Evidence to the NHS Pay Review Body – November 2024

Introduction and summary

The Society of Radiographers is the professional body and trade union for all those working in diagnostic imaging and radiotherapy. The Society of Radiographers (SoR) represents more than 34,000 members, most of whom work in the NHS across all four nations, at all grades across clinical imaging and radiotherapy.

The SoR welcomes the opportunity to submit evidence to the Pay Review Body (PRB) for the 2025-26 pay round. We recognise that the evidence round has started earlier in an effort to support members receiving an increase as close as possible to the increment date of 1 April 2025. Paying people an increase on time is important for the credibility of any pay system and can also, in the long run, help stabilise industrial relations by providing a stronger framework in which wider discussions about pay structures and systems can take place.

However, this change in timetable does create some challenges this year regarding presenting our evidence. Firstly, we are in effect submitting evidence twice in the same year, and some of the data sources we traditionally use have not yet been updated or re-aligned with the new timetable. We strive to use the latest available workforce data, but it is possible that more up-to-date data may need to be provided before we give our oral evidence early in 2025.

Secondly, we are conscious that, at time of writing, the various joint workstreams that arose from the 2023-24 pay award are only just finalising reports and we have no information as to the new government's response to any consequent recommendations. Our evidence reflects to some degree what we anticipate the recommendations will be and what we think the reaction from government will be, including where we think the recommendations are too limited to make the impact needed for our members. Overall, we would say that a key lesson from these working groups has been how difficult it has been to get the three keys groups – employers, unions and professional associations, and the DHSC – into a space where consensus about practical changes can emerge. This has been reflected equally in the Social Partnership Forum (SPF) during the same period, where progress towards addressing even agreed key concerns, such as bullying and harassment in the workplace, has been extremely limited.

Since the change of government, there has been more positive discussion across the range of joint forums, with a welcome upturn in the DHSC's willingness to actively engage in work towards change. However, these are early days in what requires a significant and sustained culture shift. We welcome the additional investment in the NHS announced in the budget, but also recognise this can only credibly be seen as a first instalment on repairing the 20% funding gap between the UK and EU15 spending on health and social care, referenced in our previous PRB evidence[i]. We are also awaiting the outcomes of the public consultation on the future of the NHS and consequent revisions in the 10-year workforce plan.

We remain completely opposed to splitting Agenda for Change (AfC), and in particular the idea of a separate pay spine for nurses. No AfC professional works in isolation. Even though nine out of 10 patients on a treatment pathway will be supported by a radiographer, and while addressing shortages of radiographers could be central to tackling the waiting-list crisis, we do not think radiography is more important than other professions. There are already within the AfC arrangements to target recruitment and retention initiatives for key groups (such as greater use of Annex 20, which is largely limited to midwives at present). Strong recommendations from the PRB in support of appropriate targeting would be welcomed – alongside calls for adequate funding to recruit enough staff to sustain safe working practices,

greater access to flexible working, space for career development and incentives at key points in careers for radiographers. However, we'd expect you to say these could be extended to all professions without demolishing AfC structures. Indeed, with so much change and the government finally recognising the need to move from short termism towards longer-term planning, maintaining a stable, common pay and reward structure to safely encompass reform of practice is even more critical than ever. We urge the PRB to specifically recommend that AfC should not be broken up.

However, we also acknowledge in our evidence the growing frustration of NHS staff regarding their pay and reward, which has fallen significantly behind the rest of the economy since 2008. This frustration was at the root of the industrial action during 2023, and remains evident in our discussions with members and representatives. One area where this can be seen is the pressure for revision of job profiles and job evaluation. We are in no doubt that we have members whose jobs have significantly changed, not least as a result of new technologies and advanced and enhanced practice across all areas of radiography. This will continue to happen if ambitions for early diagnosis and wider scanning programmes to support early detection and prevention are met over the coming years. At the same time, the job-evaluation process has not been consistently well-managed or sustained. We can point to examples where people with almost identical roles are banded differently in different trusts, as a result of the degree of proactivity or resistance to requests for revalorisation from their local employer. However, we are equally concerned that efforts to address this are neither used to sidetrack the more important priority of addressing fair pay rates and the consequences of pay restoration across grades, nor used as an extension of a Nurses First agenda. Job evaluation can and must be addressed, preferably in parallel to a longer-term review of pay rates and bands. But it must not be used to play off one group of staff against the others. This is a critical point in the evolution of the NHS, and the PRB should use its voice to specifically caution against parties becoming side tracked by division.

Against this backdrop of potential for change and reform, we urge the PRB to take the opportunity to recommend:

- a significant above-inflation pay award for 2025-26 for all NHS staff, to begin restoring comparative pay rates against the UK economy as a whole.
- using the PRB remit to address equal pay, recognising and amplifying the equal-pay challenges evident in the NHS – the UK's biggest employer.
- targeted recommendations in key areas to support recruitment and retention initiatives, while also helping to establish a supporting environment for longer-term reform.
- a comprehensive joint review of the current pay and reward structures to better support the aims of the Long Term Workforce Plan (LTWP) and to accelerate pay restoration. We suggest the outcomes from this should be implemented as they are agreed, and completed in full to support the 2028-29 pay round and beyond.
- a full review of job profiles and role boundaries to recognise changes to working practices and professional roles across AfC, but not in lieu of whole-band pay restoration.
- adequate funding for sustainable modernisation of the AfC system, to be guaranteed within the 10-year plan.
- modernisation of the role of the PRB as a genuinely independent body that reviews the impact of pay and reward strategies against the benchmark of continued progress and assessment of the LTWP, including adjustments for changes in known demand, and where progress happens more quickly or more slowly than anticipated in the plan.

Our evidence expands on the reasoning behind each of our proposed recommendations.

NO SHORT-TERM FIX AND THE PRB'S PLACE IN SUSTAINING LONG-TERM RENOVATION OF NHS SYSTEMS

The PRB has always struggled to fulfil its full remit and potential because it has been contained by the annual government dictate regarding spending limits. This has been amplified by government's consistently promoting a short-term approach to all NHS funding. When any serious strategy to improve recruitment, retention and motivation of staff invariably requires at least a medium-term level of secure and sustained investment, government funding plans have consistently promoted short-termism. When we've needed to have confidence in a serious 10-year plan, managers have struggled to know where they stand 10 weeks ahead. The ultimate sign of short-termism is the previous government's consistent habit of not submitting its evidence in time because it wanted to respond to the latest micro-fluctuations in markets or inflation.

This year, the new government is signalling a changed approach, founded upon long-term planning, increased transparency and genuine use of data to plan and forecast provision against demand patterns. This should be an opportunity for the PRB to broaden its own response. Your recommendations should encourage sustaining the shift in culture by including broader longer-term interventions that could make a significant difference to recruitment, retention and, ultimately, stable delivery to patients. In short, we don't think the PRB needs to be afraid of saying what needs to happen not just now, but for the coming few years – making recommendations that lay the foundations for continued and sustained intervention.

This can include highlighting how existing strategy has constrained progress in recruitment and retention in key workforce groups such as radiography, and openly challenging why vacancy rates remain dangerously above where they should to be, if the LTWP aspirations to double the radiography workforce by 2035 are to be met.

We urge the PRB to frame its recommendations around:

- The immediate: measures implemented from April 2025 that anchor progress and signpost future intentions. These will be implemented as a full, comprehensive pay and reward review takes place, recognising that some of these outcomes will need to be carefully developed, modelled, equality-proofed, etc and so are likely not be ready for implementation until 2026 or 2027.
- The medium term: in parallel with the full review, targeted measures can be tested to see if they shift the dial on recruitment and retention in key areas – for example, measures to improve development and career progression for the support workforce, and targeted support for new professionals and international recruits across radiography.
- The long term: using the full review of pay and reward to re-enforce the foundations of the unified AfC system, with the review agreeing measures, anchored to the LTWP, to support a safe, fair and sustainable system for the long term. This will need to include addressing full pay restoration and mechanisms to make sure competitive pay levels are maintained, to help secure the long-term stability of the NHS.

We think that if the PRB adopts this approach it can regain the confidence of some unions and professional associations as to its independence and usefulness.

Community Diagnostic Centres (CDCs): a case study in not forgetting the workforce

The SoR welcomed the English government's adoption of the Richards Report in 2022[ii], which outlined a strategy to address the critical diagnostic supply crisis. Richards' plan centred on creating around 160 new Community Diagnostic Centres (CDCs), where patients could access early diagnosis using new equipment in easily accessible locations. Richards showed how this strategy could more than pay for itself with a range

of long-term efficiencies detailed, such as increasing the NHS reporting radiography capacity to save on outsourcing. The strategy recognised that patients would need to be supported by 4,000 additional radiographers, 2000 additional radiologists and further additional professionals, assistant practitioners and specialist admin support, requiring short-term investment for longer-term benefits and savings.

The previous government welcomed the report and championed the CDC programme, with £2.3bn of capital investment sunk into the CDC programme by summer 2024. The new government has renewed this support, promising in the recent Budget a further £1.3bn of targeted resources to increase diagnostic capacity.

However, all independent assessments of the CDC programme point to its still failing to meet its potential or to provide the improvements warranted by the investment and political profile given to the investment. The programme was intended to be producing 17 million more scans by 2025, but the All-Party Parliamentary Group (APPG) for Diagnostics' [iii]report in January 2024, sponsored by the Royal College of Radiologists and others, including the SoR, found that the programme was set to fall well short of its target, with government figures for the project's scans missing off the word "extra", and with only about half of the CDCs being new or in genuine community settings. There was no conscious staffing strategy for the programme and little to none of the additional investment was specifically allocated to cover additional staff. This means that, in most areas, CDCs are merely robbing Peter to pay Paul, as the same staff are merely moved between their local CDC and their acute setting, with limited increased total output. Rather than being a big idea to turn the tide we all hoped CDCs could be, the reality is that CDCs are currently amplifying – and potentially escalating – the workforce crisis.

If the new government is genuinely committed to recognising and addressing the radiography workforce crisis, then it must learn from, rather than repeat, the lessons of the CDC rollout to date. To deliver more scans in an efficient and sustainable manner, you need to provide the specific funding for additional staff. This also needs to incorporate measures to support transforming the support workforce through skills-mix initiatives, requiring investment in post-registration education and training. When these are in place, there will be solid foundations to make the most of extra funding for equipment. From there it will be necessary to monitor and adjust the level of focused investment in the future.

CULTURE CHANGE TO RETAIN THE RADIOGRAPHY WORKFORCE IN THE NHS

It is worth revisiting why radiography is the clearest of all lenses through which to see the workforce challenges facing the NHS. The radiography workforce has, like the rest of the NHS, been growing throughout this century. However, workforce growth has lagged dramatically behind demand. In 2018, the Kings Fund forecast [iv]that diagnostic radiographer numbers needed to grow by 6% per annum, and therapeutic radiographers by 7% per annum, to meet forecast demand by 2030. In fact, 2023 was the first year since 2009 when the number of diagnostic radiographers increased in line with the 6% growth figure. Growth in the number of therapeutic radiographers continues to fall short of the 7% identified in 2018. In almost all other years, growth has averaged around 3%, or half what was needed, thus creating the workforce crisis that has contributed to the sharp rise in numbers of patients waiting for scans. The LTWP re-enforced the scale of the challenge by setting a target of doubling the radiography workforce by 2035.

To meet these ambitious targets a consistent strategic approach is required – both in terms of recruitment and retention and wider government policy and practice. Although the recognition of the crisis and some targeted investment is making an impact, more needs to be done to maintain and sustain the progress. In particular, we need more people more quickly, which in part relies upon improved retention and

recruitment incentives, including support for "grow your own" initiatives and further endorsement of changing the skill mix to better use the skills across the whole workforce from support worker to advanced or consultant radiographer. These will need to incorporate rapid improvement in working conditions founded upon more people with more time to do their job well and to progress their careers inside the NHS.

In last year's evidence we highlighted the stubborn lack of significant progress towards securing a safe workplace for our members. The 2023 NHS Staff Survey [v]revealed some small improvements in key measures around workforce morale after a sharp fall during the pandemic. However, these still show entrenched cultural challenges regarding how staff view their treatment in their workplace, with scores still below pre-pandemic levels. For example:

- A minority (46.7%) said they were able to meet all the conflicting demands on their time.
- Only around a quarter (26.25%) said there were never or rarely unrealistic time pressures on them at work.
- Only 32.4% said they had enough staff to do their job properly.
- More than a third (35%) said to some extent they'd be unhappy with the standard of care provided by their organisation for a friend or relative.
- More than two-fifths (41.7%) said they'd felt unwell in the last year as a result of work-related stress.
- A majority (54.83%) said they'd gone into work in the previous three months despite not feeling well enough to perform their duties.
- Fewer than a third (31.32%) say they are satisfied with their level of pay.
- A minority (44.92%) said they were satisfied with the extent to which their organisation values their work.
- Just over half (56.4%) said their organisation acts fairly with regard to career progression and promotion.

While these stats are entrenched and barely shift from year to year, they should not be seen as inevitable. For example, only 22% say they always eat nutritious and affordable food while they are working. **Recommending that the government subsidise free nutritious food for NHS staff would have a positive wider and, in the long run, cost-effective impact on staff morale, wellbeing and turnover.**

It is also important that the PRB now meets its broader remit and urges government to meet the resourcing requirements for safe staffing as well as securing time off for training and professional development. Resourcing for safe staffing, along with small measures such as funding to levels that secure time off for training and subsidising food for staff, should be recommendations built into a call for a broader review of the pay and reward framework.

Our 2023 Workplace Experience Survey confirmed the challenges reflected in the wider NHS Staff Survey – and in some cases highlighted an even greater depth of concern. Given the particularly critical need to grow and retain the radiography workforce, these results should be of particular concern to the PRB. For the first time, our survey included members working in the independent sector and so also highlighted the perceived differences between the two – and so signposts why many are leaving.

Our survey highlighted:

An NHS unsafe for patients or staff:

- Only 11% of NHS staff said they feel safer at work now than before the pandemic, while 40% said they feel less safe. By contrast, in the independent sector, the numbers were 19% and 24%.

- 24% said they lacked confidence their employer would do anything to make their environment safer if they were injured at work.
- 52% said they had witnessed a colleague being abused, bullied, threatened or harassed at work.
- Most said the perpetrator was most likely to be a colleague rather than a patient.
- Only 38% expressed confidence that their employer would support them if they were a victim of abuse, bullying, harassment or threats at work. This figure was down from 42% in 2022.
- Only 56.7% said they would recommend a career in radiography to family and friends, down by 7% from 2022. Only 52% would recommend working for their employer, as opposed to 48% who said they wouldn't: a negative shift of 5% since 2022.

Barriers to career development:

- About equal numbers of NHS members said they do and don't have adequate access to professional development and support (48.5% and 46.3%, respectively).
- Only 12.5% of NHS members said they had protected study time.
- 46% of NHS members saying their employer did not encourage them to seek promotion.
- 21.5% said promotion wasn't financially viable for them.

Not enough staff:

- 82% of all responses said there were not enough staff to meet their department roster without requiring regular overtime.
- Improved figures on numbers of staff since before the pandemic, but 48.6% still say there are fewer rostered than before.
- 39% still believe it is unlikely that colleagues leaving in the next 12 months will be replaced.

A further recent survey of SoR members found 33% of members telling us they knew their department had deliberately delayed advertising for a replacement post, with only a quarter (24%) saying they were certain this had not happened in their department[vi]. The survey shows that delaying recruitment to save money in the short term is commonplace in one of the professional areas where the NHS most critically needs to reduce vacancy rates. Our members will normally have between two and three months' notice periods, but failure to advertise until a few weeks before the end of the notice –and then running even more short while the NHS goes through its laboured recruitment process and the successful candidate must then serve their notice period –just promotes burnout and unsafe practice. In the medium term, is it is unproductive and more expensive.

All of these results scream out the need for the NHS to address access to flexible working and safe staffing levels – to support retention and also patient safety. Ultimately, access to flexible working is also an equality issue. It is absurd in 2024 that any organisations that rely upon mostly female graduates in key professional roles, such as radiography, are designed and funded in ways that almost systematically deny access to flexible working and a credible, sustainable work-life balance. Flexible working should be baked into workforce planning. For the PRB not to directly challenge why this still isn't the case would be a dereliction of your duty regarding your full remit.

PAY RESTORATION: SUPPORTING AN EQUAL-PAY AGENDA AND WIDER ECONOMIC GROWTH

While there is evidence that the period of highest inflation in living memory has settled, it is important that the PRB does not run ahead of most people's reality nor discount continued economic uncertainty and instability – especially as regards to the potential impact of global crisis arising from the on-going conflicts

in Ukraine and the Middle East, or possible trade implications from the USA. While the rate of inflation as a whole is falling, this doesn't mean prices are falling – merely rising more slowly than they were. Nor does inflation, especially when measured by CPI, impact all people and families in the same way. Over recent years, we have highlighted how the freezing of tax thresholds, pension-contribution changes and the proportionately higher impact of inflation on some costs (such as basic foods, heating and transport) have combined to limit the impact of awards in terms of net take-home pay and real disposable income for key groups of members – in particular, our lower-paid support workers and our new professionals in Band 5 (see more on these bands below).

Additionally, we note the government's stated aim of leveraging the public sector's local economic power, as a large local employers, to stimulate growth. The NHS is Europe's biggest employer. In many communities the NHS is the biggest source of stable, professional employment. For example, the NHS employs more people in the South West than the population of Exeter, and more in the Eastern Region than the population of Cambridge.

Frankly, the government's ambition if NHS staff see their pay continually capped merely to the headline rate for price rises – and no closing of the gap that has opened up since 2008 between their pay and others' across the economy as a whole. Their relative spending power has been continually reduced for more than a decade.

Awarding an above-inflation pay award for all NHS staff in 2025-26 would send the strongest positive signal to NHS staff still battling on following the pandemic. It would also support local economic growth and recovery. It may not be practical to close the pay restoration gap in one go (although at some AfC pay points we suggest this is both possible and necessary, such as starting pay for Band 5s) it is critical the PRB recognises the need to do so in as soon a timeframe as is economically practical.

This should include support for exploring mechanisms that facilitate pay restoration, while protecting NHS pay from any further risks of falling behind in the future. This can then be explored during a comprehensive joint review of the pay and rewards structures to better support the aims of the LTWP, including looking at establishing mechanisms to accelerate pay restoration and protect NHS pay from falling behand again – for example, recommending future pay awards should be at least 1% above inflation and supporting other targeted incentives (see more below).

Whatever the short-term financial cost, the UK cannot afford for NHS staff to continue to be the poorer relation in their local economies.

Pay restoration

As **Table One** shows, from Band 2 to Band 9, all NHS grades have seen their pay maxima fall by comparison total pay across the economy as whole. The 2024-25 award made little to no difference in most cases regarding closing this gap, as it remained broadly in line with other average awards across the economy. The pay-restoration gap is between 12-30%. For all graduate-entry posts it remains close to 20% or above. Everyone above Band 3, with the exception of Band 7, has also seen their starting pay on entry to the grade fall relative the rest of the economy. For new professionals, the gap is now 11%. For those in management and leadership roles, the starting pay gap is more than 15%.

	2008			2024-25			Difference			% Difference		
BAND	Min	Mstart	Max	Min	step	Max	Min	Mstart	Max	Min	Mstart	Max
1	12517		13617	23615		23615	11098		9998	89		73
2	12922		15950	23615		23615	10693		7665	83		48
3	14834	16307	17732	24071		25674	9237		7942	62		46
4	17316	18385	20818	26530		29114	9214		8296	53		40
5	20225	21373	26123	29970	32324	36483	9745	10951	10360	48	51	40
6	24103	27191	32653	37338	39405	44962	13235	12214	12309	55	45	38
7	29091	33603	38352	47148	48526	52809	18057	14923	14457	62	44	38
8a	37106	39896	44527	53755	56454	60504	16649	16558	15977	45	41	36
8b	43221	46782	53432	62215	66247	72293	18994	19465	18861	44	42	35
8c	52007	55806	64118	74290	78814	85601	22283	23008	21483	43	41	33
8d	62337	66790	77179	88168	93571	101677	25831	26781	24498	41	40	32
9	73617	80883	93098	105385	111739	121271	31768	30856	28173	43	38	30

This is the result of short-termism defeating strategic need during a prolonged period of underfunding NHS pay. Among the side effects of underfunding and short-termism are local managers and employers forced to make invidious choices – not filling vacant posts as funding may not have been sustainable, which leads to rejected flexible-working requests, which prompts more to leave, or discouraging job-evaluation requests because they couldn't afford the post if the person was successful, thus prompting retention and morale difficulties.

A further example is the way that support-workforce transformation is consistently referenced as a good thing. But there is rarely any serious initial investment in the education and training of the support workforce – or scope in workforce planning to facilitate release for training and development. The potential gains this would provide in releasing higher trained staff to deliver more complex aspects of patient care then can't be delivered, either.

Given that addressing waiting lists has been the top political priority since the end of the pandemic, it is heartbreaking to see the number of examples the SoR has of managers turning down end-of-budget-year offers of funding for new equipment because there is no corresponding guarantee of funded staff to maximise the efficiency of the new equipment. Equally, we see managers challenged about the productivity of their team when their equipment is too old and unreliable. We have specifically highlighted the Community Diagnostic Centre programme as an example of failing to fulfil huge potential in a project.

Among the most perverse cases the SoR has identified are members seeking to train in advanced professional areas with critically high vacancy rates at the core of the waiting-list crisis, such as sonography or mammography, and being told they'll have to leave their post or drop down a band to do so, as there isn't capacity within their team to release them. **We urge the PRB to recommend directly that this be prevented by an amendment to the AfC handbook.**

Equal pay

For the first time in more than a decade we now have encouragement from the government to take a broader and more positive approach. The PRB should make specific recommendations to eradicate these short-term practices. One justification should be using your remit around equal pay. Rachel Reeves, as the first female Chancellor in our history, has made great play of wanting to finally address equal pay gaps. The logical and easiest place for her government to start should be with its own employees. The NHS is its biggest single workforce group, and a significant majority of NHS employees are women.

The NHS has an evident equal pay gap – largely as working practices discourage women from advancing into senior and leadership positions. You can't address equal pay without addressing greater access to

flexible working – and this requires supporting adequate staffing levels targeted funding that secure safer, fairer working practices. In turn these will also improve both productivity and quality of service to patients. Likewise, women are much more likely to wokr part time. Trusts must be actively discouraged from forcing staff on to Bank contracts with reduced pay rates and wider conditions of service. We are alarmed, as the PRB should be, too, that an increasing number of trusts are seeking to force workers on to Bank contracts to save money on overtime. We are seeing an increasing number of disputes with trusts around Bank terms, including where they routinely opt Bank staff out of NHS pension membership, significantly reducing their relative pay and reward. **We urge the PRB to recommend a national framework for Bank contracts so that they cannot be used as a means to reduce wider terms and conditions.**

Further, following the changes to the medical-grades pay frameworks in the 2023-25 awards, the genuine risk of equal pay challenges across the NHS is rising – from women senior leaders trapped in the AfC pay bands comparing their pay with the financial advances of recently qualified medics they work alongside, and over whom they may have had a pay lead prior to these changes. This risk requires acknowledgement and the PRB's active support for a full review of AfC pay and reward structures (see more on managers and leaders below).

How much are calls for a grading review about pay?

The AfC structure is long overdue assessment and review. Any job evaluation and grading system needs regular review and refresh to ensure that job profiles reflect the work people do now, as opposed to what and how work was done when the scheme was introduced. The SoR supports a full review of all job profiles and the job evaluation system as part of a joint review of the NHS pay and reward structure. However, it is also important when deciding to embark on a pay and grading review to understand and manage the expectations of those calling for it.

Our view is there's a serious risk this is not being understood by some of those calling for this review. It is important to identify and separate the genuine grading issues from equally genuine but different concerns about fair and competitive pay levels. It is our belief these are being blurred. It is understandable that someone from Band 2 to Band 9 can credibly ask, "How am I only paid X when I do all of these things and my work carries all of these risks, especially as I could earn more doing something else with far less risk or responsibility outside of my profession?" However, as everyone can potentially ask the same thing, the core problem is how pay hasn't kept up with the wider economy as a whole.

We agree that some, including our members, would be able to say their jobs have changed more than others, and that they've taken on additional responsibilities in comparison with other roles in the NHS. We detail some of these below. However we also know many are at risk of conflating the two issues, asking, "How am I earning less than £26,000 as a mammography support worker when I could earn more on a checkout in the local supermarket?" or "How, given what I do and the responsibility I carry, can it be right that I'm earning at least £10,000 a year less than my friend who graduated alongside me five years ago but went into the civil service instead?" When they work closely with colleagues in higher bands they start to ask why, if some of their work is the same or similar to their colleagues', are they not in the same band. In fact, the real problem is that all staff have seen the relative value of their salaries fall and become uncompetitive.

So while we've set out below that we think there are issues for groups of our members in relation to job evaluation and job profiles, we also urge the PRB to direct the government away from any temptation to park addressing uncompetitive pay in favour of a long and drawn out review. This approach would only raise expectations and then disappointment. It would be more efficient and safer for the NHS to recognise and start to address uncompetitive pay now and then run a review in the background during the period of our proposed pay and reward review, assimilating upward grading reviews where these are demonstrably needed, as well as and alongside pay restoration.

We believe this need is emphasised further by detailed analysis of the disparities between grades in the current pay system, amplified by recent awards. Put simply, not all pay grades have been treated equally. This is directly contributing to the calls from many within these same grades for a wholescale review of the AfC system. They are recognising an unfairness but there is a risk of applying the wrong remedy – or failing to apply any remedy while further tests continue.

The calls for pay reform are coming most strongly from those who feel undervalued and stuck in Bands 2, 3, 4 and 5 and those in first-level manager/supervisor roles or advanced-practitioner roles in Band 7 and especially 8a. We are in no doubt there will be examples in these groups where job evaluation would see an upgrading. But there are things that should and could be done to address inequitable side effects of pay awards for all of these groups that would help address concerns and assist recruitment and retention without impacting on job evaluation. These should be progressed with the greatest urgency.

KEY GROUPS AND AREAS

The latest official NHS statistics for the end of September 2024 [vii]show that 1,587,000 patients were waiting for a key diagnostic test – only 3,400 fewer than at the end of September 2023. Of those, 359,900 had been waiting more than six weeks. This is 56,000, or 3.9%, less than in September 2023, but a higher proportion of those waiting (22.7%) had been waiting longer than six weeks, compared with the 19.9% in October 2023. The operational standard measure is 1% or less waiting six weeks or more for the 15 key diagnostic tests. This has not been met nationally since November 2013. In the latest figures, while there has been some noticeable improvement after targeted investment in some specialist tests, such as a 15% reduction in the percentage waiting more than six weeks for a DEXA scan, and a 6% reduction in the percentage waiting more than six weeks for a CT scan on the whole progress remains painfully and dangerously slow. Each month between one in four and one in five patients requiring a diagnostic scan are waiting longer than six weeks, with the monthly average at 22.7%.

These gloomy statistics does not mean that our members are not performing more scans or that the additional investment in growing is being wasted. There were 120,000 more scans carried out across England in September 2024, compared with a year earlier. Staff had almost met the National Imaging Board target of 120% pre-pandemic output set to clear the pandemic backlog, operating now at 119%. Our evidence cites continued frustration in the system about equipment that is too old and unreliable, or staff shortages meaning capacity isn't being fully utilised. Likewise, we have countless examples of staff with high level skills, such as reporting, not being fully utilised because of under investment in developing the support workforce numbers or skills. However, it is difficult to sustain a credible argument that this challenge is primarily about inefficient systems or poor productivity. What it proves is that the level of investment and support can and does make a difference – but this now needs to be taken to another level if the government is serious about ending long and dangerous diagnostic waiting times.

Critical to sustaining the progress while additional investment comes in will be sending a clear and more positive message to the staff in the system. Setting targets like the 120% pre-pandemic productivity target to reduce waiting lists are cruel and demoralising to staff if those setting them are merely playing some political game, knowing all along that even if this target is met, known increases in demand will stop waiting lists from falling. This is amplified when these staff, who have battled on post the pandemic with ever increasing intensity, see requests for flexible working turned down, have to drag themselves into work when ill, continue to miss their children's school assemblies and plays – only to be told they need to be more productive or more efficient. These staff now need urgent recognition if they are to be retained.

Our evidence to the PRB has repeatedly highlighted concerns about staff vacancy levels – these now need to be urgently heeded. Alongside investment in equipment there needs to be a clear, prominent statement of intent from government about valuing the radiography workforce who are the keystone to their public health and cancer strategies. Their long wait for recognition needs to end.

The latest NHS vacancy rates data [viii](September 2024) show there are still more than 120000 vacant posts across NHS England. 5 out of 7 English regions have seen an increase in the number of Allied Health Professional vacancies in the last year. We are awaiting updated data from the NIB regarding specific vacancies across imaging modalities but mean average vacancies are unlikely to have fallen much below last year's 13.4%.

Geography & Disproportionate Impacts on Rent & Pensions

The SoR like all NHS unions are opposed to local or regional pay. Localising pay across the public sector has been explored at different points in different areas during the last decade and always ends up being divisive and counter-productive, even more so in areas like radiography where there is a national shortage of professionals and so there is a serious risk of cross border movement wherever lines are drawn. This is already especially evident in Northern Ireland, where the HSC loses radiographers to the Republic, as a result of significant pay leads in the South. To see this happening on a county by county basis across England and Wales would add unsustainable chaos to the NHS.

However, we all also have to be conscious that the UK's economy is unequal – with some areas being vastly more expensive to live in and move to than others. One of the biggest factors unpinning this inequality is access to and the relative price of housing, especially for rent. Renting costs are especially critical to three key groups of the radiography workforce – support workers who are less likely to own due to their incomes; new professionals who are also more likely to have moved areas to start their careers; and international recruits, certainly within their first few years of working in the UK. This is why the SoR is urging the PRB to recommend government consider additional housing support, especially for these groups, as part of a targeted recruitment and retention strategy.

Further, disproportionate housing costs are most extreme in and around London. Consequently, recruitment and retention rates in and around London are even more critical than elsewhere. Recently published HCPC data shows that London had the lowest radiographer registration renewal rates of any UK nation or region in 2024 – only 76.1% renewing. Data from NHS BSA also shows that pension opt out rates from the NHS pension scheme in London have now reached almost 1 in 5 (19%) of eligible members inside London. **Therefore, it is essential that the PRB support at least maintaining the relative value of London weighting in any uplift, and we urge you to include an independent review of London weighting levels in a long term review of pay rates.**

With regard to pensions, there is evidence of a need to take actions that urgently stem an emerging crisis and to better understand and therefore address the deeper reasoning behind why some groups opt out more than others. The opt-out rates are highest among Band 5s, international recruits and the lower paid in bands, 2, 3 and 4. These groups are most likely to opt out across the UK but the figures are markedly higher in London. An analysis of the impact of London weighting on where people start to pay different contribution rates leads us to think there is a causal link.

Under CARE, any time out of the scheme has a significant compound impact on your pensionable earnings in retirement. CARE was designed to balance off the discriminatory impact on women that surfaced in any final salary schemes but if the thresholds are impacting disproportionately then women professionals in London are being disproportionately impacted in a significant way because the benefit of the London weighting is being markedly eroded by higher pension contributions, unless they opt-out of the scheme. If they opt-out then their pension incomes are disproportionately lower as well.

In the last few years there has been more open recognition from HM Treasury and the DHSC that pension contribution thresholds have a link to basic pay. There has previously been an attempt to consciously underplay this and amplify that many pension scheme members work part time or irregular hours etc. While the right balance is important, underplaying any link ignores that groups such as new professionals, international recruits and others joining the NHS will inevitable look at their basis pay to work out how much they have to contribute and decide if they can "afford" to be in the pension scheme.

After a series of delayed awards, the link between pensions and pay became more prominent – when many scheme members with earnings close to contribution thresholds found themselves losing large proportions of a delay award as a result of backdated pension contributions. Accordingly, efforts have been taken to try to ensure pay awards are recognised and contribution thresholds adjusted so as to avoid indirectly undermining confidence in the pension scheme. These mechanisms have themselves amplified the link between pay and pensions. Last year's award has now drawn significant traction from those in London who feel they are having to make far higher contributions than colleagues doing the same roles elsewhere.

Pension thresholds are generally crossed when scheme members move:

- To the top of band 4 (rising from 6.5% to 8.3%)
- From the Band 5 step to the top of at the top of Band 5 (rising from 8.3% to 9.8%)
- From the step in Band 7 to the top of Band 7 (rising from 9.8% to 10.7%)
- To the step in 8B (rising from 10.7% to 12.5%)

However, in London the thresholds are in very different places. Full time Band 2's in Inner and Outer London would start off paying 8.3%. A Band 3 working on the London Fringe would lose 52% of the value of their first step increment in increased pension contributions, which Band 3's outside London would not expect to be impacted by. A new band 4 in Outer London is paying 9.8% pension contributions when someone in the same role outside London is only paying 6.5% contributions. Someone working in Inner London making their first step at 8a would be paying £2,110 per annum more in pension contributions than someone doing the same the role in Reading for example.

A similar issue is disproportionately impacting many radiographers. Our evidence shows that the vast majority of our members claim at least two if not three regular additional allowances for working anti-social hours, irregular patterns and/or consistently rostered overtime. This is directly linked to their being more likely to work regular, even rostered "overtime", with a majority of our members routinely working

more the than the standard 37.5 hours. While overtime itself is non-pensionable these allowances are quite rightly pensionable (in most cases). Accordingly, our members close to the pension thresholds will often end up crossing them and "losing out" – for example many of our members at band 5 still pay higher pension contributions on reaching their first step, especially those working in busy hospitals in inner city areas who are expected to do long hours. This is nearly always the case in London and again this is contributing either to our members working excessive hours and risking burnout as their wages don't go as far or to them opting out of the pension scheme.

We of course recognise that the long term benefit of paying higher contributions on higher pay is that the scheme members' pension will eventually be higher as well. However, we do not think that the PRB or government can ignore the mounting evidence that people are instead opting out of the scheme – especially in the key groups of staff hardest to recruit and retain, or especially in London. The NHS pension scheme already has the highest contribution rates of any public sector scheme. For these to be higher for those professions in shortest supply and required to work longer and harder, or in areas where recruitment and retention is hardest, is counter-productive in the short-term and unfair and inequitable in the long term.

The SoR recognise that the PRB could be especially uncomfortable about making any or specific pension recommendations However, the PRB cannot credibly divorce itself from the part pensions play in total pay and reward. It can therefore not ignore the evidence that current pay rates and pension thresholds now work against each other, with unfair and inequitable risks and side effects that are impacting on pension scheme membership / rewards. These "inconvenient truths" cannot be ignored.

There are two ways to address the problem. The PRB could directly recommend pension changes – such as an immediate reduction in contributions with no loss to scheme members for those in receipt of pensionable allowances, including London allowances and urging the government to consider pension contribution reductions or holidays in hard to fill posts and/or areas which are difficult to recruit or retain staff, extending this to all international recruits in their first three years of NHS service.

If however these are deemed beyond the scope of the PRB or too difficult then an alternative approach would be needed to avoid ongoing unfairness and inequity from an unaffordable scheme – namely, recognising that future pay awards will have to compensate NHS staff for high, and in some cases excessive contribution rates. The PRB should decide between these options and make a recommendation clear in this year's recommendations.

Sonography and mammography

2 modalities in particular highlight how the workforce crisis in radiography is playing out. With non-obstetric ultrasound (NOUS) still accounting for 562,700 or 35.5% [ix]of all those waiting longer than six weeks for a diagnostic scan, the sonography workforce had average vacancy rates of nearly 15%. The vacancy rate for both qualified mammographers, and mammography associates was higher still.

Nightingale et al[x] cites mammographers and sonographers as the 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.

In mammography, we have identified several examples of Band 6 radiographers seeking to train in mammography as a specialism, with no long term obvious financial gain but for purely professional reasons and being told to do so they would have to take a pay cut during the training, despite the desperate shortages and the highest vacancy rates in any imaging modality.

The latest available data from the NiB (December 2023) showed 29% of the sonography workforce near or beyond normal retirement age and there is no clear plan to renew this advanced practice workforce. There is no direct radiographic pathway into sonography – it is recognised as an advanced skill, with a sonography apprenticeship in its infancy. The training pathway has been blocked by failure to release people for training due to increased demand on the existing workforce and some being expected to earn less while they train. We estimate 29% of the sonography workforce are near or beyond retirement age, compared to an average age of the radiography workforce being around 40 or younger.

Sonography is now one of the largest areas of the independent radiography sector. Most sonographers work at the top of band 7. Their pay has fallen in comparison to the rest of the economy by 22% against average pay and 21% against total pay since 2008. Closing a 21% pay gap would mean increasing their basic pay by £11,090 per annum.

The majority of qualified mammographers work at the top of Band 6. Their pay gap mirrors Band 7 in percentage terms. Closing their 21% gap would mean increasing the Band 6 maxima by £9,442 per annum. This would be £1,595 per annum more than the current maxima for Band 7 and indeed more than the current starting pay for Band 8a. Nothing shows how NHS professionals pay has been devalued more than this fact. Mammography based screening programmes also rely heavily upon trained specialist assistants and support workers, who are also especially difficult to recruit and retain. Their pay gaps, mostly at the top of Bands 3 and 4 are equally stark, unfair and unsustainable.

The failure to close these pay gaps is already costing the NHS millions in outsourcing and agency costs. Figures from 2022 showed the average outsourced NOUS scan cost the NHS £78.33 per scan compared with an NHS tariff of £40 – we await updated data but do not anticipate this gap will have closed significantly. In 2023 we identified three regions with an agency rate for sonographers at £120 per hour. The easiest and cheapest way to reduce this bill is simply to pay the workforce more to stay in the NHS.

International recruits

Imaging has become increasingly reliant on international recruitment over the last decade. NHSE figures show 56% of the 3% growth in diagnostic radiographer recruitment into the NHS between 2016 and the end of 2020 was due to international recruitment. [xi]While the number of UK-based FTE radiographers in the NHS grew by 9%, the number of internationally trained FTE working in the NHS grew by 147% in the same period. It is important to note that Medical Radiographers remain on the Home Office Shortage Occupation list, with the UK even more reliant on international recruitment in areas involving non-obstetric ultrasound where you need additional training and experience.

Post pandemic, and with recognition in the LTWP of the increasing importance and urgency of addressing the radiography workforce crisis, this reliance has moved to a new level. This was perhaps exemplified by the only specific money allocated to the CDC programme for staff being ringfenced specifically to recruit 400 new international radiographers specifically for the programme.

While there continues to be a loop hole in the registration regulations for internationally recruited sonographers (as sonography is only recognised as an advanced practice within radiography in the UK

sonography isn't recognised as a separate profession whereas in some countries you can train specifically in sonography) the HCPC's tracking of registered radiographers provides important insight into the size of the potential radiography workforce and where these people are.

Table 2 shows the growth in the number of registered radiographers with the HCPC since 2021. This shows clearly that efforts to grow the domestic labour market have had some effect, with 1997 more UK based and trained registrants (a 6.2% increase). However, the vast majority of the 27% increase in the potential pool comes from those who are internationally trained and/or overseas. There has been a 141% increase in international registrants since 2021.

Table 2: HCPC data on Registered Radiographers (provided Nov 24)

Year	International	UK	Total
2021	5,700	32,135	**37,835**
2022	6,187	33,901	**40,088**
2023	12,676	33,701	**46,377**
2024	13,765	34,132	**47,897**

However, the latest HCPC figures relating to new registrants (table 3) show an alarming reduction in 2024 of the number of new international registrants across radiography. The total number of new registrants in 2024 has fallen to almost 2021 levels, largely due to a sharp fall in the number of new international registrants (a fall of 2084 or 67% in 12 months).

Table 3: HCPC Data on new radiography registrants (provided Nov 24)

Modalities	Registration route	2021	2022	2023	2024	Total
Diagnostic radiographer	International	997	3,007	3,110	1,026	**8,140**
	UK	1,227	1,275	1,460	1,485	**5,447**
Therapeutic radiographer	International	24	125	186	73	**408**
	UK	227	259	277	278	**1,041**
Diagnostic radiographer & Therapeutic radiographer	International	4	12	13	10	**39**
	UK	5	2	4	1	**12**
Not recorded	International	1	2	7	0	**10**
	UK	2	7	39	3	**51**
Total		**2,487**	**4,689**	**5,096**	**2,876**	**15,148**

These figures are alarming but not overly surprising, given SoR feedback from our internationally trained membership and managers, who have shared their experiences of trying to recruit into the NHS from overseas.

Not all overseas registrant's come to the Uk. Of those who do a disproportionate number still seem likely to be recruited into the private sector rather than the NHS, including many recruited by agencies or to fill outsourced NHS posts in areas like sonography. Of those who do join the NHS directly, many appear to move on or return home.

Exploitation is not uncommon. We have encountered cases where international recruits have not been paid what they were promised; forced to work excessive hours and denied leave; threatened with having to repay £1000's in false costs allegedly associated with training, housing or visa fees if they tried to leave;

and sacked then kicked out of their rented accommodation for being pregnant. Some of this has been identified in companies with NHS contracts. This concern has prompted the SoR to publish, in partnership with the Royal College of Midwives and Chartered Society of Physiotherapists, an Principles and Standards document for international recruitment[xii]. We are currently following this up by developing comprehensive help guides for any international recruit considering applying for UK posts in either the public or independent sectors.

Even in the NHS, we see too much poor practice. Our Manager members tell us that recruiting from overseas into the NHS is daunting and takes even longer than the usually inefficient NHS recruitment processes. When under pressure to fill a post or lose it timing doesn't support international recruitment. Where Trusts do recruit they find the lack of information available to international recruits about their area can mean it is difficult to retain the recruit, who will typically look to move to a cheaper area or one with higher concentrations of people from their diaspora.

Once recruited support for international recruits is almost exclusively limited to professional guidance and adaptation – with little to no formal recognition of a need for wider cultural and social induction or support. Even support with assimilating into a role in a new country and culture is not guaranteed or consistent, with many examples of international recruits being expected to work at full pace from day one.

In 2024 this is ridiculous and inexcusable. If the NHS and government are serious about competing in the global market for highly skilled scarce professionals in a highly technical area like diagnostic or therapeutic radiographers then they should take providing both a financial and reward package, and a cultural and professional induction package seriously. Any private sector company seeking to recruit globally for new or experienced graduates with technical skills in shortage areas would be subsidising housing; providing transport; sorting schools and jobs for family members; offering to pay for 2 or more trips back to their homeland each year; and initially offering a phased entry to the work place with time off to acclimatise culturally. Almost none of these are ever available to NHS radiographers coming from overseas – indeed, the opt out rate from the NHS pensions scheme across this group suggests even the basic package is not properly explained and sold. It is also interesting to compare the limited support in the NHS to the relocation packages for UK based civil servants that remain common place. This difference may not even be conscious. It could instead reflect the kind of unconscious bias only too evident to the recipient from abroad – reflecting an arrogant almost imperialistic perspective that of course the colonial would be grateful for the chance to work in the UKs NHS.

That said, there are also examples of good practice that should and could be identified and replicated. Interestingly, the specific programme to support international recruitment into the CDCs from India has been very successful and lessons from this – including structured support and protected time in the first year after moving and placing NHS recruiters in the country they are sourcing staff – must be learned and replicated. However, even there it is not easy to source the best people and meet the promises they perceive being sold to them when they arrive.

The SoR therefore urges the PRB to support:

- An assessment of what a competitive international recruitment offer should contain to sustainably recruit and retain radiographers, and other key shortage professions.
- National academy/programme for international recruits to complete training and induction
- Including new internationally recruited NHS staff in incentives around pensions, housing, food, training and preceptorships, etc proposed for other groups of staff.
- Addressing the poor pay and working practices impacting on sustainable international recruitment and retention into radiography and other shortage skills AHPs.

- Specific independent tracking and publication of data regarding the recruitment and retention of international professionals by specific profession, recognising that current data is sporadic and ineffective with regards to truly informing best practice re recruitment and retention of international professionals.

Band 5s and new professionals

Band 5s new professionals are arguably the most important strategic group in addressing the long-term recruitment and retention challenges across all of radiography. These are the entry point salaries that potential graduates look at, alongside how quickly they'd expect to progress upon graduation and how much they could reasonably expect to earn after three, five or seven years in their profession. They are the jump in salary that support workers look at first if considering taking up study or apprenticeships to extend their existing roles into professional and graduate ranks.

Band 5 has consistently been treated differently for the wrong reasons. They now deserve some positive targeting. Since 2008, the starting salary for a Band 5 has grown by less in percentage terms than all other bands below Band 8. The current starting salary is 11% less than it would have been if it had retained parity with the growth in average pay across the whole economy – a difference of £3,297 or a starting salary of £33,267. This figure would be £943 more than the current value of the first progression step.

NHS graduates are now among the few in the UK public sector with a starting salary still below £30,000. The average starting salary elsewhere is, we believe, getting closer to £35,000. This inevitably has an impact on the study choices of those considering public-sector graduate careers. The LTWP notes the need to double the radiography workforce by 2035. While numbers are growing, and the number of new HCPC registrants doubled between 2023 and 2021 (see table 2 above) the bulk of this growth was from those registering and training overseas – very many of whom never arrive in the UK. For 2024, the number of new registrants has fallen back to close to 2021 levels. While international recruitment will continue to form a critical part of growing the radiography workforce to meet known demand (see above) we also know many of these new registrants are experienced international radiographers looking for posts at Band 6 or above. Newly qualified professionals coming to work immediately in the UK would face additional and different pressures. Such a reliance on overseas trained recruits is unsustainable and more needs to be done to make a career in radiography more appealing and sustainable through the critical early career phase.

The reality for our young professional members, many of whom have to move away from their homes to work in their first jobs with additional costs and pressures, is one of financial hardship and difficult choices. 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 third-year Band 5 living in shared rented accommodation in Salford highlights some important pointers for the PRB (see table 2 a and b). This tracking data shows that the combination of the 2024 pay award and removing the pension penalty we highlighted in 2022 to 2024 has had an important impact for this critical group in the workforce. For the first time since our tracking began in 2021, the real disposable income for these members increased in actual terms - by £8 per week. However, this still only leaves this third year graduate professional with £131 per week: £13 less than they would have had two years ago before the highest rise in inflation in living memory. This £131 a week needs to cover food, clothes, wider travel, further study costs and any saving for holidays or future life events.

As mentioned above, those who are receipt of more than £367 per annum in pensionable allowances would incur the pension penalty and have to pay 9.8% on all their earnings instead of 8.3% to remain in the pension scheme, further reducing their net disposable income, unless they opt out of the pension scheme.

Before anything else this small progress, where it is realised, has to be protected. If the 2025-26 award was to re-introduce the pension penalty and trigger the 1.5% extra pension contribution payments for all Band 5s reaching their first step, then their real disposable income would likely have again fallen in 2025-26. Alternatively many will choose to opt-out of the NHS pension scheme harming their future earnings in retirement. We know Band 5s already have one of the highest pension opt-out rates.

We also know the alternative, that choosing to work excessive hours in your early career, increases burnout and longer term retention challenges, as well as being bad for patients. This was also emphasised in Nightingale et al's research into why people leave radiography. **We urge the PRB to both recognise the positive impact of removing the pension penalty and the need for more targeted support for Band 5s and new professionals.**

We also urge the PRB to recommend closing the pay gap in this critical area in one go to send the clearest signal possible that the NHS is serious about a long term commitment to growing the professional workforce.

Further, we also **urge the PRB to recommend a joint review of the NHS pay and reward structure to explore and cost, ahead of the 2026-27 PRB process, of accelerating progress on supportive preceptorship for all new professionals at Band 5 with recommendations to utilise Annex 20, and accelerate progress into Band 6 where this can be professionally justified**. Appropriate, supported preceptorships can embed positive professional practice and discourage excessive working and early career burnout. Earlier access to Band 6 would also encourage recruitment from future graduates, and reduce excessive working and burnout.

Additionally, we urge the PRB to recommend the same review seriously explore the business case for all NHS graduates to have access to:

- Early career pension breaks or reductions to incentivise full engagement and career long membership of the scheme;
- Incentives for Trusts and new professionals to invest in subsidised housing for their new professionals – something that could be combined to fill vacancies in hard to fill geographic communities;
- Subsidised travel initiatives, which can also discourage driving to work and increase safety for women members of staff who would otherwise be at risk of lone travelling to and from work;
- Subsidised access to healthy, nutritional food for all staff when working, especially at night or long shifts, which would, we believe, disproportionately support younger staff and new professionals.

Assistant and support workforce (Bands 2, 3 and 4)

One of the greatest risks of separating the nursing profession from the rest of AfC would be losing the connection between the ever-important Assistant and Support workforce who are in Bands 2, 3 and 4 from the bands that require graduate entry, and the professionals they work most closely with.

Assistant practitioners and Imaging Support workers have been identified in the LTWP as critical groups to retain and grow. There is enormous potential to grow from within, by expanding and advancing Assistant

practitioners and Support grade staff, as recognised by the Richards Report. However, we are not doing enough to recruit and retain this critical strategic group to start with.

We have no doubt that some of our support-worker members would and should qualify for a regrading if the AfC job-evaluation scheme could be made to work. But we are equally certain that all of them deserve more competitive and fairer pay for what they do now.

Possibly the clearest case for immediate re-banding are in Trusts where radiography support workers are being held back in Band 2 roles. This simply shouldn't be the case as there is clarity in existing job profiles. Saving money by deliberately devaluing roles at the lowest end of the AfC scales is simply unacceptable and should stop. If this is not addressed nationally, it is very likely to continue to be a source of dispute and disruption until it is addressed.

In most Trusts key support roles in screening programmes are carried out by Band 3 trained support workers, while 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, while others Trust resist calls for re-evaluation saying they can't afford it and if successful they'd simply have to reduce staffing numbers or flexibility. This also needs to be addressed.

However, the SoR find that whether at Band 3 or 4 these members are aggrieved about being underpaid and relatively unrewarded. It is easy to see why.

Pay progression within band is an important element of public sector pay. However, in some grades this has been eroded far more than in others. In Band 3, in 2008 the pay range covered 16.4% min to max. If they were to then progress in their career and eventually reach the maximum of Band 4 they'd progress by a further 14.9%. However, currently the range from the starting point of Band 3 to the top of Band 3 is only 9.1%. If they were to progress their career to the top of Band 4 they would then only earn a further 11.9%. Combined the career progression for a support worker has fallen by more than a 1/3rd comparatively since 2008. Literally, the price of higher starting pay has been a cap on pay progression. Were they to gain promotion / obtain a revalorisation, their pay on moving from the maxima of Band 3 to the starting point of Band 4 would rise by only £10 a week net (from £398 to £408[xiii]). The net pay differential for someone at the top of Band 3 compared to the top of Band 4 is now only £36 per week net. Band 3 seem to have literally paid a price for higher starting pay.

This is in addition to their pay falling behind the rest of the economy more generally in the same period. Average pay across the whole economy has risen by 60% since April 2008, average total pay by 59%. So while it would be possible to argue that Band 3 starting pay has at least kept pace (rising by 62% after the 2024-25 award between 2008 and 2004) the maxima for Band 3 has risen by only 46%: a 13%-14% pay gap. This means someone at the top of Band 3 is being paid at least £3,338 per annum less than they'd expect to be earning if they had done almost anything else during the same period.

Band 4 support workers are the first NHS group where even their starting pay has failed to keep up with the growth of average total pay since 2008. Band 4 starting pay has risen by only 53% since 2008, a 6% pay gap and 9% less than the relative increase at Band 3 and Band 7 by comparison. They now also make much less relative progress than they would traditionally have expected – their maxima has increased by only 40% since 2008, presenting a 19% pay gap after the 2024-25 award – a difference of £5,532 per annum.

This level appears to have been tightly linked to the same % increase at the top of Band 5, despite many support workers in clinical imaging arguing that their roles have increased in complexity and responsibility. This fuels a sense of unfairness which we believe is making it difficult to retain vital experienced support staff in key areas. When experienced Band 4s look at their pay and realise they should be earning at least £34,646 p/a it isn't surprising some want re-banding as a Band 5.

We therefore believe that our proposed immediate restoration of starting pay for Band 5s would start to create the structural space for fairer pay for Band 4 and below.

Managers and leaders (Bands 8a and above)

The new government's emphasis on transparency and greater accountability around delivering high quality services to patients requires confident, appropriate local first line management and leadership. This requires well supported, motivated and therefore fairly paid managers. The opposite is currently true in the NHS – the scale of the problem and consequences of which are clear from our own surveys and members, including our Managers and Leaders Network members. Equally, as radiography becomes ever more central to patient pathways and controlling demand is critical to progressing patients efficiently and safely, moving radiographers into senior leadership roles would be hugely positive for the NHS. However, you may recall our 2022 evidence, using ESR data and our own evidence, highlighted 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 linked to working practices and the challenges facing a majority female workforce being denied flexible working in leadership roles – and part of it will be because the pay differential versus the level of responsibility is simply not worth the grief. This has to change if the NHS wants more and better key frontline leaders.

In late 2022 we launched a Manager Members' Survey. It found:

- Only 54% said they'd been in their post for three years or more, suggesting high turnover.
- 52% said they manage 20 or more staff.
- 39% said they manage 30 or more staff.
- 45% said they had received no specific training from their organisation in managing their team.

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. There is no significant difference between the number of extra additional hours worked regularly by members in different pay bands until 8b and above, averaging between four and six hours for Bands 5 to 8a, before rising to an average 11 additional hours a week for 8d. All bands have members working significantly longer than this at least occasionally, with the Working Time Regulation limits regularly passed by radiographers all bands.

Starting salaries from 8a upwards have been consciously reduced year-on-year by more than other bands. The minima for Band 8a has increased by only 45% since 2008, compared to 62% in Band 7. Compared to the increase in average total pay across the economy as a whole over the same period, this means a new band 8a is being underpaid by 14% or £7526 per annum. The starting position in 8b, 8c and 8d is comparatively even worse, at 43%, 42% and 41% respectively.

Even with the re-introduction of a Band 8 step point in the 2024-25 award, the reward for promotion from Band 7 to 8a is negligible. Excluding overtime, difference in pay from the top of Band 7 to the start of 8a

remains only 1.8% gross or 1.6% net – meaning the net take home pay increase on promotion would be £13 p/w. When our evidence shows most managers at 8a would be expected to work at least the same number of hours but be excluded from overtime is it still hugely probable that any radiographer obtaining promotion from Band 7 to 8a would see their pay fall as a reward. This is irrational – and when 74% of radiographers are women then increased potential for equal pay challenges cannot continue to be ignored.

Nor is progression through the Band 8 ranges yet resolved. While we welcome the reintroduction of a step point in each of the bands 8a and above, when compared to the closest comparator to a step point in 2008, these only emphasise how poorly these leaders have fared comparatively in the last 16 years – being worth 41% of the nearest comparator point in 2008 at 8a – compared with the equivalent step point in Band 5, which has increased by 51% in the same period. The reason for the deflation in a comparative step point is that the maxima for the highest bands have been consciously devalued by even more than other AfC grades since 2008.

Table 1 shows that the band maxima for Bands 8a and above have been devalued by around ¼ compared to pay across the economy as a whole since 2008. The maxima for 8a has lost 23% of its comparative values, equivalent of £13,916 per annum – or £1,160 per month. For 8b, the figures are 24% or £17,351 per annum (£1,446 per month); for 8c the figures are 26% or £22,256 per annum (£1,855 per month); for 8d they are 27% or £27,453 per annum (£2,288 per month); and for a Band 9 the difference is 29% or £35,168 per annum (£2,931 per month).

On these figures is it any wonder that ambitious and capable AfC professionals would look outside the NHS or outside the UK to fulfil their potential and feel valued? As stated above, the reintroduction of steps for Bands 8a and above in the 2024-25 award was a long overdue start to recognising the failing pay system for managers and leaders , but there remains a significant way to go before the problem is even close to being redressed**.** We therefore recommend that an urgent start is made in 2025-26, with a minimum increase to the starting point for all bands upwards of 8a of at least 10% above the headline rate. This will make a serious inroad into starting pay restoration, signpost clear recognition of the problem and create some headroom underneath for structural reform from Bands 5 to 7.

Conclusion

In recent years, the SoR's set out similar arguments, data and research in our PRB evidence. Each year we have done so in the hope the critical, central importance of addressing the radiography workforce crisis could be evidenced and recognised. We did the same in 2024-25 when all other unions boycotted the PRB process. We do so again this year.

Each year our evidence covers not only the challenges around pay and reward but also some of the context behind these challenges – the how people are treated, why and how these impact upon recruitment and retention. The PRB remit extends further than merely how much people should be paid but also to equality and fairness which underpin recruitment and retention – as well as patient interests. Again we have done the same this year, especially highlighting some of the inequality risks that are ever more evident across the NHS.

We have also made the consistent case for investment in more staff as well as higher pay and reward. We recognise evidence shows people don't just leave the NHS for more pay and that, for example, access to flexible working is usually cited more prominently than pay as a reason for going elsewhere. This is part of why we cite examples of wider rewards and targeted incentives that could significantly help boost morale

and retention. However, we again also make the point that uncompetitive pay and reward are a key signpost to the overall recognition and standing of these critical professionals and as such, an essential part of securing the sustainable recruitment and retention levels needed to meet the NHS and patients needs now and into the future. We have to get ahead of the demand curve and to date our evidence in this regard has not been recognised. This year we have highlighted areas, such as agency and outsourcing costs, or the failure to maximise the potential of CDCs set out in the Richards Report, as examples of false economies arising from the failure to provide a fair core recruitment and retention offer.

The SoR is also proud to be politically independent. Therefore, each year we have highlighted how the workforce crisis is founded upon short-term political choices – chiefly to under-fund the NHS and social care. Laid on top of these foundations is the complicity of NHS leaders in compromising around these poor choices, then failing to develop and sustain a credible strategic workforce plan. These weak foundations are now evidently threatening to bring down the AfC structure, with others already looking to succeed from the AfC union.

Therefore, much of our evidence and argument may sound familiar to the PRB. However one key thing has changed in 2024. We now have a new government, elected in large part because of a recognition that the NHS is not working. Already we have heard much that is encouraging about both additional investment in staff and equipment, including some targeted specifically at the radiography workforce crisis. While the limited progress in closing waiting lists has to be acknowledged and signposts the scale of the challenge and investment needed a government inviting all stakeholders to look for and help develop a long-term strategic consensus around what needs to happen to save the NHS has to be recognised and welcomed.

Therefore, this year of all year's the PRB must be prepared to fulfil its full remit and consider recommendations that start to make the significant difference needed to overcome the workforce crisis and save the NHS. We believe this requires the PRB to support a series of actions – some of which are immediate, others where the costs and details will need to be worked up from now as part of a comprehensive joint review of the whole AfC pay and reward structures. We believe this combination of actions will secure momentum for change and signpost to key parts of the workforce that change is coming if they stay in the NHS.

Therefore we propose the PRB recommends:

A comprehensive joint review of the current pay and reward structures. This would aim to achieve reforms that better support the aims of the Long Term Workforce Plan (LTWP) around recruiting and retaining a highly skilled workforce. We suggest the outcomes from this should be implemented as they are agreed, and completed in full to support the 2028-29 pay round and beyond. The outcomes of the review should therefore secure:

- Sustainable pay restoration to 2008 levels in a credible period for all grades, alongside agreed tracking measures to inform future pay setting that remove the risk of NHS pay ever again falling behind average total wage growth across the economy. This could be supported by mechanisms such as guaranteeing minimum future headline awards at least 1% above inflation and/or average pay increases during the previous year.
- Testing any new pay rates and rewards to secure safe and sustainable pay rates at all grades.
- A full equality audit of new rates and systems to secure confidence in sustainably fair and equitable pay across the NHS.

- A full review of job profiles and role boundaries to recognise changes to working practices and professional roles across AfC, but not in lieu of whole band pay restoration. This review would ensure the AfC Job evalution system remains fit for purpose and can safely deliver fair and equitable pay and reward for all groups of staff.
- Identified levels of funding anticipated over the period of the 10-year plan, so that the LTWP can be met. These can then be independently audited and tracked against changes in demand and progress towards targets for all professions as set out in the LTWP.

A significant above inflation pay award for all AfC staff at all grades for 2025-26. This will help to begin to restore NHS pay comparative to the rest of the economy and bottom out the unfairness and inequality arising from 14 years of undervaluing and under funding NHS staff.

Immediately restoring the starting rate for Band 5 to the level it would have been if it had grown in line with the rest of the UK economy since 2008 – an 11% increase.

Immediately increasing the starting point from 8a upwards by a minimum of 10% more than the headline increase, with a commitment to restore the rate of starting pay for these leadership grades by 2027.

- These two measures combined will create some pay room to reframe and restructure pay more widely in line with the recommendation below for a full pay and reward review.

Specifically promoting the use of Annex 20 more widely than it is currently used to accelerate progression for AHP professionals while a full pay and reward review is being undertaken.

Highlighting the positive impact of removing the Band 5 step pension penalty, and ensuring that none of the pension thresholds move for those working regular contracted hours in 2024-25, while also recognising the need for any pay and reward review to be risk assessed against pension thresholds).

Recognising the mounting inequity and unfairness arising from the tensions between the workings of the AfC pay and poorly placed pension contribution thresholds.

- The PRB could decide to make specific recommendations to immediately ease these challenges and risks or it could call for a parallel review of pension rates and contribution thresholds in line with the wider review of AfC pay, reward and systems. If calling for the latter it should specifically recognise that future pay awards would have to directly offset remaining risks around unfairness and inequality left after such a pension review.

An urgent review of the NHS Handbook so that amendments can specifically prevent:

- Reducing pay and other terms and conditions for any NHS staff engaged on a Bank in relation to their equivalent substantive terms.
- Any NHS staff member being asked to take a pay cut to complete training in a higher, enhanced or advanced practice where qualifications would help address a critical skills shortage.

Exploring a series of softer, targeted benefits that should be developed and piloted during 2025-26 for wider assessment and implementation following completion of a wider pay, rewards and AfC system review. These should include:

- Recommending employers subsidise nutritious food for NHS staff
- Recommending employers consider subsidised travel for NHS staff, especially those who work at night

- Student loan holidays for new professionals and those who take up posts in hard to fill areas or professions, with the possibility of extending these to all NHS professionals being costed and explored.
- Examining opportunities for supporting subsidised rent and housing for key groups of staff – especially international recruits, new professionals and those moving to take up posts in hard to fill areas or professions.
- Resourcing minimum protected study time for training and professional development.

An urgent joint review of the package of support, systems and processes needed to improve and encourage sustainable international recruitment and retention – including pay and reward, induction, professional training and development and accessible practices.

Ensuring international recruits are included in any incentives around pensions, housing, food, training and preceptorships, etc proposed for other groups of staff.

We also recommend that the PRB clarifies an expectation that the full, comprehensive joint pay and reward review has included within its remit:

- Address equal pay, recognising and amplifying the equal pay challenges evident in the NHS – the Uk's biggest employer.
- An assessment of what a competitive international recruitment offer should contain to sustainably recruit and retain radiographers, and other key shortage professions
- A full review of Bank contracts so that they cannot be used as a means to reduce wider terms and conditions.
- Modernisation of the role of the PRB as a genuinely independent body that reviews the impact of pay and reward strategies against the benchmark of continued progress and assessment of the LTWP, including adjustments for changes in known demand and where progress happens more quickly or more slowly than anticipated in the plan.

We also call on the PRB to make specific recommendations to government to establish means to better track workforce data across the NHS. A strategic LTWP but be the anchor to future pay and reward policy over the period of the 10 year NHS recovery plan. Without confidence in accurate and detailed data by specific profession it will be impossible to accurately track and respond to shifts in recruitment, retention and wider demand. This also needs to be extended to detailed, clear analysis of recruitment and retention of international recruits by professional group, and should be able to illustrate full equality auditing.

References & Further reading


NIB Programme Pack - Dec 2023.pdf


DWTA-September-2024-Report_9CL34R.pc


RA Renewal Demographics 2024 (


PRB Research analysis 2024.xlsx


pay restoration table sept 224.xlsx

---

[i] PRB Evidence February 2024 GetFile.aspx
[ii] NHS England » Diagnostics: Recovery and Renewal – Report of the Independent Review of Diagnostic Services for NHS England
[iii] APPG for Diagnostics – New report examines government's
[iv] The NHS 10-year Plan | The King's Fund
[v] https://www.gov.uk/government/statistics/2023-nhs-national-staff-survey
[vi] https://www.independent.co.uk/news/uk/hospitals-nhs-alan-jones-b2651210.html
[vii] Diagnostic Waiting Times and Activity Report
[viii] Introduction - NHS England Digital
[ix] Diagnostic Waiting Times and Activity Report
[x] Retention of radiographers in the NHS: Influencing factors across the career trajectory - Radiography (radiographyonline.com)
[xi] SoR PRB Submission February 2024 | SoR
[xii] 25042024_Supporting-International-Recruitment-—-Principles-and-Standards-Final
[xiii] 2024/2025 NHS Hourly Pay Rates Gross & Take Home