Summary of Offer to BMA UKRDC

Introduction

There are **five parts** to this offer:

1. **Pay:** Nodal Point Reform in addition to annual pay awards, as informed by the DDRB – the revised pay structure will improve retention and unlock productivity, with the values of the revised pay scale fully realised in 2027/28.
2. **Wider Support Measures**: Funding to cover:
    - the fees of the first two attempts of mandatory royal college exams from April 2026;
    - the fees of royal college and faculty membership and portfolio fees from April 2027; and
    - an increase in the Clinical Academic Flexible Pay Premia from £5.6k to £10k from April 2027.
3. **Access to Training Places:** A package of measures designed to address the BMA's concerns about access to specialty training places and secure the future employment of resident doctors.
4. **Measures to improve the working lives of resident doctors:** including contractual standardisation for Locally Employed doctors (LEDs),[1] and improvements through the 10 Point Plan and Medical and Education Training Review (METR).
5. **Future Working Arrangements:** The BMA UKRDC will be a crucial partner in the delivery and implementation of this deal. This will be operationalised through the establishment of the Industrial Relations Committee. Membership and Terms of Reference of this Committee is to be agreed.

This deal aims to:

6. Set the foundations for more positive industrial relations between resident doctors and government and end the dispute on training places and pay, so that doctors now and in the future can feel valued and secure working and training in the NHS.
7. Better recognise the productive value and service being delivered by resident doctors by allowing them to progress as they gain more competencies - whether they are in formal training or employed locally.
8. Address the bottlenecks that have emerged in speciality training through a combination of additional posts which will mean that resident doctors can better progress through their training and careers.

[1] Reference to LEDs throughout this document is regarding locally employed doctors paid according to a pay point equivalent to a pay point that exists under the 2016 Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) (TCS) or 2002 TCS.

9. Recognise the value of Locally Employed Doctors (LEDs) who play a vital role in the NHS and should benefit from the same pay, benefits and conditions as their counterparts in formal training, where possible.
10. Enable equal opportunities for pay progression for Less than Full Time (LTFT) doctors in training who will be supported to have their Annual Review of Competence Progression (ARCP), at 12 months as the standard, whilst retaining the flexibility to have it later.

Part 1: Pay

Pay for 2026/27

11. In July 2025, the Department of Health and Social Care (DHSC) remitted the independent pay review body on Doctors' and Dentists' Remuneration (DDRB) and subsequently received pay recommendations for doctors in training in March 2026.

    I. DHSC has accepted the headline pay recommendation for Resident Doctors of the Review Body on Doctors' and Dentists' Remuneration (DDRB) of 3.5%, with an effective date of 1 April 2026. Pay will be backdated to 1 April 2026.

    II. This nodal point reform will be applied in addition to the DDRB increase, as set out below. This will also be backdated to 1 April 2026.

Pay for 2027/28 and 2028/29

12. By committing to engage in the independent pay setting process for this year and beyond, both the BMA UKRDC and DHSC ensure that pay setting remains independent from government. This allows the DDRB to consider various factors and evidence submitted by both the government and other organisations, including the BMA.

    I. The Department of Health and Social Care and BMA UKRDC commit to continue to engage in the DDRB process as the means for setting resident doctors' pay.

    II. As part of the commitment to engage in this deal, both DHSC and BMA UKRDC will submit evidence each year to the DDRB.

13. DHSC will highlight in its remit letters and evidence to the DDRB that Government investment into this deal beyond the DDRB recommendations, including nodal point reform, is intended to recognise the greater service and the system gains as resident doctors progress and work more productively. It is not the government's intention that this is considered as a substitute for a future pay award.

Nodal Point Reform

14. Resident doctors gain valuable experience at each stage of their careers - both within formal training programmes and outside them. However, recognition typically occurs only at specific training milestones, which can create unnecessary obstacles for advancement – particularly for LEDs. This limits opportunities to enhance productivity across the training pathway, and in the service.

15. This proposal sets out to change the way in which the NHS recognises and remunerates resident doctor skills. It introduces additional pay-steps which will allow for more frequent pay progression for both doctors in training and LEDs.

These uplifts will be directly linked to competencies, and the service will benefit from productivity gains.

16. This is significant pay scale reform, which will be phased over two years.

Year 1:

17. As a result of the DDRB award all resident doctors will receive a minimum increase of 3.5% compared to 2025/26.

18. With the nodal point reform also applied, Foundation Year 1 and Foundation Year 2 doctors will receive the full extent of proposed investment – with a cumulative total of 6.2% and 7.1% respectively in Year 1 compared to 2025/26, while Resident doctors at 3a, 3b, 4b and 5b will receive a minimum cumulative total of 4.5% compared to 2025/26. Resident doctors on nodal points 4a and 5a still receive a minimum of 3.5% compared to 2025/26. Full details are set out in the table below.

Year 2:

19. All resident doctors will benefit from the annual pay uplift arising from the DDRB process for 2027/28 when it is known. The final stage of nodal point reform will be implemented, in line with what is set out in Table 1 below.

Table 1: New pay-scale and cumulative increases compared to 25/26 by the end of the deal.

	Nodal point	2025/26	2026/27 (DDRB +NPR)*	Cumulative % uplift from 2025/26	2027/28**	Cumulative % uplift from 2025/26
Foundation Year 1	**1**	**£38,831**	**£41,226**	**£2,395 / 6.2%**	**£41,226**	**£2,395 / 6.2%**
Foundation Year 2	**2**	**£44,439**	**£47,610**	**£3,171 / 7.1%**	**£47,610**	**£3,171 / 7.1%**
ST1 / CT1	**3a**	**£52,656**	**£55,355**	**£2,699 / 5.1%**	**£55,534**	**£2,878 / 5.5%**
ST2 / CT2	**3b**	**£52,656**	**£55,355**	**£2,699 / 5.1%**	**£56,925**	**£4,269 / 8.1%**
ST3 / CT3	**4a**	**£65,048**	**£67,325**	**£2,277 / 3.5%**	**£67,325**	**£2,277 / 3.5%**
ST4 / CT4	**4b**	**£65,048**	**£67,998**	**£2,950 / 4.5%**	**£69,345**	**£4,297 / 6.6%**
ST5	**4c**	**£65,048**	**£67,998**	**£2,950 / 4.5%**	**£71,415**	**£6,367 / 9.8%**
ST6	**5a**	**£73,992**	**£76,582**	**£2,590 / 3.5%**	**£76,582**	**£2,590 / 3.5%**
ST7	**5b**	**£73,992**	**£77,348**	**£3,356 / 4.5%**	**£78,660**	**£4,668 / 6.3%**
ST8	**5c**	**£73,992**	**£77,348**	**£3,356 / 4.5%**	**£80,730**	**£6,738 / 9.1%**

*The 2026/27 pay-scale includes both the impact of the accepted 3.5% DDRB recommendation and the subsequently applied negotiated nodal point reform increases.

**The pay award remains unknown for 2027/28; we commit to engaging with the independent pay process for this year.

Note: Exemplars for those at various nodal points are provided in Annex A

Details of the changes:

For doctors in training programmes:

20. Progression through pay points for doctors in training programmes will be linked to the achievement of competencies required for advancement during the Annual Review of Competence Progression (ARCP), thereby creating the opportunity for annualised pay progression.
21. This process applies to Less Than Full Time (LTFT) doctors in training - to enable the opportunity for equal pace of progression, ARCPs will be set at 12 months by default for both full time and less than full time doctors in formal training. Doctors working LTFT will also retain the option for an ARCP at the equivalent to 12 months full-time and inform their Training Programme Director of their choice.
22. Where full-time doctors are consistently working above 40 hours per week on average and have gained additional competencies, employers will more widely utilise the existing option to bring ARCP panels forward, if and where this is agreed with their clinical supervisor. Doctors will also continue to have the right to request an appeal of their ARCP Outcome decision.
23. We will work together to develop and enforce a national set of terms and condition for LEDs that mirror all areas of the 2016 RD contract and with equivalent status to other national contracts, aside from amendments to reflect their non-training status and appraisal processes.

For Locally Employed Doctors

24. NHS England will design an enhanced annual appraisal by October 2026 for locally employed doctors that will be conducted by trusts, to allow doctors to demonstrate attainment of relevant competencies to achieve pay progression from August 2026. This appraisal process will apply to all LEDs on contracts that mirror the 2016 Terms and Conditions of Service for NHS Doctors and Dentists in Training (TCS).
25. UK RDC will be involved and consulted during the design and implementation phases of the new enhanced appraisal process.
26. This process will assess if an LED is able to perform the competencies required to work at a higher level in a specialist field.
27. Experience and competencies gained outside of formal training can be recognised in the enhanced annual appraisal. This will be the means through which LEDs are able to access the opportunity for annualised pay progression.
28. This process applies to LTFT LEDs – who can unlock the same opportunity for annualised pay progression at their enhanced annual appraisal, subject to demonstrating the relevant competencies.

29. Furthermore, on re-entry to formal training, LEDs may have their competencies recognised towards training by requesting a review of their competencies at an early ARCP within the first three months, after beginning training. This means that completion of that stage of formal training could be quicker on re-entry.

30. To ensure enhanced appraisals are fair and consistent for LEDs, competencies will be signed off by a supervisor or a doctor with relevant clinical experience.

For Foundation Year Doctors

31. The proposal will uplift the F1 basic salary in year one of this deal from £38,831 in 2025/26 to £41,226, including the DDRB recommendations and reform, which recognises the growing complexity, pressures and increased competition recent postgraduates are experiencing.

32. The proposal will uplift the F2 basic salary in year one of this deal from £44,439 in 2025/26 to £47,610, including the DDRB recommendations and reform, recognising they become fully registered doctors with the General Medical Council and can offer greater productivity.

33. By Foundation Year 2, resident doctors will have developed their skills and will work faster, more safely and with fewer prompts, enabling them to progress.

Productivity

34. By linking pay progression to training and competencies, we hope to recognise and reward Trainees and LEDs at each step of the pathway, to make sure that they are incentivised to complete the various steps and unlock pay increments.

35. With enhanced appraisals, trusts will be supporting LEDs to illustrate how they are demonstrating the development of their skills, with their pay progressing accordingly, and resultantly rewarding LEDs for the competencies that they have developed.

36. At each of these stages, these additional pay increments will reflect increasing capability and therefore productivity gains as all doctors progress. The productivity gains will be appropriate to the different stages of training and competency– and most fruitful in later stages of training – e.g. at ST5 onwards – unlocking responsibilities such as autonomous practice, supervision of trainees through procedures, Board Rounds etc. These will be different for each specialty.

Part 2: Wider Support Measures

Royal college mandatory exam fees

37. Resident doctors in training and local employment experience uniquely high and frequent examination costs as they train, and to progress. In recognition of this pressure, we will allocate funding to reimburse royal college and faculty exams.

    - Additional funding will be allocated to cover mandatory Royal College examination fees for resident doctors in training and local employment, in England (the first two attempts per mandatory exam).
    - By mandatory we mean those exams that a resident doctor must take in order to complete training and obtain a Certificate of Completion of Training (CCT) in their chosen specialty. This will cover all specialities.
    - Where multiple royal college and faculty examinations are necessary in the case of dual accreditation or practice, this will be permitted.
    - It is acknowledged that a resident doctor may sit these exams while working as a Locally Employed Doctor before entering training.
    - Individual resident doctors will receive direct reimbursement from employers who will be provided funding.
    - DHSC, NHSE and the BMA UKRDC will work with the Royal Colleges and the GMC to establish an agreed list of examinations that will be covered, which would be subject to review as requirements change.
    - Relevant dental exams will also be covered as part of this offer, the details of which will be confirmed with the BDA.
    - As per existing arrangements, the Advanced Life Support training will be funded locally for resident doctors if it is mandatory for training, and for locally employed doctors where it is mandatory for the role.
    - Reimbursement will begin for exams sat from 1 April 2026.

Royal College and Faculty Membership and Portfolio Fees from 1 April 2027

38. Resident doctors in training and local employment experience uniquely high cost and mandatory royal college and faculty memberships and portfolio fees, required for progression and re-validation.

    - Whilst RDs will still need to pay these fees upfront they will be eligible for reimbursement for mandatory royal college and faculty memberships and portfolio fees required for progression and re-validation
    - Where multiple royal college and/or faculty memberships are necessary in the case of dual accreditation or practice, this will be permitted.

- It is acknowledged that a resident doctor may be a member of a royal college and/or faculty and complete/maintain a portfolio while not in formal training.
- Individual resident doctors will receive direct reimbursement from employers.

Clinical Academics Flexible Pay Premia

39. In recognition of the increased impact on lifetime earnings the nodal point reform would make on clinical academics specifically, this offer would increase the Flexible Pay Premia for Clinical Academics to £10,000 effective from April 2027.

Part 3: Access to Training Places

Up to 4,500 Specialty Training Posts

40. Alongside addressing training bottlenecks through the Medical Training Prioritisation Act, we will increase the number of specialty training posts, whilst maintaining the quality and experience of training.
    - A minimum of 4,000 new additional specialty posts will be delivered over the next 3 years.
    - At least 1,000 of these specialty training posts, are planned to be delivered by August 2027, with 250 of these roles starting in February 2027.
    - The February 2027 starts will be additional NTNs.
    - The remaining 3,000 speciality training places will be implemented over the following two years.
    - Up to a further 500 places will be made available over the second and third year of this agreement, if there is sufficient service appetite, training capacity and patient need as advised by the Training Allocation and Distribution Group (explained below).
    - Trusts will be asked to create these roles with funding partially coming from repurposing spending on medical locums, agency work and some LED roles coming to an end. No LED contract will be terminated early as a result of job conversion into training posts.
    - We will seek to maintain a sustainable level of workforce growth into the future subject to future spending reviews and the ongoing review of the 10 Year Workforce Plan.
    - Working together with NHS England who have oversight of postgraduate training, the Training Allocation and Distribution Group, will review training post distribution across core and higher to ensure workforce alignment with future population healthcare needs and to ensure alignment with post-CCT (Certificate of Completion of Training) vacancies.

Establish a group to manage distribution of the training places

41. With the introduction of up to 4,500 specialty training posts, the views of resident doctors will be taken into account when determining where these posts should be distributed and in which specialties, alongside current and future patient need and service capacity.

42. We will establish a " Training Allocation and Distribution Group" (TADG) as a forum to consider the expressions of interest for additional speciality training places from trusts. The TADG will bring together clinical and workforce planning views – including the BMA UKRDC - to assess any proposals against current and

future patient need, service capacity, RD experience and quality assurance of training. The Group will draw on national and local data, to agree the appropriate distribution of the new specialty training posts, geographically and by specialty. The Training Allocation and Distribution Group will consider the distribution of additional specialty training posts in forthcoming years.

Supporting career progression opportunities for Locally Employed Doctors

43. In addition to the up to 4,500 posts, we will work with the BMA RDC to support progression opportunities for Locally Employed Doctors to gain core specialty competencies through structured support allowing them to progress in higher training or as a SAS doctor.

Part 4: Measures to improve the working lives of resident doctors

Locally Employed Resident Doctors Contract

44. LEDs are employed on varied terms and conditions. Standardising and reforming terms and conditions for LEDs will be key to enabling them to benefit from Nodal Point Reform, the introduction of the Enhanced Appraisal and supporting LEDs to have better access to supervision and workplace protections.

45. In the first instance, we will expect that trusts move LEDs onto repurposed 2016 contracts by September 2026, while a new standardised contract is developed should the doctor wish to.

46. From August 2026, employers will be expected to transition LEDs to substantive employment contracts, except where there is a legitimate reason to use a fixed term one (e.g. where a person is employed for the purposes of covering a secondment, long term sickness, maternity, paternity shared parental leave or adoption leave).

47. The Resident Doctors Industrial Relations Committee and relevant stakeholders will work together to develop and enforce a national set of terms and conditions for LEDs that mirror all areas of the 2016 RD contract and with equivalent status to other national contracts, aside from amendments to reflect their non-training status and appraisal processes.

48. The enhanced appraisal for resident doctors will become the default mechanism to assist LEDs to identify gaps in their competencies and their development needs. It will also be the mechanism for determining pay progression. The enhanced appraisal will be developed by October 2026 and a new standardised contract for LEDs will be fully implemented by April 2027.

49. NHS trusts will be expected to offer all LEDs the opportunity to migrate to the new contract.

50. Where LED posts have been identified for conversion into training posts, DHSC will expect employers to give as much notice as possible to the individual doctors occupying those posts. Where possible, this should be greater than the existing contractual notice period. This will need to be determined on a case-by-case basis.

51. To ensure that the measures set out above are adhered to and enacted in trusts, monitoring and compliance measures will be taken forward by the 10 Point Plan and the Resident Doctor Industrial Relations Committee (please see further information in Part 5 below).

2002 Contract Phase Out

52. The expectation following the introduction of the 2016 contract has been that the 2002 contract will be phased out. However, we note that some trusts still use these terms for employing LEDs.
53. We will remove the 2002 pay scales from the circular, archive it and the current transitional pay protection will expire in August 2026 as currently described in the TCS.
54. A new pay protection mechanism for locally employed doctors on 2002 pay transferring over to 2016 terms will be devised, which will be designed to cater to the additional pay points. There will be guidance provided on managing this transition and best practice for employers.
55. Employers should move any existing doctors either onto 2016 TCS pay points or onto locally approved scales. Where doctors remain on locally approved scales our expectation is that these will be maintained locally in line with annual pay uplifts.
56. Locally approved scales may only be available in specific situations, such as when a resident chooses to stay on 2002 TCS or where other bespoke arrangements are mutually agreed between providers and resident doctors. Trusts will need to make sure that this is appropriately recorded and logged on the NHS Electronic Staff Record workforce services.

Involvement in Medical and Education Training Review (METR)

57. Phase 2 of the NHS England Medical and Education Training review, chaired by Dame Jane Dacre will address issues highlighted in the first phase, including focusing on workforce needs, better service integration and trainee wellbeing.
58. BMA UKRDC will be key stakeholders of Phase 2 of the Medical and Education Training Review.
59. The BMA will be engaged in all workstreams of the METR.
60. Resident doctors, including the BMA UKRDC will be involved in the workstreams of the METR.
61. We expect the METR to impact on the role of the Deaneries in the long term. More immediately, as part of the work to abolish NHSE and create a new Department of Health and Social Care, we are considering how more functions might be devolved to regions and trusts, in line with the aims of the 10YP. The BMA UKRDC will be engaged in these developments to ensure that any reforms result in better trainee experience and outcomes.

Continuous Improvement and expansion of the 10 Point Plan

62. The 10 Point Plan sets out to fix unacceptable working practices and get the basics right for resident doctors. We will continue to deliver the 10 Point Plan.
63. As part of this deal, we will look for ways in which to enhance and go further on the 10 Point Plan.
64. New aspects included in the 10 Point Plan going forward will be:
    - Ensuring that trusts adopt a repurposed 2016 contract for LEDs.
    - Determining what will be captured in the Lead Employer Model
    - Resident Doctor Peer Leads will be supported by Senior Board Leads and non-executive directors to achieve the necessary improvements to the working lives of resident doctors.
    - Trusts will continue to monitor their performance against the key 10 actions and include a report on this in their Annual Accounts.

Review aspects of Exception Reporting

65. It is recognised that the implementation of improvements to Exception Reporting has proven more complicated than planned and is causing concern in many places, for example the geolocation and corroboration requirements. These are not intended to question the probity or professionalism of doctors, and the Resident Doctors Industrial Relations Committee will review implementation and identify good practice that meets governance requirements in ways that command the support of the BMA RDC. Where mutually agreed, viable alternatives identified through this process will replace current practices.

Reframing the GP Flexible Pay Premia (FPP)

66. The 2016 TCS categorises the GP FPP as part of the “hard-to-fill training programmes”. In recent years, there has been significant numbers of applications to general practice training posts and therefore would not meet the definition as “Hard to Fill”.
67. As part of the offer, we will rename the GP Flexible Pay Premia to the General Practice Registrar Enhancement.
68. We will separate it from the hard to fill section in the Medical and Dental Pay Circular, in recognition of its actual purpose within the contract and its value to GP registrars.
69. Whilst it will be separated from hard to fill supplements, it will retain all contractual provisions associated with hard to fill supplements, such as the pay protection arrangements related to hard to fill specialities for doctors moving between specialties.

70. We will commit to introduce these changes during the update of the TCS and pay circular as part of this deal.

Part 5: Future Working Arrangements

71. A Resident Doctors Industrial Relations Committee (RDIRC) comprised of DHSC, NHS England, NHS Employers and BMA UKRDC will be set up to monitor and ensure the implementation of all elements of this offer are upheld in the spirit of the agreement and that timelines are met.
72. 'Task and Finish' groups consisting of a range of relevant stakeholders will be established and will be responsible for delivering strands of the deal. They will report to the RDIRC.
73. The RDIRC will be empowered to hold 'Task and Finish' groups to account and will be responsible for steering changes.
74. A Terms of Reference will be agreed, and this will outline a shared understanding of the governance arrangements and escalation pathways.
75. National collective bargaining arrangements will be set up to deliver regular maintenance of the doctors in training contract and address future national Resident Doctor disputes in a timely manner with the exception of pay, as well as to ratify arrangements made as part of this deal which apply to the contract.
76. DHSC and NHSE will be observers only to this process and can by invitation provide subject matter expertise.
77. The BMA, DHSC and NHSE will review areas impacting the working lives of resident doctors which sit outside of the remit of national collective bargaining to ensure that resident doctor voices are represented.

Implementation and Timeline

Once the deal is confirmed, we will establish the Resident Doctors Industrial Relations Committee for the duration of implementation.

Proposals	Year 1 26/27	Year 2 27/28	Year 3 28/29
Part 1: Pay			
NPR	Phase 1 including introduction of Enhanced Appraisal for LEDs by October 2026	Phase 2 implemented in April 2027	N/A
Headline Pay	DDRB accepted and backdated to April 2026	Engage in DDRB process	N/A
Part 2: Wider Support Measures			
Mandatory Exam Fees	Implemented and backdated to April 2026	Continued	Continued
Mandatory Royal College Membership and Portfolio Fees		Implemented from 1 April 2027	Continued
Increase to the Clinical Academic Flexible Pay Premia		Implemented from 1 April 2027	Continued
Part 3: Access to Training Places			
Up to 4,500 specialty training posts (minimum 4,000 with a potential to increase by a further 500 based on trust appetite	Recruitment begins for up to 250 NTNs starting in February 2027. Recruitment begins for 750 speciality training posts introduced by August 2027	Recruitment begins for up to 1,750 training places to be implemented in regular recruitment cycles – including February (Y2)	Recruitment begins for up to 1,750 training places to be implemented in regular recruitment cycles – including February (Y3)

and service need in future years).		(includes 250 additional places subject to training capacity and service need)	(includes 250 additional places subject to training capacity and service need)
Training Distribution Group	Established Summer 2026 to agree distribution for 2027 starts	Meet to agree distribution 2028 starts	Meet to agree distribution of 2029 starts
Part 4: Measures to improve the working lives of resident doctors			
Locally Employed Resident Doctors Contract	National contract for LEDs is developed, by February 2027		
2002 Contract Phase Out	Introduced by August 2026		
Involvement in METR	Established	Review	Review
Continuous Improvement of the 10 Point Plan	Established	Review	Review
Rename GP Flexible Pay Premia (FPP) and list it separately in the pay circular	Introduced by August 2026		

NB: Where sections refer to ‘established’ and ‘review’, this is based on work being established in this area and then reviewed in later years if the workstream is needed.

Expectations in return for reform

78. If this offer is accepted, both parties will be committing to implementing this deal and to working together in the spirit in which it has been designed.

End of the disputes on pay and training places.

79. In accepting this offer, the BMA Resident Doctors Committee in England commit to the following:

    - The BMA, the Resident Doctors Committee and its officers will consistently and firmly recommend to their members that this offer be accepted, highlighting it as the best negotiated outcome that can be secured, and representing a comprehensive, fair and reasonable settlement of the dispute.
    - That the acceptance of the offer by members terminates the present trade disputes with the government in relation to the resident doctor workforce in England;
    - That accepting the offer will see both BMA RDC and DHSC commit to facilitating industrial stability and cooperation whilst the deal is implemented.

Implementation of the Deal

80. The BMA Resident Doctors Committee and DHSC, along with NHS England and NHS Employers will engage fully in the Resident Doctors Industrial Relations Committee, to implement and address any concerns about the implementation of this deal, and to ensure resident doctor grievances are addressed in a timely and collaborative manner to the benefit of Resident Doctors, Employers and the users of the NHS.

81. In the event that either party seeks to engage a process outside of the RDIRC to resolve an issue or dispute covered by this deal, the terms of this deal will be considered to have been broken.

82. Either party may in the event that the deal is broken by the other party need to review and assess the feasibility of continuing to implement aspects of the deal. In relation to the Department for Health and Social Care it will review and assess feasibility. In relation to the Department for Health and Social Care it will conduct this assessment, subject to considering affordability, capacity limitations, and other practical factors that may arise as a consequence of national industrial action.

Annex A: Exemplars of nodal point reform

The examples below are intended to illustrate hypothetical scenarios and may not reflect actual circumstances.

The figures presented below reflect the impact of the nodal point reform increases over two years (incorporating the 2026/27 DDRB outcome). Final pay scales for 2027/28 will reflect respective DDRB outcomes for those years.

Example 1: Core Surgical Trainee

Resident Doctor W is a full-time core surgical trainee (CT1) who was being paid a basic salary of **£52,656** in 2025/26, they have the intention to continue in formal training. If this offer is accepted, then their basic salary at CT1 will be **£55,355** in 2026/27 building on the DDRB uplift that is already applied. If they complete their ARCP they will become a CT2 in August 2026.

In April 2027, the final stage of nodal point reform will be implemented, this means that as a CT2 they can expect their pay to increase to **£56,925**, even before that year's DDRB outcome is applied.

Resident doctors in training will continue to benefit from Government investment in training worth approximately **£14,000** per training post per year.

Example 2: Higher Specialty Trainee in paediatrics

Resident Doctor X is a full-time higher specialty trainee (ST6) on paediatrics who was being paid a basic salary of **£73,992** in 2025/26. If this offer is accepted and they complete their ARCP each year, their basic salary will be **£76,582** during the first year rising to £77,348 when they complete their ARCP and move to ST7. Their pay will then increase to **£78,660** in April 27, excluding the impact of future DDRB outcomes.

Resident doctors in training will continue to benefit from Government investment in training worth approximately **£14,000** per training post per year.

Example 3: Locally Employed Doctor working in Emergency Medicine

Resident Doctor Y has been working as a full time locally employed doctor (ST1) since completing their foundation training and has been seeking to apply to core specialty training.

If this offer is accepted, then their basic salary which was **£52,656** in 2025/26 will be **£55,355** in 2026/27 building on the DDRB uplift that is already applied. If they have been developing their competencies these will be assessed in the annual enhance appraisal and will allow higher pay steps to be unlocked.

Example 4: Locally Employed Psychiatrist progressing outside formal training

Doctor Z is a locally employed psychiatrist (working at ST4-equivalent level) who was being paid a basic salary of **£65,048** in 2026/27. If this offer is accepted, then their basic salary will be **£67,325** in 2026/27 building on the DDRB uplift that is

already applied. If they subsequently complete their enhanced appraisal demonstrating their competencies equivalent to ST4 their basic salary will increase to **£67,998**, with a further increase in April 2027 to **£69,345**, even before that year's DDRB outcome is applied.

Annex B: Exemplars of reimbursed exam fees

Exam fees vary from specialty to specialty however for most doctors represent a significant financial cost to progress through training.

Below are three illustrative examples of the types of mandatory Royal College exam fees which will be reimbursed from **1 April 2026**. Please note that exam fees are subject to change; these examples use the rates as of **March 19, 2026**.

Psychiatry:

Exam	**Fee**
MRCPsych Paper A	£568
MRCPsych Paper B	£511
MRCPsych Paper CASC (UK)	£1,129

Total cost reimbursed: **£2,208**

Paediatrics and Child Health:

Exam	**Fee**
MRCPCH FOP (theory exam)	£365
MRCPCH TAS (theory exam)	£365
MRCPCH AKP (theory exam)	£659
MRCPCH Clinical	£925

Total cost reimbursed: **£2,314**

Ophthalmology:

Exam	**Fee**
Part 1 Fellowship Examination	£725
Part 2 Fellowship Written Examination	£725
Part 2 Fellowship Oral Examination	£1,395
Refraction Certificate	£900

Total cost reimbursed: **£3,745**

Obstetrics and Gynaecology:

Exam	Fee
MRCOG Part 1	£577
MRCOG Part 2	£577
MRCOG Part 3	£620

Total cost reimbursed: **£1,774**