades time. But that will inevitably be undermined by them finding out how much more they are having to pay than school and university friends who have instead entered other careers. A new graduate teacher will enter their profession with a pay lead of around £3800 p/a on the newly qualified radiographer and will initially pay 7.4% into their pension compared to our radiographers' 8.3%. After two years, our radiographer would need to wait for promotion to Band 7 before their teacher friend was paying the same percentage into their pension scheme.

The comparison with the local government or civil service schemes is even more stark – again with virtually no obvious additional benefit in terms of accrual or scheme flexibilities. A graduate entrant in the Civil Service Pension Scheme (PCSPS) would be paying 4.6% to stay in their scheme, and someone earning the same in local government would be paying 6.5% for membership of the LGPS.

This is repeated for the vast majority of NHS AHPs – for example, someone at the top of Band 7 needs to pay 10.7% into the scheme, whereas someone earning the same in local government would be paying 6.8%. Someone earning the same in the civil service would be paying around ½ as much, 5.45%.

This begins to feel like an additional NHS Pension tax for the 'benefit' of working the longest hours with the least flexibility and most difficult working conditions. It certainly isn't the incentive it should be to stay in career-long membership of the NHS.

London Weighting and Pensions

In our evidence last year, we also introduced our concern about pension opt-outs in London, an area where recruitment and retention into the AHPs is especially challenging. London weighting is meant to offset some of the additional costs of living or commuting into London and has historically provided some incentive for early-career professionals to start their careers there. However, some of the incentive is eroded by the pension thresholds not being adjusted for London weighting. We believe this is a factor in high London opt-out rates (alongside high use of Bank staff and higher concentrations of international recruits who also tend not to opt out of the scheme disproportionately (see more below)) – around 20% for most of 2025.

It can be argued this is as much a perceived unfairness as a real one, but the perception counts if it prompts someone to opt out of the scheme, even for a period. For example, it would take a lot of explanation to clarify to someone working at Band 3 or 4 in inner London why it is fair for them to pay 8.3% when others doing the same roles are paying 6.5%. If you extend this across the wider public sector schemes, then the perceived unfairness translates to a genuine problem. A Band 3 radiography assistant in a busy central London hospital pays £2673 into the NHS pension scheme. That this is more than someone earning £45,000 a year in the DHSC is expected to pay into the civil service scheme defies fairness and reason.

5. The Workforce Crisis Continues Unabated

In the SoR's most recent PRB evidence submissions, we have highlighted the workforce crisis gripping the NHS. Last year, this included extensive reference to the findings of the most recent NHS Staff Survey, alongside our most recent Workforce Conditions Survey, which highlighted why people left the NHS to work in the independent sector.

The 2024 NHS Staff Survey again provides grim reading and insight into what a difficult and unhealthy working environment our members have to experience to support patients. As stated above, whilst paying a reward is only part of the causes for the workforce crisis, they are an intrinsic element of the cause of unsafe staffing levels, concerns about flexible working opportunities and healthy work-life balance, opportunities to train, and lack of confidence in career progression within the NHS. They will also have to be part

of the solution to improving culture so that it feels safer and more secure for staff, and consequently, patients. The 2024 NHS Staff Survey's key findings include:

- Only a minority (47.3%) continue to say they can meet all the conflicting demands on their time
- Only around ¼ (27.1%) said there were never or rarely unrealistic time pressures on them at work
- Only just over 1 in 3 (34%) said they had enough staff in their area to do their job properly
- Over 1/3 (36%) said to some extent they'd be unhappy with the standard of care provided by their organisation for a friend or relative
- More than 4/10 (41.6%) said they'd felt unwell as a result of work-related stress in the last year
- A majority (55.8%) said they'd gone into work in the previous 3 months despite not feeling well enough to perform their duties
- Less than 1/3 (32%) say they are satisfied with their level of pay
- A minority (44.4%) said they were satisfied with the extent to which their organisation values their work
- Only just over ½ (55.9%) said their organisation acts fairly with regard to career progression and promotion
- Only just over ½ (54.6%) said they were content with the opportunities to develop their career in their organisation, a lower figure than in 2023
- Less than 2 in 3 (61.8%) said they felt safe speaking up about anything that concerned them in their organisation, also a lower figure than in 2023; and
- A minority (49.5%) had confidence in their organisation to address a concern they raised.

We are due to repeat our Workforce Conditions survey later this year, with results expected in early 2026. In the meantime, we are seeing no reason or evidence to think there are grounds to be less concerned since our evidence was submitted 9 months ago.

Vacancy Rates remain high

Where we do have updated staffing data since presenting last year's evidence, we see that the vacancy rates remain a critical concern. The NHS's own latest data shows the total number of vacancies at 102,576 – higher than the end of Q4 in March 2024. The number of AHP vacancies has fallen since last year, but remains higher than when we submitted our PRB evidence in November 2024. This doesn't take into account any deleting of vacancies, meaning the 'real vacancy rate' is likely to be higher still.

Our National Conference for Radiology Managers report in the final quarter of 2024 showed 40% of managers reporting a freeze on some department posts, and 41% reporting that workforce retention was negatively impacting service delivery. This evidence was collected before the additional recruitment freezes were imposed across England following the call from the DHSC on ICBs to implement 50% in-year budget cuts.

Diagnostic vacancy rates remain at 14.9% in England and 15.3% across Wales. Our manager members report vacancy rates in Band 5 posts now reaching 24.8% and 18.8% amongst Band 4 radiographer support workers. Below, we talk about vacancies in sonography being much higher still, with stark regional variations.

We are still examining evidence of how many newly graduated radiographers and radiotherapists are still to secure their first new professional posting. Anecdotally, this is happening in several parts of the country. It is a new and irrational problem. The number of course places was expanded to accommodate these students because of an identified need to grow the radiography and radiotherapy workforces to meet known rising demand. Yet there are no jobs immediately available as they approach graduation.

Not training enough graduates is still a problem for the NHS and patients, so creating avoidable barriers that risk losing those who do graduate as they enter the profession is self-defeating. New graduates not finding stable employment obviously increases the risk of losing jobs permanently. Our evidence last year highlighted research showing how newer radiographers are especially prone to leaving the profession when the reality of the role fails to meet their expectations and the professional promise made when they chose radiography (Retention of radiographers in the NHS: Influencing factors across the career trajectory - Radiography radiographyonline.com). Job freezes prompted by short term ICB budget cuts add further pressure on new graduates. Those forced to start their careers in temporary posts without a stable working pattern and environment for any organised preceptorship, will also be at risk for the same reasons. Basic pay on entry is already uncompetitive and difficult in reality to live on independently (see more below), but expecting a new graduate to stick at it for long if their income is even lower and less stable is also unsustainable and self-defeating.

6. Demand continues to outstrip supply

The risk of losing new professionals is further amplified by the realisation that demand for radiotherapy and diagnostic scans continues to rise ahead of supply. For example, the NHS's latest diagnostic waiting time data (July 2025) continues to highlight the scale of the workforce and waiting list challenge. In July 2025, there were 2,608,700 diagnostic tests performed across the NHS in England. This was an increase of 98,500 or 3.9% in July 2024. However, there were 1,730,900 people awaiting a diagnostic test, up by 103,600 in July 2024. In other words, despite our members carrying out almost 100,000 more tests than last year, the waiting list rose by a further 100,000.

Most critically, the number waiting more than 6 weeks remains desperately high at 378,800 – 21.9% of all those waiting for a test. The statutory target is 1%. This figure is 15,000 more than in July 2024, even though it is 0.5% lower as a percentage of the overall total of people waiting. These figures vary depending upon what imaging you need and where you live in England, with almost 1 in 4 (24.8%) of patients waiting 6 weeks or more for their tests in the Midlands and 29.8% in Eastern England.

Whilst some good progress is being made in reducing the numbers waiting more than 6 weeks for certain scans, such as DEXA (down 6.3%) or MRI (down 3.1%), those waiting longer than 6 weeks for a non-obstetric ultrasound scan increased by 1.4% to 19.1% (see more on ultrasound challenges below).

The total number waiting for MRI scans increased between July 2024 and 2025 by 6.2%. Those waiting for a non-obstetric ultrasound test increased by 10.1%. We don't currently have official NHS data on pressures impacting radiotherapy demand, but we can find no evidence of any let-up in the rise in demand for cancer treatment, and we remain concerned about the prolonged impact of COVID on waiting times for diagnosis, treatment, and cancers having progressed during the delay in diagnosis and treatment.

Therefore, it is critical that the NHS has a successful strategic plan to grow the radiography workforce at all levels across all of its specialisms. Whilst we await publication of a revised workforce plan, all evidence indicates a continuing need to grow the workforce across all areas of radiography, radiotherapy, and clinical imaging at the same rate consistently identified as being needed over the last

decade – namely, around 7% p/a, culminating in doubling the pre-pandemic workforce by 2035.

For this growth to be realised, the NHS needs to do much better than it has been, and there are serious concerns for each of the following groups, where existing and in some cases new barriers to recruitment and retention are evident.

In each, we can see identifiable strategic barriers relating to strategic planning and basic reward. These both need to be urgently addressed.

7. New Professionals

One of the key structural changes urgently needed to support radiography involves securing quick and structured progress to band 6 as soon as is possible, via a national preceptorship scheme. We continue to actively support extending the use of Annex 20 to facilitate this, alongside giving active support to establishing the content of such a preceptorship.

This in itself doesn't negate the need to again examine how and why starting pay at band 5 has only increased by 53% since 2008, a devaluation of 14% against total pay across the wider economy in the same period. This is a further 3% widening of the pay gap since 2024-25. This translates to a shortfall of £3415. Since 2008, Band 5 starting pay has increased by a smaller percentage than any band below Band 8. It looks like reducing the value of AHP new professionals' starting pay has been a targeted, deliberate, and sustained choice by Governments and the PRB. This undermines any credible message about understanding and seeking to address recruitment and retention in AHPs.

The gap at the Band maxima for those who don't make or continue to await opportunities to progress into Band 6 is even greater – 22%. This translates to £8315 p/a. This figure is only £469 short of the current maximum for Band 6.

We repeat what we have said in our recent PRB evidence about the importance of new professionals and band 5 pay. The additional financial and emotional pressures on this group are significant. Many have to move away from their homes to work in their first jobs, with housing deposits and accommodation start-up costs to be incurred. We have identified mature students with families who have been made homeless from not being able to meet rising rents out of their frozen pay packets.

Our analysis tracking the real-terms disposable income of the notional typical 3rd year Band 5 living in shared rented accommodation in Salford highlights some important pointers for the PRB (see annex). This tracking data showed that 2024 was the first year since we began tracking in 2021 that the real disposable income had increased in real terms, by £8pw. However, this assumed their pension payments stayed the same and they were not earning the few £100 a year in pensionable allowances needed to still cross the pension threshold on reaching their first progression step.

Largely because of lower NI contributions and evidence that rents have peaked in the North West, it is possible to see further improvements – we think our notional third year graduate professional would have £169 real disposable income left a week after deductions and core bills. This would be £46 more than last year, but only £19 a week more than September 2022, before the steep inflation rises. This £169 a week needs to cover food, clothes, wider travel, further study costs, and any savings for holidays or future life events. Food inflation is currently 5.1% having risen for each of the last 5 months.

Especially if Governments are relying on replacing internationally trained AHPs with more homegrown graduates, their offer, from their first day to the day they retire, will need to be more competitive and sustainable. A range of options should be considered - including student loan write-offs and pension contribution holidays, especially to work in hard-to-fill geographical areas of shortage, AHPs areas, alongside competitive basic pay rates.

But most importantly, the PRB should signal now an acceptance that years of undervaluing Band 5 pay by design, even in comparison to the rest of AfC, has been a mistake and one that a) cannot be repeated going forward and b) needs to be quickly rectified in the parallel structural reforms.

8. The Imaging Support Workforce

Assistant Practitioners and Imaging Support Workers were identified in the last Government's long-term workforce plan (LTWP) as critical groups to retain and grow. With demand continuing to rise faster than we have been able to grow supply, we anticipate this being even more prominently stated in the imminent new Workforce Plan. The SoR has long supported expanding and advancing Assistant practitioners and Support grade staff. We believe there is enormous potential to grow from within – something also recognised by the Richards' Report NHS England » Diagnostics: Recovery and Renewal

– Report of the Independent Review of Diagnostic Services for NHS England. There are numerous examples of excellent practice we can point to, whilst highlighting the frustration associated with a hugely uneven geographical spread of assistant and support grade staff across different regions. However, for this potential to start to be realised, more needs to be done to improve pay and reward.

We remained concerned by some Trusts that are holding back some radiography support workers in Band 2 roles. Saving money by deliberately devaluing roles at the lowest end of the AfC scales is unacceptable and should stop. Where this continues, it will remain a source of dispute and disruption until it is addressed.

We also continue to see examples of inconsistent banding between Trusts. In most Trusts, key support roles in screening programmes are carried out by Band 3 trained support workers, whilst in other Trusts, almost identical work is paid at Band 4. This happens as local Trusts utilise job evaluation to find a way around recruitment and retention challenges in the local area, whilst other Trusts resist calls for re-evaluation, saying they can't afford it, and if successful, they'd simply have to reduce staffing numbers or flexibility. These local issues can be addressed with more support nationally for improved job evaluation, but the best solution would be to recognise and tackle the cause rather than the symptoms – namely unfair and uncompetitive pay rates.

Strategically growing this part of the radiography workforce won't happen if the motivation for doing so is merely to secure a cheap workforce. The SoR has identified that whether our support workforce members are Band 3 or Band 4, they are aggrieved about being underpaid and undervalued.

Pay progression within Band 3 was 16.4% from minima to maxima in 2008. Progression across Band 4 was 14.9%. The difference between the minima and maxima in Band 3 is now just £1661, or 6.7% of the minima. In Band 4, the difference is only £2677 or 9.7% of the minima. In the same period, the Band 3 minima is the last point on the AfC pay ladder where pay has increased in line with average earnings across the whole economy since 2008, rising by 68% against a 67% average increase. But the cost of maintaining the relative value of starting pay has been to cap progression. Band 4s have been caught up in this, with their starting pay now 8% behind where it would have been relative to 2008.

The cap on progression of course highlights the pay gap at the Band 3 and Band 4 maximas. In Band 3, the pay gap is now 17%, or £4522 p/a. This would be more than the current starting pay for a Band 5 new graduate. In Band 4, the pay gap is now 22%, or £6636 p/a or £553 p/m. Little could amplify the strategic failure underpinning AfC pay and reward by the PRB and Governments than how much they have devalued pay near the bottom of the AfC ladder.

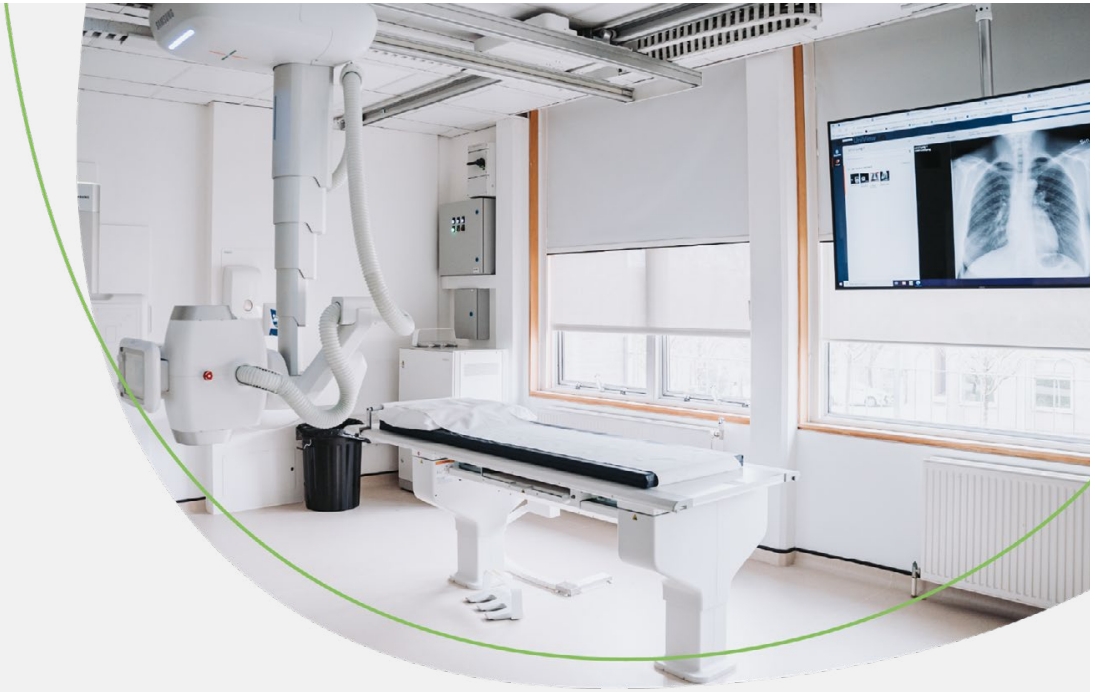
This devaluation is having a real impact on recruitment and retention. These are important, critical, skilled roles where our members are supporting the delivery of critical screening programmes. The NHS 10-year plan means we will continue to need more of our support

worker members in community and prevention roles, including in areas like mammography. This won't happen if the NHS remains blind to their importance and potential – or if they can continue to earn more in less pressured and more flexible roles, where they are more valued and where they see better longer-term career prospects in other parts of the economy, such as retail.

9. Competing Internationally for Trained Imaging Professionals

As set out above, and explained in our annual PRB submissions, there is a critical need to continue to grow the radiography workforce. Beating waiting lists and supporting earlier diagnosis depends upon it. Whilst the NHS continues to face challenges recruiting and retaining radiographers with competition from the independent sector and to some extent globally, there has been some useful progress in growing the available potential workforce, as measured by the number of qualified HCPC radiographer registrants. However, this growth has been massively reliant upon internationally trained radiographers wanting to come to work in the UK.

Since around 2018, there has been a broad consensus that the radiography workforce needs to grow by around 7% p/a. Whilst this isn't all translating into the NHS workforce, the number of HCPC-registered radiographers has grown steadily since from 36601 in August 2020 to 49953 in August 2025 www.hcpc-uk.org/data/the-register/register-over-time. This amounts to a 36.5% increase.



Recognising a sharp spike in 2023, this averages around the target at 7.2% – although the growth rate has dropped to 5% since August 2024. Sustaining this rate of growth until at least 2035 will be essential to defeating diagnostic waiting lists and meeting cancer treatment targets.

This growth has been massively reliant on increasing the number of internationally trained radiographers registering to work in the UK. In August 2020, this covered 5838 registered diagnostic and therapeutic radiographers, 16% of the total. By August 2023, this had more than doubled to 12526. In August 2025, the figure stood at 14460 or 29% of all HCPC-registered radiographers. This means 8622 more internationally trained radiographers were registered to work in the UK with the HCPC in August 2025 than five years earlier. This means

65%, almost 2 in 3, of the growth in registrants is internationally trained.

It doesn't follow, of course, that all these registrants are in fact working in the UK. What it does show is that Britain must compete globally for highly skilled critical professions who are in short supply across the globe. Rationally, we would be recognising the opportunity to compete in this global market and especially the advantage the English language provides to those training in countries such as Australia, New Zealand, India, and Nigeria. Rationally, we should be putting together targeted packages that enhance the chances of these international talents choosing the UK over other options – for example, by including support with securing accommodation, school places for children, and jobs for partners if needed. This would be enhanced by a soft landing in the workplace and a supportive extended induction and professional assimilation programme that recognises there are bound to be important differences in practice, procedures, and culture between their home country and the UK. This is what any business competing internationally for a shortage of high-skilled professionals knows and does.

However, reason is in retreat. We have previously reported examples of poor treatment bordering on exploitation of internationally recruited radiographers in the UK. However, the prospects have got significantly worse since the publication of the NHS 10-year plan and early indications around core elements of the new Workforce plan. The new stated aim is to reduce the reliance on internationally trained radiographers during the period of the 10-year plan, with a target of no more than 10% by 2035. This new hostile strategy is further reinforced by the Immigration Bill. For example, extending the time taken to qualify for an indefinite right to remain to 10 years will provide a major disincentive for any mother to move to the UK if her children are approaching secondary school age and so cannot guarantee securing British residency before they apply for university.

Put plainly, this is a bomb underneath any workforce plan that will destroy any prospect of meeting the Government's own waiting list targets – an act of self-sabotage the likes of which the NHS has possibly never seen. The maths required to achieve the target simply doesn't add up, especially if we're to continue growing our workforce at the rate we know is needed to safely manage the ongoing rising demand. We would need to almost immediately stop any additional overseas recruitment whilst magically increasing the number of graduates immediately entering the workforce – when they're not in training yet!

Worse still, reinforcing the hostile environment will not just put off those currently overseas and thinking about moving to the UK. The racism underlying this policy shift is already empowering NHS staff and users to challenge and abuse all black staff and especially black women NHS workers. This makes the NHS a less attractive employer for all potential recruits. However, our own research into changing SoR membership shows a growing proportion of new professionals also appearing to be of non-white British or white European ethnicity, including a continuing proportion of around 3 in 4 being women. It isn't plausible to believe that active measures

to make recruiting young black women professionals from overseas will not make potential young black women professionals from the UK consider any option other than working in an openly hostile environment and culture?

Therefore, the SoR urges the PRB to openly recognise the risk involved in this change of strategy. The PRB must assert any independence you have left and urge for a more honest, credible, and positive approach from the Government to international recruitment into the NHS, especially in radiography.

10. Sonography and Mammography

For a number of years, our evidence has sought to highlight how the radiography workforce crisis is playing out through 2 modalities – Sonography and Mammography. These are critical specialist areas. Direct entry routes via apprenticeships are in their infancy, and patients are still reliant on either the NHS's ability to grow more from within or recruit directly from overseas. The pattern of our evidence has highlighted how the NHS has been poor at the first, making us even more reliant on the second, which the Government now seems to want to shut down.

Accordingly, the strain on these groups of members is intense. Nightingale et al[i] cites Mammographers and Sonographers as two of the groups most likely to leave in later career due to burnout and injury in the NHS. This is supported by SoR evidence in successful

personal injury claims, the vast majority of which involve these two groups of members, despite their making up about 1 in 10 of our overall membership.

Sonography is always at the top of imaging vacancy rates. SoR research indicates sonography vacancy rates average at 27.4% nationally, but are 48% in Wales, 42% in London, and 38% in the South East. In other regions, we believe vacancies have been deleted in favour of agency hires or outsourcing to the independent sector at far higher costs. The normal advertised rates for qualified agency

[i] Retention of radiographers in the NHS: Influencing factors across the career trajectory - Radiography (radiographyonline.com)

sonographers and mammographers appear to be between £55 - £65 p/h, depending upon experience across each region of the UK. They can pick their hours. Additionally, National Imaging Board data has suggested that close to 1 in 3 sonographers are approaching or beyond 60 when they can retire with full access to most of their pension.

Both modalities generate high interest amongst diagnostic radiographers, but barriers to training prevent progress in both – we continue to hear examples of Band 6 radiographers being told they'd have to take pay cuts to Band 5 for the duration of the training to help cover departmental budget pressures arising from releasing them to train as mammographers. Our research also indicates there are fewer sonographers in training now than in 2019, when 78% of managers responding to our survey said they had at least 1 person in Consortium for the Accreditation of Sonographic Education (CASE) training compared to only 64% now.

As well as being a prime source for agency costs, this is also coming at a cost to patients and the reputation of the NHS. Non-obstetric ultrasound scans (NOUS) are at the top of the waiting list tables. In July 2024, there were 568513 people waiting for a NOUS. 17.7% had been waiting 6 weeks or more. In July 2025, the numbers had risen to 626123 waiting, a 10% increase in the last year. 19.1% had been waiting 6 weeks or more, an increase of 1.4%. This is despite an increase in the number of scans being performed each month, rising from 771768 to 795048.

We can't keep losing the battle to recruit and retain these key specialists. In such a competitive market, there will need to be a sustained strategic plan, but the first step will have to be sending a clear message to these professionals that their value and importance are genuinely appreciated. Pay has to be a part of that. In the last year, the pay gap increased from 21% to 24% across Band 6 and 7. Like other bands, both have been devalued broadly by the equivalence of 1 full pay band since 2008. Closing the pay gap would require an increase of £11,179 for those at the top of Band 6 and £13,130 at the top of Band 7. These may seem impossibly high, but the NHS is paying agencies or the independent sector the equivalent full-time salary rate of between £100,000 and £127,000 consistently.

If closing the waiting list is the key measure of success in the Government's 10 Year Plan and consequently a key driver for the new Workforce Plan, then it is clear they literally can't afford not to address pay restoration.

11. Managers and Leaders (Bands 8a and above)

Our recent evidence to the PRB has highlighted the importance of confident managers who can use their knowledge and expertise to guide accountable service delivery improvements in areas they understand. As radiography becomes ever more central to managing and controlling demand, supporting radiographers into senior leadership roles would be hugely positive for the NHS. However, in

2022, using Electronic Staff Record (ESR) data, we showed how the number of radiographers at Band 8b and above had flatlined since 2014, despite the relative growth in the total radiography profession over the same period. We can find no published evidence of any improvement since. Part of this will be because the pressures and working conditions mean people don't think they could do the job as well as is needed. Part of it will be inadequate rewards, making them question if promotion is worth the added grief.

Many managers continue to tell us they retain some direct clinical responsibility or often step in as cover, due to staffing supply problems. Our own pay research shows leadership grades in the grip of a long-hours culture. They are still expected to work excessive and unsociable hours but are not being paid any overtime.

The basic net pay increase for someone at the top of Band 7 moving into a Band 8a role is currently £13 a month (see annex). Even 1 additional hour paid overtime a month for the Band 7 would cancel the pay increase on promotion. Even with the reintroduction of the 8a pay step, the Net pay increase from the top of Band 7 is only £43 p/m. Almost all 8a first-line managers will still be taking home less pay than the radiographers they manage, accessing regular overtime. This has to be recognised and addressed by introducing paid overtime and addressing Pay Restoration as a priority for AfC managers and leaders.

The AfC pay gap is at its widest in managerial grades. There is a 16% gap between the size of 8a starting pay and its relative value against the whole economy in 2008. The gap widens to between 18-20% across the starting pay for 8b to 9.

At the band maximum, the pay gaps are even more stark – showing that Governments and PRBs have strategically devalued AfC management roles over the last decade or more. To close the pay gaps:

- Band 8a would need 26% more, or £16297;
- Band 8b would need 27% more, or £20222;
- Band 8c would need 29% more, or £25718;
- Band 8d would need 31% more, or £32654; and
- Band 9 would need 32% more, or £40204

At some point, if the Government and the PRB are serious about saving the NHS and addressing waiting lists and the workforce crisis, then these catch-up costs will need to be found. Every year, the

Government and the PRB fail to begin closing the pay gap the more expensive it gets to eventually fix, even if it doesn't widen as it did in 2025-26.

The numbers for individuals may seem high, but this is money the Government should have been expecting to pay if you'd merely maintained the relative value of these vital workers' pay against the rest of the economy. It also hides the inefficiency costs arising from reduced productivity and inefficiency arising from these managers having to struggle to contain chaos.

These workers are also taxpayers and members of the pension scheme, so some of the cost of closing the gap is offset by higher tax and pension contributions, and, like all NHS workers, people spend their extra earnings in their local economies.

Annex: NHS Pay Bands 2025/26

This annex presents the NHS Agenda for Change pay scales for 2025/26. Two formats are included:

1. Full Detail Replication – showing gross, net, monthly, weekly, hourly, and deductions per band.
2. Simplified Summary – showing gross and net annual pay with percentage increases.
3. Band 5 cost of living cost analysis 2023 and 2025.

1. Full Detail Replication

Band 3					
Stage	**Gross**	**Net**	**Monthly**	**Weekly**	**Hourly**
Year 1	£24,938	£20,178	£1,682	£388	£10.05
Years 2+	£26,598	£21,287	£1,774	£409	£10.60

Band 4					
Stage	**Gross**	**Net**	**Monthly**	**Weekly**	**Hourly**
Year 1&2	£27,485	£21,484	£1,790	£413	£11.02
Top	£30,162	£23,207	£1,934	£446	£11.90

Band 5					
Stage	**Gross**	**Net**	**Monthly**	**Weekly**	**Hourly**
Year 1	£31,647	£23,813	£1,984	£458	£12.21
Year 2	£33,488	£25,006	£2,084	£481	£12.82
Year 4+	£37,796	£27,770	£2,314	£534	£14.24

Band 6					
Stage	**Gross**	**Net**	**Monthly**	**Weekly**	**Hourly**
Year 1	£38,682	£28,310	£2,359	£544	£14.87
Years 2–4	£40,823	£29,712	£2,475	£571	£15.23
Years 5+	£46,581	£33,405	£2,783	£642	£17.12

Band 7					
Stage	Gross	Net	Monthly	Weekly	Hourly
Year 1	£47,810	£34,194	£2,849	£657	£17.52
Years 2–4	£50,373	£35,413	£2,951	£681	£18.16
Years 5+	£54,710	£38,494	£3,208	£740	£19.74

Band 8a					
Stage	Gross	Net	Monthly	Weekly	Hourly
Year 1	£55,690	£39,174	£3,298	£753	£20.09
Years 2–4	£58,682	£40,724	£3,393	£783	£20.88
Years 5+	£62,682	£42,888	£3,574	£825	£21.99

Band 8b					
Stage	Gross	Net	Monthly	Weekly	Hourly
Year 1	£64,455	£43,107	£3,593	£832	£22.11
Years 2–4	£69,632	£45,216	£3,768	£870	£23.20
Years 5+	£74,896	£48,380	£4,032	£930	£24.81

Band 8c					
Stage	Gross	Net	Monthly	Weekly	Hourly
Year 1	£76,965	£49,424	£4,119	£950	£25.35
Years 2–4	£81,651	£51,791	£4,316	£996	£26.56
Years 5+	£88,682	£55,320	£4,610	£1,064	£28.37

Band 8d					
Stage	Gross	Net	Monthly	Weekly	Hourly
Year 1	£91,342	£56,685	£4,890	£1,090	£29.37
Years 2–4	£97,861	£59,512	£4,959	£1,154	£30.50
Years 5+	£105,337	£63,753	£5,313	£1,226	£32.69

2. Simplified Summary (Top → Top)

From → To	Gross £ (Top → Top)	% Gross ↑	Net £ (Top → Top)	% Net ↑
Band 3 → Band 4	£26,598 → £30,162	13.40%	£21,287 → £23,207	9.02%
Band 4 → Band 5	£30,162 → £37,796	25.31%	£23,207 → £27,770	19.66%
Band 5 → Band 6	£37,796 → £46,580	23.24%	£27,770 → £33,405	20.29%
Band 6 → Band 7	£46,580 → £54,710	17.45%	£33,405 → £38,494	15.23%
Band 7 → Band 8a	£54,710 → £62,682	14.57%	£38,494 → £42,888	11.41%
Band 8a → Band 8b	£62,682 → £74,896	19.49%	£42,888 → £48,380	12.81%
Band 8b → Band 8c	£74,896 → £88,682	18.41%	£48,380 → £55,320	14.34%
Band 8c → Band 8d	£88,682 → £105,337	18.78%	£55,320 → £63,753	15.24%

3. Band 5 Living Cost Analysis

Band 5 New Professional (after 2 years)

- Annual salary: **£30,639**

Deductions	Annual (£)	Monthly (£)	Weekly (£)
Income Tax	£3,013	—	—
National Insurance	£2,394	—	—
Pension Contribution	£3,003	—	—
Student Loan	£301	—	—
Total Deductions	£8,711	—	—
Take-Home Pay	£21,928	£1,827	£422

Band 5 Living Cost Analysis – Sep2025

Band 5 New Professional (after 2 years)

- Annual salary: **£33,487**

Deductions	Annual (£)	Monthly (£)	Weekly (£)
Income Tax	£3,527	—	—
National Insurance	£1,673	—	—
Pension (9.8%)	£3,282	—	—
Student Loan	£451.53	—	—
Total Deductions	£8,933.53	—	—
Take-Home Pay	£24,553.47	£2,046.12	£472

Living Example 2025 (Band 5 sharing with 1 other young professional, Salford)

Expense	Monthly (£)
Rent	£845
Council Tax	£122.60
Utilities	£200.61
Transport (work travel)	£100
Internet & TV	£50
Mobile Phone	£36
Total Living Costs	£1,354
Disposable Income	£692
	£159/week

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