Department of Health & Social Care

The Department of Health and Social Care's written evidence to the Doctors' and Dentists' Remuneration Body for the pay round 2024 to 2025

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Contents

Data and evidence sources

The Department of Health and Social Care is committed to ensuring that our evidence to the Pay Review Bodies is transparent and upholds the principles of the Code of Practice for Statistics.

Most data that we use comes from published sources and include links to source material. Where required we describe any transformations to source data. In a small number of cases, we include DHSC analysis of other data sets where such analysis is not possible from other sources. In these cases, we outline the data that has been used and the rationale behind its inclusion.

Our core data sources, and the primary chapters they relate to, are listed below.

Core sources

Workforce, education, training, and planning (Chapter 3)

Chapter 3 provides more detail on the LTWP and how current and future programmes of training, education, recruitment, and retention will support the plan's ambitions. It is supported by chapter 4 which details the size and make-up of the current workforce and how this has changed in the last year.

The NHS staff survey (Chapter 4)

The NHS staff survey continues to provide a valuable insight into the aspects of staff experience in the workplace. The latest staff survey took place in November 2023 and the results will be published on 7th March 2024. The most recent available data is from the March 2022 survey [https://www.nhsstaffsurveys.com/results/national-results/].

The electronic staff record (ESR) (Chapters 4 and 5)

The ESR is the HR and Payroll system used by NHS providers (trusts & foundation trusts) in England but does not cover primary care, social care, or the independent sector.

The ESR is a comprehensive dataset with more than 1.5 million rows of data per month. It provides high quality data on the roles people are employed to do and what they are paid. We acknowledge that there is varying robustness to this data with the quality of some data items (such as reason for leaving) being less than other data items (e.g. pay) and it cannot track people moving from secondary care into other parts of the health system.

- NHS England data on average earnings for NHS Staff (based on ESR data) - NHS Staff Earnings Estimates

- NHS England data on the NHS workforce (based on ESR data) - NHS workforce statistics

- NHS England vacancy data (based on ESR and other sources) - NHS Vacancy Statistics (and previous NHS Vacancies Survey)

- We also perform our own analysis of the ESR where this is not possible via standard publications (e.g., longitudinal tracking) or in some cases may separately commission data where data are not routinely published or not published at the desired level of granularity. The data accompanying these commissions are available at NHS England HCHS workforce data pack 2023 - NHS Pay Review Body evidence

Labour market data (Chapter 5)

Data for the wider economy is primarily sourced from the Office for National Statistics (ONS) who produce a range of statistics on average earnings across the economy including by occupation group. We also draw on information published from other bodies including the Low Pay Commission and Department for Education (DfE).

- ONS data on earnings in the wider economy - Labour Market Overview / Annual Survey of Hours and Earnings

- DfE data on Longitudinal Education Outcomes - LEO Graduate outcomes provider level data, Tax year 2020-21

Supplemental data

To assist the Pay Review Bodies with pay costings, we have supplied more granular estimates on the costs of employing different types of staff in the NHS. The data for 2021 to 2022 and 2022 to 2023 is Supplementary evidence to NHSPRB: hospital and community health sector These estimates are based on ESR data which is scaled to NHS England workforce estimates.

1. NHS strategy and introduction

This chapter provides the context for the Department's evidence to the Review Body on Doctors' and Dentists' Remuneration (DDRB) for the 2024 2025 pay round.

For the 2023 to 2024 pay round, the government sought recommendations from the DDRB for all workforces covered by its remit, with the exception of those doctors covered by multi-year agreements Specialty and Specialist (SAS) doctors and independent General Medical Practitioner contractors). Despite this, the DDRB's recommendations included an uplift for SAS doctors covered by a multi-year agreement. After careful consideration the DDRB's recommendations were accepted in full by the government.

Independent contractor General Medical Practitioners are no longer subject to a 5-year pay agreement between NHS England and the BMA. From 2024 to 2025, the Department will return to seeking annual recommendations for contractor as well as salaried GPs. This year the government is seeking recommendations for all doctors and dentists within the remit group.

The NHS workforce

Recruiting and retaining a skilled and diverse workforce is essential to meeting key health objectives such as addressing the elective backlog, improving access to primary care and bolstering urgent and emergency care. There are currently record numbers of staff working in the NHS. In the past year there are over 71,200 more people working in the NHS, including over 6,600 more doctors and 20,700 more nurses. The government has also delivered on its 50,000 additional nurses manifesto commitment six months early, with over 360,000 nurses working across the NHS – over 59,000 more than September 2019.

The NHS Long Term Workforce Plan (LTWP), published by the Government in June 2023, sets out the plan to train, retain and reform to meet the workforce requirements the NHS has for the future. The plan models workforce supply and demand to 2036, providing a roadmap for workforce expansion, reform and retention and highlighting the need to prioritise the NHS settlement to enable this and deliver key objectives. Having the right workforce to meet future demand will be a key driver of staff engagement and staff retention. The Government's 2023 mandate to NHS England reinforces, this, making it clear that a well-trained and well supported workforce is central to the delivery of its priorities.

Whilst the LTWP sets out a path for a more sustainable future workforce position, the NHS mandate priorities sets out the direction of travel to start this journey. Priority 2 in the mandate is to 'support the workforce through training, retention and modernising the way

staff work'. Each of these elements will be expanded upon by our, and NHS England's, evidence.

The core of this priority is to putting NHS workforce supply in England on a sustainable footing, recognising this is collectively driven by multiple factors, not just pay, but also dependent on drivers such as workload, reforms to education and training, improved working environments and more positive working cultures, more flexible working practices, and opportunities for learning and continuous professional development, So putting the workforce on a sustainable footing is not just about size and pipeline, it is also about staff health, wellbeing, and morale. Workplace culture is an important driver of motivation, and the government recognises the role that a diverse and inclusive workplace that prioritises staff wellbeing has to play in recruitment and retention.

Chapter 3 provides more detail on the LTWP and how current and future programmes of training, education, recruitment, and retention will support the plan's ambitions. It is supported by chapter 4 which details the size and make-up of the current workforce and how this has changed in the last year. Broadly, this evidence shows a growing workforce with a steadily increasing variety of entry points to an NHS career, especially through apprenticeships and growing numbers of training places in specialities like general practice. There is further to go, however, if the NHS is to meet the ambitions set by the LTWP, especially in terms of retention. NHS England's plans on these elements are set out in chapter 3.

Looking to the future, the total reward package, which includes but is not limited to pay, will continue to be important in attracting and retaining the workforce the NHS needs, alongside programmes to improve the working lives of the workforce and tackle staff burnout. Chapter 5 looks at the earning and expenses data across remit groups to provide an idea of the value of total financial reward for NHS staff. Chapters 6 and 7 give more depth on how this impacts specific remit groups and how the NHS pension and non-pay offers from employers round out the total reward package.

The NHS settlement

In 2023 to 2024, the financial pressures on the NHS settlement have become more pronounced due to inflationary pressures and the lasting impact of COVID-19 on budgets.

As we enter the final year of the spending review settlement agreed in 2021, and despite additional funding that has been made available in the intervening period, the NHS England and DHSC settlement is stretched. The recurrent impact of the 2023 to 2024 pay awards continues to affect budget capacity in 2024 to 2025 and means flexibility beyond the planned affordability at the 2021 spending review (SR21) is extremely constrained. The ongoing impact of inflation and industrial action is also putting unforeseen pressures

on all budgets, including the costs to trusts of covering strike days. Inflation is significantly higher than the assumptions within which the SR21 settlement was made. These pressures have necessitated the reprioritisation of budgets for 2024 to 2025, even prior to subsequent decisions on this 2024 to 2025 pay award.

While the government has continued to prioritise investment into the NHS, these factors have increased the costs of delivering services, and the financial pressures systems are facing. HM Treasury have provided further overarching evidence on the economic impact of the PRB settlements across different workforces.

Chapter 2 of our evidence focuses on how the changing context has impacted the department's settlement and how NHS finances are being targeted at meeting key priorities.

This year's pay round takes place in the context of ongoing unrest across the industrial relations landscape from multiple British Medical Association (BMA) committees representing the majority of the hospital doctor workforce, as well as those doctors represented by the Hospital Consultants and Specialists Association (HCSA). This evidence will not comment on the ongoing unrest or relative positions of trade unions and the government, focussing instead on ensuring the DDRB has the evidence it needs to perform its duties effectively for the 2024 to 2025 round.

We look forward to receiving your report in May 2024.

2. NHS finances

This chapter describes the financial context within which NHS pay awards will need to be set.

The focus for the NHS continues to be recovering overall performance following the COVID-19 pandemic, including addressing the significant elective recovery challenge. This will be achieved through supporting innovation, the adoption of the right digital health technologies, and through ensuring that the workforce is well supported to continue delivering the excellent care it provides. Long-term NHS financial sustainability is essential to achieving these objectives.

However, the financial landscape poses significant challenges. With inflationary pressures continuing to impact the wider economy, the pay awards should be considered in the context of the commitments made within the 2021 spending review (SR21) settlement. This is leading to unforeseen pressures on budgets. These pressures are compounded by the recurrent impacts of COVID-19 and industrial action on budgets. Taken together, the financial landscape has already necessitated the reprioritisation of budgets for 2024 to 2025.

Although SR21 and subsequent fiscal events have provided new funding for DHSC and NHS England, including substantial additional funding for the elective backlog, the health and social care system still holds significant cost pressures resulting from the lasting impact of the COVID-19 pandemic. This year, exacerbated by the impact of industrial action, it was necessary to provide additional support to the NHS to meet pressures during the winter months. This was included as part of the financial package announced in November 2023, providing systems with £800 million. Furthermore, the ongoing impact of inflation on funding and the costs of delivering services means budgets are continuously being stretched. For example, systems had initially planned to overspend by £720 million in 2023 to 2024 but are now at a significant risk of further overspends.

There is also a system challenge for 2024 to 2025 of meeting the efficiency and productivity savings as set out in SR21, as well as refining and implementing plans to deliver the labour productivity ambition of up to 2% (at a range of 1.5-2%), as set out under the LTWP. This is significantly higher than the c. 1% per year the NHS has historically delivered. The current settlement also requires the NHS to deliver annual efficiency savings of at least 2.2% each year.

Pay awards should be considered within this context.

Economic context

Inflation and the lasting financial impacts of COVID-19 and industrial action are putting unforeseen pressures on all budgets and, as a result, government borrowing. In this context, the government is committed to price stability and has re-affirmed the Bank of England's 2% CPI target at the Autumn Budget.

Inflation has more than halved since its peak in Autumn 2022 of over 11% but remained well above the 2% target in January 2024 at 4.0%This is significantly higher than the assumptions within which the SR21 settlement was made. The expectation at the time was that inflation would peak at 4.4% in Q2 2022. The Bank of England forecast that inflation will return to the 2% target in the second quarter of 2024 before rising slightly again, towards the end of the forecast period.

The Bank of England's resulting increases in its base rate to 5.25%, the highest level in decades and necessary to bring down high inflation, have weighed on economic growth. This has resulted in additional borrowing costs for many mortgage-holders, businesses, and government. The government is committed to supporting the MPC to bring inflation back to target by aligning fiscal and monetary policy. Further borrowing, above what is forecast, would add to inflationary pressure which would in turn put upward pressure on interest rates. Despite initial economic growth at the start of the year, the UK economy formally entered into a technical recession with a contraction of 0.5% across Q3 and Q4 2023.

Funding growth

SR21 took steps to place the NHS on a sustainable footing and to fund the biggest catch-up programme in NHS history. The increase in funding for elective recovery, growing the workforce and allowing the NHS to continue to respond to the lasting impact of the COVID-19 pandemic, will further enable the NHS to deliver better service and health outcomes for patients.

The Government is committed to delivering its manifesto commitments on workforce, ensuring that we can keep growing a diverse and skilled NHS workforce through the LTWP. The Government announced £2.4 billion with the publication of the plan to fund additional education and training places over five years. To support elective recovery, the Government plans to spend more than £8 billion between 2022 to 2023 and 2024 to 2025. As part of the Autumn Statement 2022, the government announced an additional £3.3 billion for 2023 to 2024 and 2024 to 2025 to support the NHS in England, enabling rapid action to improve emergency, elective and primary care performance towards pre-pandemic levels. The department has also committed to a £5.9 billion investment in capital for new beds, equipment, and technology.

Table 1: Mandate Funding for NHS England

NHS England (NHSE)	NHSE Revenue Departmental Expenditure Limits (RDEL) excluding ringfence (RF) (cash) £ billion	NHSE Capital Departmental Expenditure Limits (CDEL) excluding ringfence (RF) (cash) £ billion
2013 to 2014	93.676	0.200
2014 to 2015	97.017	0.270
2015 to 2016	100.200	0.300
2016 to 2017	105.702	0.260
2017 to 2018	109.536	0.247
2018 to 2019	114.603	0.254
2019 to 2020	123.377	0.260
2020 to 2021	149.473	0.365
2021 to 2022	150.614	0.337
2022 to 2023	158.521	0.330
2023 to 2024	163.326	0.444
2024 to 2025	165.841	0.219

Source: 2023 to 2024 financial directions to NHS England

Table 1 above shows the closing mandates for NHS England up to 2022 to 2023, the opening mandate in 2023 to 2024, and indicative amounts for future years, in line with the outcomes of SR21 and the Autumn Statement 2022. The 2023 to 2024 and 2024 to 2025 RDEL figures have not yet been adjusted for education and training budgets. The figures are adjusted annually to account for reallocation of resource, additional funding, and changes of responsibility between government bodies. These figures include an increase for pensions revaluation which was provided alongside the LTP settlement. Figures exclude depreciation, annually managed expenditure (AME) and the technical accounting budget, namely capital grants, or Private Finance Initiative.

Financial position

The Government's 2023 mandate to NHS England outlines the headline objectives for the NHS. The 2023 to 2024 Financial Directions to NHS England reflect further funding to deliver manifesto commitments agreed at Spring Budget 2020, as well as funding to meet considerable pressures arising due to the lasting impact of the COVID-19 pandemic and to support the recovery of elective services in the 2022 to 2023 financial year.

The NHS ended the 2022 to 2023 financial year in a marginal underspend position - a smaller underspend than in 2021 to 2022. A proportion of this underspend is driven by specific ringfenced budgets, and so alternative uses of this spend would not be possible. In the provider sector specifically (as set out in the table below), there is now a significant deficit position of nearly £1 billion, which is a marked deterioration on the year before.

Final audited spend in the 2022 to 2023 financial year will be laid before Parliament and available in NHS England's published Annual Report and Accounts.

However, the fiscal and economic environment has pushed the NHS into a challenging financial position in 2023 to 2024 onwards. The 2023 to 2024 pay awards have been financially challenging on the DHSC Group in the context of the wider financial and economic context described above and will continue to have a knock-on impact on future years. NHS England are also facing increasing and significant pressures on their budgets through inflation and industrial action. For example, NHS providers are incurring additional pay costs to secure staff cover on strike days and to catch up on lost activity to reduce the elective backlog.

Table 2 shows the breakdown of funding provided to NHS providers since the 2017 to 2018 financial year, including preliminary outturn data for 2022 to 2023.

Table 2: NHS providers RDEL breakdown

NHS Providers RDEL Breakdown (£m)	2017 to 2018	2018 to 2019	2019 to 2020	2020 to 2021	2021 to 2022	2022 to 2023
Gross deficit	2,433	2,755	1,560	158	126	1,001
Gross surplus	-1,337	-1,889	-567	-363	-442	-299
Reporting adjustment	-105	-39	-323	-450	-240	-252
NHS providers SRP (Sector Reported Performance)	991	827	670	-655	-556	450
Plus additional RDEL adjustment	47	-1	338	-77	-39	528
Net NHS providers RDEL NRF	1,038	826	1,008	-732	-595	978

Share of resources going to pay

Table 3 shows the proportion of funding consumed by NHS provider permanent and bank staff spend since the 2016 to 2017 financial year. Note that NHS provider permanent and bank staff spend only covers staff working within hospital and community health settings, excluding agency spend by these organisations.

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

Year	NHSE RDEL (£ billion)	NHS Provider Permanent and Bank Staff Spend (£ billion)	% of spend on staff	Increase in total spend	Increase in provider permanent and bank staff spend
2016 to 2017	105.7	47.7	45.1%	n/a	n/a
2017 to 2018	109.5	49.9	45.6%	3.63%	4.64%

2018 to 2019	114.4	52.6	45.9%	4.46%	5.35%
2019 to 2020	120.5	56.1	46.6%	5.34%	6.75%
2020 to 2021	140.6	62.7	44.6%	16.65%	11.79%
2021 to 2022	146.5	66.2	45.2%	4.21%	5.47%
2022 to 2023	155.7	71.1	45.6%	6.25%	7.39%

Notes:

- 2016 to 2017 to 2019 to 2020 NHS England RDEL represents the budget, while underspend was negligible.
- 2019 to 2020 NHS England RDEL excludes £2.8 billion for the revaluation of the NHS pensions scheme.
- 2020 to 2021 reflects spend and excludes £6 billion unspent funding and £2.8 billion for the revaluation of the NHS pensions scheme.
- 2021 to 2022 reflects spend and excludes £1.3 billion unspent funding and £2.8 billion for the revaluation of the NHS pensions scheme.
- 2022 to 2023 represents the budget, as underspend was negligible, excluding £2.8 billion for the revaluation of the NHS pensions scheme.
- 2019 to 2020 NHS provider permanent and bank staff has been revised since last year's evidence to the Pay Review Bodies due to recalculation of exclusion for the revaluation of NHS pensions.
- 2022 to 2023 NHS provider permanent and bank staff excludes £2.5 billion for the non-consolidated pay award.
- Figures in the table are correct to the specified level of significance. Percentage increases may not match increases calculated from budget or spend figures as given in the table due to rounding.

In 2023 to 2024, the pay awards were above the government's affordability envelope. As a result, a reprioritisation exercise within DHSC Group was undertaken to identify the funding necessary (together with additional HMT funding). The DDRB recommended a 6% pay increase for salaried GP practice staff, consultants, and high-street and salaried

dentists. Doctors in training (junior doctors) received a permanent pay increase of on average 8.8% - between 8.1% and 10.3% depending on where they are in their training.

The government accepted and implemented the DDRB recommendations in full which was, a further £1 billion above provision for DDRB.

Following an agreement between the government and NHS trade unions, non-medical staff working on the Agenda for Change (AfC) contract received a 5% consolidated pay award in 2023 to 2024 and two non-consolidated payments relating to 2022 to 2023. In addition, the lowest paid staff have seen their pay matched to the top of band 2, resulting in a pay uplift of 10.4%, or £2,113 in 2023 to 2024.

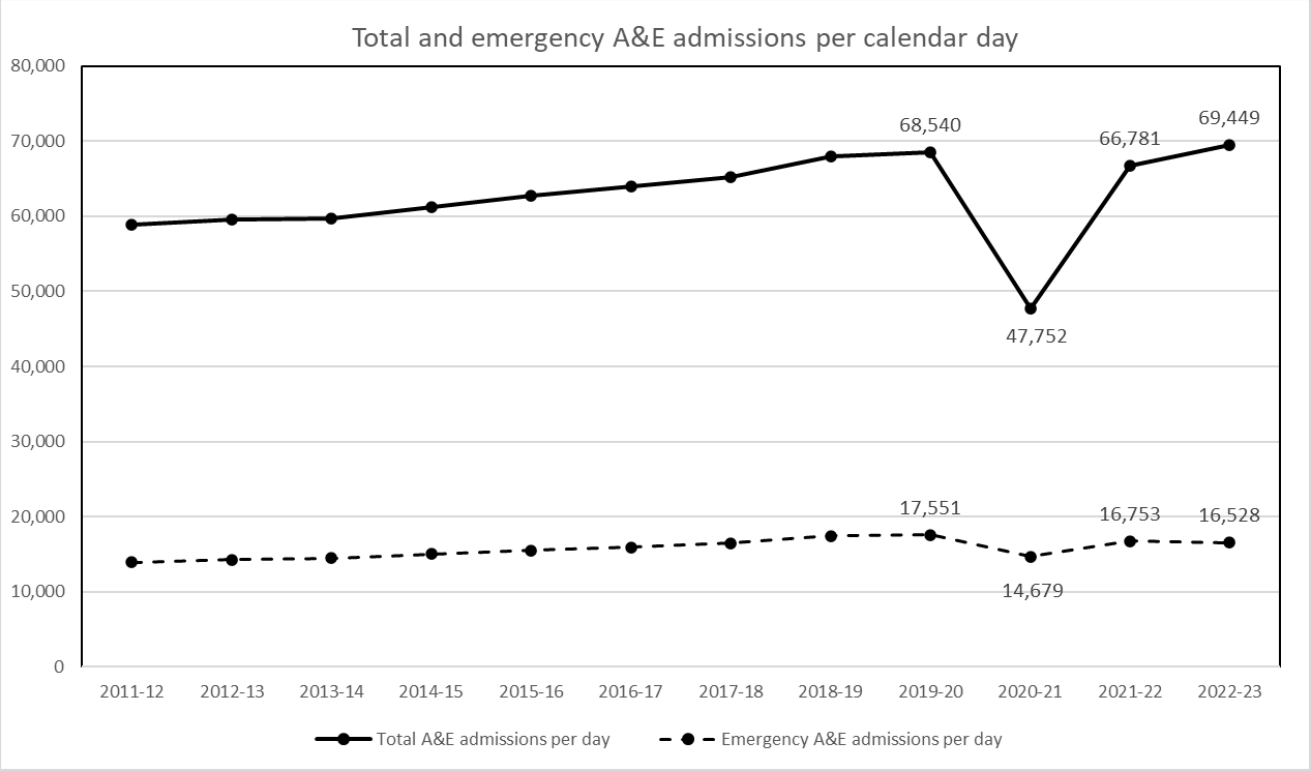
This resulted in an impact of 5.2% in 2023 to 2024 on the AfC paybill following negotiations with the NHS Staff Council - 2.2% (equivalent to £1.6 billion) above what was provisioned for pay at SR21.

Demand pressures

Activity and demand levels in the health system for elective care dropped dramatically in 2020 to 2021 as numbers of self-presenting patients reduced and the NHS freed up capacity to manage COVID-19 demand, including the suspension of all non-urgent elective operations.

Demand for non-elective care in 2022 to 2023 returned to levels seen before the COVID-19 demand spike.

Figure 1: Total and emergency admissions per calendar day



Source: A&E attendances and Emergency Admission Statistics

Figure 1 shows the total attendances and emergency admissions to NHS in England per calendar day between 2011 to 2012 and 2022 to 2023.

In 2019 to 2020, there were 68,540 A&E attendances and 17,551 emergency admissions per day. In 2022 to 2023, there were 69,449 A&E attendances and 16,528 emergency admissions per day. This equates to a 1% increase in attendances and a 6% decrease in emergency admissions between 2019 to 2020 and 2022 to 2023.

Table 4: Total referral to treatment (RTT) pathways completed per working day

Year	RTT clock starts	RTT total completed pathways and unreported removals	Waiting list at year end (31 March)
2011 to 2012	59,771	59,897	2,443,952
2012 to 2013	63,085	62,150	2,677,497
2013 to 2014	66,281	64,806	3,052,280
2014 to 2015	69,473	68,853	3,209,293

2015 to 2016	73,252	71,403	3,675,298
2016 to 2017	77,956	77,085	3,897,530
2017 to 2018	79,764	78,945	4,102,999
2018 to 2019	82,231	81,272	4,345,467
2019 to 2020	79,712	79,552	4,386,297
2020 to 2021	55,824	53,595	4,950,297
2021 to 2022	74,916	69,322	6,365,772
2022 to 2023	79,511	75,665	7,331,186

Source: NHS England consultant led referral to treatment statistics. Data adjusted for non-submitting trusts and exclusion of sexual health services from 2013. Clock start data was not submitted prior to 2016. Therefore, clock start figures and unreported removals figures are based on estimated clock start figures for 2015 to 2016 and earlier.

In recent years, pay review bodies have asked about the scale of increases to care backlogs. During the first wave of the COVID-19 pandemic, activity levels dropped to around 40% of normal levels. This reduction in activity meant that patients who would have normally been treated were not, and therefore the waiting list has grown to over 7 million, an increase from 4.4 million at the start of COVID-19.

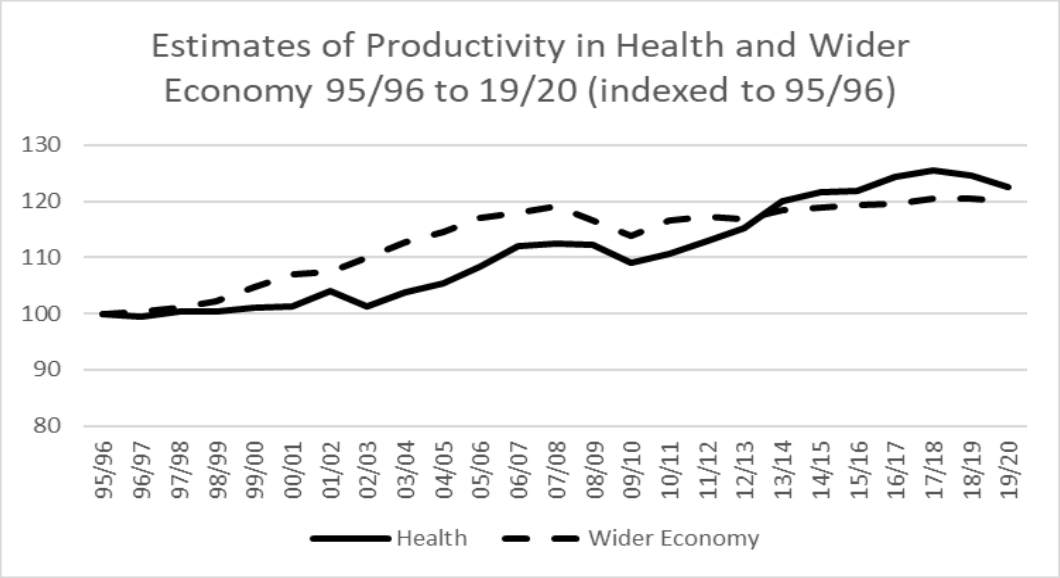
The Elective Recovery Delivery Plan looks to boost activity levels to around 30% higher than they were before COVID-19, and therefore help reduce the overall waiting list in the longer term. Activity has been recovering to pre-COVID-19 levels and, including the impact of advice and guidance, the estimated Year to Date (YTD) figure for 2023/24 is 111.5% compared to pre-pandemic levels. Excluding adjustments for advice and guidance the estimated YTD figure is 102.5% compared to pre-pandemic levels.

The impact of the more than 40 days of industrial action in 2023 to 2024 has also created a further loss of elective activity as well as unavoidable financial costs, estimated to be around £1 billion. To cover these costs, £800 million has been allocated to systems and the elective activity target for 2023 to 2024 has been adjusted to a national average of 103%, to be maintained for the remainder of the financial year.

Productivity in the NHS

Historically, the NHS had been able to achieve productivity improvements in the acute sector through a combination of medical and operational advancement (for example, moving planned care from overnight stays to day-case settings, with surgical techniques becoming less invasive) and reducing lengths of stay for medical admissions, meaning the NHS was able to deliver more care with our workforce and infrastructure. Productivity improvements will build on the achievements of the 2016 Carter Review and the operational productivity programmes which saw a saving of £3.57 billion by January 2020. Productivity continues to be a priority as looking ahead, the NHS will serve an increasingly older population with more complex needs. NHS productivity has increased on average by 0.8% per annum from 1995 to 1996 until 2019 to 2020. This is a similar level to wider economy productivity growth – health was lower prior to the 2008 financial crash but higher from the 2008 financial crash to the COVID-19 pandemic in 2020.

Figure 2: Productivity growth in health and the wider economy up until 2019 to 2020. Productivity measures are indexed to 1995 to 1996 = 100.



Note: The latest figure is 2020 to 2021, it is not included in this graph as an outlier (see below)

Table 5 - Average productivity growth in health and the wider economy, both prior and after the financial crash.

Years	Health	Wider Economy
1996 to 1997 - 2007 to 2008	1.0%	1.5%
2008 to 2009 - 2019 to 2020	0.7%	0.1%

NHS productivity fell by 25.6% in 2020 to 2021. This was the result of increasing inputs (for example, staff) to cover the risk of surges in COVID-19 patients and reductions in the number of outputs (for example, operations) due to infection controls and limiting elective treatments. It is important to note that infection controls and lockdowns implemented throughout the COVID-19 pandemic have delivered health benefits (for example, fewer COVID-19 cases) that are not captured in our usual measures of productivity.

Formal ONS NHS productivity estimates are currently only published up until 2020 to 2021. The post-pandemic environment the NHS is facing is still materially different from the pre-pandemic environment. Although the formal measure has a long lag time, the ONS publish a total public sector productivity measure to shorter time scales, of which the health sector comprises 40%. The latest publication (July to September 2023) showed public sector productivity is recovering but is still 6.3% below the equivalent pre-pandemic level. The ONS's experimental 'nowcast' statistics suggest health productivity is 5.5% below the pre-pandemic level. It should be noted that this is an untested methodology which is giving lower figures than those suggested by the Institute for Fiscal Studies and Institute for Government. It is likely that NHS productivity has improved since 2020 to 2021 but is still well below the pre-pandemic level.

While public service productivity remains at low levels, this creates challenges for the NHS. As a result of the COVID-19 pandemic, there are currently large backlogs for elective care due to issues such as the direct effects of managing COVID-19, delays to discharge and longer non-elective length of stay (therefore constraining elective capacity), higher staff sickness and absence, use of agency staff and wider vacancies, and opportunity loss as a consequence of industrial action. Reductions in productivity result in reductions in outputs in the NHS, which means less of the elective backlog can be tackled.

The government is clear that recovering and increasing productivity will be crucial to recovering the performance of the NHS. In June 2023, the Chancellor announced that the Chief Secretary of the Treasury would lead a major public sector productivity programme across all government departments. This is currently underway.

In addition, the LTWP is underpinned by an ambitious labour productivity assumption of 1.5-2%, over double the long-run historical average for the NHS. This sets an ambitious target to be delivered.

As part of the £8 billion funding announced at SR21, the government has invested in programmes to help the NHS achieve an ambitious productivity trajectory while recovering key services. Key productivity programmes supported by this investment are:

- improving patient pathways
- surgical hubs

- expanding community diagnostic centres (CDCs)
- making outpatient care more personalised
- digital productivity programmes

Productivity improvements going forward now need to come from a combination of delivery of the same care in lower cost settings e.g., moving treatment from theatres into outpatient settings, moving hospital admissions to hospital at home, delivering large-scale skills mix opportunities as well as upskilling and retaining our staff, and reducing the administrative burden on clinicians through technological advancement, such as artificial intelligence (AI) and robotic process automation.

General practice finances

In March 2024, the Five-Year Framework for General Practice, which was agreed between NHS England and the BMA's General Practitioner's Committee (GPC) in 2019, will come to an end. Funding for the core practice contract, including GP contractor pay, between 2019 to 2020 and 2023 to 2024 was agreed and fixed for the five-year period at the outset of this five-year deal.

In 2023 to 2024, following the DDRB's pay recommendation for salaried GPs, the GP contract was uplifted to provide a 6% uplift for all salaried General Practice staff (including GPs, nurses, and admin). GP contractors were excluded from this uplift as they are independent contractors and subject to the five-year framework agreement until 2023 to 2024.

From 2024 to 2025, the Department will return to seeking annual recommendations for contractor, as well as salaried, GPs.

The 2024/25 GP contract arrangements were published on 28 February 2024 and are available here: NHS England » Arrangements for the GP contract in 2024/25.

Investment in general practice

The Five-Year Framework for General Practice implemented the commitments set out in the NHS Long-Term Plan (LTP), aimed to transform general practice. It was underpinned by a record level of additional investment in primary medical and community care (an extra £4.5 billion in real terms by 2023 to 2024). This investment looked to fund workforce expansion, new services to support growth of more preventative, community-based healthcare, address demand pressures and meet the goals set out in the NHS LTP. This was updated in 2020 to invest at least an extra £1.5 billion to grow and diversify the

general practice workforce. Furthermore, the government made £520 million available to improve access and expand general practice capacity during the COVID-19 pandemic.

Data on investment in general practice for England is published by NHS England. The latest available data is from 2021 to 2022 and a timeseries of investment since 2017 to 2018 is shown in Table 6 and Table 7. Overall, investment in general practice has consistently increased over time in both cash and real terms.

Table 6: Investment in general practice in England in real and cash terms excluding reimbursement of drugs dispensed in general practices, A&E streaming and COVID-19 costs, between 2017 to 2018 and 2021 to 2022 (£ millions).

Year	Excluding reimbursement of drugs, cash terms (£)	Year-on-year change excluding reimbursement of drugs, cash terms	Excluding reimbursement of drugs, real terms (2021 to 2022 prices, £)	Year-on-year change excluding reimbursement of drugs, real terms
2017 to 2018	10,255	6.8%	11,302	5.0%
2018 to 2019	10,570	3.1%	11,444	1.3%
2019 to 2020	11,615	9.9%	12,257	7.1%
2020 to 2021	12,661	9.0%	12,574	2.6%
2021 to 2022	13,471	6.4%	13,471	7.1%

Source: NHS England, Investment in General Practice in England, between 2017 to 2018 and 2021 to 2022, August 2023, table 1. Real terms figures have been based on unrounded figures.

Spending on general practice services between 2017 to 2018 and 2021 to 2022 increased by 31.4%, rising from £10.3 billion to £13.5 billion in cash terms. In real terms, investment has increased from £11.3 billion to £13.5bn over the same period, equating to an increase of 19.2%.

Table 7: Investment in general practice in England in real and cash terms including reimbursement of drugs dispensed in general practices and A&E streaming costs, between 2017 to 2018 and 2021 to 2022 (£ millions).

Year	Including reimbursement of drugs, cash terms (£)	Year-on-year change including reimbursement of drugs, cash terms	Including reimbursement of drugs, real terms (2021 to 2022 prices, £)	Year-on-year change including reimbursement of drugs, real terms

2017 to 2018	10,937	6.9%	12,054	5.1%
2018 to 2019	11,271	3.1%	12,204	1.2%
2019 to 2020	12,343	9.5%	13,025	6.7%
2020 to 2021	13,387	8.5%	13,295	2.1%
2021 to 2022	14,236	6.3%	14,236	7.1%

Source: NHS England, Investment in General Practice in England, between 2017 to 2018 and 2021 to 2022, August 2023, table 7. Real terms figures have been based on unrounded figures.

When including reimbursement of drugs and A&E Streaming, cash terms investment in general practice has increased from £10.9 billion in 2017 to 2018 to £14.2 billion in 2021 to 2022, an increase of 30.2%. In cash terms, investment has increased from £12.1 billion to £14.2 billion over the same period, an increase of 18.1%.

Table 8: Showing the reported investment in general practice in England, between 2017 to 2018 and 2021 to 2022 (£ thousands). This shows total investment including non-contractual investment in more detail.

	2017 to 2018	2018 to 2019	2019 to 2020	2020 to 2021	2021 to 2022
Global Sum/MPIG (GMS only)	3,371,241	3,546,434	3,618,898	3,854,038	4,141,896
Balance of PMS expenditure	1,642,804	1,629,884	1,600,264	1,602,006	1,629,791
APMS essential & additional services and other payments	310,071	306,384	292,687	308,961	291,886
Primary Care Network (PCN) participation	N/A	N/A	104,383	104,975	107,118
Clinical negligence scheme for general practice	N/A	N/A	310,377	312,430	214,546
Quality & Outcomes Framework	722,294	719,127	733,107	756,265	818,126
Enhanced Services (GMS, PMS)	381,552	377,728	315,894	332,793	259,317
Other Selected Services	42,833	47,314	40,270	37,095	50,196
Local Incentive Schemes (GMS, PMS)	568,109	605,196	648,597	718,130	778,947
GP Extended Hours Access (GMS, PMS)	15,273	15,236	11,137	9,698	19,520
APMS Enhanced Services	26,260	17,773	36,355	30,156	34,040

Premises	882,980	882,036	882,810	940,480	984,888
PCO administered funds	722,065	735,385	1,018,848	1,130,877	1,134,488
Out of Hours	428,463	429,907	479,809	480,184	485,328
IT (incl. centrally funded IM&T)	414,274	395,986	382,524	558,212	519,996
Improving access to general practice	144,316	237,142	293,137	314,470	451,866
Estates and technology transformation programme	159,508	130,867	137,350	95,959	13,138
General practice workforce programmes	77,328	96,236	116,294	133,088	134,338
Other general practice transformation programmes	129,634	170,523	142,937	163,196	195,918
New models of care	11,433	N/A	N/A	N/A	N/A
PCN Direct Enhanced Services	N/A	N/A	243,016	568,474	1,017,203
Provisional investment in Public Health by Local Authorities	23,321	29,257	24,165	12,069	11,592
Cost of dispensing fees	181,574	197,123	182,197	197,674	176,992
Reimbursement of Dispensed Drugs	576,368	592,976	617,078	614,711	625,069
Primary care streaming in A&E	105,647	108,813	110,446	111,550	139,652
COVID-19 Support Fund, COVID-19 Expansion Fund and Other COVID-19 Related Costs	N/A	N/A	N/A	370,968	70,545
COVID-19 Vaccination Programme Costs	N/A	N/A	N/A	333,851	727,037

Source: NHS England, Investment in General Practice in England, between 2017 to 2018 and 2021 to 2022 (August 2023, table 8).

Notes:

These costs were included in the report for the first time in 2019 to 2020 and, in future may fall as well as rise, as reported by NHS Resolution. Indeed, there was a fall in 2021 to 2022 and £214 million comprises the increase in provision for future liabilities in 2021 to 2022 and the £7 million administrative costs of running the Clinical Negligence Scheme for General Practice (CNSGP) and Existing Liabilities for General Practice (ELGP) schemes. Both are as reported in the NHS Resolution 2021 to 2022 Annual Report and Accounts – Financial Statements.

Figures for recruitment and retention are included in the Primary Care Organisation (PCO) Administered Funds line. Additional training costs met by Health Education England were

included in the PCO Administered Funds line for the first time in 2016 to 2017 and have been restated in this report from 2017 to 2018 to capture all the associated costs.

Expenditure on the DHSC funded GP System of Choice was included for the first time in 2015 to 2016. It is now known as GP IT Futures Improving Access to General Practice in earlier years includes expenditure in relation to the Prime Minister's Challenge Fund, The Prime Minister's GP Access Fund and the Improving Access to General Practice programme. Since 2013 to 2014, Investment in Public Health by Local Authorities moved from PCTs to Local Authority control. Provisional data for 2019 to 2020 has been updated to use the audited final accounts data published by MHCLG in the Revenue Expenditure Outturn (RO3). For items dispensed and/or personally administered by dispensing doctor and prescribing doctor practices.

The investment by trusts in services provided by General Practice in A&E followed the announcement in the 2017 Spring Budget Statement that funding had been made available to ease pressure on A&E departments. The next steps on the NHS Five Year Forward View set out that, from October 2017 every hospital must have comprehensive front-door clinical streaming so A&E departments are free to care for the sickest patients. Additional, capacity funding was available April to September 2021, plus additional clinical director support. Additional clinical director support is included in the COVID-19 vaccination programme costs below, as it was in 2020 to 2021.COVID-19 vaccination programme costs include funding available to Primary Care Networks (PCNs) to distribute throughout the PCN, including to GP practices and others brought into PCNs, to cover additional reasonable costs.

Dental finances

NHS dentistry in England is funded by a combination of payments from NHS England and patient charges. From 1 April 2023, all Integrated Care Boards (ICBs) took on delegated responsibility for commissioning primary care dental services from NHS England. Dental funding for 2023 to 2024 is over £3.6 billion (dependent on patient income).

Faster, simpler and fairer: our plan to recover and reform NHS dentistry was published on 7 February 2024, and is backed by £200m for 2024 to 2025. NHS primary care dentistry is delivered through contracts structured around Units of Dental Activity (UDAs) – each treatment is allocated a number of UDAs in proportion to the complexity/amount of work required. There are currently 4 UDA bands (with band 2 split into three sub-bands from November 2022). Commissioners negotiate contracts with practices to deliver a certain number of UDAs each year. Contract holders are awarded funding at the start of the financial year based on the contracted number of UDAs. Where a contract holder has delivered less than 96% of contract value by the end of the financial year, funding for the contract under-delivery is recovered by the NHS in the following financial year.

From 24 April 2023, patient charges were increased by 8.5% to band 1 treatment at £25.80, all band 2 treatments at £70.70 and band 3 treatments at £306.80. This was the first uplift in dental patient charges since December 2020.

For 2022 to 2023, the value of the combined allocation for dental services, community pharmacy and primary care ophthalmology was over £5.3 billion and the total funding for primary care NHS dentistry, including community dental services and secondary care, in 2022 to 2023 was over £3.3 billion. Regional and ICB commissioning teams worked to implement the dental system reforms announced in July 2022, including raising the minimum UDA value to £23, allowing practices to deliver up to 110% of contract activity and awarding more UDAs for complex work through the subdivision of band 2 treatments.

In prior years (2020 to 2021 – 2022 to 2023), due to the COVID-19 pandemic, the Government along with NHS England provided dental practices with income protection to ensure practices remained stable, despite the necessary reduction in activity. There was also an additional £50 million made available in January 2022 to be targeted at those most in need of urgent dental treatment, including children.

Affordability

Previously in this chapter we have set out the economic and NHS financial landscape for 2024 to 2025 which builds on the challenging position following the 2023 to 2024 pay round.

The SR21 settlement provided DHSC with a budget allocation for each year of 2022 to 2023, 2023 to 2024 and 2024 to 2025. Since this point, the financial landscape has changed with both inflation and pay awards across the economy substantially higher than anticipated and planned for at the Spending Review 2021. The resulting financial pressures have been compounded by the costs of recovering services disrupted so significantly by COVID-19 and by the direct and indirect costs of industrial action. All of these have a recurrent financial impact into 2024 to 2025, which has necessitated the reprioritisation of budgets for 2024 to 2025, even prior to the submission of this evidence and subsequent decisions on the pay award. The pay award should be considered in the context of the SR21 settlement and its underpinning assumptions, as well as changes to the broader context since.

If further reprioritisation were also required, this would impact on NHS priorities. These NHS priorities are currently to support ambulance services, tackle the elective backlog, establish a strong care sector, and improve access to primary care. Pay awards above affordability may also necessitate further government borrowing at a time when inflation remains above target headroom against fiscal rules is historically low.

Meeting the DDRB recommendations and the AfC pay deal for 2023 to 2024 has necessitated challenging decisions on how the NHS budget could be allocated and with recurrent impacts into 2024 to 2025. For example, funding for investment in service transformation is being reallocated to fund pay awards. To put this into context, each additional 1% of pay for the whole Hospital and Community Health Service (HCHS) workforce costs around £1.1 billion per year allowing for the full system costs beyond the substantive workforce. The previous two years have provided recommendations above what was considered affordable at SR21 by £1.4 billion and £2.6 billion respectively and so required reprioritisation of budgets to allow. The £2.6 billion in 2023 to 2024 is comparable to the amount (£2.4bn) announced in June 2023 for the LTWP. However, these costs were also higher than SR21 had planned due to increased workforce growth and changes in workforce mix. This will have the same knock-on impact into 2024 to 2025. While every effort was made to protect frontline services, and the department went as far as possible in making further efficiencies by looking at all areas of central and corporate spend, meeting the DDRB recommendations and AfC pay deal for 2023 to 2024 necessitated some tough decisions.

As part of our decisions around wider affordability across the NHS, the government has increased the rates of the immigration health surcharge. These rates have remained unchanged for the last three years despite high inflation and wider pressures facing the system. The increase is intended to ensure that the surcharge reflects the genuine cost to the NHS of providing healthcare to those who pay it.

These are challenging times for everyone and our focus is ensuring a fair pay award which recognises the vital importance of public sector workers whilst minimising inflationary pressures and managing the country’s debt. It is therefore essential that within this fiscal and economic climate, pay remains fair but affordable.

3. Workforce planning, education and training

Chapter summary

This chapter sets out what the government and NHS England are doing to grow the NHS workforce and ensure its long-term sustainability to meet the changing and growing demands being placed on the NHS.

It covers publication of the Long Term Workforce Plan (LTWP) and what it means for expansion of training, retention of current staff, and reforms to training and to work. It also sets out how local workforce planning should work through Integrated Care Systems (ICSs).

The chapter covers medical expansion and reform in detail, setting out what is in the LTWP and building on current progress. This includes, for example, the shortening of medical degrees, apprenticeships, new roles, and the expansion of Physician Associates (PAs) and Anaesthesia Associates (AAs).

Finally, the chapter sets out plans for training expansion in general practice, along with a boost to recruitment, and plans to train more dentists. This is alongside measures set out in Faster, simpler, and fairer: our plan to recover and reform NHS dentistry to improve recruitment and retention in dentistry.

Workforce planning

The NHS in England is the largest employer in the country and is staffed by a dedicated and diverse workforce. As of June 2023 there are over 142,000 medical staff working across NHS trusts and integrated care boards, which is over 133,000 full time equivalents (FTE). The NHS workforce as a whole has grown significantly over recent years, with more people employed by the NHS now than at any time in its history. As of June 2023, there were almost 63,600 more FTE staff, including over 6,000 more medical staff compared with a year earlier.

Whilst we have made progress in recruiting more staff and increasing the number of training places on offer, the workforce remains under pressure. Staff vacancies remain high across different roles and specialities, and there are challenges related to geographical differences across the country, with it being more difficult to recruit in certain areas.

The NHS is evolving, with new models of care transforming services for patients, allowing greater choice and options, integration of services and an increased focus on prevention and providing more services within the community. We know that the demand on the NHS and wider social care system will continue to grow, impacted by the changes in the way services are provided, population growth in the coming years, and demographic changes with an increasing ageing population with different and more complex health needs. This is why it is essential that we have an effective workforce strategy in place to ensure we have the right mix and number of staff, with the rights skills and experience, in the right places to deliver safe, high-quality care that patients expect from the NHS.

DHSC is responsible for setting the strategic direction for national workforce policy and, in partnership with NHS England and other delivery partners, the implementation of those policies. The merger of NHS England and HEE (and NHS Digital) has brought together service planning and delivery, education and training and financial planning into one organisation which will ensure a common strategic approach to workforce planning and deployment.

On 30 June 2023, the NHS published the NHS LTWP which the government backed with over £2.4 billion of investment over the next five years to fund additional education and training places. The LTWP is an ambitious plan which demonstrates a very real commitment to growing and expanding the workforce. It sets out the steps the NHS and its partners need to take to deliver an NHS workforce that will meet the changing needs of the population over the next 15 years to put the workforce on a sustainable footing for the long term.

The LTWP sets out ambitions to recruit more staff, including doubling medical school places, increasing the number of GP training places by 50 per cent and almost doubling the number of adult nurse training places by 2031. This represents a significant expansion of domestic education, training, and recruitment, which will mean more healthcare professionals working in the NHS. The plan also sets out how the NHS plans to retain its dedicated workforce by allowing greater flexibility and career progression and improving culture, leadership, and wellbeing, while continuing to focus on equality and inclusion. This will lead to up to 130,000 fewer people leaving the NHS over the next 15 years. There are also commitments to reform the way the NHS works so that staff have the right multidisciplinary skills and can harness new digital and technological innovations, allowing them to focus giving patients the care they need.

Integrated Care Systems (ICSs) and local workforce planning

ICSs are partnerships that bring together NHS organisations, local authorities, and others to take collective responsibility for planning services, improving health and reducing inequalities for people living and working in their localities. Each ICS will have an Integrated Care Board (ICB), which is a statutory body responsible for planning and

funding most NHS services, and an Integrated Care Partnership (ICP), which are statutory committees that bring together system partners including NHS organisations, local authorities, independent care providers and the voluntary sector.

Working through ICBs and ICPs, ICSs have a key role to play in ensuring joined up workforce planning, working with system partners to ensure effective system wide coordination of recruitment, retention, and growing the workforce to meet the future needs of their local populations. Furthermore, these new structures will enable local NHS systems and local authorities to work together more effectively to provide integrated care that will meet the health and care needs of people within their localities. Integrated workforce planning requires a joined-up approach to bring together workforce, service and financial planning, that also includes the education and training needs of the workforce.

Medical expansion and reform

The LTWP sets out an aim to double the number of medical school places in England to 15,000 places a year by 2031 to 2032, and to work towards this expansion by increasing places by a third, to 10,000 a year, by 2028 to 2029. The first 205 additional medical school places have been allocated to schools for the 2024 academic year[1]. The Department is working closely with partners including the Department for Education, NHS England and the Office for Students on the implementation of further medical expansion from 2025 onwards and will set out further details in due course.

This will build on the recent increase in the number of medical school places the government has funded. There are now an additional 1,500 medical school places per year for domestic students in England – a 25% increase, taking the total number of medical school places in England to 7,500 each year. This expansion was completed in September 2020 and delivered five new medical schools in England.

The plan commits to ensuring a commensurate increase in specialty training places that meets the demands of the NHS in the future.

Alongside expanding the number of medical school places, the LTWP sets out aims to reform medical education - for example, by shortening the undergraduate medical degree, Accreditation of Prior Learning (whereby students avoid repeating work where they have already gained relevant skills and knowledge prior to the start of their course) and to ensure a future medical workforce that maintains generalist skills to meet the needs of older patients with multiple conditions. The intention is that allocation of places will be used to incentivise medical schools to deliver these reforms. In 2024 to 2025, we aim to pilot an

[1] https://www.gov.uk/government/news/expansion-of-medical-school-places-to-be-accelerated-to-next-year

internship model for newly qualified doctors to trial shortening undergraduate training time, with a view to improving preparedness for practice. This will involve medical students graduating six months earlier and entering a six-month remunerated internship programme. We will work with partners to ensure internships can be delivered safely and effectively.

Medical degree apprenticeships and new roles

In addition, we are continuing to progress new roles and new routes into medicine. NHS England is piloting a medical degree apprenticeship from 2024, with 200 apprenticeships funded for pilots starting in the 2024 academic year, with an ambition for up to 400 places by the 2026 academic year. The LTWP sets out an overall ambition to have 2,000 medical students training via this route by the 2031 academic year, with growth to more than 850 by 2028 to 2029. This will enable the NHS to attract and recruit from a wider pool of people in local communities. It will enable individuals from under-represented backgrounds to start medical training when they otherwise would not have done so through full-time higher education and training routes.

In addition, we are expanding the number of Physician Associates (PAs) and Anaesthesia Associates (AAs) to support consultants and work as part of multi-disciplinary teams. PAs undertake a 2-year postgraduate degree and are generalist healthcare professionals trained to a medical model. PAs bring new talent to the NHS and enrich the skill mix within multi-disciplinary teams. They act in an enabling role, helping to reduce the healthcare team's workload. AAs are highly trained, skilled practitioners that work within the anaesthetic team under the supervision of a consultant anaesthetist. All qualified AAs have successfully completed a 2-year postgraduate Anaesthetic Associate training programme. Upon qualification, PAs and AAs enter the workforce on Agenda for Change (AfC) terms and conditions. A national role profile exists for PAs at entry level mapped to the AfC Band 7.

The government is planning to bring AAs and PAs in scope of the GMC registration as soon as possible. Legislation is currently before Parliament. Subject to parliamentary approval, regulation will begin at the end of 2024.

Regulation will give the GMC responsibility and oversight of doctors, PAs and AAs, allowing it to take a holistic approach to the education, training and standards of the roles. This will enable a more coherent and coordinated approach to regulation and help embed them in the workforce by making it easier for employers, patients, and the public to understand the relationship between these roles and doctors. The development of the PA role, through regulation, will help health services deal with ongoing pressures and provide high quality care to patients. For example, regulated PAs will be able to request ionising

radiation (x rays) after appropriate training. Regulation is also a necessary step towards the longer-term aspiration of extending a form of prescribing responsibilities to PAs (and AAs) in order to maximise their capability.

From 2023 to 2024, around 1,300 physician associates (PAs) will be trained per year. This will increase to over 1,400 a year in 2027 to 2028 and 2028 to 2029, supporting an ambition to increase training places to over 1,500 by 2031 to 2032. The LTWP emphasises the need to focus this expansion on primary care and mental health services. Anaesthesia associate (AA) training places will increase to 250 by 2028 to 2029. This will support our ambition to increase places to 280 a year by 2031 to 2032.

The LTWP commits to doing more to leverage opportunities to fully embed digital technology in training pathways, to support more efficient and effective ways of learning and improved learner experience. A blended learning nursing degree has been created, with the model expanded to AAs. NHS England is commissioning an independent evaluation of all the blended learning programmes, to be completed in the next year.

International recruitment

Internationally trained staff have been part of the NHS since its inception in 1948 and continue to play a vital role. Of the doctors who joined the UK workforce in 2022, 50% were international medical graduates. The LTWP envisages a reduction in the proportion of international new joiners to the NHS (from 24% to 9-10.5% by 2036 to 2037) linked to the investment in, and expansion of education and training programmes. For doctors, it forecasts that an expansion of medical school places by 60-100% would support a reduction of 17,000 to 18,000 internationally recruited doctors (locally employed doctors, specialty and associate specialist doctors and junior doctors) and 3,300 internationally recruited consultants by 2036 to 2037. This planned reduction will rely on delivery on increased domestic supply and productivity, and therefore is likely to take effect in the later years of the LTWP. The NHS remains a destination of choice for overseas doctors and there will continue to be a role for the international recruitment of doctors and the new insights and ways of working that brings.

International recruitment must be done ethically, acknowledging that health and care professionals are globally mobile, and that migration provides opportunities and challenges for the individual, home country and receiving country. DHSC updated its Code of Practice for International Recruitment of Health and Social Care Personnel in March 2023 to align with the latest World Health Organisation (WHO) advice with eight new countries added to the Code's red list.

The Code prohibits active recruitment from red list countries identified by the WHO as having significant health workforce challenges. However, the Code is mindful of an

individuals' right to migrate and where individuals in red list countries want to come to the UK to work, they have every right to apply to a health and social care employer for a job directly and can expect equitable and fair treatment during the process.

In December 2022, DHSC published guidance to ensure prospective candidates are well informed about the process, benefits, and challenges of seeking a health or care job in the UK. The guidance raises awareness, sets out working rights and standards, how to identify and deal with exploitation and signposts to further help or support. The guidance is published alongside an easy read leaflet which aims to engage international candidates and summarise the key messages. We are working with FCDO in-country health advisors and diaspora organisations to ensure the guidance is disseminated widely and reaches potential international candidates before they have taken the decision to move to the UK.

Health and care staff coming to the UK can do so quickly and easily. The bespoke Health and Care Worker Visa provides a guaranteed decision within 3 weeks, discounted visa fees and an exemption from the Immigration Health Surcharge for those coming to work in UK health and care roles, including doctors and dentists.

Since 2016, we have seen increases in joiners of nearly all staff types. By proportion, 34.5% (7.8% EU/EEA, 26.8% Rest of World) of medical hospital and community health staff have a non-UK nationality (June 2023). While some of these professionals will stay in the UK to further their career, some return to their home countries, taking with them enhanced experience in new clinical settings and new skills.

Leadership review

Strong leadership across health and social care is an important driver of performance. It is key to building a positive organisational culture and an engaged and motivated workforce which will help ensure high quality care and the efficient and innovative use of public resources.

Published in June 2022, the Leadership for a Collaborative and Inclusive Future review, focusses on the best ways to strengthen leadership and management across health and with its key interfaces with adult social care.

The report found that ‘a well-led, motivated, valued, collaborative, inclusive, resilient workforce is the key to better patient and health and care outcomes.’ The review identified 7 recommendations to foster and replicate the best examples of leadership through improved training, career development and talent management, and through embedding inclusive cultures and behaviours within health and care:

1. Targeted interventions on collaborative leadership and organisational values

2. Positive equality, diversity, and inclusion (EDI) action

3. Consistent management standards delivered through accredited training

4. A simplified, standard appraisal system for the NHS

5. A new career and talent management function for managers

6. Effective recruitment and development of non-executive directors (NEDs)

7. Encouraging top talent into challenged parts of the system.

The recommendations were accepted by government and work to implement all 7 recommendations has commenced, with planning and implementation led by NHS England and Skills for Care. There are plans to launch a new national induction framework for all new staff later this year, as well as the development of a management and leadership programme for first time managers.

The Hewitt review

The Hewitt Review was published in April 2023 and the government's response in June 2023. The Hewitt Review set out a number of recommendations to enable ICSs to succeed. This included a focus on collaboration within and between systems and national bodies, ensuring a more streamlined set of shared priorities and allowing local leaders the space and time to lead. The Hewitt Review also supported many of the recommendations of the "Leadership for a Collaborative and Inclusive Future" review as set out above. In the government's response to the Hewitt Review, we have affirmed our commitment to fostering the success of systems by committing to:

1. Aim for a smaller number of national priorities, and reflect these in a shorter, streamlined mandate;

2. Continue to support systems as they mature including through changes to NHS England's new Operating Framework;

3. Continue to work to reduce small in-year funding pots to where absolutely necessary and ensure any additional reporting requirements accompanying future funding of this type are proportionate.

General practitioners

General practice (GP) is the most commonly used and often first point of access to the NHS. This section explains our strategic approach to this medical workforce.

The Delivery Plan for Recovering Access to Primary Care sets out how we aim to address the current challenges facing the sector by focussing primarily on streamlining patient access to care and advice. We recognise that growing the general practitioner (GP) workforce is critical to achieving the ambitions set out in this plan.

We have delivered on our manifesto commitment for 50 million more general practice appointments per year since 2019. We are growing the number of doctors in general practice and diversifying the workforce, building on the commitments in the LTWP to create a larger, more flexible workforce.

We recognise the importance of building the future pipeline of GP trainees. To boost recruitment, we've increased the number of GP training places available to 4,000 per year – up from 2,671 in 2014, with 4,032 doctors accepting a place on GP training in 2022. The LTWP has committed to expanding the number of GP training places by 50%, from 4,000 to 6,000 by 2031 to 2032, with the first 500 new places available from September 2025. The LTWP also aims to enable a wider range of clinical staff to work more flexibly in general practice, which will give additional capacity to general practice and improve patient access.

The department continues to work with NHS England to boost recruitment of GPs, address the reasons why doctors leave or reduce their working hours, and encourage them to return to practice.

Our Recovery Plan includes support for international trainees, who make up over half of all GP trainees, to ensure they can become fully qualified GPs. The plan also sets out how we will retain existing expertise, including through pension measures announced in the 2023 Spring Budget. This is alongside a number of retention schemes to boost the GP workforce that are already available.

The 2023 to 2024 updated Five-Year GP Contract Framework announced a review of new retention schemes alongside continued support for existing schemes for the general practice workforce. Written evidence to the DDRB for the 2023 to 2024 pay round provided an overview of the key schemes including the Supporting Mentors Scheme, the New to Partnership Payment, The GP Retention Scheme and The National GP Induction and Refresher Scheme. Further information on these schemes and retention measures included in our Recovery Plan can be found in chapter 4.

The additional roles reimbursement scheme (ARRS)

Diversifying the workforce by increasing the number of primary care professionals is also key and will help to reduce GP workload and deliver more appointments. The five-year GP contract framework provided funding for 26,000 additional staff in primary care networks (PCNs) via the additional roles reimbursement scheme (ARRS). The ARRS enables PCNs to recruit a diverse range of professions directly into primary care with the aim of providing a wider range of care options for patients, and multi-disciplinary support according to local needs.

This scheme will help patients to be seen by a wider range of professionals who are more expert at dealing with their particular needs, and also help to free up capacity for GPs to focus on what only GPs can do. We also expect this to improve retention of GPs who are increasingly citing high workloads as reasons for reducing their hours or leaving the workforce. Further detail on non-pay factors that affect GP recruitment and retention can be found in chapter 4, including the government's work to reduce bureaucracy and address the reasons why GPs leave the profession.

Between March 2019 and September 2023, the 26,000 target was exceeded with over 34,000 of these primary care professionals having been recruited into general practice. These additional primary care professionals have immediately made an impact, delivering COVID-19 vaccinations and a wider range of services through PCNs, as well as advanced practitioners and professionals in more senior roles anecdotally taking on some GP workload. The 2023 updates to the ARRS added the apprentice physician associate role and advanced nurse practitioners as reimbursable roles and increased the number of advanced practitioners and mental health practitioners available through the scheme.

Dentists

This section outlines our strategic approach to the dentistry workforce.

NHS long-term workforce plan (LTWP) and dental recovery plan

As set out in the NHS LTWP, we will grow the dental workforce in England by expanding undergraduate dentist training places to a record-breaking level. We will expand dental undergraduate training places initially by 24% to 1,000 places by 2028 to 2029. We will then expand training places by 40% from current levels to over 1,100 places by 2031 to 2032, making access to NHS care faster and fairer for patients.

We recognise that a significant proportion of dental graduates are likely to live and work near their dental school after graduation. Therefore, we wish to undertake this expansion in a way that is targeted to improve provision in areas of the country where it is most needed. We will set out further detail on how we will allocate places. If required to deliver our ambitions on workforce expansion, we will explore the creation of new dental schools in currently under-served parts of the country. Having more dentists is not the sole solution to current workforce challenges in NHS dentistry. More than 35,000 dentists are registered with the General Dental Council in England; however, only 24,151 of them delivered at least some NHS care in 2022 to 2023. We need dentists to do more NHS work alongside, or instead of, their private work.

The taxpayer makes a significant investment in the education and training of dentists in England. It is fair that the public expects this investment to be reflected in access for patients to NHS dentistry. As referenced in Faster, simpler and fairer: our plan to recover and reform NHS dentistry, we will launch a consultation this spring on introducing a ‘tie-in’ for graduate dentists. This would ensure that graduates spend at least some of their time delivering NHS care in the years following the completion of undergraduate training.

Dental education reform programme (DERP)

NHS England continues to implement the DERP to improve recruitment and retention, in line with its 2021 Advancing Dental Care Review. The review identified ways to improve the use of skill mix of the dental workforce and widen access and participation to training, allowing for more flexible entry routes and developing training places for dental professionals in areas of greatest need.

The DERP aims to improve skills and competencies of the dental workforce, improve individual training quality and flexibility in its pathways, improve retention and more effective alignment of the workforce to meet local service needs. The 4-year programme established governance, stakeholder engagement and delivery plans in 2021 to 2022 with implementation commencing in 2022.

NHS England will provide further detail on the key projects in the DERP.

Community dental services

The Community dental services workforce is a vital part of the dentistry landscape and provides specialised dental services targeting particular patient groups who may find it harder to access care from general dental practitioners. This includes patients who may have additional specialist needs as a result of disabilities that may preclude them from accessing care in from general dental practitioners.

Community dental services are available in a variety of places to ensure everyone can have access to dental care. These include hospitals, specialists' health centres and mobile clinics, as well as home visits or visits in nursing and care homes.

ICSs are responsible for identifying areas of local need and determining the priorities for investment.

NHS England published guidance in October 2023 that provides ICBs with options and points to consider when utilising existing commissioning flexibilities to address local priorities within the national dental contractual framework.

4. Data on recruitment, retention and motivation

This chapter describes and discusses the existing size of the workforce and how it has changed with regards to patterns of recruitment, retention, and motivation.

There are currently a record number of almost 134,000 full time equivalent doctors and dentists working across NHS trusts and other core organisations in England, almost 20% more than in 2019, while there are 8% more full time equivalent doctors working in general practice compared to 2019. The NHS trust workforce continues to become ever more diverse in terms of ethnicity (with 48% of staff citing non-white ethnicity in 2023 compared with 38% in 2016) and gender (with 40% of consultants now female compared to 35% in 2016).

However, trends in vacancies, temporary staffing, retention rates and the numbers of staff joining and leaving have been impacted by the COVID-19 pandemic. Leaver rates fell significantly in the early stages of the pandemic, then increased to higher than pre-pandemic levels, and have since returned to previous levels for medical staff. It should be noted that the leaver rate includes all staff leaving 'active service', which will include, for example, those going on maternity leave, and those moving to other parts of the system such as social care.

The NHS LTWP sets out how the NHS will build on the NHSE People Plan to improve the culture and leadership of the NHS so that up to 130,000 fewer staff leave the NHS over the next 15 years, helping staff to work flexibly, have access to health and wellbeing support and work in teams that are well-led.

At the end of this chapter, we share more information as requested by the DDRB on future workforce supply challenges, including assessments on future levels of international recruitment.

Numbers in work

NHS hospital and community health services (HCHS) workforce

The HCHS workforce is at record levels, as is the medical workforce. As of June 2023, there are over 6,000 (4.8%) more doctors than a year ago. Growth has accelerated in the past year compared to historic trend, mainly driven by an increase in international recruitment.

The joiner and leavers data discussed below shows those joining and leaving the NHS trust sector so includes flows from and to other sectors e.g., primary care, the independent sector, and to Scotland or Wales. Analysis from wider datasets suggests leaver numbers from the medic profession are low: leaver rates from the GMC register are around 4% and analysis of flows of medic graduates from LEO[2] suggests of those medical graduates in sustained employment, around 80% are employed in the health sector 10 years after graduating, with others working in related areas such as higher education or research.

Despite record workforce numbers, there are signs that the workforce is feeling stretched and burnt out. NHS staff are reporting high levels of stress and report not having sufficient resource in the NHS Staff Survey. Sickness absence rates remain above pre-pandemic levels and the single largest cause of absences is stress.

In last couple of years some of the workforce trends described below are likely to have been impacted by Covid-19. These include:

a) Graduates being registered early in 2020;

b) A drop in international recruitment in 2020;

c) Delayed leavers in 2020, followed by an increase in leavers in 2021 and 2022 (a trend that is common across the public sector);

d) Falls in recorded vacancies in 2020 followed by rebound afterwards. This is likely to reflect changes in recruitment during the pandemic rather than an underlying change in workforce needs;

e) High levels of sickness absence in 2022 (also reflected across the public sector) reflecting rates of covid across the UK.

We therefore need to be cautious in reading too much into some of the year-on-year movements in the last few of years.

Staff numbers

The numbers of doctors working in NHS hospital trusts and other core organisations continues to increase. The number of Hospital and Community Health Service (HCHS) medical staff has increased by over 20,000 (19.7%) full-time equivalents (FTEs) between June 2019 and June 2023. However, there are variations in the scale of

[2] Longitudinal Education Outcomes, LEO Graduate Industry dashboard (shinyapps.io) Subject by Industry tables

increases between staffing grades. Consultant numbers have increased by almost 6,800 (14.1%) but there have been larger proportionate changes in SAS doctors (20.6%) and doctors in training grades (25.0%). Table 9 shows the number of full-time equivalents for each year between June 2019 to June 2023 by staff group.

Table 9: Number of HCHS doctors as at June each year 2019 to 2023, FTE

Staff Group	Jun-19	Jun-20	Jun-21	Jun-22	Jun-23	Change since Jun-19
Consultant	48,166	50,243	51,801	53,111	54,961	6,795 (14.1%)
Associate Specialist	1,902	1,919	1,906	2,007	2,234	332 (17.5%)
Speciality Doctor	7,180	7,467	7,898	8,163	8,708	1,528 (21.3%)
Staff Grade	290	293	309	320	360	70 (24.1%)
Speciality Registrar	29,335	30,698	32,350	32,228	32,911	3,575 (12.2%)
Core Training	11,821	13,637	15,401	17,706	19,805	7,984 (67.5%)
Foundation Doctor Year 2	5,539	6,062	6,224	6,334	6,474	935 (16.9%)
Foundation Doctor Year 1	6,249	9,322	6,439	6,551	7,017	768 (12.3%)
Hospital Practitioner / Clinical Assistant	520	529	574	581	606	87 (16.6%)
Other and Local HCHS Doctor Grades	857	821	826	807	807	-50 (-5.8%)
Grand Total	111,860	120,990	123,727	127,808	133,883	22,023 (19.7%)

Source: NHS England HCHS monthly workforce statistics

Doctors are a highly skilled workforce and, as part of their professional development and the scope of their work, it is common to take career breaks from the NHS or move between employers, particularly during their training grades. The joiner and leaver data published by NHS England (based on data from the Electronic Staff record, ESR) reflects this. For example, doctors have a higher annual leaver rate than nurses, but also a higher joiner rate as doctors move into NHS trusts from other providers. This is largely driven by doctors in training rotating in and out of hospital settings as part of planned rotations of training and by, as the GMC report, an increasing number of doctors seeking opportunities to work in more flexible ways.

Retention of staff

Joiner rates and trends

Over 27,500 doctors joined active service in hospital and community services in the year to June 2023. This is 41% more than in the year to June 2018. While the number of joiners has increased as the overall size of the medical workforce has increased, it has also in

part been driven by increased numbers of international recruits. More information about international recruitment is set out in the international workforce section.

Joiner rates are the percentage of the HCHS doctor workforce joining active service in their staff group each year. Not all will be new recruits: many will be moving into the NHS trust sector after working for other providers, working outside England or returning from parental leave. For medical staff, joiner rates are relatively consistent across regions. Joiner rates were steadily growing in all regions up until the year to June 2019, reflecting the increases in total doctor numbers seen. Data for the years to June 2020 and June 2021 are impacted by the pandemic, including changes in the timing of graduating doctors joining the workforce. The joiner rates in all regions vary between 18.8% and 20.7% in the year to June 2023 as shown in Table 10.

Figure 3: Annual HCHS rates of staff joining active service in the group by staff group, years to June 2011 to June 2023, headcount.

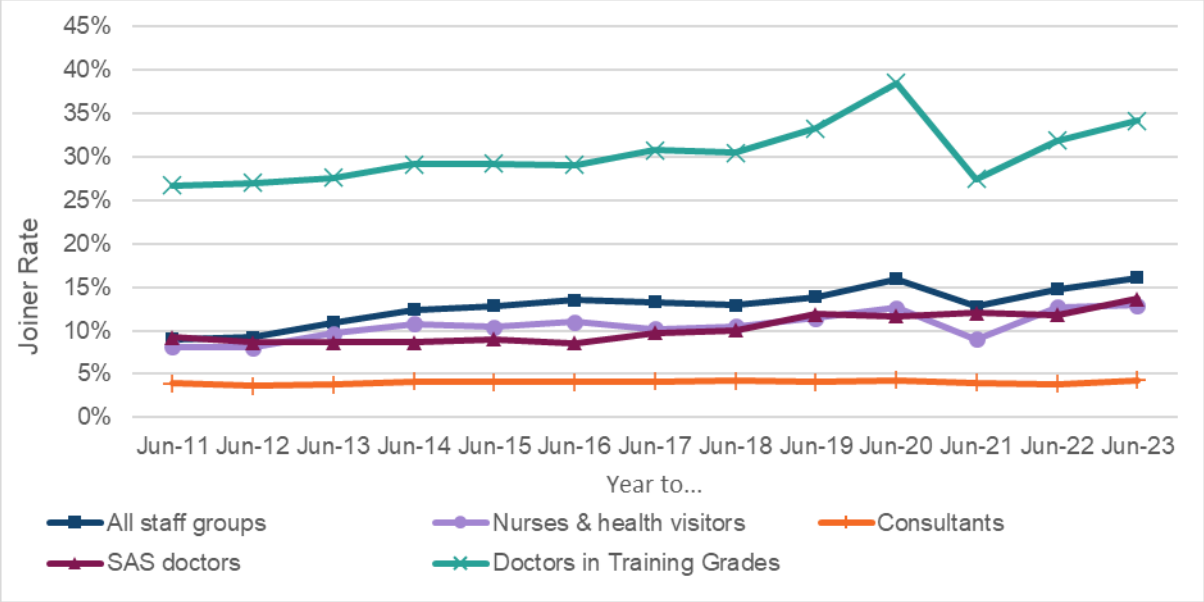


Table 10: annual rates of HCHS doctors joining active service by region, years to June 2018 to June 2023, headcount.

NHS England Region	Jun17 - Jun18	Jun18 - Jun19	Jun19 - Jun20	Jun20 - Jun 21	Jun21 - Jun22	Jun22 - Jun23
All Regions	17.1%	18.5%	21.2%	16.1%	18.1%	19.7%
London	17.7%	18.0%	19.7%	16.2%	18.0%	19.2%
South West	17.2%	18.9%	21.7%	15.4%	18.4%	19.3%
South East	17.7%	18.6%	21.4%	16.2%	18.2%	19.6%
Midlands	17.0%	19.1%	21.6%	17.6%	18.4%	20.7%

East of England	18.2%	19.6%	21.9%	17.3%	18.9%	20.6%
North West	15.9%	18.2%	21.8%	16.1%	17.4%	20.0%
North East and Yorkshire	16.3%	17.7%	21.5%	13.8%	17.3%	18.8%

Source: NHS England HCHS monthly workforce statistics

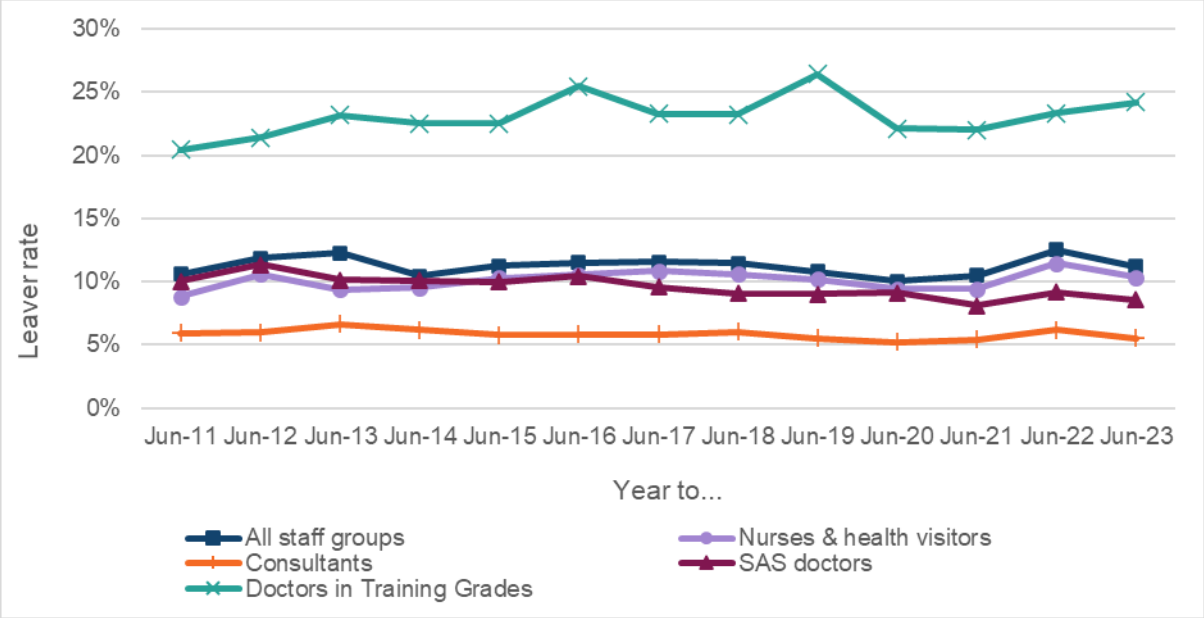
Leaver rates and trends

The leaver rate is the percentage of the workforce leaving their staff group in NHS trusts and other core organisations in a year. It excludes staff moving between trusts but includes movement of doctors from trusts to other settings such as general practices. This is important as doctors in training may often leave trusts to work in other settings or countries during their training.

The annual leaver rate for HCHS medical staff over the last 13 years is shown in Figure 4. When excluding doctors in training grades (who are more likely to be moving between healthcare settings in a planned way as part of their development), medical staff leaver rates are below other non-medical staff groups. Consultant leaver rates for the year to June 2023 were 5.5% and the combined rate for Specialty and Specialist (SAS) Doctors was 8.6%.

Over time, the consultant leaver rates have remained steady, whilst the SAS leaver rates declined before slightly increasing in recent years. For context, a thousand additional/fewer consultants leaving the NHS equates to about a 1.7% change in the leaver rate and in the year to June 2023 over 3,000 consultants left active service across Hospital and Community Health Service settings.

Figure 4: Annual HCHS rates of staff leaving active service in the group by staff group, years to June 2011 to June 2023, headcount.



Source: NHS England HCHS monthly workforce statistics

Over time, HCHS medical staff leaver rates have varied between 12.8% to 16.9% across regions. As with joiner rates though, there is relatively limited variation between rates in regions at a given point in time.

Table 11: annual rate of medical staff leaving active service in hospital and community health service settings by region, years to June 2018 to June 2023, headcount.

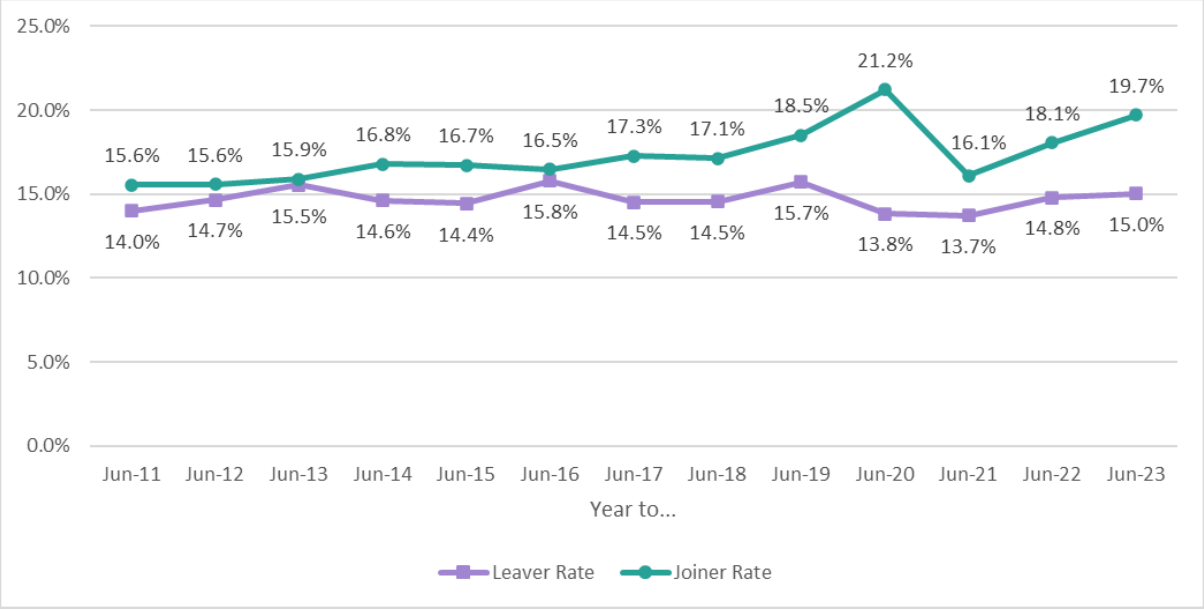
NHS England Region	Jun17 - Jun18	Jun18 - Jun19	Jun19 - Jun20	Jun20 - Jun 21	Jun21 - Jun22	Jun22 - Jun23
All NHS England regions	14.5%	15.7%	13.8%	13.7%	14.8%	15.0%
London	15.2%	15.4%	13.9%	13.6%	14.7%	15.0%
South West	15.0%	16.1%	14.4%	14.6%	15.2%	15.9%
South East	14.7%	16.9%	13.9%	13.1%	14.3%	15.1%
Midlands	14.3%	14.9%	15.1%	13.6%	14.8%	14.9%

East of England	14.3%	15.4%	12.9%	13.9%	15.1%	14.7%
North West	14.2%	16.6%	13.5%	14.5%	15.0%	15.0%
North East and Yorkshire	14.0%	15.3%	12.8%	13.1%	14.7%	14.8%

Source: NHS England HCHS monthly workforce statistics

Figure 5 below shows the significant impact of COVID-19 on annual joiners, with increased numbers in the year to June 2020, as graduating doctors joined the service early, and the corresponding dip in the year to June 2021. The graph shows the higher level of joiners which is driving continued increases in the total number of doctors in post.

Figure 5: annual joiner and leaver rates from active service for HCHS doctors, years to June 2011 to June 2023, headcount



Source: NHS England HCHS monthly workforce statistics

GP workforce data

As the department highlighted to the DDRB last year, we recognise the need to increase the GP workforce and workload continues to be a primary factor in low morale and retention of the workforce, as seen in the 2021 GP Worklife Survey. This circular

relationship underpins our efforts to expand and diversify the general practice workforce, and trends in workforce data can provide useful insight.

Data on the general practice workforce is published by NHS England. General practice workforce numbers are subject to seasonal variation, linked to recruitment and training cycles each year: they historically reach an annual high in September, as the next cohort of GP trainees start training, followed by a gradual decline over the rest of the year. Comparisons look at long term trends in capacity and should therefore only be made with the same annual time point, for example, September to September.

Tables 12 and 13 present a summary of doctors by role type working in general practice by headcount and full-time equivalent, since 2018. As of September 2023, there were a total of 37,419 full time equivalent (FTE) doctors in general practice in England (46,842 headcount).

Table 12: Doctors in general practice in England, FTE, by role, September 2018 to September 2023.

Practitioner type	September 2018	September 2019	September 2020	September 2021	September 2022	September 2023
All doctors in general practice	34,369	34,729	35,393	36,495	37,026	37,419
GP partners	19,293	18,462	17,641	17,059	16,750	16,342
Salaried GPs	8,115	8,496	9,133	9,752	9,865	10,065
GPs in training grade	5,880	6,547	7,454	8,576	9,470	10,116
GP retainers	121	186	228	254	252	272
GP regular locums	960	1,037	937	854	689	623

Source: General Practice Workforce, 30 September 2023, NHS England, October 2023, table 1a. Data includes estimates for practices that did not provide fully valid staff records

Table 13: Doctors in general practice in England, headcount, by role, September 2018 to September 2023.

Practitioner type	September 2018	September 2019	September 2020	September 2021	September 2022	September 2023
All doctors in general practice	42,343	43,442	44,617	45,980	46,283	46,842
GP partners	21,856	21,100	20,363	19,876	19,537	19,073
Salaried GPs	12,315	13,109	14,257	15,267	15,433	15,914
GPs in training grade	5,986	6,686	7,558	8,664	9,628	10,353
GP retainers	315	485	576	640	618	655
GP regular locums	2,469	2,532	2,297	2,117	1,668	1,457

Source: General Practice Workforce, 30 September 2023, NHS England, October 2023, table 1b. Data includes estimates for practices that did not provide fully valid staff records. Headcount totals may not equal the sum of components as individuals may work across multiple roles.

Overall, the general practice workforce data show the number of doctors in general practice grew by 2,690 FTE from September 2019 to September 2023, an increase of 7.7% (3,400 or 7.8 % increase by headcount). This is driven by growth among salaried GPs and doctors in GP training. However, the number of FTE GP contractors continued to decline from September 2022 to September 2023. While this means there has been an overall loss in the number of FTE qualified permanent GPs, excluding regular locums and those in training grade, (465 fewer FTE compared to September2019), the number of headcount qualified permanent GPs has increased over the same period (a headcount increase of 847). This is due in part to differences in working patterns between partner and salaried GPs (see participation rates and part-time working in Tables 15, 16 and 17). A number of policy programmes are being undertaken to boost retention and increase participation, as outlined in the section on GP retention below.

Demographics of the GP workforce

The demographic makeup of the workforce by job role and gender is broadly similar to previous years. As of September 2023, there were more female doctors in general practice than males, with a headcount of 26,910 (57.4%) and 19,826 FTE (53.0%) for females compared to a headcount of 19,595 (41.8%) and 17,342 FTE (46.3%) for males. However, more males continue to work as GP partners (57.3% of all GP partners, or 9,361 FTE) and regular locums (52.0% of all regular locums, or 324 FTE). GP trainees in September 2023 made up 27.0% FTE of the workforce, an increase from 25.6% FTE in September 2022.

Age and gender distribution also varies with role. Salaried GPs and doctors in GP training make up a higher proportion of the younger workforce, female doctors make up a higher proportion of GPs under 45, and there is a higher proportion of male GPs in older age bands. Differences in working patterns (see participation rates and part-time working in tables 15, 16 and 17) between male and female workers are likely to impact workforce trends in FTE by role.

Table 14: Doctors in general practice, FTE, by job role and gender, September 2023.

Practitioner type	All	% of all GPs by type	Male	% of all male GPs by type	Female	% of all female GPs by type
GP partners	16,342	43.7%	9,361	54.0%	6,840	34.5%
Salaried GPs	10,065	26.9%	3,130	18.0%	6,839	34.5%

GPs in training grade	10,116	27.0%	4,462	25.7%	5,649	28.5%
GP retainers	272	0.7%	66	0.4%	204	1.0%
GP regular locums	623	1.7%	324	1.9%	294	1.5%

Source: General Practice Workforce, 30 September 2023, NHS England, October 2023, table 1a. Data includes estimates for practices that did not provide fully valid staff records.

GP part-time working and participation rates

Participation rates are used to measure the extent of part-time working in the GP workforce. They are defined as the ratio of full-time equivalents to headcount. Participation rates as of September 2023 are shown by role and gender in table 15, by age and gender in table 16 and by role since September 2018 in table 17. A full-time working week is considered to be 37.5 hours.

Participation rates are lower for female GPs in each job role and in every age band. Contractor GPs and GPs in training have the highest participation rates regardless of gender; regular locums and retainers have the lowest. GPs in training grade participation rates appear to be higher as a trainee's full-time contract is 40 hours, compared to the standard full time salaried and/or contractor GP contract which is 37.5 hours. Overall, participation rates are broadly similar to last year, and table 17 shows how this changed between 2018 and 2023.

Table 15: Participation rates of doctors in general practice by gender and job role, September 2023 (%).

Practitioner type	Male	Female	All (including unknown)
All doctors in general practice	88.5	73.7	79.9
GP partners	92.7	77.6	85.7
Salaried GPs	68.8	61.0	63.2
GPs in Training Grade	102.3	94.4	97.7
GP retainers	48.0	39.8	41.5
GP regular locums	44.5	41.1	42.8

Source: General Practice Workforce, 30 September 2023, NHS England, October 2023, tables 1a and 1b. Data includes estimates for practices that did not provide fully valid staff records.

Table 16: Participation rates of doctors in general practice by age and gender, September 2023 (%).

Age band	Male	Female	All (including unknown)
All	88.5	73.7	79.9
Under 30	104.6	102.4	103.2
30-34	91.5	80.8	85.0
35-39	85.0	70.1	75.5
40-44	85.9	67.5	74.2

45-49	89.5	68.4	77.2
50-54	89.9	70.4	79.0
55-59	90.0	71.4	80.5
60-64	81.6	69.2	76.8
65 and over	77.4	70.1	75.7
Unknown	69.5	58.6	69.1

Source: General Practice Workforce, 30 September 2023, NHS England, October 2023, tables 2a and 2b. Data includes estimates for practices that did not provide fully valid staff records.

Table 17: Doctors in general practice, participation rates, by role, September 2018 to September 2023 (%).

Staff group	September 2018	September 2019	September 2020	September 2021	September 2022	September 2023
All doctors in general practice	81.2	79.9	79.3	79.4	80.0	79.9
GP partners	88.3	87.5	86.6	85.8	85.7	85.7
Salaried GPs	65.9	64.8	64.1	63.9	63.9	63.2
GPs in training grade	98.2	97.9	98.6	99.0	98.4	97.7
GP retainers	38.3	38.4	39.6	39.7	40.8	41.5
GP regular locums	38.9	41.0	40.8	40.4	41.3	42.8

Source: General Practice Workforce, 30 September 2023, NHS England, October 2023, tables 1a and 1b. Data includes estimates for practices that did not provide

GP locums

The number of regular locums, as of 30 September 2023 was 623 FTE (1,457 headcount). There were an additional 469 FTE ad hoc locums working in general practice during September 2023 (2,416 headcount). This was 27 FTE fewer ad-hoc locums working in general practice compared to September 2022 (65 more headcount). 575 ad-hoc locums worked in another general practice role during the reporting period, for example as a salaried or contractor GP at another practice, 11 more than in September 2022.

Many locum GPs work for practices on a long-term or regular basis, for example maternity cover or a regular weekly or monthly session and are referred to as regular locums. ‘Ad-hoc’ locums are those who work on a less regularised basis, such as covering sessions at short notice.

As part of the methodological changes implemented in the June 2021 publication to facilitate the move to monthly practice workforce reporting, ad hoc locum GP figures were removed from the main publication and instead included in an annex. Figures for ad-hoc

locums are collected and calculated differently to the rest of the general practice workforce, which includes regular locums, in that they represent ad-hoc locum use across the whole quarter, rather than a snapshot of the general practice workforce.

Other primary care staff

We are also taking steps to diversify the workforce in general practice. Since 2019, there has been an increase of 34,380 additional primary care professionals f in general practice, covering a range of roles including pharmacists, social prescribers, physiotherapists, and dieticians. This means bigger teams of staff providing a wider range of care options for patients. We have hit our commitment to recruit 26k additional staff a year ahead of the March 2024 target.

In September 2021, to complement the existing general practice and primary care networks (PCNs) level workforce data, NHS England introduced experimental quarterly statistics on the entirety of the primary care workforce. As of September 2023, this publication showed that there were 34,380 FTE more direct patient care staff, such as physiotherapists, social prescribers and pharmacists working in practices and PCNs compared to March 2019. This includes 5,082 FTE direct patient care staff that have been recruited directly by practices since March 2019.

Table 18: All staff working in general practice (excluding PCNs), FTE, September 2018 to September 2023.

Staff group	Septem ber 2018	Septem ber 2019	Septem ber 2020	Septem ber 2021	Septem ber 2022	Septem ber 2023
All staff	128,107	131,370	133,663	138,372	143,126	146,033
All staff excluding doctors	93,739	96,641	98,270	101,877	106,099	108,614
Doctors	34,369	34,729	35,393	36,495	37,026	37,419
Nurses	16,310	16,530	16,635	16,510	16,779	16,903
Other direct patient care staff	11,161	12,154	13,148	14,519	15,754	16,601
Admin/non-clinical	66,268	67,957	68,487	70,848	73,567	75,110

Source: General Practice Workforce, 30 September 2023, NHS England, October 2023, table 1a. Data includes estimates for practices that did not provide fully valid staff records.

Table 19: Direct patient care staff recruited to general practice and primary care networks since March 2019, FTE, September 2021 to September 2023

Staff group	September 2021	September 2022	September 2023
Other direct patient care staff	12,832	20,973	34,380

Source: Primary Care Workforce Quarterly Update, 30 September 2023, Experimental Statistics, NHS England, table 1a. These figures represent an enhanced view of the direct patient care (DPC) staff group FTE, using ARRS data in combination with National Workforce Reporting Service data. Headcount data is not available from this data source. Data not available before September 2021.

Table 20: All staff working in general practice, headcount, September 2018 to September 2023.

Staff group	September 2018	September 2019	September 2020	September 2021	September 2022	September 2023
All staff	176,365	180,924	183,234	188,476	192,011	194,449
All staff excluding doctors	134,050	137,506	138,654	142,565	145,800	147,682
Doctors	42,343	43,442	44,617	45,980	46,283	46,842
Nurses	23,419	23,773	23,807	23,554	23,490	23,284
Other direct patient care staff	16,625	17,874	18,994	20,712	21,840	22,560
Admin/non-clinical	94,390	96,181	96,190	98,690	100,958	102,322

Source: General Practice Workforce, 30 September 2023, NHS England, October 2023, table 1b. Data includes estimates for practices that did not provide fully valid staff records.

Dental workforce data

From 1 April 2023, all Integrated Care Boards (ICBs) took on delegated responsibility from NHS England for commissioning primary care dental services from providers to meet local dental needs in England. Providers are individuals or corporate bodies who hold a contract with the NHS. NHS dentists can be either performer only (also known as associates), who subcontract with or are employed by dental contract holders to deliver NHS dentistry, or providing-performers (contract holders who perform NHS dentistry). Dentists can also offer private care alongside NHS services.

The 2022-23 NHS dental statistics (NHS Dental Statistics for England, 2022-23, Annual Report - NHS Digital) show a positive trend in the recovery of NHS dentistry following the pandemic. The effect of a long reporting period for adults seen in the previous 24 months means the impact of the reduced throughput and dental activity seen during the pandemic is continuing to impact upon the headline statistics.

24,151 dentists performed NHS activity (any amount over 1 Unit of Dental Activity) during 2022 to 2023, a decrease of 121 on the previous year and 533 fewer than in 2019 2020. However, 18.1 million adults were seen by an NHS dentist in the 24 months up to 30 June 2023, an increase of 1.7 million (10%) when compared to the previous year, and 6.4 million children were seen by an NHS dentist in the 12 months up to 30 June 2023, an increase of 800,000 (14%) when compared to the previous year. Furthermore, 32.5 million Courses of Treatment (CoT) were delivered in 2022 to 2023, an increase of 23.2% compared to the previous year.

Further data on the dental workforce will be provided in NHS England's evidence.

Table 21: Number of dentists with NHS activity by dentist type, 2007/08 and 2022/23.

Dentist type	2007/08	2022/23	% of total (2007/08)	% of total (2022/23)
Providing performer	7,286	4,604	35%	19.1%
Associate (Performer)	13,529	19,512	65%	80.8%
Unknown	N/A	35	N/A	0.1%
Total	20,815	24,151	100%	100%

NHS Digital, NHS Dental Statistics, August 2008, Annex 3, Table G4. (For Table 1 only)

Table 22: Number of dentists with NHS activity by dentist type, 2018/19 to 2022/23.

Dentist type	2018/19	2019/20	2020/21	2021/22	2022/23
Providing performer	4,954	4,863	4,682	4,752	4,604
Associate (Performer)	19,550	19,781	19,026	19,485	19,512
Unknown	41	40	25	35	35
Total	24,545	24,684	23,733	24,272	24,151

Sources: NHS Digital, NHS Dental Statistics 2022/23, Workforce Overview, Table 1b.

Table 23: Number of dentists with NHS activity by gender, 2018/19 to 2022/23

Dentist gender	2018/19	2019/20	2020/21	2021/22	2022/23
Female	12,380	12,659	12,303	12,779	12,933
Male	12,165	12,025	11,430	11,493	11,218
Total	24,545	24,684	23,733	24,272	24,151

Table 24: Number of dentists with NHS activity by gender and age group, 2022/23

Age band	Female	Male
Under 35	40.3%	30.3%
35-44	31.1%	25.4%
45-54	20%	22.7%
55 or over	8.6%	21.6%
All	53.6%	46.4%

Source: NHS Digital, NHS Dental Statistics 2022/23, Workforce Overview, Tables 1d and 1e.

Table 25: Number of dentists who left and those who joined the NHS in the years ending 31 March 2018/19 to 2022/23

	2018/19	2019/20	2020/21	2021/22	2022/23
Joiners	1,753	1,806	1,398	1,953	1,885
Leavers	1,667	2,349	1,414	2,006	-
Net change in number of dentists from previous year	237	139	-951	539	539
% change in number of dentists from previous year	1%	0.6%	-3.9%	2.3%	2.3%

Source: NHS Digital, NHS Dental Statistics 2022/23, Workforce Overview, Table 1a.

International workforce

Overseas-trained dentists and other dental care professionals remain an important part of the NHS workforce. In chapter 6, we outline the context of overseas dentists' recruitment.

Table 26: Dentists on the GDC register as of 31 December 2022 by region of qualification:

Region of qualification	Amount	% of total
UK qualified	31,134	70.5%
EEA qualified	7,573	17.0%
ORE - UK Statutory Examination	3,801	8.5%
Rest of the world qualified	1,617	4.0%
Total	44,125	100%

Recruitment and retention

HCHS reasons for leaving

Reasons for staff leaving are collected within the ESR system and provide insight into some aspects of staffing motivation. Any conclusions drawn from this need to be mindful of a continually increasing rate of an ‘unknown’ reason being recorded; for example, over 47% of total reasons for leaving from 2022 to 2023 were recorded as ‘unknown’. We have noted the requests in the past few years for more information in this area, but we are

limited to the data captured within the ESR system. Consideration of the burden on the health system of any changes to current data collection are key in this area and the department has no current plans to seek an expansion of the data collected.

The most specified reason for leaving is medical staff reaching the end of a fixed term contract, making up 32% of total reasons for leaving in 2022 to 2023. However, this is linked to doctors in training grades rotating between training posts. The number of voluntary resignations has fallen for 2022 to 2023 but is higher than levels prior to 2021 to 2022. Among those leaving voluntarily, the most common reasons are relocation, promotion and work life balance. It is not possible to determine the specific impact of COVID-19 within this.

In the ‘Completing the picture survey’, the GMC found the most commonly cited reasons for leaving (respondents can pick multiple reasons) are very varied with a mix of more ‘neutral’ reasons, such as returning to their country of previous residence (32%) and retiring (26.8%), and more negative reasons, such as burnout (27.2%) and dissatisfaction (35.7%). Other less common reasons are also noteworthy, including bullying (5.5%) and harassment (3.1%). The General Medical Council Workforce Report for 2023 found similar reasons for doctors leaving the register across the UK with the most common main reasons provided were ‘wanting to practice abroad’ (25%), retirement (24%) and wanting to live abroad (8%).

Table 27: HCHS doctors, reasons for leaving, 2017 - 2018 to 2022 - 2023

Reason for leaving / Year to	March 2018	March 2019	March 2020	March 2021	March 2022	March 2023
Dismissal	68 (0.4%)	71 (0.4%)	53 (0.3%)	56 (0.3%)	62 (0.3%)	71 (0.3%)
Employee transfer	164 (1.0%)	673 (3.7%)	195 (1.1%)	245 (1.4%)	261 (1.3%)	106 (0.5%)
End of fixed term contract	6,807 (41.2%)	6,942 (37.7%)	6,048 (34.5%)	5,427 (31.6%)	6,216 (31.7%)	6,662 (31.6%)
Others	52 (0.3%)	53 (0.3%)	69 (0.4%)	105 (0.6%)	65 (0.3%)	75 (0.4%)
Redundancy	26 (0.2%)	34 (0.2%)	26 (0.1%)	22 (0.1%)	11 (0.1%)	27 (0.1%)
Retirement	927 (5.6%)	914 (5.0%)	917 (5.2%)	995 (5.8%)	1,095 (5.6%)	1,064 (5.1%)
Voluntary resignation	2,893 (17.5%)	2,686 (14.6%)	2,751 (15.7%)	2,531 (14.7%)	3,226 (16.5%)	3,167 (15.0%)
Unknown	5,587 (33.8%)	7,052 (38.3%)	7,475 (42.6%)	7,791 (45.4%)	8,662 (44.2%)	9,886 (46.9%)
All reasons for leaving	16,524	18,425	17,534	17,172	19,598	21,058

Source: NHS England HCHS monthly workforce statistics.

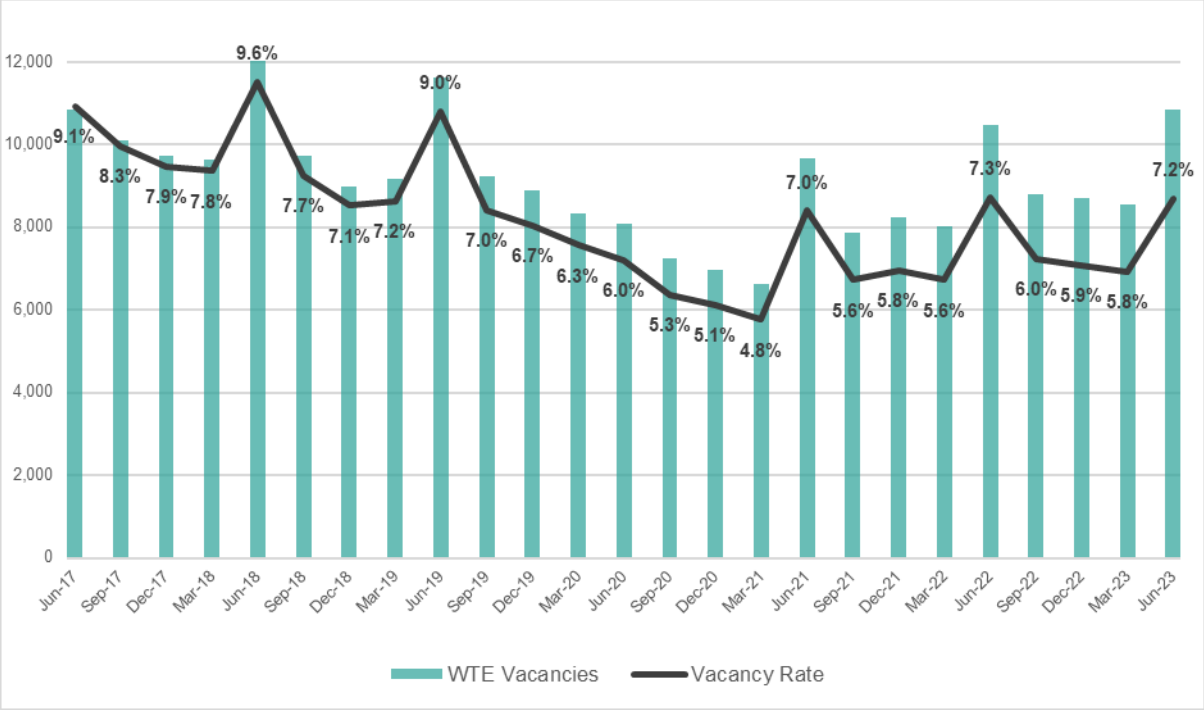
NHS trust vacancies

There are multiple measures for vacancies which NHS England collate and publish as an experimental statistics release. As part of that series, NHS England undertake a monthly workforce data collection from NHS trusts, which includes data on staff in post and vacancies (defined as the difference between the reported whole-time equivalent substantive staff in post and planned workforce levels). This is the most commonly presented statistic but is still subject to some variation in trust interpretation of measurement of planned staffing levels.

The vacancy rate for medical staff has shown large variation over the last 6 years, ranging from 4.8% to 9.6%, which is equivalent to vacancies of around 6,600 to over 12,000. The recorded rate has stabilised post COVID-19 at a rate lower than that seen pre-pandemic. NHS England report that the drop-in vacancy rates over 2020 and 2021 was in part due to the impact of COVID-19 on the ability of trusts to complete comprehensive workforce planning during the pandemic.

Bank and agency staff are used to cover a significant proportion of the vacancies, in addition to covering sickness absence and long-term leave.

Figure 6: Medical vacancies and vacancy rates, June 2017 to June 2023, FTE



Source: NHS England HCHS monthly workforce statistics

GP recruitment

Growing the future pipeline of trainees is critical to increasing the number of doctors in general practice. To boost recruitment, we have increased the number of GP training places. The highest ever number of doctors accepted a place on GP training in 2022; 4,032 trainees. Table 28 shows the growth in the number of GP training places available and accepted since 2018.

The Long-Term Workforce Plan has committed to expanding the number of GP training places by 50%, from 4,000 to 6,000 by 2031/32, with the first 500 new places available from September 2025. Increasing the number of GP trainees will help to ease workloads and increase capacity in practices, allowing more patients to get the care they need. Just as in hospitals, trainees provide direct patient care whilst being safely supervised and supported.

Our recovery plan announced new measures to support international medical graduates, who make up over half of all doctors in GP training. We recognise the important role that international medical graduates play in helping to grow the GP workforce, and the barriers that they can face upon successful completion of GP Specialty Training. We have introduced an additional four months for these doctors at the end of their visa which will

allow newly qualified international GPs who wish to work in the UK the time they require to find employment following completion of their training.

The GP training model continues to undergo reform to support better training for GPs and a more balanced distribution of trainee capacity across the NHS. GP trainees have traditionally spent around half of their 3-year training working in general practice, but this is increasing to 2 years in general practice placements through a phased approach. As of August 2022, 90% of GP trainees in England are spending 2 years in general practice. This is helping to better prepare trainees for a role in general practice. GP trainees are able to support fully qualified GPs, helping to ease workloads and increase capacity in general practice, allowing more patients to get the care they need. Further to these changes, the LTWP sets out measures to ensure that all foundation doctors can have at least one four-month placement in general practice, with full coverage by 2030/31.

There are schemes in place to attract more doctors to GP speciality training including the 'choose GP' advertising campaign and the targeted enhanced recruitment scheme (TERS) which started in 2016. TERS is a national incentive scheme that funds a £20,000 salary supplement to attract trainee GPs to work in areas of the country where training places have been unfilled for a number of years. Since 2016, the scheme has widened its criteria to include under-doctored and deprived areas. The scheme has grown from 122 places advertised in England in 2016 to 800 places available per year.

Table 28: General practice speciality training places available, accepted and fill rate.

GP speciality training	2018	2019	2020	2021	2022	2023
Places available	3,250	3,250	3,750	4,000	4,000	TBA
Acceptances	3,473	3,540	3,793	4,001	4,032	TBA
Fill rate	107%	109%	101%	100%	101%	TBA

Source: Health Education England, General Practice ST1 Recruitment Figures.

GP retention

The 2020 updated Five-Year GP contract framework announced a number of new retention schemes alongside continued support for existing schemes for the general practice workforce. Work continues on targeted efforts to retain GPs in the workforce. These include the supporting mentors scheme, the GP retention scheme and the GP return to practice programmes (formerly combined with the GP international induction programme to form the national GP induction and refresher scheme). Retention measures have also been put in place to support international medical graduates due to complete GP speciality training to identify practices with visa sponsorship licenses, so that they continue to live and work in England once they qualify as a GP.

Voluntary early retirements

According to analysis of NHS pensions scheme membership, of the GPs taking their 1995 Section pension on an age or voluntary early retirement (VER) basis, the proportion doing so on a VER basis increased from 21.5% in 2008 to a peak of 52.6% in 2017. The proportion taking VER has dropped slightly since but has remained high at 38.2% in 2023. Table 29 contains further detail on the number of GPs taking their pension.

However, this is not a measure of retirement, but a measure of GPs taking their pension and anecdotally, we know that some GPs will take their pension and return to the workforce (retire and return). We do not currently have robust data on the number of GPs that take their pension and remain in the workforce, and if they do stay in the workforce, in what capacity this is, including job role.

Table 29: the number of GPs taking their pension (NHS Business Services Authority analysis of 1995 pensions scheme membership)

Pension year ending	Number of GPs in total claiming NHS pensions*	Total number of GPs** claiming VER pensions	% taking VER
2008	1137	245	21.5
2009	1324	280	21.1
2010	1513	347	22.9
2011	1346	407	30.2
2012	1343	503	37.5
2013	1186	494	41.7
2014	1513	775	51.2

2015	1240	595	48.0
2016	912	457	50.1
2017	1349	710	52.6
2018	1155	518	44.8
2019	1228	567	46.2
2020	1212	509	42.0
2021	1156	469	40.6
2022	884	335	37.9
2023	1289	492	38.2

Source: NHS Business Services Authority analysis of the number of GPs taking their pension (1995 pension scheme only).

Includes NHS pensions awarded to GPs on an age and VER basis. There will be a very small number of ophthalmic medical practitioners included.

GP retirement ages

Data is not held on overall average retirement ages for GPs, as there are two types of retirement - voluntary early retirements (as explained above) and age retirements - both of which have different average retirement ages. The 1995 Section has a normal retirement age of 60. Age retirements are taken at or after 60, whilst voluntary early retirements are taken before 60.

The table 30 below shows the average age at which GPs take age and voluntary early retirements from the 1995 Section of the NHS Pension Scheme. The proportion of these retirements which were taken on a VER basis is shown in the table above.

Pension Year Ending	Average age of GPs taking VER pensions	Average age of GPs taking age pensions
2008	57.59	61.72
2009	57.4	62.07
2010	57.05	61.72
2011	56.94	61.54
2012	57.01	61.27
2013	56.75	61.13
2014	57.04	60.86
2015	56.87	60.94
2016	57.01	61.02
2017	57.11	60.86
2018	57.24	60.95
2019	57.01	60.43
2020	57.14	60.44
2021	57.35	60.62
2022	57.44	60.85
2023	57.49	60.74

Table 30 above shows that the average retirement ages for GPs have not changed significantly in recent years.

Older GPs leaving the profession

We recognise the importance of retaining highly qualified and experienced GPs. Early retirement impacts GP retention and we understand that exhausting the annual and lifetime allowances for tax-free pension saving may have been a factor, amongst others, that prompted some GPs to take retirement when reaching those thresholds.

At the 2023 Spring Budget, the government increased the annual allowance for tax-free pension saving by 50% to £60,000 and abolished the £1 million lifetime allowance. These substantial reforms alleviate the tax disincentives for GPs from continuing their NHS work or taking on extra hours.

Alongside the pension tax reforms announced at the Spring Budget, the department is also implementing new retirement flexibilities to help retain experienced GPs, whilst making it easier and attractive for retired staff to return.

From 1 April 2023, we abolished the rule that staff could only work up to 16 hours a week in the first month after returning from retirement without affecting their pension. We also removed the rule that prevented retired staff who return to NHS work from re-joining the scheme and building up more pension.

From 1 October 2023, a new ‘partial retirement’ option is available as an alternative to full retirement. Staff can draw down some or all their pension whilst continuing to work and build up further pension.

Whilst not just for GPs, these measures will support existing GPs to continue contributing their expertise for longer and incentivise those who have retired to return to practice.

More information on changes to the NHS Pension Scheme can be found in Chapter 7.

GP wellbeing and morale

The national GP Worklife survey is a regular series of studies, commissioned by the department and carried out by the University of Manchester, which focuses on GPs’ experiences of their working lives, including job satisfaction, sources of pressure and job attributes. The 11th survey was published in April 2022 and ran between December 2020 and December 2021. The results from the survey showed that:

- the mean level of overall satisfaction rates decreased significantly from 4.49 to 4.3 (on a scale from 1-7) between 2019 and 2021). Overall satisfaction has reduced to a level similar to 2015.

- The pressure experienced as a result of common job stressors all decreased (except for 'adverse publicity by the media', 'dealing with problem patients' and 'increased demands from patient), however these all remain high, with increasing workloads the most common stressor. More than 8 out of 10 GPs reported experiencing considerable or high pressure from increasing workloads and increased demands from patients.

- Average working hours worked in a week reported by GPs surveyed in 2021 was 38.4 hours, a decrease of 1.6 hours from 2019. When compared to average participation rates detailed in table 15, this suggests that some GPs are working more than their contracted hours. Of those surveyed, over a third (33.4%) of GPs said there was a considerable or high likelihood of them leaving 'direct patient care' within 5 years. For GPs under 50, the 'intention to quit' is at its highest level compared to previous surveys. However, the percentage of GPs over 50 who expressed this is lower than 2019 and at its lowest level since 2015.

Further to this, the expansion of roles across primary care and the increase of GP speciality training places has intensified the role of the GP trainers and their workload. According to the GMC's National Training Survey, 52% of GP trainers reported feeling burnt out to a high/moderate degree in 2023 (same level as 2022), which presents a risk to the quality of training. This survey also found that trainers were facing significant challenges which are 'especially concerning given the ambition for further expansion of training capacity'.

Within the RCGP Fit for the Future: Reshaping general practice infrastructure in England, 47% of general practice staff said their practice has a shortage of educators/supervisors limiting their capacity to take on GP trainees or other learners. The GMC's The state of medical education and practice in the UK found that within both 'GPs and specialists, trainers were more likely than non-trainers to be struggling (63% of GPs with a training role were struggling compared with 53% of GPs who did not hold such a role). With the expansion of GP speciality training places from 4,000 to 6,000 by 2031, with the first 500 additional places available from September 2025, maintaining the current cohort of GP trainers and ensuring that it remains an attractive option to those considering becoming a GP trainer is critical in supporting the increasing trainee pipeline, and growing number of doctors in general practice.

As part of the Delivery plan for recovering access to primary care, published by NHS England in May 2023, we remain committed to continuing to reduce demands on general practice time from unnecessary or low value asks. This builds on a cross government concordat called bureaucracy busting concordat: principles to reduce unnecessary

bureaucracy and administrative burdens on general practice published in August 2022 that agreed to seven principles to reduce bureaucracy in general practice.

We have made several changes to reduce unnecessary bureaucracy for GPs to free up time for appointments, including expanding the range of healthcare professionals who can carry out tasks such as signing 'fit notes' and providing medical evidence to the Driver and Vehicle Licensing Agency. We continue to reduce evidence requests and increase self-certification.

The provision of mental health services, such as NHS England and RCGP's #LookingAfterYouToo and the #LookingAfterYourTeam, is important for building resilience and reducing burnout in general practice. These coaching support services provide access to mental health services to all primary care workers, managers and leaders employed or contracted to deliver work on behalf of the NHS and aim to encourage psychological wellbeing and resilience in teams.

HCHS diversity analysis

The NHS hospital and community health service medical workforce is significantly more ethnically diverse than the working age population across the economy. Within the NHS medical workforce, approximately 44% of the workforce is white, while 6% are black or Black British and 31% are Asian or Asian British. There are currently 8% of the workforce with 'unknown' or 'not stated' ethnicity. As a comparison, the 2021 census showed that almost 81% of the working age population across England and Wales is white.

Table 31 hospital and community health service doctor ethnicity by medical grade, June 2023

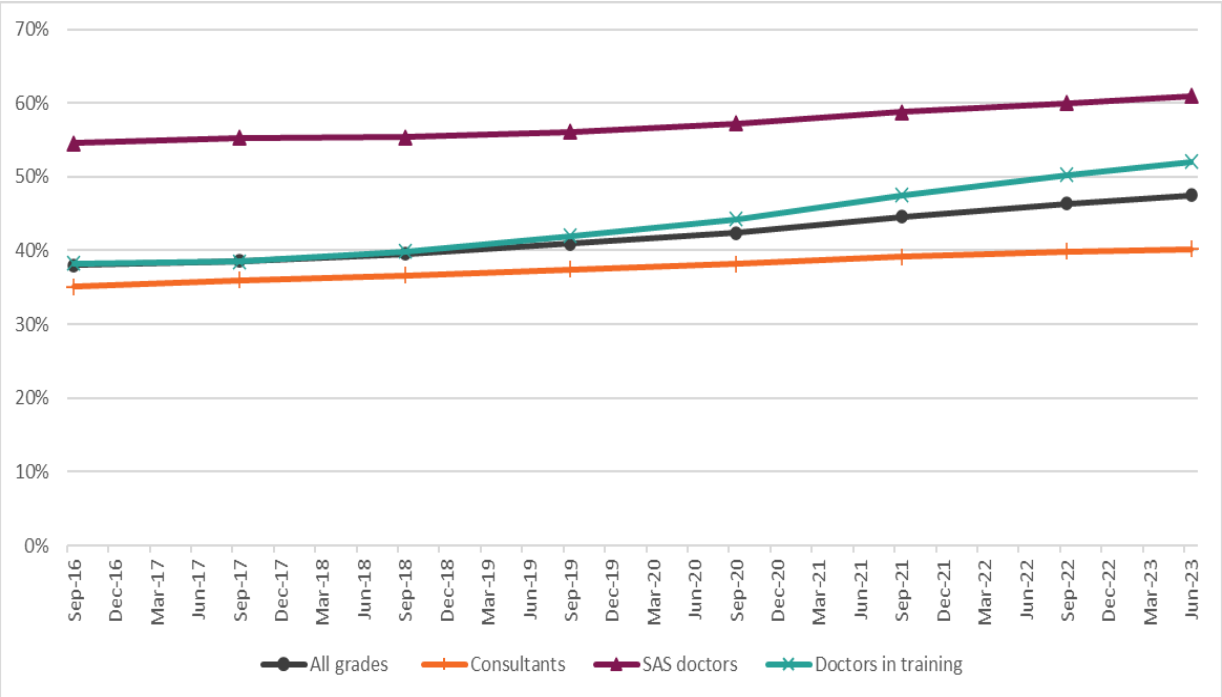
June 2023 (Headcount)	Asian or Asian British	Black or Black British	Chinese	Mixed	White	Any Other Ethnic Group	Not Stated	Unknown
All grades	30.7%	5.7%	2.5%	3.7%	44.1%	5.4%	6.0%	1.8%
Consultant	28.7%	3.0%	2.2%	2.6%	53.6%	3.9%	4.8%	1.1%
Associate Specialist	41.5%	4.8%	1.0%	3.2%	35.6%	6.9%	5.5%	1.5%
Specialty Doctor	41.3%	8.2%	0.9%	4.0%	29.4%	8.3%	6.2%	1.7%
Staff Grade	34.8%	6.3%	2.3%	5.0%	28.5%	8.3%	9.3%	5.5%

Specialty Registrar	29.3%	7.8%	3.1%	4.7%	40.4%	6.2%	6.4%	2.2%
Core Training	33.8%	9.6%	2.5%	4.8%	31.7%	7.3%	7.1%	3.1%
Foundation Doctor Year 2	32.3%	5.7%	3.6%	4.4%	38.3%	5.2%	7.9%	2.6%
Foundation Doctor Year 1	28.5%	5.7%	4.7%	4.8%	42.1%	4.6%	7.8%	1.8%
Hospital Practitioner / Clinical Assistant	20.8%	2.4%	1.0%	1.4%	58.7%	1.4%	9.1%	5.1%
Other and Local HCHS Doctor Grades	24.5%	2.9%	1.8%	2.5%	58.1%	2.6%	5.8%	1.7%

Source: NHS England HCHS monthly workforce statistics

The overall representation of staff with non-white ethnicity within the workforce has been increasing across all grades since 2016. Within the three broad staffing groups, SAS doctors continue to have the highest proportion of non-white staff while consultants have the lowest.

Figure 7: proportion of staff reporting non-white ethnicity by medical grade, September 2016 to June 2023, headcount



Source: NHS England HCHS monthly workforce statistics

Gender balance in the medical workforce

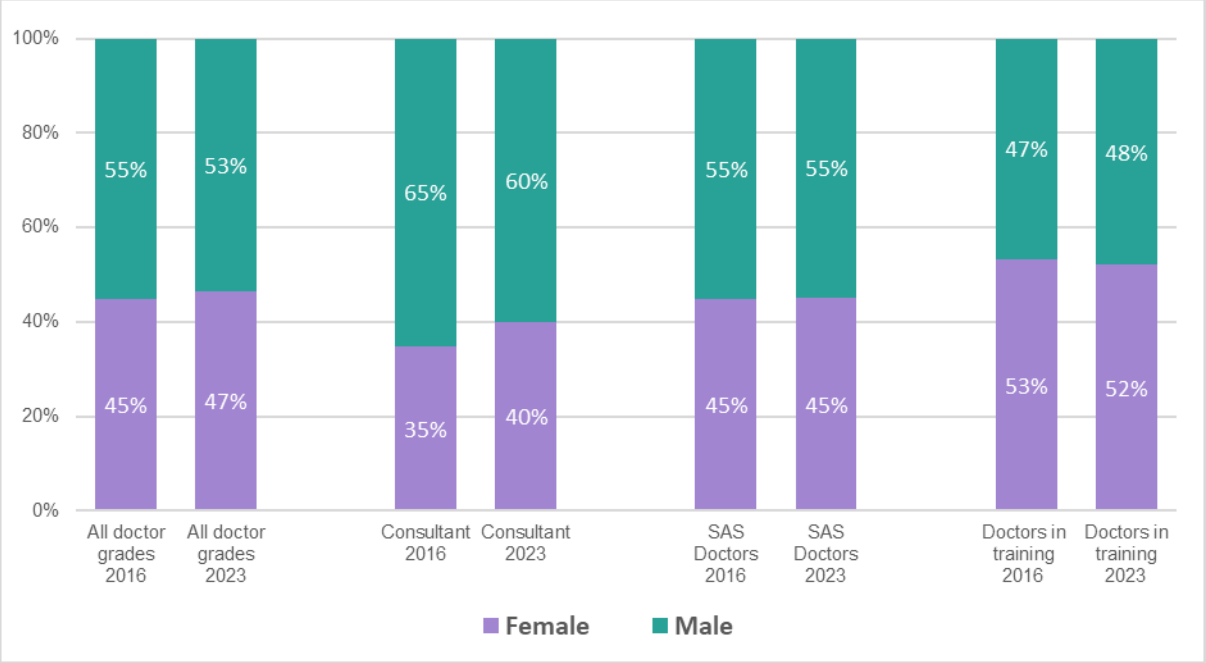
Data from June 2023 shows that 46.5% of the medical workforce are female. The proportion of female staff varies by grade with higher proportions of female staff in the training grades (foundation year 1, 59.0%, foundation year 2, 56.4%, and speciality registrar, 51.3%). The overall proportion of female staff has slightly increased over the past 7 years (44.9% to 46.5%), but the majority of the increase has occurred in grades where females were previously underrepresented: the proportion of consultants who are female has risen from 34.8% to 39.9%.

Table 32: gender by medical grade, June 2023, headcount

Staff group	Female	Male
All doctor grades	46.5%	53.5%
Consultant	39.9%	60.1%
Associate specialist	40.6%	59.4%
Specialty doctor	46.4%	53.6%
Staff grade	42.8%	57.2%
Specialty registrar	51.3%	48.7%
Core training	49.5%	50.5%
Foundation doctor year 2	56.4%	43.6%
Foundation doctor year 1	59.0%	41.0%
Hospital practitioner / clinical assistant	53.1%	46.9%
Other and local HCHS doctor grades	68.4%	31.6%

Source: NHS England HCHS monthly workforce statistics

Figure 8: gender breakdown by HCHS medical grades, 2016 and 2023, headcount



Source: NHS England HCHS monthly workforce statistics

Temporary staffing

The deployment of a temporary workforce is an important element of efficiently running the NHS, allowing the NHS to meet demand fluctuations without the need to increase capacity above that which would be required on a sustained basis. Staff can be drawn from internal staff banks or external agencies. The Department and NHS England's temporary staffing strategy aims to support NHS providers to reduce their agency staff bills and encourage workers back into substantive and bank roles.

Measures were introduced in 2016 to curb NHS agency spending, including price caps, the mandatory use of approved frameworks for procurement, and the requirement for all systems to stay within the specified annual expenditure ceilings for agency staff. The measures, which are regularly monitored for compliance and effectiveness, aim to reduce cost and give greater assurance of quality.

Metrics used to monitor performance on agency usage are included in the NHS Oversight Framework, which reinforce the rules that NHS trusts and FTs should comply with. Trusts are encouraged to develop and improve their strategy, procurement, and commercial negotiation in their approach to temporary staffing. NHS England supports NHS trusts to reduce off-framework supply and to develop staff banks, increasing transparency and collaborative arrangements. The NHS is experiencing a period of unprecedented demand and there has been an increase in expenditure on both bank and agency staff in the three years to 2021 to 2022. Bank expenditure increased by 51% (from

£3.45 billion to £5.2 billion) and agency expenditure increased 23% from £2.4 billion to £2.96 billion. Bank and agency spend increased further in 2022 to 2023 to £5.8 and £3.46 billion respectively, although there are signs that agency spend is beginning to decrease again in 2023 to 2024.Price cap compliance for all staff groups has remained constant at 60% since 2018 until 2022 to 2023 when it dropped to 55%. However, for the medical and dental staff group, compliance is typically around 13% (13.3% in 2021 to 2022). The national shortages of medics in certain specialities (such as orthopaedics, geriatrics, cardiothoracic oncology and radiology) may contribute to poor compliance rates amongst this group. This causes greater variability in hourly rates between on and off-framework spending.

Doctors who choose to work through agencies are motivated by the flexibility, relatively higher pay, improved support systems, culture and a smaller admin burden whereas the main reasons for choosing to work substantive shifts are involvement in teaching and research; learning and development; and predictable pay and hours.

Agency spend accounted for 4.5% of the NHS pay bill in 2022 to 2023. NHS Planning guidance states that the system should reduce agency spending across the NHS to 3.7% of the total pay bill in 2023 to 2024. The investment set out in the LTWP should reduce reliance on agency staff over time. The plan estimates that reliance on temporary staffing in FTE terms would reduce from 9% in 2021 to 2022 to around 5% in 2032 to 2033.

Working hours

NHS Digital data shows doctors continue to work close to full time on average. The overall HCHS doctor participation rate (the ratio of FTE to headcount) has remained at 94% over the decade to 2022. The participation rate of trainees has fallen slightly over the past ten years, down 1% point for core trainees and specialist registrars. It has increased for associate specialists (+1% point) and specialty doctors (+4% points). The trend for consultants is a slight fall, down 1% point over the decade.

NHS England report data on contracted FTEs based on the proportion of time staff work in a role. The FTE data does not capture contracted or additional work above ‘full-time’ (FTE = 1). Therefore, levels and trend of hours worked above full-time will not be represented.

The Royal College of Anaesthetists Census Medical Workforce Census Report 2020 shows 62% of UK consultant anaesthetists and 72% of SAS doctors worked more than full time (+10 programmed activities). This is a fall from 2015 when more consultants (74%) worked above full time. The RCoA report that the fall was likely a result of pension taxation changes. The Department notes that since 2020 there have been significant reforms to pension tax. At Budget 2020 the annual allowance taper threshold was raised by £90,000 to £200,000 when it became clear that the previous threshold was disincentivising doctors

from taking on additional work and responsibilities. Then at Budget 2023, the standard annual allowance for tax-free pension saving was increased by 50% to £60,000 and the lifetime allowance would be first suspended and then removed. The minimum tapered annual allowance also increased from £4,000 to £10,000 and the adjusted income threshold for the tapered annual allowance increased from £240,000 to £260,000. These major reforms should ensure that consultants are not disincentivised from continuing their NHS work or taking on extra hours.

Male consultants were more likely to work above 'full time' (67%) compared with female consultants (52%). Anaesthetics is the largest hospital based medical specialty, though they may not be wholly representative of other medical specialities.

Table 33: average and trend participation rates (the ratio of FTE to headcount) for all HCHS doctor grades

	2022			Percentage point change over past decade[3]		
Gender	All	M	F	All	M	F
All HCHS doctors	94%	96%	92%	0%	0%	1%
Consultant	93%	95%	91%	-1%	-2%	0%
Associate Specialist	89%	95%	81%	1%	1%	1%
Specialty Doctor	88%	94%	81%	4%	2%	6%
Staff Grade	90%	93%	87%	11%	5%	23%
Specialty Registrar	96%	98%	93%	-1%	-1%	-1%
Core Training	98%	99%	97%	-1%	-1%	-1%
Foundation Doctor Year 2	99%	100%	99%	0%	0%	0%
Foundation Doctor Year 1	100%	100%	99%	0%	0%	0%
Hospital Practitioner / Clinical Assistant	35%	36%	35%	8%	10%	8%
Other and Local HCHS Doctor Grades	62%	61%	63%	-2%	2%	-3%

NHS Digital March 2023.

In 2022, women doctors averaged 92% of full-time, men 96% of full-time (NHS Digital). This is in part due to women choosing to work part-time following maternity leave. It is common for mothers to work part-time after returning from maternity leave, on average contracted hours drop to 85% of full time for doctors/dentists. Fewer than 2 in 5 work full-time 2 years after going on maternity leave, compared to 94% 4 years before maternity leave (IFS Maternity and the labour supply of NHS doctors and nurses).

[3] Change over decade for men and women uses data at September annually and may differ slightly from the annual average for the All gender data.

The IFS also found levels of part-time working vary by specialty. The higher the proportion of men in a specialty the less likely women are to go on maternity leave, and they return on higher hours if they do so. Conversely, in many female dominated specialties the impact of maternity on FTE is larger. These differences may result from different attitudes to flexibility across specialties, or from the characteristics of doctors that choose different specialities. The rate of change towards more part-time working will depend not only on the proportion of women in the workforce, but whether these variations by specialty change.

The long-term trend has been a greater proportion of women entering medical school. This has led to more women in training grades. It is expected there will be a trend towards more part-time working in the senior doctor grades as more women move into these grades.

In August 2022, HEE introduced more flexibility to work less than full time for a period in foundation training and for all specialty training specialties. This may lead to increased part-time working.

The trend in part-time working will mean more doctors are required to provide the same level of FTE in future. The impact of flexibility from part-time working in all grades may also lead to increased retention, which will help boost supply and counter the reduced hours worked. The impact of less than full-time working on retention is not yet known.

Staff engagement and wellbeing, sickness rates and motivation

Staff engagement and wellbeing

The NHS staff survey provides information on many aspects of staff experience at work.

The most recent NHS staff survey was undertaken in November 2022 and published in March 2023. As in the previous year, the results were aligned with the 7 themes of the NHS People Promise. As this is only the second year of the change away from the earlier themes, it is no longer possible to provide a year-on-year comparison on themes other than staff engagement and morale, which have remained. However, the individual questions have largely remained the same, enabling comparisons with previous years to be made. The results of the 2022 survey saw a small drop in the response rate and there was a mixed picture across the results. The positive results that emerged from the survey were where there has been sustained action in areas such as flexible working, the quality of line management and staff engagement. For example, the number of respondents who feel they can approach their manager to talk openly about flexible working has increased from 66.9% in 2021 to 68.5% in 2022.

The 2022 results were fairly consistent with the previous year with staff engagement remaining at 6.79. Satisfaction with pay dropped considerably by 7 points (2021 32.6% to 25.6% in 2022). Numbers of staff wishing to leave the NHS and seek work outside of the NHS also saw a decrease from 5.96 in 2021 to 5.88 (out of 10) in 2022 and represents the lowest score of the past 5 years.

Morale saw the lowest score in the last 5 years shifting from 5.77 in 2021 to 5.74 in 2022. There are measures in place including the continuing investment in workforce growth to alleviate workforce pressures and ongoing work to improve leadership, culture and staff experience.

Following a call for immediate action to tackle the issue of sexual misconduct in the NHS, and for organisations to be able to understand its prevalence and to address the issue, a new question has been included in the 2023 staff survey on this issue. The new question asks specifically about unwanted behaviour of a sexual nature and will be an important step in developing and implementing actions to protect and support staff. The NHS People Promise remains the key vehicle for action to support staff wellbeing, create a compassionate and inclusive culture and leadership, and promote flexible working opportunities. The aims of the People Promise align closely with the NHS LTWP.

The NHS LTWP is clear that opportunities for flexible working must be prioritised and go beyond minimum statutory requirements. The ambition is that flexible working options be considered for all roles and jobs to ensure the NHS remains competitive in attracting and retaining talent. The number of respondents who feel they can approach their manager to talk openly about flexible working has increased from 66.9% in 2021 to 68.5%. 42% of consultants agreed that they could talk openly with their manager about flexible working compared to 32% of junior doctors.

Women between the ages of 45 and 54 make up a fifth of all NHS employees, and the majority of women will experience menopause symptoms. Good menopause care has both direct and indirect impacts on workforce retention, productivity, presenteeism and absenteeism. In November 2022 NHS England published menopause guidance for NHS line managers and colleagues. NHS England has also launched e-learning packages for staff, and have launched a menopause specific section in the health and wellbeing app, Shiny Mind, which is available to the nursing workforce.

NHS England are continuing to invest in specialist mental health support and wellbeing with NHS Staff Survey results indicating that 38.2% of consultants, and 34.8% of junior doctors agreed that their organisation takes positive action on health and wellbeing. 13.6% of consultants and 16.6% of junior doctors reported that they disagreed.

The department has worked with NHS England to ensure that support continues to be available to NHS staff through the mental health hubs that are in place in every region

during 2023 to 2024. NHS England has invested £2.3 million into local ICSs to help support them in developing their own, locally delivered health and wellbeing offers where they are best placed to tailor this support to the needs of their workforce.

Those NHS doctors and dentists in need of mental health support can also access NHS Practitioner Health, a national support service for staff with more complex mental health needs brought about by serious issues such as trauma or addiction.

The role of Health and Wellbeing Guardians is now well established and supports boards in creating an organisation culture that prioritises the health and wellbeing needs of its staff. This is coupled with training for line managers to enable them to facilitate health and wellbeing conversations with their staff. NHS England have set out in their evidence more detail about the health and wellbeing initiatives and programmes to support staff and create a culture of wellbeing.

Many of these programmes of work are focused on creating a sustainable long-term cultural shift, as identified in the NHS LTWP and the impact will not be seen immediately; they require time and sustained investment. NHS staff continue to work in challenging circumstances, so it remains vital that this support continues to ensure that they feel supported and have a positive experience of working within the NHS.

Provision of occupational health services has been variable with some organisations providing in house support or others contracting out to external providers. The NHS staff survey reported 56.6% of staff believed that their organisation was taking positive action on health and wellbeing. NHS England has published a strategy to improve occupational health and wellbeing; Growing occupational health and wellbeing together strategy. This sets out a roadmap for the NHS and partner organisations with the expectation that they will work together to develop and invest in occupational health and wellbeing services for the NHS over the course of the next 5 years.

Hospital and community health services sickness absence

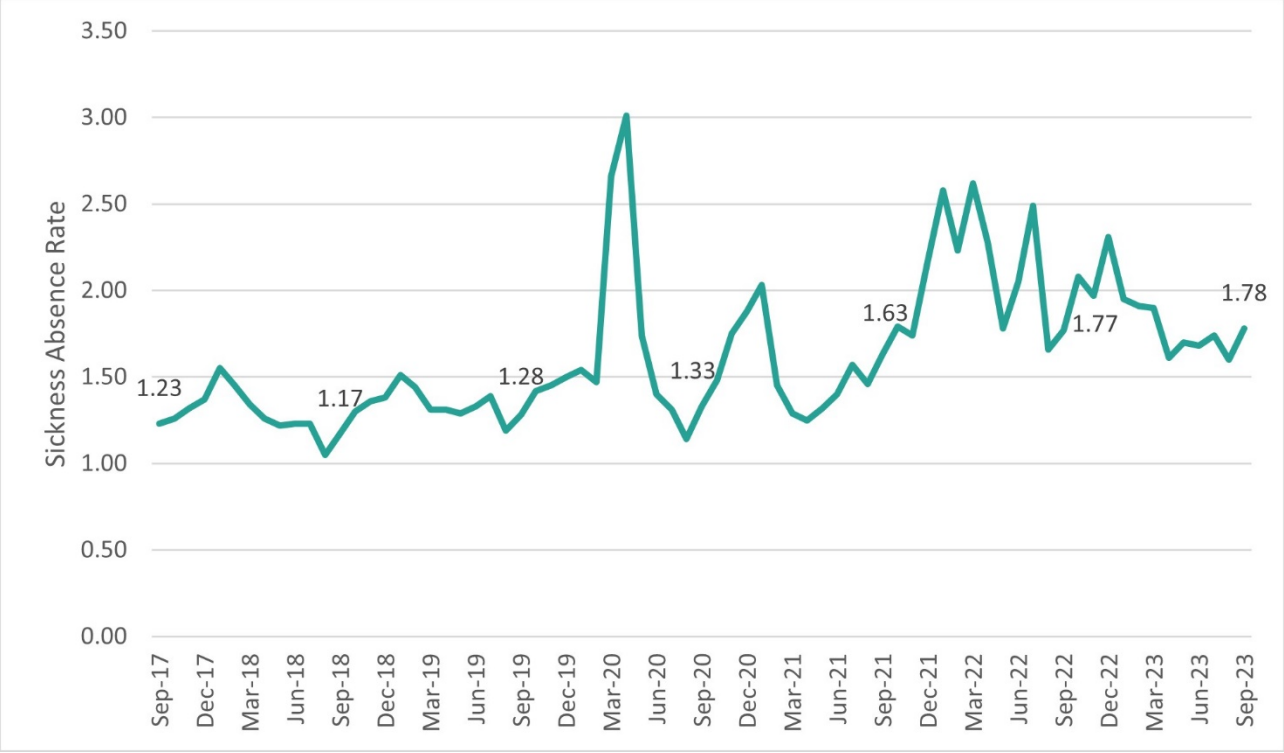
For the year to March 2023, the recorded absence rate for medical staff was 2.01% which compares to 5.38% across all HCHS staff groups. The rate of sickness absence had seen very small increases pre-pandemic, with rates between 1.16% and 1.29%. Increases in more recent years are in part due to the COVID-19 pandemic. Sickness absence rates have fallen since the peaks they reached during the COVID-19 pandemic, with levels of COVID-19 in the community remaining high through 2022 to 2023. However, they still have not returned to the rates from pre-pandemic levels.

Table 34: HCHS annual doctor sickness absence rates, year to March 2011 to March 2023, FTE

Year to	Sickness Absence Rate (%)
March 2011	1.16%
March 2012	1.19%
March 2013	1.25%
March 2014	1.22%
March 2015	1.21%
March 2016	1.23%
March 2017	1.25%
March 2018	1.29%
March 2019	1.29%
March 2020	1.49%
March 2021	1.65%
March 2022	1.82%
March 2023	2.01%

Source: NHS England HCHS monthly workforce statistics

Figure 9: monthly sickness absence rates for medical staff, September 2017 to September 2023, FTE



Source: NHS England HCHS monthly workforce statistics

Data is also available by grade. In general, changes in an individual grades' rates of absence have followed the pattern for the medical workforce as a whole. Where changes have been larger, for example, the hospital practitioner grade, these tend to be the staff groups with the smallest staff numbers. Doctors in training grades and consultants have lower rates than SAS doctors.

Table 35: Annual sickness absence rates by medical grade, year to March 2018 and March 2023, FTE

Grade	2017 to 2018	2018 to 2019	2019 to 2020	2020 to 2021	2021 to 2022	2022 to 2023
HCHS doctors	1.29%	1.29%	1.49%	1.65%	1.82%	2.01%
Consultant	1.24%	1.24%	1.40%	1.54%	1.63%	1.74%
Associate Specialist	2.88%	2.50%	2.79%	3.07%	2.69%	3.27%
Specialty Doctor	2.11%	2.05%	2.37%	2.61%	2.61%	2.99%
Staff Grade	3.37%	3.47%	1.97%	1.68%	2.68%	4.37%
Specialty Registrar	1.19%	1.20%	1.44%	1.57%	1.83%	1.96%
Core Training	1.09%	1.10%	1.38%	1.56%	1.79%	2.15%
Foundation Doctor Year 2	0.99%	1.12%	1.22%	1.47%	1.81%	2.23%
Foundation Doctor Year 1	0.97%	1.02%	1.25%	1.72%	1.97%	2.26%
Hospital Practitioner / Clinical Assistant	1.38%	2.65%	2.69%	1.00%	1.76%	3.43%
Other and Local HCHS Doctor Grades	2.20%	2.05%	2.25%	1.95%	2.21%	1.96%

Source: NHS England HCHS monthly workforce statistics

Over the past 5 years, sickness absence rates have generally been higher for medical staff in the North West, North East and Yorkshire compared to medical staff in London, as shown in Table 36. This pattern is the same as that seen for non-medical staff.

Table 36: HCHS annual doctors sickness absence rates by region, years to March 2019 to March 2023, FTE

Region/ Year to	March 2019	March 2020	March 2021	March 2022	March 2023
England	1.3%	1.5%	1.6%	1.8%	2.0%
London	0.9%	1.1%	1.6%	1.4%	1.4%
South West	1.4%	1.6%	1.6%	1.9%	2.2%
South East	1.2%	1.4%	1.6%	1.8%	1.9%
Midlands	1.5%	1.6%	1.6%	1.8%	2.2%
East of England	1.3%	1.5%	1.6%	1.7%	1.9%
North West	1.5%	1.7%	1.6%	2.1%	2.3%
North East and Yorkshire	1.5%	1.6%	1.6%	2.2%	2.4%

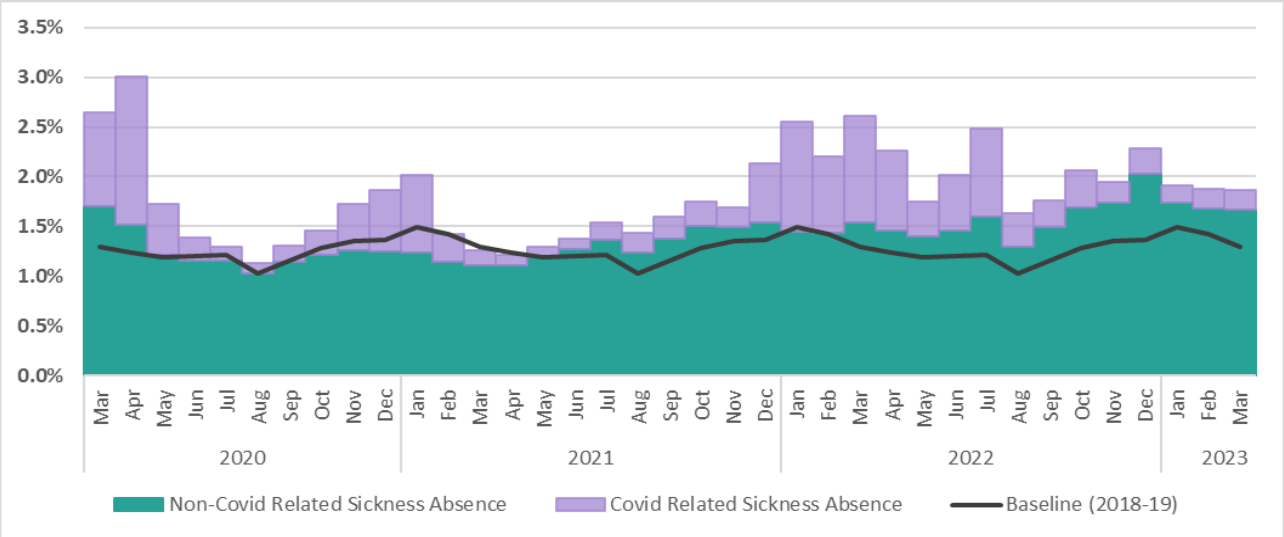
Source: NHS England HCHS monthly workforce statistics

COVID-19 related sickness absence

Monthly NHS England data is available to describe trends in sickness absence during the response to COVID-19. Additional coding has been made available on the ESR for organisations to record against. This data will not track staff absence for non-sickness reasons.

Figure 11 shows the ESR reported rates of sickness absence for medical staff split by those coded as COVID-19 related or not. The underlying rate of non-COVID absence is currently above that seen in the baseline year of 2018 to 2019 and will be monitored going forward. The high level of COVID-19 absence in 2022 is consistent with the ONS Covid Infection Survey which showed some of the highest levels of Covid-19 in the community as a whole through 2022.

Figure 10: monthly COVID and non-COVID sickness absence rates for medical staff, March 2020 to March 2023, FTE



Source: NHS England HCHS monthly workforce statistics

Violence and sexual violence

Sexual assault in the NHS has received national and trade media attention, with the recent publication of an independent report into sexual misconduct in surgery, bringing the issue rightly to the forefront.

To tackle the issues of sexual misconduct and violence, in July 2023, NHS England established a Domestic Abuse and Sexual Violence programme to build on safeguarding processes to protect patients, improve the support available to victims and focus on early intervention and prevention. The programme has also been expanded to address sexual safety in the healthcare workplace with NHS England expecting every NHS trust and local health system in England to have a domestic abuse and sexual violence lead in place.

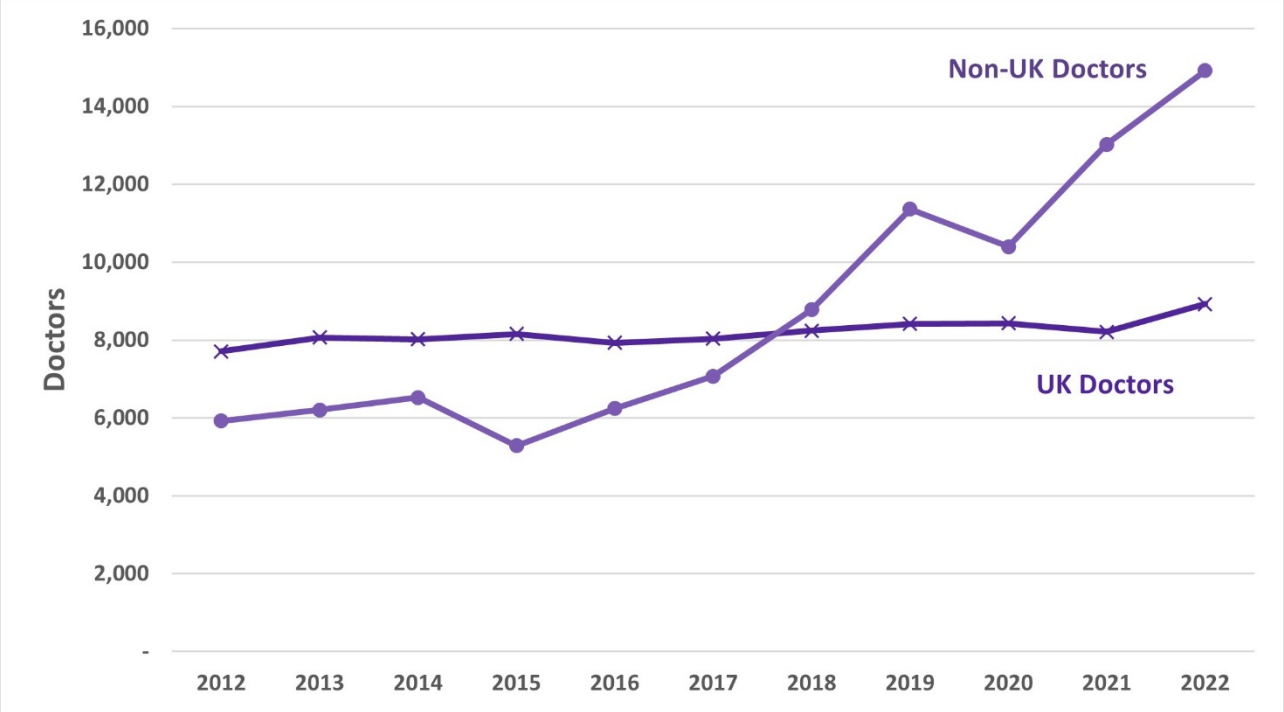
NHS England have also developed the health service's first organisational Sexual Safety Charter following an urgent call for action to tackle the issue of sexual misconduct in the workplace. The Charter, produced in conjunction with Royal Colleges, those with lived experience, trade unions and regulators, sets out ten principles with those organisations signing up to the Charter committing to taking and enforcing a zero-tolerance approach to this behaviour, with a commitment to implement these pledges by July 2024.

The 2023 NHS staff survey will also include a question focussed on how many times staff have been the target of unwanted behaviour of a sexual nature and will provide a clearer indication of the prevalence of this behaviour within the workplace.

International workforce trends

Since 2018, the number of doctors joining the UK workforce with a non-UK primary medical qualification (PMQ) has exceeded the number with a UK PMQ. Except for 2020, the number grew each year from 2018 to 2022 when it reached almost 15,000 non-UK joiners.

Figure 11: Doctors taking up (or returning to) a licence to practice.



Source: [The state of medical education and practice in the UK: The workforce report 2023, GMC]

Growth of International Medical Graduate (IMGs) (+55%) in the UK outstripped the growth in all licenced doctors (+22%) over the five years from 2017 to 2022.

There has been an increasing proportion of IMG joiners entering postgraduate training or SAS and locally employed roles. In 2022, there were over 42,500 IMGs licensed as SAS and locally employed doctors which is over 19,200 (83%) more than in 2017. Additionally, there were over 15,000 IMGs in training which is over 8,400 (128%) more than in 2017. Growth of IMGs in GP or consultant posts was much lower, around 15% over the 5 years. The growth was likely driven by existing IMGs completing UK training and moving into these roles rather than direct recruitment from overseas.

Non-UK graduates made up around half of doctors working in GP training posts, and a quarter of specialist training posts in England in 2022. The use of overseas doctors to fill training posts is expected to fall when the 1,500 medical school expansion of 2018 to 2020 start to enter core, GP, or run-through training from 2025. Over 1,000 international graduate doctors are likely to be required to fill the current number of specialty training posts, despite the 1,500 medical school expansion.

The ethical recruitment of health and care staff from overseas is vital, we have outlined our approach to ethical recruitment and the Code of Practice for International Recruitment of Health and Social Care Personnel in chapter 3.

Table 37: medical joiners to NHS trusts and other core organisations in England by top 10 nationalities, headcount, year to June 2023.

Nationality Group	Listing	Headcount	Proportion of all staff
British	N/A	13,792	50.1%
Indian	Green	2,568	9.3%
Pakistani	Red	1,657	6.0%
Nigerian	Red	1,067	3.9%
Egyptian	Green	939	3.4%
Sri Lankan	Green	686	2.5%
Unknown	N/A	535	1.9%
Malaysian	Green	532	1.9%
Irish	Green	445	1.6%
Sudanese	Red	358	1.3%

Source: NHS England: NHS Workforce Statistics, June 2023 - Turnover Tables

5. Earnings and expenses

Introduction and headline narrative

It is important that the NHS pay offer can effectively recruit and retain the staff that it needs across the full range of roles and seniority. Similarly, the pay system should ensure that all staff are rewarded fairly for the service they deliver and have the opportunities and incentives to progress and develop in their chosen line of work. As such, the competitiveness of the NHS reward package, for both existing staff and potential new recruits, is an important consideration when setting pay rates.

This chapter includes information on the pay and earnings for doctors and dentists in England and covers staff working in the Hospital and Community Health Sector (HCHS), general practice and the dental sector. This covers junior doctors, SAS doctors, consultants, independent contractor GPs, salaried GPs providing-performer and associate general dental practitioners (GDPs) and salaried GDPs.

In 2023 to 2024, the government accepted the recommendations of the DDRB in full. This resulted in a consolidated 6% increase in pay scales for consultants and SAS doctors on the old contract, as well as a consolidated increase worth 6% + £1,250 for doctors in training. SAS doctors on the new contracts received an additional 3% above what was agreed in the multi-year agreement to reduce differentials with those on the old contract. We expect these increases to feed into data over the coming year.

In 2024 to 2025, there are no pre-existing multi-year agreements following the conclusion of the SAS multi-year agreement in 2023 to 2024.

In 2022 to 2023, average basic pay per FTE for medical staff in the HCHS sector increased by 3.6% while total earnings increased by 3.3%. We judge that this is broadly consistent with our expectations as a result of the pay award in 2022 to 2023. In 2021 to 2022, average income before tax for general practitioners increased by 8.0% for contractor GPs and 4.8% for salaried GPs.

Medical staff are highly paid individuals with a legitimate expectation of a salary towards the upper end of the wage distribution. Average earnings for HCHS doctors are in the top 5% of the wage distribution following a clear path of career advancement as they develop competence in their specialty and progress to more senior grades.

As detailed in this section, the relative position of medical staff in the UK wage distribution has remained relatively stable over time and the 2023 to 2024 pay award was broadly in line with pay settlements across the wider economy.

Medical pay structures

The medical pay system in 2023 to 2024

Medical staff benefit from clearly defined routes of career advancement which see them from leaving university to being "doctors in training" and eventually to long term careers as consultants, SAS doctors or GPs. In 2023 to 2024, basic pay for medical staff on national contracts ranges from £32,396 for Foundation Year 1 through to £126,281 for the most experienced consultants.. Medical staff who complete additional work, work unsocial hours, or who are recognised through Clinical Impact Awards, receive additional payments as set out in medical contracts.

The medical pay structure is based around factors including career grade, stage of training and level of experience. After graduating from medical school, most junior doctors will enter a training pathway that includes the 2-year foundation programme followed by specialty or core training. The pay system for doctors in training includes a series of 5 ‘nodal points’ with different pay for the different stages of training with higher pay for more advanced trainees. Since 2020, the most senior junior doctors have benefited from a fifth nodal point reflecting their skills and service contribution.

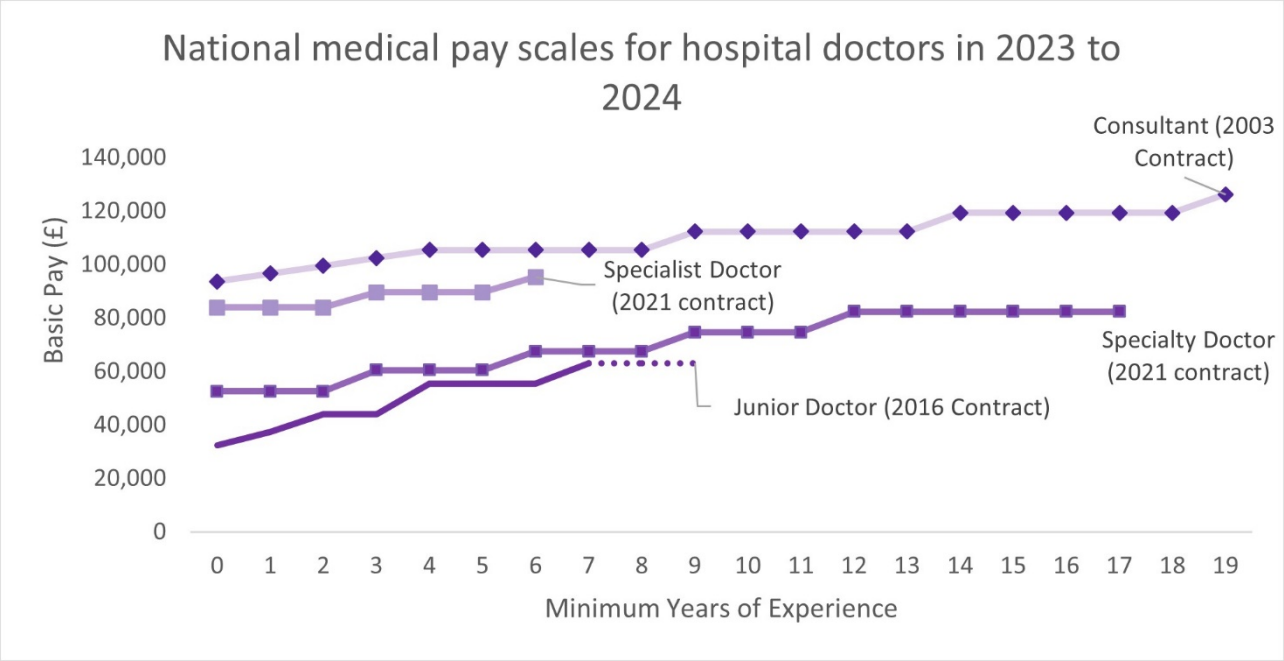
The 2003 consultant contract currently includes a series of 8 pay thresholds which staff are eligible to progress through at specified time intervals with staff requiring 19 years of service to reach the top of the pay scale. The recent offer to the consultant workforce in England proposed a reduction in the number of pay thresholds to 4, with 14 years of service in the consultant grade required to reach the top of the pay scale. This offer was recently rejected by the BMA and HCSA memberships.

The 2021 Specialist and Specialty doctor contracts are the reformed contracts for the SAS workforce that came into operation from 2021. The reformed specialty doctor contract contains 5 pay points which will enable those doctors to access the top of the pay scale more quickly while the specialist contract is designed for people to be experts in their fields.

Doctors working in general practice are either "salaried" with a salary range set out in pay circulars, or "partners" which sit outside of the national pay system.

Figure 13 shows the current system of national pay contracts for medical staff in 2023 to 2024 and the minimum number of years of experience required to reach each pay point - note that in some cases (e.g. 2016 junior doctor and 2021 SAS) progression points are linked to competence as well as time served (or years of experience to match the chart axis label).

Figure 12: HCHS medical pay scales by contract and minimum time in post - pay scales as of 1 April 2023.



Source - [NHS Employers Pay Circular - August 2023]

Table 38 highlights the extent of pay progression in the 4 main national contracts for hospital doctors and the total pay progression that is possible between entry into the foundation programme and the top of the consultant pay scale. For example, junior doctors basic pay almost doubles between nodal point 1 (FY1) and nodal point 5 (which takes at least 7 years) and basic pay can nearly quadruple over the full career path from FY1 through to the top of the consultant pay scale.

Table 38: minimum and maximum pay values by medical contract in the year 2023 to 2024.

Pay journey	Starting basic pay	Maximum basic pay	Increase
Junior Doctors	32,398	63,152	95%
Specialty Doctor (2021 Contract)	52,530	82,400	57%
Specialist Contract (2021 Contract)	83,945	95,275	13%
Consultants	93,666	126,281	35%
Pay Route	Starting basic Pay	Maximum basic pay	Increase
F1 - Consultant Max	32,298	126,281	290%

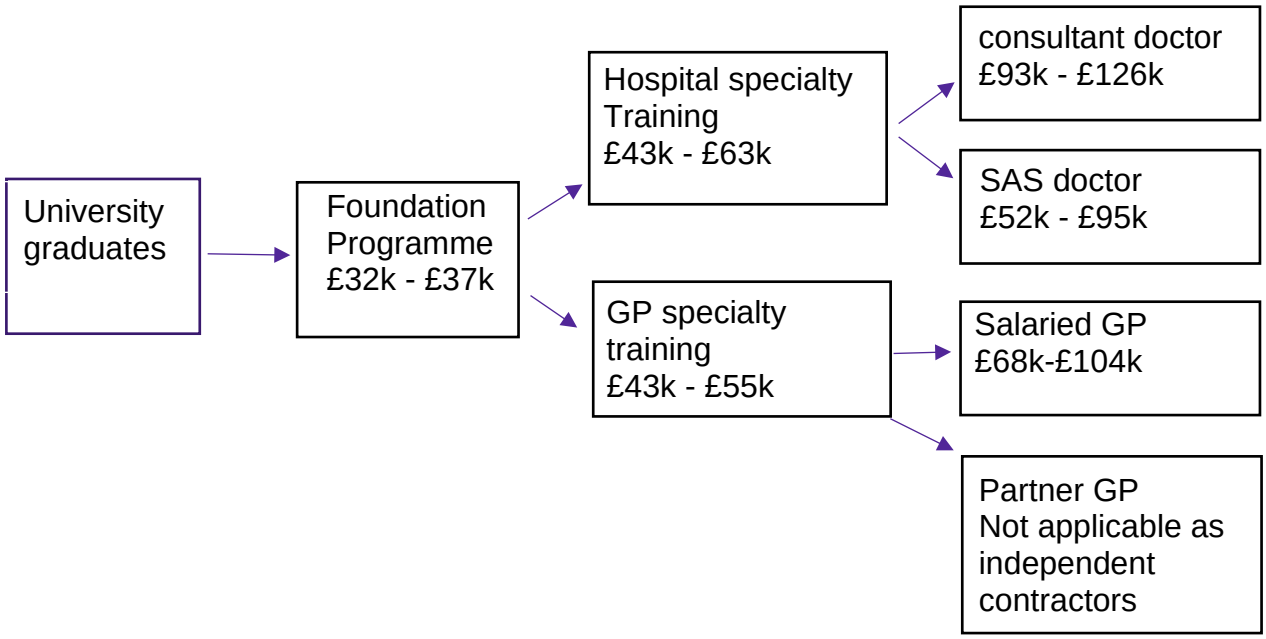
Source - [NHS Employers Pay and Conditions Circular (M&D) 4/2023]

Typical medical career pathways (including LEDs)

There are many career paths open to medical staff depending on their choice of speciality and setting. We note that these pathways may not always be "straight lines" for all doctors - some may opt to spend time out of the workforce prior to commencing, or during, training, or may decide to take local posts while waiting for an appropriate training opportunity.

After graduation from medical school, all doctors must complete the 2-year ‘foundation programme’ after which most doctors will enter specialty / core training on either a hospital or primary care pathway. Those following a hospital pathway are likely to become consultants or SAS doctors, while those on the primary care pathway will usually become GPs. Individuals who obtain their ‘primary medical qualification’ (PMQ) outside the UK, as well as those returning to practice, or from other sources, may enter at different levels depending on their qualification and experience.

Table 39 illustrates some of the different pathways that medical graduates might take and the current (2023 to 2024) salary ranges at different stages.



Source - NHS Employers Pay and Conditions Circular (M&D) 4/2023

We can use longitudinal tracking from the Electronic Staff Record (ESR) data to look at how individuals move around the HCHS system over time. Table 39 considers staff who were employed in the HCHS sector in March 2013 and shows any change in career grade between 2013 and 2023.

It shows that:

- Just under two thirds (64%) of consultants in 2013 were still employed as consultants in the HCHS sector after 10 years.

- In the HCHS sector, around one third of junior doctors in 2013 were consultants by 2023, with a small proportion in the SAS grades. A further 13% were still in the junior grades which reflects the length of some medical training pathways.

Where a record is identified as "not present" an individual was not employed in the HCHS sector in 2023. This will include individuals who have moved to other parts of the healthcare system, including general practice. This is regularly the case for Junior Doctors where around 50% of training places are on primary care training pathway.

Table 40: medical career pathways - comparison of medical career grades in 2023 for those employed in HCHS sector in 2013.

	Consultant	SAS	Junior Doctor	Other	Not Present	Rounded Count
Consultant	64%	0%	0%	0%	36%	40,000
SAS	15%	36%	1%	0%	47%	10,000
Junior Doctor	37%	3%	13%	0%	47%	48,000
Other	3%	3%	1%	23%	71%	3,000

Source - DHSC Analysis of Electronic Staff Record

Average pay and earnings in 2022 to 2023

Average pay and earnings for doctors

HCHS

NHS England publish information on average pay and earnings for the HCHS workforce split by career grade. There are 3 principal measures that can be used depending on the context:

- Total earnings per person - this is the average level of earnings across the group and includes all pay elements: basic pay, additional activity and clinical impact awards. This measure is not available on a ‘per FTE’ basis as it cannot be assumed that earnings increase in direct proportion with FTE.

- Total basic pay per FTE - This is the average level of basic pay across the group if it is assumed that all staff were working full time. It is possible to calculate this measure because basic pay increases directly with working time.

- Total basic pay per person - This is the average amount of basic pay received with no adjustment for FTE and will therefore be lower than the ‘per FTE’ measure. This measure does not include any additional pay element such as additional activity or impact awards.

Table 41 shows average pay and earnings for the HCHS sector for the 12-months to March 2023 and can be used to assess change for the whole workforce, and specific career grades, over this time period. Doctors employed on the 2021 specialty doctor contract are in the ‘specialty doctor’ grade and those employed on the 2021 specialist doctor contract are in the ‘associate specialist’ career grade.

The change in basic pay per FTE ranges from -1% (staff grade) to 4.4% (consultant) and the change in total earnings per person ranges from -0.4% (staff grade) to 4.0% (associate specialist/specialty doctor). Average earnings per person increased to over £37,000 for F1 doctors and over £127,000 for consultants.

The "staff grade" is a closed grade and so the reduction in average pay/earnings will reflect changes in the composition of the small number of staff remaining on that contract, for example, a reduction in average FTE per person or a less senior pay point mix. We assume that earnings for individual doctors would, all other things being equal, have increased in line with the pay award.

The changes in pay in 2022 to 2023 are broadly in line with what was expected as a result of the pay award which included:

- Consultant pay scales were increased by 4.5% but the value of Clinical Impact Awards were frozen;

- It was the final year of the 4-year junior doctor agreement which ran from 2019 to 2020 to 2022 to 2023 - pay scales increased by 2% with additional investment in nodal point 5 for the most experienced junior doctors;

- Pay scales on the old SAS contracts were increased by 4.5%;

- Pay scales for SAS doctors transferred to the 2021 SAS contracts were increased in line with the multi-year agreement.

Table 41: average pay and earnings for the HCHS sector for the 12-months to March 2023 and a comparison to the previous year.

Medical Grade	**Average FTE**	**Basic Pay per FTE**	**Growth in Basic Pay per FTE**	**Earnings per Person**	**Growth in Earnings per Person**
HCHS doctors	131,007	£73,467	3.6%	£88,055	3.3%
Consultant	53,843	£105,484	4.4%	£127,228	3.9%
Associate Specialist	2,067	£94,638	3.0%	£102,438	4.0%
Specialty Doctor	8,269	£71,382	3.4%	£76,112	4.0%
Staff Grade	330	£60,542	-1.0%	£71,225	-0.4%
Specialty Registrar	33,195	£49,109	3.8%	£63,350	2.9%
Core Training	18,456	£43,350	2.5%	£56,175	1.9%
Foundation Doctor Year 2	6,342	£33,718	1.9%	£43,506	1.4%
Foundation Doctor Year 1	7,095	£29,243	2.1%	£37,071	1.9%
Hospital Practitioner / Clinical Assistant	602	£123,616	2.1%	£45,926	7.0%
Other and Local HCHS Doctor Grades	808	£99,063	2.4%	£60,604	6.3%

Source - NHS England Earnings Statistics, 12-Months to March 2023 in NHS Trusts and Core Organisations , Table 1 , NHS England Workforce Statistics , May 2023 , NHS Trusts and Core Organisations

Data for the 12-months to the end of March 2023 will not include the impact of pay awards in 2023 to 2024. For doctors in the HCHS sector, this included:

- Consultant pay scales increased by 6% with the value of Clinical Impact Awards frozen.
- Doctors in training and those on mirrored terms received a consolidated pay award worth 6% + £1,250. This means that the 2022 to 2023 pay scale is increased by 6% and then an additional £1,250 is added. In total pay scales on the 2016 contract increased by between 8.1% and 10.3%.
- SAS pay scales on the old SAS contracts were increased by 6%
- SAS pay scales on the 2021 SAS contracts received an additional 3% uplift on top of what was already in place because of the multi-year agreement. This resulted in an increase of between 4% and 9.3% depending on an individual's contract and pay point.

Additional earnings

Additional earnings are the difference between basic pay and total earnings and can be earned by staff working additional hours, working at unsocial hours or, for consultants, being in receipt of either local clinical excellence awards or national clinical impact awards.

Figure 15 shows the contribution of additional earnings to total pay in the 12-months to March 2023 and is split by medical career grade. Overall, just under a quarter of total earnings are not from basic pay which is effectively unchanged from the 12-months to March 2022.

Figure 13: additional earnings (non-basic pay) as proportion of total earnings by medical career grade - 12 months to March 2023

Source - NHS England Earnings Statistics, NHS Trusts and Core Organisations, 12-Months to March 2023, Table 1

Earnings distribution

Across the medical workforce, and within individual career grades, there will be differences in earnings linked to factors including an individual's pay point, contract and working patterns.

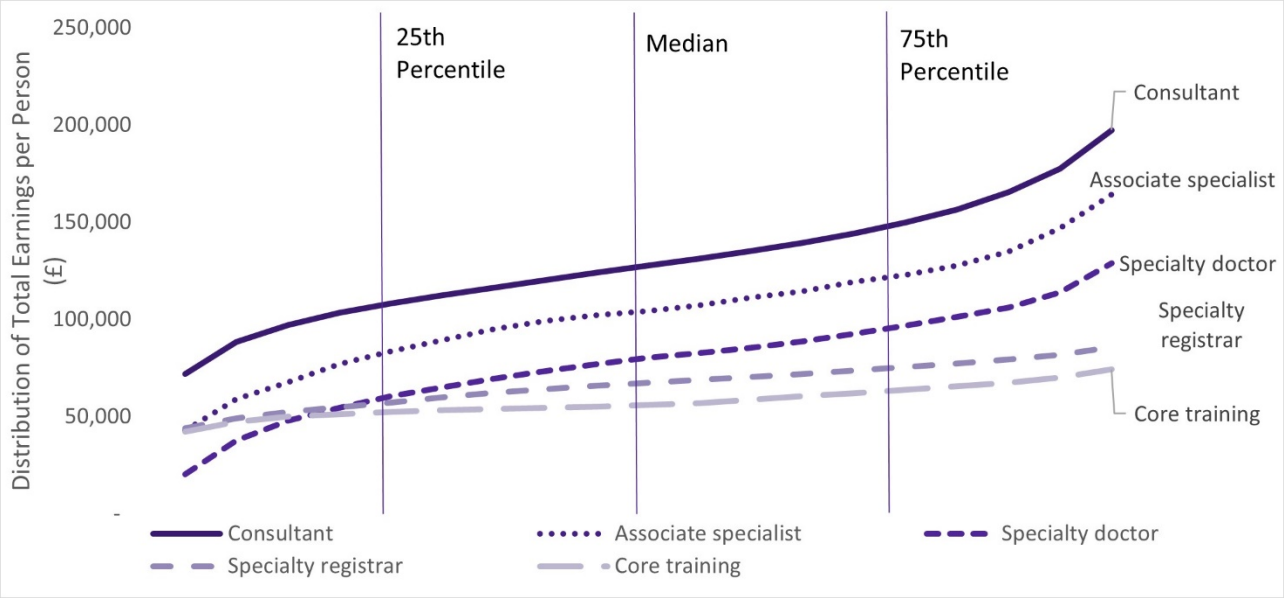
Figure 16 is based on data on the income distribution for medical staff published by NHS England. To ensure that this analysis is not impacted by people leaving or switching

grades, these data only include staff who were employed in the same career grade throughout the period April 2022 to March 2023, which is why it does not include F1 and F2 doctors.

As would be expected, consultants have the highest incomes at all parts of the income distribution, followed by SAS doctors and then junior doctors.

This also points to a shallower earnings distribution for junior doctors compared to those in consultant positions which may reflect the ability of some consultants to earn significant amounts through additional work or via Clinical Impact Awards.

Figure 14: Distribution of total earnings per person by medical career grade, 12-months to March 2023



Source - NHS England Earnings Statistics

Pay growth drivers

Several factors drive changes in average earnings. Some relate to changes in the composition of the workforce, some relate more specifically to pay rates. Table 42 presents trends in average earnings growth for HCHS medical staff and its component drivers over recent years.

The headline pay award is the expected change in total earnings per FTE due to changes in pay rates following the annual pay award. The difference between observed total earnings per FTE growth and the headline pay award is ‘total earnings drift’, which represents the change in average earnings that is not explained by the pay award. Total earnings drift can be broken down into the different components shown in the table:

- basic pay drift (excluding grade mix effect), reflecting changes in average basic pay per FTE due to changes in the distribution of staff across pay points within grades;

- additional earnings effects due to additional earnings changing at a different rate to basic pay (this may include increased or decreased use of payments for additional activity, shift working, medical awards, etc.); and

- grade mix effects, reflecting shifts in the distribution of staff between higher and lower earning grades (for example, consultants vs junior doctor grades). This is based on the HCHS medical staff groups that are presented in NHS England published data (and used in Table 41).

Pay growth estimates are based on analysis of data on workforce earnings and size published by NHS England. Drift estimates, the difference between pay growth and the pay award, are based on changes to pay values from pay circulars weighted by pay point workforce size estimates based on NHS England workforce data. The analysis is based on data for NHS trusts and core organisations and NHS support organisations and central bodies combined. Therefore, figures for average basic pay and earnings growth may differ slightly from the figures based on NHS trusts and core organisations in table 42. Growth in earnings per FTE may also differ from growth in earnings per person due to changes in average FTE per person.

Table 42 - breakdown of average earnings growth for HCHS medical staff

Pay growth element	**2017 to 2018**	**2018 to 2019**	**2019 to 2020**	**2020 to 2021**	**2021 to 2022**	**2022 to 2023**
Basic pay per FTE growth	2.8%	2.3%	3.3%	2.1%	3.0%	3.6%
Additional earnings per FTE growth	-1.5%	-2.4%	-2.9%	3.5%	2.8%	2.5%
Total earnings per FTE growth	1.7%	1.1%	1.8%	2.5%	3.0%	3.3%
Components of Total earnings per FTE growth	-	-	-	-	-	-
(a) Headline pay awards	1.0%	1.0%	3.4%	2.7%	2.7%	3.7%
(b) Total earnings drift	0.7%	0.0%	-1.6%	-0.3%	0.2%	-0.4%
Components of (b) Total earnings drift	-	-	-	-	-	-
(b1) Basic pay drift (excluding grade mix effect)	1.6%	1.2%	0.3%	0.4%	0.2%	0.0%
(b2) Additional earnings drift impact (excluding grade mix effect)	-1.1%	-1.3%	-1.7%	0.1%	0.0%	-0.1%
(b3) Grade mix effect	0.2%	0.2%	-0.2%	-0.8%	-0.1%	-0.3%

Source: DHSC analysis based on NHS England workforce earnings and size data and NHS Employers pay circulars

The impact of headline pay awards on average earnings for doctors in 2022 to 2023 compared to 2021 to 2022 was 3.7%, which reflects the combined effect of:

- 4.2% impact for consultants (average of 4.5% increase to basic pay scales and no change in the value of clinical excellence awards (CEAs), discretionary points and distinction awards)

- 2.6% impact for junior doctors (average impact across all junior doctors, including those not on the 2016 contract, reflecting 2% increase to basic pay scales with a higher increase for nodal point 5 on the 2016 contract).

- 4.2% impact for SAS doctors (average impact across all SAS doctors, reflecting 4.5% increase to basic pay scales for pre-2021 contracts, and average impact of uplifts varying by pay point for 2021 contracts under the multi-year agreement)

Average total earnings grew by less in 2022 to 2023 than the pay awards impact (3.3% vs 3.7%), implying negative earnings drift. Earnings drift reflects the combined effect of:

- a neutral ‘basic pay drift’ (excluding grade mix effects) of 0.0% in 2022 to 2023, reflecting no net impact from wider workforce mix effects such as shifts in the distribution of staff within grades towards lower or higher pay points.

- a negative ‘additional earnings drift impact’ of -0.1%, which indicates a decrease in the overall use of additional earnings payments in 2022 to 2023. The trend over recent years has been affected by the phased implementation of the junior doctor contract reforms introduced in 2016 and the 2018 junior doctor contract refresh, with reduction in the use of banding supplements contributing to a negative additional earnings drift impact between 2017 to 2018 and 2019 to 2020. Reduction in the use of banding supplements continued to have some impact in 2022 to 2023 (as junior doctors remaining on the pre-2016 contract moved out of the junior doctor workforce), though this was partly offset in 2022 to 2023 by increases in the use of some other elements of additional earnings across the medical workforce, including some increase in the use of "local" payments across most grades although these remain a relatively small component of total pay.

- a negative ‘grade mix effect’ of -0.3%, reflecting a shift in the workforce towards lower earning medical grades, and in particular junior doctors. Consultant, SAS doctor and junior doctor FTEs have all grown over recent years, but since 2019 to 2020, the junior doctor workforce has grown more quickly than other parts of the workforce which reflects recent expansion of doctor training posts, increased training post fill rates, and significant international recruitment to junior grades. The grade mix effect in 2022 to 2023 is at a broadly similar level to 2019 to 2020. The larger negative effect seen in

2020 to 2021 was linked to earlier than usual recruitment of foundation year doctors as part of the response to the COVID-19 pandemic.

General dental practitioners' earnings and expenses

Data on earnings and expenses is available for self-employed primary care dentists who have completed some NHS work during the financial year, however figures relate to both NHS and private income. Private earnings are determined by the amount of demand from individual patients, which may be in addition to NHS care.

In 2021 to 2022, there was a 7.4% increase in average taxable income of self-employed dentists in England from £72,500 in 2020 to 2021 to £77,900 in 2021 to 2022. The average expenses to earnings ratio for all self-employed dentists increased from 48.7% in 2020 to 2021 to 50.1% in 2021 to 2022.

A 5.13% uplift to contract values (net of pay and expenses) was awarded to dentists in 2023 to 2024, backdated to 1 April 2023. Whilst each year we strongly recommend that providing-performer dentists apply this uplift to their associate dentists' salaries, DHSC is unable to enforce practices to do so. As practices are private businesses, it falls to them to set employee pay and conditions.

We understand that the DDRB requested the rationale and the method around the uplift to the expenses element of dentists' remuneration. While pay elements for General Dental Services and Personal Dental Services contracts are uplifted in line with the DDRB process (6% for 2023 to 2024), expenses are uplifted in line with inflation (calculated using GDP deflators for 2022 to 2023 and 2023 to 2024) at the same time each year. The final uplift figure applied to the value of each contract combines both the DDRB uplift rate (for pay) and the inflation uplift rate (for expenses) based on proportion of pay (68%) and expenses in the contract (32%). We formally consult with the British Dental Association (BDA) on the uplift proposals each year before implementing them.

The DDRB requested information on the bidding process in place in England and Wales, how this may affect remuneration, and identification of any checks and balances in place to ensure that bidders for dental contracts do not undermine their viability by bidding below a sustainable level. From 1 April 2023, the responsibility for commissioning primary care dentistry to meet the needs of the local population has been delegated by NHS England to all integrated care boards (ICBs) across England.

Table 43: Gross income, expenses, and taxable income for all dentists from 2009 to 2010 to 2021 to 2022.

	Average Gross Earnings	Average Expenses	Average Taxable Income	Expenses ratio
2009-2010	£184,900	£100,000	£84,900	54.1%
2010-2011	£172,000	£94,100	£77,900	54.7%
2011-2012	£161,000	£86,600	£74,400	53.8%
2012-2013	£156,100	£83,500	£72,600	53.5%
2013-2014	£155,100	£83,400	£71,700	53.8%
2014-2015	£152,500	£82,000	£70,500	53.8%
2015-2016	£148,000	£78,900	£69,200	53.3%
2016-2017	£145,700	£77,000	£68,700	52.8%
2017-2018*	£146,700	£78,100	£68,500	53.3%
2018-2019*	£147,100	£78,500	£68,600	53.4%
2019-2020*	£144,700	£76,100	£68,600	52.6%
2020-2021*	£141,400	£68,900	£72,500	48.7%
2021-2022*	£156,100	£78,200	£77,900	50.1%

Source: Dental earnings and expenses estimates 2016 to 2017 - NHS Digital; Dental earnings and expenses estimates 2021 to 2022 - NHS Digital.

*Methodology changed in these years figures are not comparable to earlier years. They refer to England only. There was a small number of dentists in these years where it was unknown whether they were a providing-performer or associate.

In England, the earnings of a dentist vary depending on whether they are a providing-performer dentist or an associate dentist. Providing-performer dentists hold a contract with NHS England to provide a given number of units of dental activity or units of orthodontic activity. Associate dentists work as performers under the contract - they deliver NHS dental services and hold a contract with their providing-performer but do not hold a contract with the NHS. Generally, providing-performers tend to earn more (higher gross earnings and taxable income). In 2021 to 2022, providing-performer dentists had an average taxable income of £135,000, a slight increase from £132,200 in 2020 to 2021. Associate dentists also saw their average taxable income increase, by a smaller amount to £64,900 in 2021 to 2022 compared to £58,700 in 2020 to 2021.

A number of factors make it difficult to compare the level of earnings and gross income from one year to another. These factors include variations in hours worked, variation in the balance between NHS and private sector activity, the evolving nature of practice business models, the new methodology used to collect data, and the rise in practices becoming corporates or becoming parts of corporates.

Table 44: Taxable income, in cash and real terms, for providing-performer dentists and associate dentists in England.

PROVIDING-PERFORMER DENTISTS					
Year	Cash Terms	Real Terms			
	Average Taxable Income	GDP	CPI	RPI	RPIX
2017/2018	£113,200	£124,700	£123,200	£128,100	£128,500
2018/2019	£113,100	£122,500	£120,500	£124,300	£124,700
2019/2020	£112,600	£118,800	£117,900	£120,600	£121,000
2020/2021	£132,200	£131,300	£137,500	£139,800	£140,000
2021/2022	£135,000	£135,000	£135,000	£135,000	£135,000

ASSOCIATE DENTISTS					
Year	Cash Terms	Real Terms			
	Average Taxable Income	GDP	CPI	RPI	RPIX
2017/2018	£57,000	£62,800	£62,100	£64,500	£64,800
2018/2019	£57,600	£62,400	£61,300	£63,300	£63,500
2019/2020	£58,100	£61,400	£60,900	£62,300	£62,500
2020/2021	£58,700	£58,300	£61,100	£62,100	£62,200
2021/2022	£64,900	£64,900	£64,900	£64,900	£64,900

Source: Dental Earnings and Expenses Estimates, 2021-22 - NHS Digital

General practitioners' earnings and expenses

Data on GP earnings and expenses is published by NHS England and is based on a sample from HM Revenue and Customs' (HMRC) tax self-assessment database. This data is collected in a different format for GPs as they are independent contractors. As the data is based on samples with weighting applied, rather than the whole population, it is subject to sampling error and uncertainty.

As we have highlighted in previous years, the dataset includes contractor and salaried GPs working under general medical services (GMS) and personal medical services (PMS) contracts but does not include GPs who work solely as locums. It is possible that some salaried GPs may not need to complete a self-assessment tax return and as such, these individuals do not appear in HMRC's tax self-assessment database and therefore cannot be included in the sample. The available data provides information on GPs' total earnings by headcount, and it is therefore not possible to calculate the split between private and NHS work or to distinguish between full and part-time workers. Due to concerns about the validity and quality of the analysis, NHS England no longer publish experimental data on GP earnings estimates by FTE or working hours bands.

Table 44 sets out the average percentage increase in annual earnings for salaried and contractor GPs over recent years, against the uplifts recommended by the DDRB and agreed by government in the corresponding year. As highlighted last year, there does not appear to be a clear link between agreed government uplifts to pay and changes in average earnings for GPs. As independent contractors, it is for GP partners to determine uplifts in pay for themselves and their employees.

General practice was still impacted by COVID-19 in 2021 to 2022. This was the first full year of the COVID-19 vaccination programme and includes the 'Omicron Emergency' period, with general practice continuing to be the central route for most vaccinations. A number of arrangements were put in place during this financial year to support practices in delivering additional services. Further information on the impact of the COVID-19 pandemic on GP earnings is available in the NHS England GP Earnings and Expenses Estimates, 2021-22.

Contractor GPs were stood down from the remit of the DDRB for the duration of the 5-year contract, from 2019 to 2020 to 2023 to 2024. Salaried GPs were stood down for one year in 2019 to 2020, with a 2% uplift agreed for salaried GPs through contract negotiation.

Table 45: Average percentage increase in annual earnings for salaried and partner GPs and the recommended and agreed uplifts for the same year (%).

Year	DDRB recommendation	Government response	Average % earnings increase for salaried GPs	Average % earnings increase for GP partners
2015-16	1.0	1.0	-1.4	1.1
2016-17	1.0	1.0	1.3	4.5
2017-18	1.0	1.0	3.2	3.5
2018-19	4.0	2.0	3.8	3.4
2019-20	N/A	2.0 (agreed as part of the 2019-20 contract for salaried GPs)	5.0	3.8
2020-21	2.8 (salaried GPs only)	2.8 (salaried GPs only)	2.0	16.6
2021-22	3.0 (salaried GPs only)	3.0 (salaried GPs only)	4.8	8.0

Source: NHS England, GP Earnings and Expenses Estimates, 2021/22, August 2023, tables 1a and 7a.

Contractor GPs’ earnings

GP contractors are responsible for meeting the requirements set out in the contract for their practice and they take income after practice expenses. There is therefore a trade-off between contractor GP earnings, uplifts to salaried GP pay and other pressures on practice finances. In England, the average pre-tax income for a contractor GP working in either a GMS or PMS (GPMS) contract was £153,400 in 2021 to 2022, a statistically significant increase of 8.0% compared to 2020 to 2021. This compares to an average increase of 16.6% in 2020 to 2021, compared to 2019 to 2020. The data presented above represents headcount figures only, so it is not possible to isolate how changes in working hours have impacted earnings.

In 2021 to 2022, median pre-tax income for GP contractors in GMS and PMS practices was £141,600. At the 25th percentile, median pre-tax income was £108,500 and at the 75th percentile, it was £183,500.

The data in table 45 shows the change in contractor GP income in England since 2012 to 2013 in nominal terms. The latest available UK income distribution figures published by HMRC are based on total income subject to tax for the tax year 2020 to 2021 and do not account for hours worked. Contractor GPs were in the 98th percentile group (£128,000 to £183,000) in that year.

The participation rate (the average proportion of one FTE that is worked by one headcount doctor) for contractor GPs (based on contracted hours of work) in September 2021 was 85.8% (a decrease of 0.8 percentage points from September 2020 at 86.6%), although this may not accurately reflect actual working hours, particularly ad-hoc additional hours.

Table 45 represents average earnings for GP contractors in both GMS and PMS practices. The GMS contract is the national standard GP contract and in 2021 to 2022, around 70% of GP practices operated under it. Expenses are split into categories including office and general business, premises, employee, car and travel, interest, net capital allowance and other (for example, cost of drugs for dispensing GPs).

Table 46: Earnings and expenses for GP partners in England, GMS and PMS, all practice types, 2012-13 to 2021-2022[4].

Year	Report population	Estimated gross earnings, cash terms (£)	Total expenses, cash terms (£)	Income before tax, cash terms (£)
2012-13	26,200	289,300	184,200	105,100
2013-14	25,700	290,900	189,000	101,900
2014-15	25,500	302,600	198,800	103,800
2015-16	18,300	315,600	210,800	104,900
2016-17	19,850	338,300	228,700	109,600
2017-18	20,350	357,300	243,900	113,400
2018-19	20,300	380,900	263,600	117,300
2019-20	19,250	402,600	280,800	121,800
2020-21	18,600	438,700	296,700	142,000
2021-22	18,350	482,400	329,000	153,400

Source: NHS England, GP Earnings and Expenses Estimates, 2021/22, August 2023, tables 1a and 1b.

The dataset shows total earnings, expenses and income (pre-tax). ‘Earnings’ is the total that GPs receive; however, expenses come out of this sum, meaning that ‘income’ is total earnings minus expenses. Mean values are presented for earnings and expenses. Estimates have been rounded to the nearest £100, so numbers presented for taxable income may not equal gross earnings minus total expenses and the sum of numbers in a table may not equal the total.

[4] The dataset shows total earnings, expenses, and income (pre-tax). ‘Earnings’ is the total that GPs receive; however, expenses come out of this sum, meaning that ‘income’ is total earnings minus expenses. Mean values are presented for earnings and expenses. Estimates have been rounded to the nearest £100, so numbers presented for taxable income may not equal gross earnings minus total expenses and the sum of numbers in a table may not equal the total.

Salaried GPs' earnings

Salaried GPs should be on a salary no less favourable than the minimum pay range in the model terms and conditions, as set out by NHS Employers and the model salaried GP contract. In responding to the DDRB's recommendations, government will adjust the minimum and maximum pay threshold accordingly. It is, however, up to practices to determine the pay uplift for their staff.

Table 47 below shows the change in salaried GP income in England since 2012 to 2013. The average pre-tax income of salaried GPs working in either a GMS or PMS (GPMS) contract was £68,000 in 2021 to 2022, a statistically significant increase of 4.8% in cash terms compared to 2020 to 2021. This compares to an average increase of 2.0% in 2020 to 2021 compared to 2019 to 2020.

In 2021 to 2022, median pre-tax income for salaried GPs in GMS and PMS practices was £62,700. At the 25th percentile, median pre-tax income was £46,800 and at the 75th percentile, it was £83,000.

The UK income distribution figures from 2020/21, show that salaried GPs were in the 91st percentile group (£62,100 to £65,500) for that year. The participation rate for salaried GPs in September 2021 was 63.9% (a decrease of 0.2 percentage points compared to September 2020 at 64.1%), although this may not accurately reflect actual working hours.

Table 47: Earnings and expenses for salaried GPs in England, GMS and PMS, all practice types, 2012-13 to 2021-22[5].

Year	Report population	Gross employment earnings, cash terms (£)	Gross self-employment earnings, cash terms (£)	Total gross earnings, cash terms (£)	Total expenses, cash terms (£)	Total income before tax, cash terms (£)
2012-13	7,550	49,200	15,500	64,700	8,100	56,600
2013-14	8,000	48,200	15,800	64,100	9,200	54,900
2014-15	8,750	50,800	14,700	65,500	8,700	56,700
2015-16	7,250	51,500	12,300	63,900	7,900	55,900
2016-17	8,550	51,700	13,700	65,300	8,700	56,600
2017-18	9,400	52,400	15,800	68,200	9,800	58,400
2018-19	10,500	53,700	16,400	70,100	9,400	60,600

[5] There are breaks in the time series (each year between 2011 to 2012 and 2014 to 2015) due to the use of unrevised pension contribution rates when calculating adjustments to income before tax. 'Earnings' is the total that GPs receive; however, expenses come out of this sum, meaning that 'income' is total earnings minus expenses. Mean values are presented for earnings and expenses. Estimates have been rounded to the nearest £100, so numbers presented for taxable income may not equal gross earnings minus total expenses and the sum of numbers in a table may not equal the total.

2019-20	11,000	55,300	16,300	71,600	8,000	63,600
2020-21	11,950	57,200	15,300	72,200	7,400	64,900
2021-22	12,900	58,500	18,400	76,900	8,900	68,000

Source: NHS England, GP Earnings and Expenses Estimates, 2021/22, August 2023, tables 7a and 7b.

GP trainer grants

GP trainer grants had a 6% uplift applied in 2023 to 2024.

Career journeys and pay disparities

Longitudinal pay analysis

Data from the electronic staff record (ESR), the HR and payroll system used by all trusts and foundation trusts, can be used to analyse pay and earnings for individual members of staff over time. This provides insight into how employees experience the pay system and goes beyond looking at headline averages which can be impacted by other factors such as workforce growth or changes to grade mix.

Table 48 presents data on the change in average basic pay per FTE for over 58,000 medical staff who were employed in the HCHS sector in both March 2013 and March 2023 and is split according to the individual's grade in March 2023.

The median increase in basic pay per FTE was just over 42% (3.6% per annum (pa) while 25% of the workforce experienced an annual increase of over 8.8% pa, which will generally be associated with promotion to more senior grades. For example, the upper quartile figure for consultants (142% / 9.2% per annum) is likely to include the impact of promotion to the consultant grade as well as any progression within that role on top of headline pay awards.

Table 48: change in basic pay per FTE for HCHS staff employed in both March 2013 and March 2023.

Medical Grade	**Count**	**Lower Quartile (25th Percentile)**	**Median**	**Upper Quartile (75th Percentile)**
Consultant	45,800	33%	38%	142%
Associate Specialist	1,800	29%	37%	47%
Specialty Doctor	3,500	40%	57%	93%
Staff Grade	< 100	20%	20%	20%
Specialty Registrar	5,600	64%	85%	128%

Core Training	700	49%	80%	110%
ALL HCHS Doctors	58,700	33%	42%	132%

Source - DHSC Analysis of Electronic Staff Record. Staff grades shown are the individual's grade in March 2023.

Because this analysis is based on data from the ESR it does not cover individuals who may have moved to roles in other parts of the healthcare system, including general practice, and does not include any earnings beyond an individual's substantive contract in the HCHS sector.

Pay disparities - The gender and ethnicity pay gaps

It is important that the Pay Review Body take account of equality impacts when making pay recommendations and the extent to which different pay decisions could impact issues such as the gender and ethnicity pay gaps or seek to address other equality challenges within the health workforce. This section presents information on the current extent of pay gaps within the HCHS workforce and data on the profile of new staff entering the workforce. NHS England publish more detailed information on these issues through the Workforce Equality Data Standards and Equality and Diversity Statistics which can provide additional detail on the factors underlying these data. This is also covered in chapter 4 of this evidence.

Independent review into gender pay gaps in medicine

In 2020, Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England (GPG review) was published and highlighted the extent of the issue in the medical workforce and why it exists.

An independently chaired Gender Pay Gap in Medicine Implementation Panel was established in 2021 to drive delivery of the 47 recommendations and meets on a quarterly basis. Working alongside partner organisations, an annual work programme is agreed. New work programmes and changes to policy relevant to the eradication of the gender pay gap are identified and used as a focus for delivery.

The NHS Equality, Diversity, and Inclusion Improvement Plan, published in June 2023, sets out a series of high impact actions including the need for NHS organisations to address gender, ethnicity and disability pay gaps by developing and implementing their own improvement plans. There is an expectation that NHS organisations should have plans for addressing sex and race pay gaps in place by 2024. NHS England's evidence will set out their plans for implementation to reduce pay gaps across a number of protected characteristics.

Gender and ethnicity pay gaps

The GPG review undertook analysis to establish the size of pay gaps in medicine and to better understand the reasons why they develop. A similar piece of work is in development for ethnicity across the whole NHS workforce.

Factors that can contribute to a pay gap developing include differences in:

- staff group mix - a gap will develop if male or white staff are more likely to be in more senior staff groups compared to female or ethnic minority staff;
- career grade mix - a gap will develop if male or white staff are more likely to be in more senior career grades compared to female or ethnic minority staff;
- point mix - a gap will develop if male / white staff are more likely to be further up established pay scales than female or ethnic minority staff;

When considering pay gaps across the entire medical (or HCHS) workforce, the impact of career grade group mix is strongest, while pay gaps within individual staff groups reflect differences in grade and point mix.

Because of the impact that the workforce distribution has on gender / ethnicity pay gaps, this analysis should be read in conjunction with the information on workforce composition presented in chapter 4. For example, this shows that around 60% of consultants are male compared to 40% who are female. It is likely this will contribute to a gender pay gap across the entirety of the HCHS medical workforce due to this imbalance in the distribution of the most well-paid medical staff.

Gender and ethnicity pay gaps in HCHS sector

Table 49 presents the latest data on the gender and ethnicity pay gap as of May 2023 based on basic pay per FTE. Gender and ethnicity are shown separately to isolate the impact of either factor.

The results of the analysis are very similar to previous years. While there is evidence of a gender / ethnicity pay gap across the entire medical workforce, the differences within each career grade are much smaller. For example, the average white female has basic pay around 10% lower than the average white male but this reduces to 3% among consultants and 1% for SAS and Junior Doctors. This implies that there are "grade mix" effects with a higher proportion of white females in less senior grades which is consistent with other workforce estimates.

Table 49: gender and ethnicity pay gap for HCHS doctors using basic pay per FTE definition - May 2023.

Staff group	GPG - white	GPG - ethnic minority	EPG - female	EPG - male
Description	Comparison of white female to white male	Comparison of BME female to BME male	Comparison of BAME female to white female	Comparison of BAME male to white male
HCHS Doctors	-10%	-14%	-16%	-13%
Consultants	-3%	-2%	-2%	-3%
SAS Doctors	-1%	-5%	-6%	-1%
Junior Doctors	-1%	-4%	-4%	-1%

Source - NHS England Earnings Statistics - June 2023

Table 49 is based on differences in basic pay per FTE. A similar table based on differences in average earnings per person would also be impacted by any variation in working patterns or additional earnings between different groups of staff.

Gender pay gaps in GP sector

Mean earnings, expenses and income by age group and gender for salaried and contractor GPs in England are set out in Table 50 and 51. As with previous years, the data shows that for both contractor and salaried GPs, men earn more on average than female GPs in each age category, with the difference in average pay reducing for GP contractors over 60 years old.

GP earnings data does not take account of part time working and average participation rates are lower for female GPs than male. It is therefore not possible to assess the extent to which differences in working patterns may explain the observed earnings differences between male and female GPs of different ages.

As the department mentioned in evidence in previous years, the GPG review found that the mean gender pay gap for net income before tax in the 2016 to 2017 tax year was 22.6% among contractor GPs and 31.1% among salaried GPs. The report found the FTE-corrected mean gender pay gap was substantially lower for contractor GPs at 7.7% but remained high for salaried GPs at 22.3%. However, there are known limitations with the analysis, which used total income figures based on HMRC's self-assessment tax records and contracted hours or average weekly hours taken from NHS England's workforce minimum data set (wMDS). This collection does not capture the actual number of hours worked and any hours worked outside of a general practice setting would not be accounted for.

Table 50: Average GP partner earnings and expenses in England by age and gender, GMS and PMS, all practice types, 2021-22.

Age	Gender	Report population	Average total gross earnings (£)	Average total expenses (£)	Average total income before tax (£)	Comparison of female to male (%)
Under 40	Female	1,300	400,600	274,800	125,700	-23%
Under 40	Male	1,300	481,700	318,600	163,200	
40-49	Female	3,700	441,100	302,900	138,100	-19%
40-49	Male	3,600	538,100	368,400	169,700	
50-59	Female	2,950	447,000	309,200	137,900	-21%
50-59	Male	3,450	549,800	375,500	174,300	
Over 60	Female	550	426,400	285,700	140,700	-9%
Over 60	Male	1,450	456,000	301,900	154,200	

Source: NHS England, GP Earnings and Expenses Estimates, 2021/22, August 2023, table 2a. Earnings and expenses estimates are only available for GPs in England and were calculated for the first time for 2016 to 2017. The percentage difference is calculated as the mean (average) difference in average total income before tax as a percentage of men's pay.

Table 51: Average salaried GP earnings and expenses in England by age and gender, GMS and PMS, all practice types, 2021 to 2022.

Age	Gender	Report population	Average total gross earnings (£)	Average total expenses (£)	Average total income before tax (£)	Comparison of female to male (%)
Under 40	Female	4,750	68,700	7,800	60,900	-26%
Under 40	Male	1,700	97,100	14,500	82,600	
40-49	Female	3,050	72,500	8,300	64,200	-26%
40-49	Male	850	100,300	13,800	86,500	
50-59	Female	1,350	71,200	4,900	66,300	-24%
50-59	Male	550	95,300	8,600	86,700	
Over 60	Female	300	54,200	2,600	51,600	-27%
Over 60	Male	350	80,700	10,300	70,400	

Source: NHS England, GP Earnings and Expenses Estimates, 2021/22, August 2023, table 8. Earnings and expenses estimates are only available for GPs in England and were calculated for the first time for 2016 to 2017. The percentage difference is calculated as the mean (average) difference in average total income before tax as a percentage of men's pay.

Ethnicity pay gaps in GP sector

The GP Earnings and Expenses Estimates (GPEEE) data does not currently include pay data broken down by ethnicity. We have requested that NHS England include this breakdown in future reports, however it is difficult at this stage to set out a timeline for when this data may become available. We will continue to work with NHS England to understand what is needed to expand the GPEEE publication to include ethnicity pay data going forward.

Labour market assessment

Contextual summary

This section provides comparisons between earnings for medical staff, the wider economy in general, and specific comparator occupations which may attract candidates with similar skills or qualifications. This section only looks at earnings and does not adjust for the value of the wider reward package for NHS staff which is explored in chapter 6.

As set out in HMT's economic evidence, public sector earnings growth should retain broad parity with the private sector and continue to be affordable. Current information might indicate that:

- Latest information on pay settlements in the wider economy point toward median increases of between 5% and 6%. Other surveys indicate expected settlements over the next year of between 4% and 5% as the labour market loosens and inflation subsides.

- Evidence from the Annual Survey of Hours and Earnings (ASHE) suggests that the relative position of medical staff is broadly unchanged in recent years with consultants remaining in the top 2% of the income distribution.

General economic / Pay analysis

Comparison with the wider economy - average weekly earnings

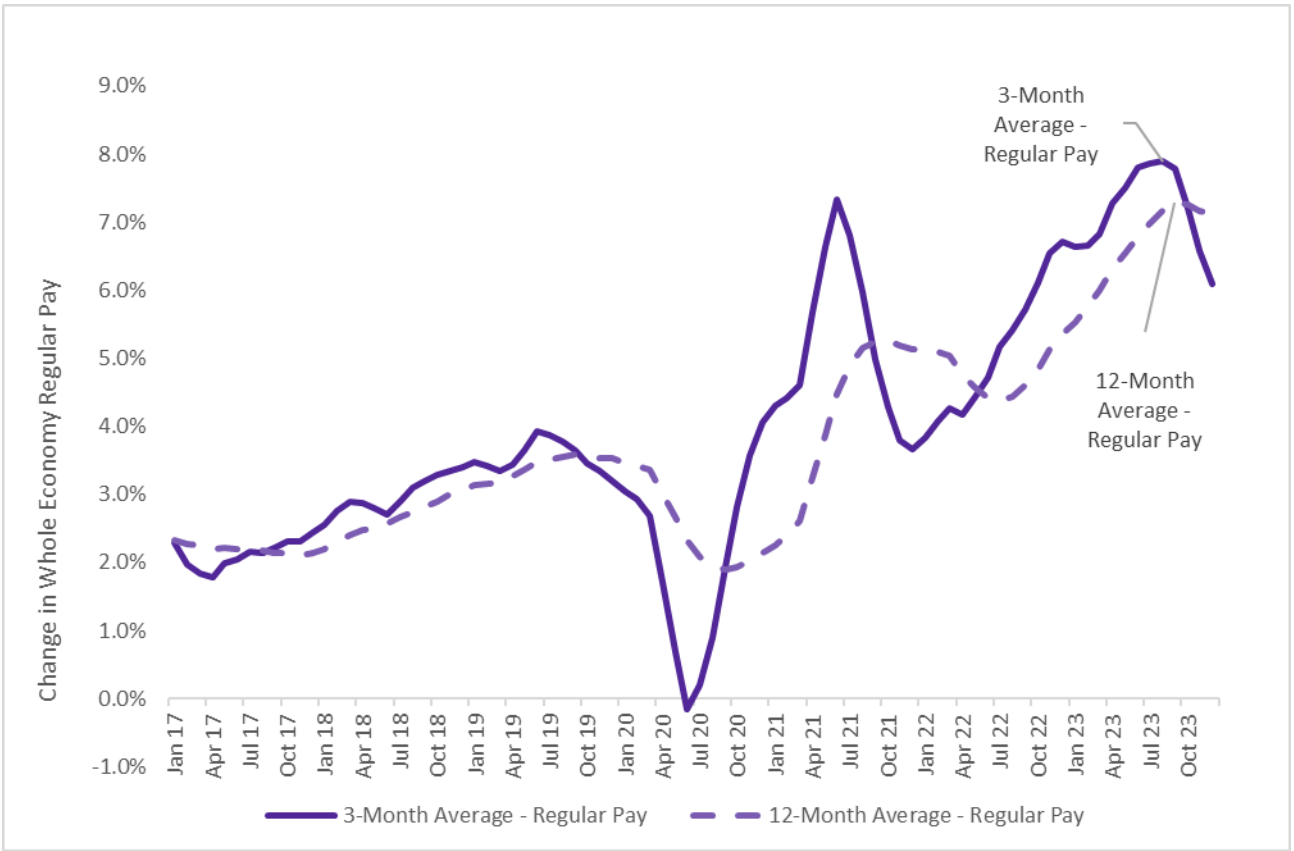
Office for National Statistics (ONS) publish data on average weekly earnings which is the lead measure on average weekly earnings per employee and is based on data collected from the monthly wages and salaries survey. These estimates cover more than just pay settlements and will include the impact of factors such as changes in average working hours, or the composition of the workforce. The latter was particularly important during the

COVID-19 period when the furlough scheme was in force, supporting the pay of over a million employees. Although we are now out of the period when these "base effects" should be having a direct impact on pay figures.

Figures for the period to December 2023 show that across the whole economy, average total pay increased by 5.8% compared with the same period 12-months ago and average regular pay (excluding bonuses) increased by 6.2%. These growth rates should not be impacted by the one-off payments made to civil servants in July and August 2023. As shown in figure 15, there is some evidence that the pace of growth may now be declining following a recent peak in September 2023.

Current estimates of average pay settlement may point to pay settlements being a little lower than headline wage growth. The most recent pay survey from XPertHR shows a median basic pay award in the three months to the end of December 2023 of 6%, although this is based on a limited number of pay settlements between October and December 2023. Information from the Bank of England Decision Maker Panel estimated year ahead wage growth of 5.2% in January 2024, which was unchanged from the previous month. Please see HMT's economic evidence for more commentary on the relationship between average earnings growth and settlement.

Figure 15: Increase in average weekly earnings, 3-month and annual growth rates between January 2017 and December 2023.



Source: Office for National Statistics, average weekly earnings

Comparator analysis / Income percentile analysis

Earnings percentile analysis

One way to assess any change in the competitiveness of medical pay is to consider how the average earnings of different grades compare with the UK income distribution.

As shown in Table 52, there have been only very small changes in the relative ranking of the different medical grades over time - HCHS doctors are consistently in the top 5% of the UK earnings distribution with consultants in the top 2% of earners. Average earnings for junior doctors are also above the UK average pay with only foundation doctor year 1 not in the upper quartile of the earnings distribution.

HCHS doctors have retained their position in the overall income distribution since 2018 with only very small changes in percentiles over the period. Changes over the COVID-19 period should be treated with caution due to the impact that COVID-19 had on employee earnings (for example, furlough) and data collection and so it is advised to look for longer term trends.

Table 52: estimated income percentile for NHS career grades based on average earnings per person in the NHS mapped against ASHE.

	12 month period ending in						
Staff group	March 2018	March 2019	March 2020	March 2021 (SOC10)	March 2021 (SOC20)	March 2022	March 2023
HCHS doctors	96	96	96	96	96	96	96
Consultant	98	98	98	98	98	98	98
Associate Specialist	97	97	97	97	97	97	97
Specialty Doctor	93	93	93	94	94	95	94
Staff Grade	92	92	93	94	94	94	93
Specialty Registrar	91	91	91	92	92	92	91
Core Training	87	87	86	89	89	88	86
Foundation Doctor Year 2	79	79	77	80	80	77	75
Foundation Doctor Year 1	70	70	67	69	69	67	64

Source: NHS England Earnings Statistics (Table 2a) , Annual Survey of Hours and Earnings (Table 1.7a) , Gross Annual Earnings for 90th to 99th Percentile. Note - A figure of "98" indicates that average earnings are above the 98th percentile but lower than the 99th percentile.

Based on a comparison of NHS average earnings per person with gross total pay from Annual Survey of Hours and Earnings. Note - this may differ slightly from previous Office

of Manpower Economics (OME) analysis as this is based on average earnings per person rather than FTE salaries.

High income professions

As indicated in the earnings percentile table, medical staff are towards the top of the income distribution and so it is also instructive to consider how earnings have changed for other professions with similarly high earnings as well as general changes for that section of the income distribution. We note that the data in this section considers general changes in earnings which will include the impact of both pay settlements and workforce composition effects.

As part of the monthly earnings release, the ONS include real-time information drawn from the PAYE system which includes information on the wage distribution. The most recent data, which includes the period to December 2023, shows that while monthly pay has increased across the pay distribution, growth has been lowest at the very top, with the smallest growth being in the 99th percentile. Conversely, the largest growth was seen in the 25th percentile, followed by the 10th percentile. This may reflect the 9.7% increase to the national living wage (NLW) from April 2023, as well as the targeted nature of some pay settlements in this pay cycle.

Table 53: Monthly pay by percentile from PAYE Real Time Information - three month moving average - ONS.

Date	**10th**	**25th**	**50th**	**75th**	**90th**	**95th**	**99th**
Dec 2023 (£ per Month)	764	1,351	2,317	3,570	5,388	7,292	15,096
Dec 2023 (% Growth)	6.9%	7.8%	6.3%	5.0%	4.6%	4.0%	3.8%

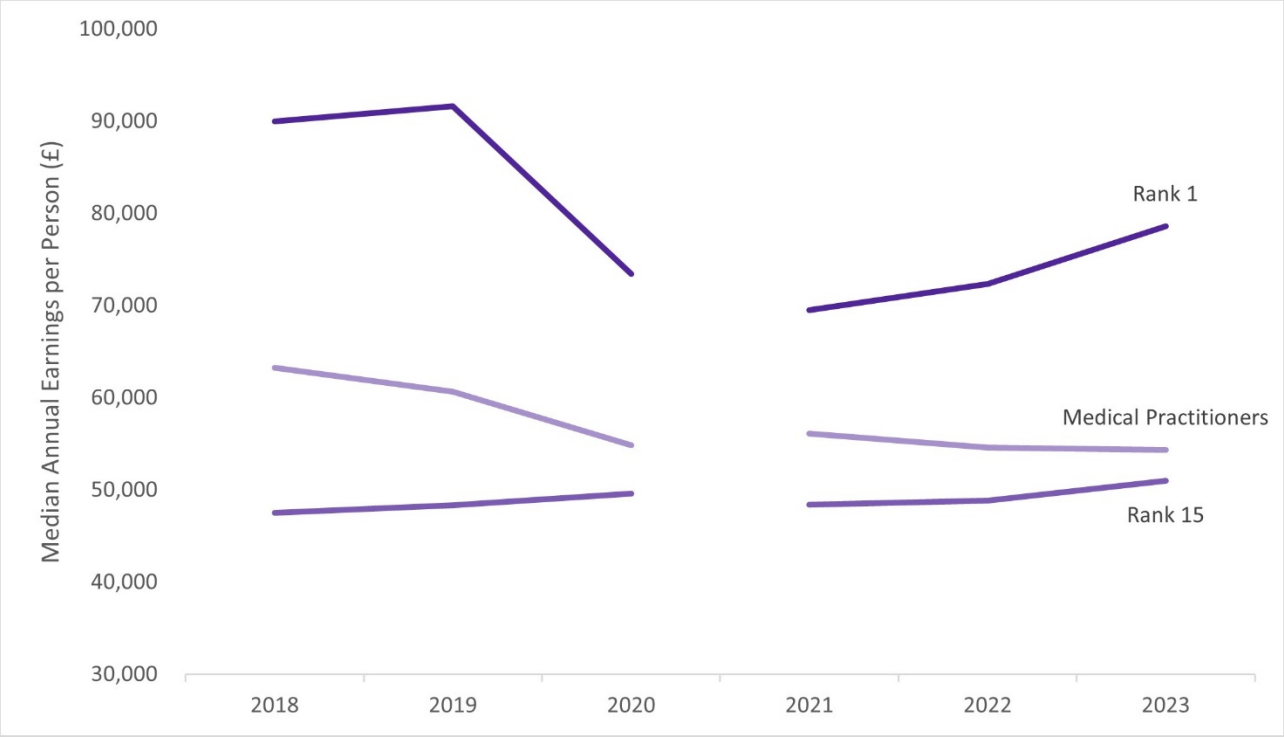
Source - Earnings and employment from Pay As You Earn Real Time Information, seasonally adjusted Monthly pay by percentile from PAYE RTI , UK, all industries, seasonally adjusted, £ per month, three month moving average.

ASHE data can be used to compare changes in earnings for specific professions. Since 2021, the coding system used by ASHE has been updated which, at the most granular level, has split medical professionals into a "specialist" and "generalist" group.

Figure 16 shows how the annual earnings of all medical practitioners compare to high-ranking occupations within the wider economy. "Medical Practitioners" is the 3-digit SOC made up of specialists and generalists, and the ranked occupations are the highest and fifteenth highest ranking 4-digit SOCs. Between 2018 and 2023, medical practitioners were always ranked within the top fifteen occupations by median annual earnings per person.

The decrease in earnings for medical practitioners since 2018 that we see in ASHE data is not consistent with the trend in NHS Digital HCHS sector data, which does show an increase in earnings during this period. Potential factors that contribute to this discrepancy may include an unrepresentative ASHE sample composition, for example, one that contains a large proportion of Junior Doctors, or a small sample size compared to the entire population. It is also important to recognise that ASHE groups together medical practitioners from the NHS with private healthcare industry, hence it is not entirely representative of NHS earnings. Finally, some earnings estimates for medical practitioners are considered by ASHE to be "reasonably precise" which implies an increased degree of uncertainty. This uncertainty is also present for occupations ranked first and fifteenth, with data ranging from "precise" to "acceptable" and should be considered when drawing comparisons.

Figure 16: Medical practitioners as compared to first and fifteenth highest ranked occupations by median annual earnings per person between 2018 to 2023.

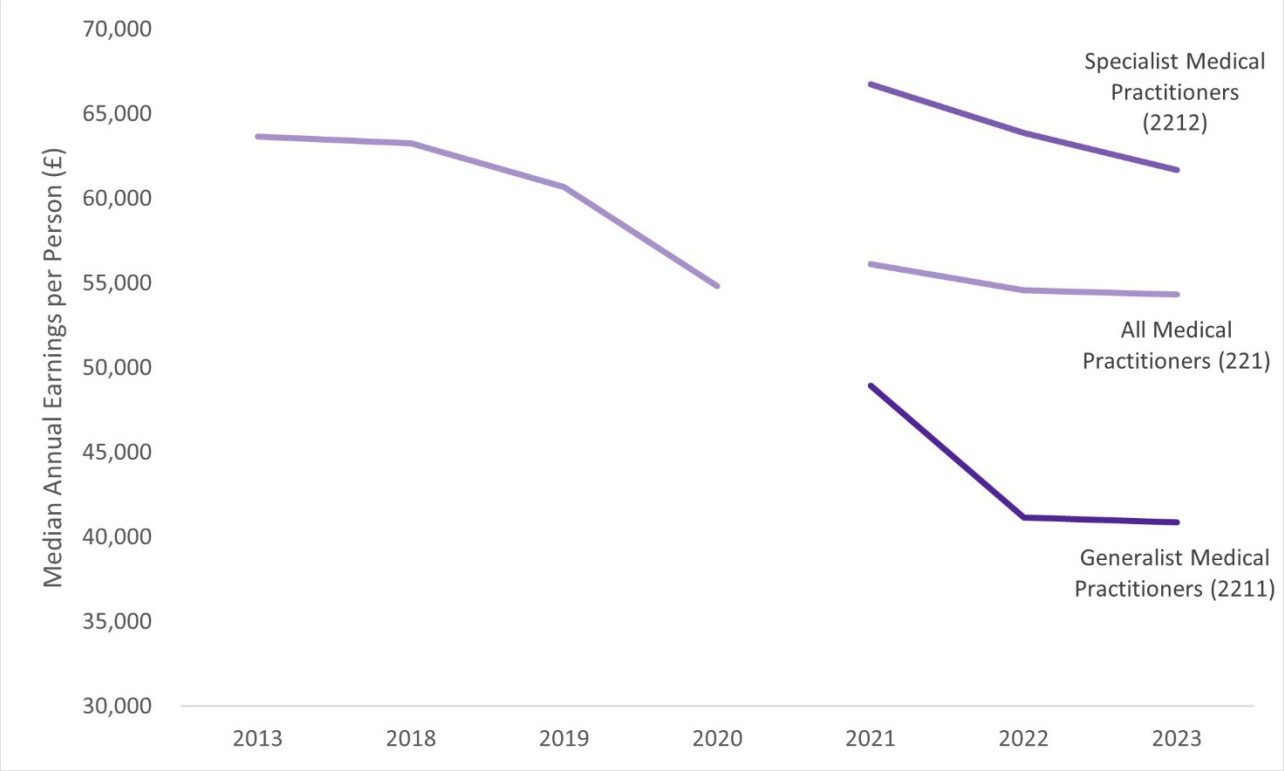


Source - [Earnings and hours worked, occupation by four-digit SOC: ASHE Table 14 - Office for National Statistics (ons.gov.uk)] Note - There is a break in the series between 2020 and 2021 due to a change in the Standard Occupation Code classification.

Taking advantage of the more granular data available following the ASHE updates, we can investigate the variation of earnings between generalist and specialist medical practitioners. Specialist medical practitioners make up approximately 70% of the combined group and as shown in Figure y - they have significantly higher annual earnings than

generalists. Once again, the decrease in annual earnings that we see in ASHE data is not consistent with data from NHS Digital.

Figure 17: Median annual earnings of medical practitioners between 2018 to 2023 broken down by 4-digit SOC.



Source - [Earnings and hours worked, occupation by four-digit SOC: ASHE Table 14 - Office for National Statistics (ons.gov.uk)] Note - There is a break in the series in 2021 following changes to the Standard Occupation Code classification. SOC20 includes the introduction of separate categories for "generalist" and "specialist" medical practitioners.

Longitudinal educational outcomes

Data from the Longitudinal Education Outcomes (LEO) dataset can be used to monitor employment and earnings outcomes for graduates and postgraduates from English higher education providers one, 3, 5 and 10 years after graduation based on information provided by the Department for Education, the Department for Work and Pensions and HMRC. The data can be used to compare outcomes for healthcare graduates (including medicine and dentistry) against those from other courses.

Table 54 compares median earnings for medicine and dentistry graduates to median earnings for graduates from other subjects 1, 3, 5 and 10 years after graduation. It shows that median earnings of those with medicine and dentistry degrees are the highest

throughout the first 10 years after graduation. Earnings after 1 year of graduation are just over 82% higher than average, and after 10 years of graduation, are just over 70% higher than the average.

Table 54: median earnings for medicine and dentistry graduates 1,3,5 and 10 years after graduation with comparison to all other subjects.

Average earnings for first degree students	**1 year after graduation**	**3 years after graduation**	**5 years after graduation**	**10 years after graduation**
Medicine and Dentistry	£39,400	£49,300	£52,600	£57,300
Medicine and Dentistry rank (35 subjects)	1	1	1	1
All subjects (student weighted)	£21,600	£26,100	£29,500	£33,600
Subject average (no weight)	£21,500	£25,600	£28,800	£32,800

Source: Longitudinal education outcomes (LEO) (Department for Education)

LEO also includes information on employment which further highlights the value of medical and dental degrees. Those with medicine and dentistry degrees are most likely to be in sustained employment or training 5 years after graduating. Although the proportion of individuals in sustained employment or training remains high in all stages after graduation, it is worth noting that this figure falls as the years since graduation increase. This is seen across all degrees and will include the impact of things like family commitments. This is shown in table 55.

Table 55: proportion of medicine and dentistry first degree graduates in sustained employment, training or both after 1,3,5 and 10 years with comparison to other subjects

Proportion in sustained employment, training or both (first degree only)	**1 year after graduation**	**3 years after graduation**	**5 years after graduation**	**10 years after graduation**
Medicine and Dentistry	96.3	92.5	92.8	88.1
Medicine and Dentistry rank (35 subjects)	1	5	1	3
All subjects (student weighted)	86.7	87.6	86.8	84.2

Source: Longitudinal education outcomes (LEO) (Department for Education)

International comparisons

The DDRB requested additional information on how medical pay in the UK compares to other countries. The Organisation for Economic Co-Operation and Development (OECD) compiles some information on remuneration for specialists and general practitioners across different countries and estimates how that compares to the average wage in respective countries.

Across the OECD, including the UK, it shows that medical staff consistently earn well above the average employee, though with some variation between countries on the extent to which medical pay is higher than average.

We do however note that it is exceptionally difficult to make appropriate comparisons between countries due to differences in things like workforce definitions, qualifications or differences in the total reward package. Therefore, we do not believe that international comparisons are very informative to pay setting.

6. Remit groups

This chapter provides further detailed information on each of the groups within the DDRB's remit. This includes information relating to pay arrangements, contractual matters specific to each of the groups, and offers which have been made to workforces in an attempt to end industrial disputes.

The chapter also provides responses to a number of the requests for information the DDRB made in their last report.

Consultants

In 2023 to 2024, the government accepted the recommendation of the DDRB and uplifted consultant pay scales by 6%. The value of Local Clinical Excellence Awards and National Clinical Impact Awards was not uplifted, as recommended by the DDRB.

As a result of the uplifts applied, the starting salary for a consultant increased by £5,302 to £93,666. The uplift applied in 2023 to 2024 increased the top of the consultant pay scale by £7,148 to £126,281.

In addition to basic pay, consultants have access to additional earnings made up of, for example, on-call allowances, Additional Programmed Activities, Local Clinical Excellence Awards and National Clinical Impact Awards. Following the uplift applied from April 2023, we estimate that in 2023 to 2024, average consultant earnings should increase to around £134,000, with around 31% of that figure made up of additional earnings.

As noted in Chapter 4, since 2019, consultant numbers have grown by 14.1%. Concerns have previously been raised that the post COVID-19 period would see a significant reduction in consultant numbers. However, as also show in Chapter 4, in the year from June 2023, numbers increased by 1,850.

Offer to consultants to end industrial action

During 2023, the BMA and HCSA consulted their consultant members on their willingness to take industrial action and secured formal mandates for strike action. Consultants represented by the BMA took strike action in the months from July to September 2023.

Formal negotiations with the BMA and HCSA have taken place throughout the year culminating, in November, in a formal offer from the government which the trade unions agreed to put to their members in a referendum. Members of both trade unions voted to reject the offer by a narrow margin - 51% reject by the BMA and 58% by the HCSA.

Subsequent to that, government and the trade unions have been discussing a way forward.

The offer focused on modernisation of the pay scale, better linking this to performance and addressing equalities issues within the current structure, alongside productivity enhancing initiatives.

If it had been accepted, the offer would have reformed the pay scale so that the number of pay points reduced from 8 to 4, with the time to reach the top of the pay scale reduced from 19 years to 14 years. Starting pay for consultants would have increased by £5,866 to £99,532 and the top pay point would have increased by £5,683 to £131,964. As part of the offer most, but not all, consultants would have seen an immediate increase to basic pay resulting from the reforms to the pay scale.

In tandem with pay scale reform, a new process of pay progression would have been introduced to better link progression to evidence of skills, competencies and experience. This would have meant that when it was time for the consultant to move to a new pay point, the clinical manager would have authorised that progression once they were satisfied certain criteria have been met. This new process would have brought consultants more in line with other NHS staff.

The offer also included a contractual right to shared parental leave as enjoyed by other NHS staff.

The offer was made on the basis that the department considered the pay increases resulting from this reform of the pay scale to be wholly separate from the DDRB's recommendation for an annual uplift of consultant pay.

Extra-contractual work

The rates of pay for work not covered by a consultant's job plan are not set out in the terms and conditions for consultants and are agreed at a local level. This type of arrangement applies to, for example, catch up work to reduce waiting lists, clinics or extra lists at weekends and covering for long term sickness absence.

As we noted in our evidence last year, the BMA created a rate card for their members which sets advisory rates of pay for extra-contractual activity at various times of the day and week. The advised rate for extra-contractual work on a weekday between 7am and 7pm is £161 per hour, which is over three times the average hourly rate of pay for a consultant. The advised rate increases to £269 per hour for work overnight.

We do not have access to data on how widespread payment of these rates has become. During the course of negotiations to resolve the industrial dispute and the subsequent member referendum, the BMA agreed not to promote the rate card.

Consultant job plans

In their last report, the DDRB asked the department to supply information on trends in the average number of Programmed Activities and Supporting Professional Activities worked by consultants, ideally disaggregated by age.

The department does not hold information on how, on average, consultant job plans are broken down into Programmed Activities and Supporting Professional Activities.

The 2003 contract for consultants in England sets out the expected partnership approach to job planning and that all job plans should be reviewed annually.

Contract reform

As noted above, if the offer for the consultant workforce had been accepted, then some elements of contract reform would have been achieved. However, there remain elements of the contract that are out of line with the modernised contracts of other NHS workforces. It remains our position that we would be interested in pursuing a full programme to reform the contract in the future.

Local clinical excellence awards

In addition to basic pay, consultants in England are contractually entitled to access an annual Local Clinical Excellence Award (LCEA) round.

As we set out in our evidence last year, from April 2022, new arrangements were introduced for LCEAs. These allow employers some flexibility to develop awards schemes to meet their own local priorities. The 2003 consultant contract has been updated to reflect these new LCEA arrangements and NHS Employers have created guidance and support to employers to help them set up new schemes.

Employers are required to invest £7900 per eligible consultant into LCEAs annually. This sum is to cover consolidated awards issued prior to 2018 which remain in pay, reversions to consolidated LCEAs for National Clinical Excellence Award holders who have been unsuccessful in applying for a new National Clinical Impact Award, and for newly awarded LCEAs. As the distribution of consolidated LCEAs will differ from trust to trust, this means the amount available for new awards will also differ. Over time, we expect the number of consolidated awards to reduce and the proportion of investment available for new awards to increase.

Our understanding is that movement by employers towards setting up new LCEA schemes has been slow. Whilst we do not have access to data to confirm this, anecdotally we understand most employers will be distributing the available LCEA funding equally amongst eligible consultants again in 2023 to 2024, as they have been doing since the start of the pandemic in 2020 to 2021.This means all eligible consultants in those trusts can expect to receive a share of the funding without having to evidence excellent performance.

While we understand the reasons behind the delay in getting the new schemes rolled out, and are sympathetic to the pressures faced by employers, this is not the intended usage of this funding which is designated to motivate and reward excellence.

For this reason, as part of the offer to consultants, we had agreed with the trade unions that, if the offer were accepted, the contractual right to access an annual LCEA round would cease. The funding for new LCEAs would then have been redeployed into remuneration. This would not have impacted on non-consolidated awards which had been issued for more than one year.

The intention under the offer was that consolidated 'old-style' awards would remain in payment and the value of those awards would be frozen. The review process for these awards would also have been removed.

As the offer for consultants has not been accepted, we would expect employers to run competitive LCEA rounds in the 2023 to 2024 financial year. We will continue to work with NHS Employers to ensure that employers are encouraged and supported to roll out their new schemes. However, as so few employers have run competitive rounds to date, we currently have no evidence that the new local awards schemes will make a real difference in improving the equality and fairness of award distribution. We hope to be in a position to provide evidence of such improvement for next years' pay round.

National clinical impact awards

Following public consultation in March 2021, the reformed National Clinical Impact Awards (NCIA) scheme was launched in 2022 with the first new awards granted for five years from 1 April 2022. Key to the reforms were the recommendations made by the DDRB in 2012 and wider evidence including the Gender Pay Gap in Medicine Review.

The number of awards in the new scheme was increased to up to 600 per year, and consequently the success rate for applications increased from 29.3% in the 2021 award round to 46.6% in the 2022 award round, with 54.7% of the 2022 awards being granted to applicants who did not hold a prior national award.

While the indications on impacts of the reforms on broadening access to awards are positive, the reformed scheme has only operated for one full round, and we therefore ask the DDRB to allow the reformed scheme further time to be fully implemented and imbedded before any further uplift is recommended.

Specialty and specialist (SAS) doctors and dentists

In 2021, a multi-year pay, and contract reform deal was agreed with the BMA for SAS doctors, covering the years 2021 to 2022 to 2023 to 2024. The deal introduced a reformed contract for Specialty Doctors and a new Specialist contract and came in with an agreement on pay uplifts for the duration of the deal.

Doctors who were already employed in the SAS grade when the deal came into force had the choice to either transfer to the new 2021 contract or remain on their current terms and conditions. This would be an individual choice for each doctor based on a range of factors relating to their own particular circumstances, including whether there would be financial benefit in moving to the new contract. As the deal included transition to a new pay scale with fewer pay points, there was no 'standard' uplift which would apply to each doctor.

During the course of the deal, the DDRB has been asked to make recommendations for doctors on the closed SAS contract, but not for doctors on the 2021 contracts where the annual pay uplifts were agreed as part of the deal.

For 2021 to 2022, the DDRB recommended an uplift of 3% to the SAS contracts not covered by the deal, which the government accepted. In 2022 to 2023, the government accepted the DDRB's recommendation to uplift the contracts not covered by the deal by 4.5%. As these uplifts were higher than many of the annual uplifts applied to the various pay points in the 2021 Specialty Doctor and Specialist contracts, this has led to a misalignment between the various pay scales.

In recognition of this, the government accepted the DDRB's recommendation in their last report to uplift the contracts not covered by the deal by 6% and the contracts covered by the deal by 3% on top of the uplift applied under the multi-year agreement. This meant that all doctors on the 2021 Specialist contract saw a pay increase of 4% while increases on the 2021 Specialty Doctor contract ranged between 3% and 9.3%. As set out in more detail below, whilst this prevented the issue from being exacerbated, the pay scales remain mis-aligned.

Benefits of the multi-year agreement

The multi-year agreement delivered reforms to the Specialty Doctor pay scale aimed at reducing the number of pay points and time taken to reach the top of the pay scale, meaning that Speciality Doctors will earn more sooner in their career.

However, the deal offered much more beyond pay, with a focus on enhancing career progression and experiences of work for SAS doctors. Key elements of the deal have included:

- Introduction of a new Specialist role to provide an opportunity for career progression to skilled and experienced Specialty Doctors and an alternative career path for doctors;
- Increase to the on-call availability supplement;
- One additional day of annual leave after 7 years of NHS service;
- Introduction of safeguards to support SAS doctors to maintain work/life balance;
- Modernisation of terms and conditions;
- Introduction of a SAS Advocate role to improve support for SAS doctors' health and wellbeing.

Reforms aimed at improvements to wellbeing are particularly important for SAS doctors as this group have regularly reported low morale associated with feeling undervalued.

The parties involved in negotiating the multi-year deal were agreed that this was a positive step forward in creating contracts that were attractive for employers to utilise and offered doctors fulfilling careers with opportunities for progression. The shared aim was to attract as many existing SAS doctors as possible to transfer to the new 2021 contracts.

Implementation challenges

As we started the final year of the agreement, data from May 2023 showed that 44% of all SAS doctors are employed on the 2021 contracts with the remainder employed on terms and conditions which are closed to new entrants.

Specifically considering Specialty Doctors, 48% are on the 2021 contract with 52% remaining on the 2008 or pre 2008 contracts.

Looking further into this data shows that, in fact, only around one quarter of Specialty Doctors on the 2021 contract have transferred from the 2008 Specialty Doctor contract. A further quarter have moved from the trainee grade. Around half of the doctors on the 2021 Specialty Doctor contract do not have a record in the previous month, suggesting they are likely to be new joiners.

The number of transfers from the 2008 Specialty Doctor contract to the 2021 contract is much lower than the parties engaged in agreeing the deal would have hoped. Although there is likely to be reluctance for individuals to move contracts for other reasons, including lack of knowledge about the impacts or general ambivalence, we believe this is largely as a result of the divergence in pay scales.

The table below sets out the differences in pay between the 2008 and 2021 Specialty Doctor contracts. This show that, for around two thirds of the 'years of experience points', pay is higher on 2008 contract which could raise equal pay concerns.

Table 56: Differences between pay on the 2008 and 2021 Specialty Doctor contracts.

Minimum Years of Experience / Pay Step Point	2021 Specialty Doctor Contract - 2023 to 2024 Pay Scale	2008 Specialty Doctor Contract - 2023 to 2024 Scale	% Gap (2008 to 2021)	£ Gap (2008 to 2021)
0	52,530	46,958	-11%	-5,572
1	52,530	50,973	-3%	-1,557
2	52,530	56,193	7%	3,663
3	60,519	58,991	-3%	-1,528
4	60,519	63,021	4%	2,502
5	60,519	67,037	11%	6,518
6	67,465	67,037	-1%	-428
7	67,465	71,142	5%	3,677
8	67,465	71,142	5%	3,677
9	74,675	75,249	1%	574
10	74,675	75,249	1%	574
11	74,675	79,356	6%	4,681
12	82,400	79,356	-4%	-3,044
13	82,400	79,356	-4%	-3,044
14	82,400	83,461	1%	1,061

Minimum Years of Experience / Pay Step Point	2021 Specialty Doctor Contract - 2023 to 2024 Pay Scale	2008 Specialty Doctor Contract - 2023 to 2024 Scale	% Gap (2008 to 2021)	£ Gap (2008 to 2021)
15	82,400	83,461	1%	1,061
16	82,400	83,461	1%	1,061
17	82,400	87,568	6%	5,168

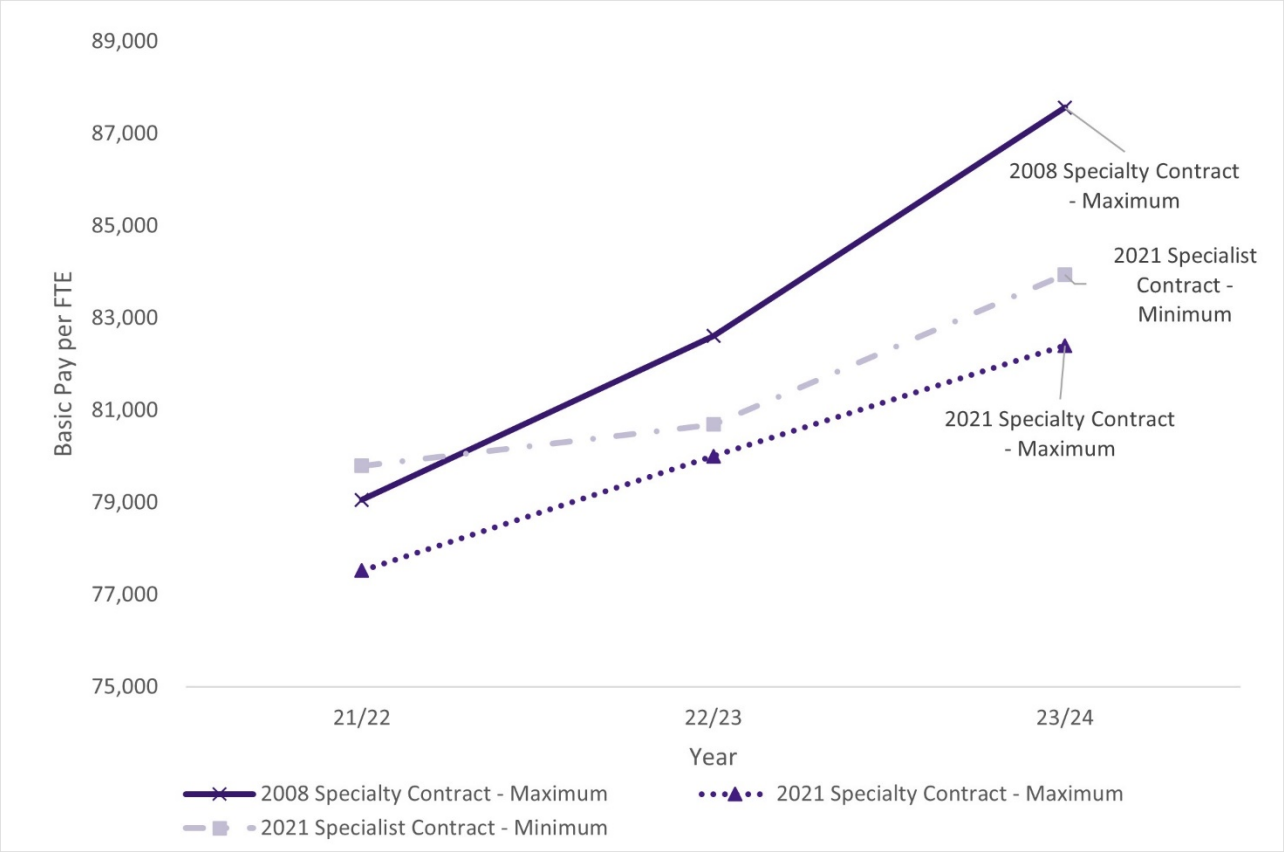
This issue is not limited to the Specialty Doctor grade. An undesirable differential has also developed between the top pay point of the 2008 Specialty Doctor and the starting pay point of the 2021 Specialist pay scales.

To illustrate the differential between the contracts that has emerged, figure 6.2 shows how the top of the 2008 Specialty contract has changed compared to the top of the 2021 specialty doctor contract and the bottom of the 2021 Specialist contract. This illustrates that:

- The difference between the top of the two "Specialty" scales has grown with the top of the 2008 specialty scale now over £5,000 higher than the top of the 2021 scale.
- The top of the 2008 Speciality scale is higher than the bottom of the 2021 Specialist scale.

Both of these might impact the decisions of doctors to transfer to the new contract or seek roles at specialist level.

Figure 19: Comparison of changes to pay at the top of the 2008 specialty doctor and 2021 specialist contracts.



Source - [NHS Employers Pay Circulars]

As doctors have a higher final pay point on the 2008 Specialty Doctor contract than the 2021 Specialty Doctor contract, this is likely to put people off transferring to the new contract. There is a potential that this could also impact on recruitment into the Specialty Doctor grade as all new Specialty Doctors and those taking new roles will be placed on the 2021 contract and pay scale.

Overall, this puts at risk our ambitions to improve SAS doctor morale and feelings of being valued. For this reason, we have sought to realign the pay scales through the offer we have recently made for SAS doctors (see 'Industrial action' section below for further detail).

Specialist grade

As noted above, one of the key aspects of the 2021 multiyear agreement was the introduction of the new Specialist grade.

Data to May 2023 shows the number of Specialist posts in England has steadily increased, with 817 Specialist posts created since the new grade was introduced in April 2021.

In England, the increase in Specialist roles continues to outstrip attrition of Associate Specialist roles, meaning that in the year April 2022 to March 2023, 'senior' SAS roles grew by just under 9%.

Just over 40% of doctors in Specialist roles have moved to that grade from the Specialty Doctor grade. Around 8% have moved from the Doctors in Training grade and 11% from the consultant grade. This mix suggests that the grade is fulfilling its intended role as a route for development for Specialty Doctors and also an alternative career path for medical staff.

As Figure 19 above shows, the top pay point of the 2008 Specialty Doctor contract is now over £3600 higher than the starting pay for a Specialist. This means that there would be no financial benefit to these doctors achieving promotion and, in theory, a doctor would be taking a pay cut. As mitigation, NHS Employers have created guidance advising employers how to handle this issue to ensure fairness and not damage prospects of recruitment. However, as set out below, if accepted, the offer made to SAS doctors seeks to provide a solution to this issue.

Industrial action

During 2023 the BMA and HCSA consulted their SAS members on their willingness to take industrial action. Both unions secured a formal mandate for strike action, however, no strike days were scheduled.

Following formal negotiations with the BMA, the government has put an offer to the SAS Committee which they have agreed to take to their members for a ballot. If the offer is accepted, then the following changes will be introduced with effect from 1 January 2024:

- the top pay point for the 2021 Specialty Doctor pay scale will be increased to improve incentivisation to transfer to the contract;
- other pay points in the 2021 Specialty Doctors pay scale will be uplifted to maintain differentials between pay points;
- the originally intended differential of £1500 between the top of the Specialty Doctor pay scale and the first pay point in the Specialist pay scale will be reinstated;
- all other pay points in the Specialist pay scale will be uplifted to maintain the differentials between pay points.

Taken together, if the offer is accepted, these actions should resolve the issues of pay scale misalignment going forward.

In addition to actions relating to the pay scale, the offer for SAS doctors includes a number of other elements aimed at supporting wellbeing and career development and progression for SAS doctors.

Working patterns

The DDRB asked for data on trends in average working hours for SAS doctors. This is not data which the department has access to.

Doctors and dentists in training

In 2023 to 2024, the government accepted the DDRB's recommendation and uplifted the pay scales for doctors and dentists in training by 6% plus an additional £1250 consolidated uplift to each nodal point. This meant that on average doctors and dentists in training received an 8.8% pay uplift. Each individual nodal point increased as follows:

Table 56a: Increases to pay for doctors and dentists in training 2023-24

Training stage	2022-23 value	2023-24 value	Increase
Foundation Year 1	£29,384	£32,397	10.3%
Foundation Year 2	£34,012	£37,303	9.7%
ST Year 1-2 / CT Year 1-2	£40,257	£43,922	9.1%
ST Year 3-5 / CT Year 3	£51,017	£55,328	8.5%
ST Year 6+	£58,398	£63,152	8.1%

The mixture of a percentage and cash uplift to the nodal points allowed doctors at the start of their training to benefit from a higher overall uplift without too much disturbance to the flow of the pay scale and gaps between different pay points.

On average, Foundation Year 1 doctors have additional earnings worth around 30% of basic pay, covering payments for additional activity and unsocial hours payments. This is

expected to result in average total earnings of around £40,800. Foundation Year 2 doctors have additional earnings worth around 34% of basic pay. This is expected to result in average total earnings of around £47,700 in 2023 to 2024.

Doctors and dentists in training represented by the BMA, HCSA and BDA have been engaged in several rounds of strikes since March 2023. There have been several rounds of negotiations between government and the BMA, however, despite the government offering a deal of a similar quantum to that put to consultant and SAS doctors, the parties have thus far been unable to reach an agreement on an offer which the BMA is prepared to put to doctors and dentists in training.

The DDRB has asked for information relating to the various financial initiatives in place, including flexible pay premia (FPPs) in England. The department's evidence in these areas should be read in conjunction with the evidence from NHS England who are responsible for recruitment to training posts.

FPPs are a recruitment and retention payment designed to support recruitment to certain 'hard to fill' specialties and training programmes, as well as to ensure certain career pathways, such as academia and dual qualification in oral and maxillofacial surgery, are not disincentivised due to their earnings potential or training requirements.

FPPs are currently worth between £2956 to £9693 per year under specific conditions. Full details on the value of these payments and eligibility are contained in the latest medical and dental pay circulars published by NHS Employers.

Pay is not the only factor influencing choice of specialty. It is hard to evaluate the success of FPP type payments without fully understanding the reasons that trainees chose their specialties, and the choices they would have made had the FPP not been available. A whole system perspective of ensuring appropriate recruitment/supply to all specialties also needs to be considered.

Table 57 shows August 2023 fill rates for each of the specialties where a FPP applies. general practice, psychiatry core and histopathology all have fill rates over 90%. However, higher specialty training in emergency medicine, psychiatry and oral & maxillofacial surgery have lower fill rates.

Table 57: summary of all specialty training programmes with FPP

Training programme	Posts	Accepts	Fill rate %
General practice ST1-4	3433	3427	99.83

Core psychiatry CT1	450	449	99.78
General psychiatry ST4+	148	122	82.36
Emergency medicine ST4+	86	34	39.53
Oral & maxillofacial surgery ST3+	23	13	54.17
Histopathology ST1+	96	96	100

Where there are multiple different FPP specialty programmes under the same specialty grouping, the following tables 58 and 59 show the breakdown of fill rates by training programme.

Table 58: outlines the fill rates across the higher specialty training in psychiatry specialties. The lowest fill rate is in the psychiatry of learning disability which is 40%.

Table 59: outlines the fill rates across the histopathology specialties. Diagnostic neuropathy has a 10% fill rate of a total of 10 posts.

Table 58 higher specialty training in psychiatry breakdown.

Speciality	Posts	Accepts	Fill rate %
Child and adolescent psychiatry ST4	52	37	71.15
Forensic psychiatry ST4	30	21	70.0
Medical psychotherapy ST4	8	8	100.0
General psychiatry ST4	148	122	82.36
Old age psychiatry ST4	65	51	78.0
Medical psychotherapy ST4	8	8	100
Psychiatry of learning disability ST4	35	14	40.57
Child and adolescent psychiatry ST4	52	37	71.15

Table 59: Histopathology breakdown

Speciality	Posts	Accepts	Fill rate %
Chemical Pathology ST3	6	5	83.33
Diagnostic neuropathology ST3	10	1	10.0
Histopathology ST1	96	96	100
Paediatric and perinatal pathology ST3	6	2	33.33

The full breakdown of all specialties is published by HEE: 2023 England Recruitment Fill Rates | Medical Hub (hee.nhs.uk)

Detailed information relating to training fill rates and the experiences of doctors and dentists in training will be covered in the evidence provided by other parties.

Locally employed doctors

We have set out in our previous evidence that the centrally held information on locally employed doctors is limited.

Doctors are employed on local terms and conditions for a variety of reasons and in various different circumstances. Some may be taking a relatively short period of time out of formal training, potentially without the level of experience required to be a SAS doctor. Others may be new to the country and to working in the NHS and taking a local contract before substantive employment on a national contract.

It is difficult to gain a completely accurate picture of the numbers of locally employed doctors due to the different employer practices in using ESR codes. However, Table 61 below uses an analysis of ESR data to set out the proportions of doctors in various contractual arrangements.

Table 60: Estimated HCHS Medical Workforce split by Grade and Contract Status. Average for 2022 to 2023.

Contract Status	Contract	Estimated FTE	Estimated Share
Open Contracts	Consultant	53,952	41%
	SAS - Specialist Contract	483	0%
	SAS - Specialty Contract	5,041	4%
	Junior Doctors - 2016 Contract	45,409	34%
Other National Terms	Junior Dentists (HCHS - 2016 Contract)	273	0%
	Closed Grades	17,491	13%
Others	Trust Grades (LED's)	9,776	7%
		77	0%

Source - DHSC Analysis of Electronic Staff Record

The table above shows that on average in 2022 to 2023, only 7% of the medical workforce were employed on 'trust grades' and could be alternatively described as locally employed doctors. The significant majority (79%) were employed on open, national contracts and a further small proportion (13%) on contracts which are closed to new entrants.

It is our understanding that the majority of locally employed doctors are employed on terms and conditions which mirror national contracts and national pay scales. Therefore, their annual uplifts will also mirror those applied to national contracts. However, ultimately employers have the flexibility to decide the terms and conditions and pay scales which will apply for their locally employed doctors.

Further work is underway to understand more about locally employed doctors, why employers are using them and the specific roles they undertake. This will help inform decisions around any future strategic action to further support doctors employed on local contracts.

General dental practitioners

On 7 February 2024 the Government and NHS published Faster, simpler and fairer: our plan to recover and reform NHS dentistry. The Plan will make dental services faster, simpler and fairer for patients and will fund around 2.5m additional appointments (or more than 1.5m additional courses of dental treatment). The Plan sets out a number of actions

which will improve access for patients, by helping the sector to recover activity more quickly, addressing underlying issues and setting out the action needed for longer term reform of the system.

A new patient premium will support dentists to take on new patients and a new marketing campaign will help everyone who needs one to find an NHS dentist. New dental vans will bring dental care to our most isolated communities and ‘golden hello’ incentives will encourage dentists into under-served areas. We will further support dentists by raising the minimum Units of Dental Activity (UDA) rate to £28 this year, making NHS work more attractive and sustainable.

Our initial package of dental system improvements announced in July 2022 followed full engagement with the dental profession and patient representatives. These initial changes were aimed at improving incentives in the contract to deliver more complex care while enabling the NHS to better work with the sector to ensure that the dental care required by patients is delivered. These improvements included:

- more UDA bands to better reflect the fair cost of work and incentivise NHS work. We introduced the first ever minimum UDA value to help to sustain practices where UDA values are particularly low. We allowed dentists to deliver 110% of their UDAs for the first time, to encourage more activity from those who want to do more;

- we made it a requirement for dentists to keep their availability for NHS patients up to date on the NHS website to make it easier to find a dentist for a course of treatment; and

- we also started the process of making it easier for dentists to come to work in the UK and brought legislation into force that enables the General Dental Council to amend the content, structure, and fees of the overseas registration exam.

Furthermore, from 1 April 2023, the responsibility for commissioning primary care dentistry to meet the needs of the local population has been delegated to all integrated care boards (ICBs) across England. This included the transfer of all funding, Units of Dental Activity and the management responsibility for National Health Service dentistry. ICBs are responsible for having local processes in place to involve patient groups, and for undertaking oral health needs assessments, to identify areas of need and determine the priorities for investment.

We are also working on further reforms to the 2006 contract, in discussion with the profession, to properly reflect the care needed by different patients, and more fairly remunerate practices. We will also review what further action we can take to support professional development and skill mix within NHS dentistry, to make NHS dental care an attractive career choice where all professionals can work to their full scope of practice.

We expect to develop options for consultation with the dental profession in advance of a further announcement later this year. Any changes would be phased in from 2025 onwards.

Dental payment models

There are advantages and disadvantages to all payment models. We have previously tested a prototype system with a mix of capitation and treatment activity. The data on access after 3 years of prototyping show that for prototype practices, there was a reduction in patients cared for to 91% of the pre-prototype baselines using a measure of 24-month unique patient access, a decrease of 9 percentage points. In contrast, comparable non-prototype contracts showed an increase in the number of unique patients seen over a 24-month period over the same timeframe to 103% of financial year 2014 to 2015 figures, or an increase of 3 percentage points. In prototype practices, access reduced for both fee-paying and charge-exempt adults. In the non-prototype contracts, access increased for fee-paying adults and reduced for charge-exempt adults. Therefore, we must proceed with care, and co-design any changes with the sector, to avoid reductions in access to care for patients.

International recruitment

Patients receiving NHS dental care benefit greatly from overseas-qualified dentists and dental care professionals. Around 30% of all dentists on the General Dental Council's (GDC) register qualified outside of the UK, and in 2022, 46% of new dentists joining the GDC register were trained overseas[6]. We will seek to ensure that further proposed improvements to international registration pathways are focussed on bringing benefit to NHS patients.

We will work to introduce legislation that creates a new provisional registration status, providing a new route for overseas-qualified dentists whose qualifications are not currently automatically recognised by GDC to join the register and practise in the UK faster.

European economic area (EEA) dentists

As of 1 January 2021, for EEA-qualified and Swiss healthcare professionals who wished to practise in the UK, the government put in place 'standstill' regulations following EU exit to ensure the UK retained a system of near automatic recognition of EEA professional qualifications. Following a ministerial review of the EU exit standstill provisions, dentistry qualifications from the EEA will continue to be unilaterally recognised by the General Dental Council (GDC). We have set out further detail on these arrangements in our report

[6] Registration statistical report 2022 (gdc-uk.org)

on the review of EU Exit standstill provisions as published on 29 June 2023 (Professional qualifications - EU Exit standstill provisions: review by the Secretary of State)

The Overseas registration exam (ORE)

The ORE is the main route for holders of overseas dentistry qualifications which are not recognised automatically for registration with the GDC to demonstrate they meet the high clinical standards required for registration.

The number of places available for the ORE Part 1 was tripled for sittings from August 2023 and for all sittings in 2024. The number of Part 2 sittings has also been increased from three to four in 2024.

The GDC consulted in 2023 on routes to registration for internationally qualified dentists and dental care professionals (consultation on routes to registration for internationally qualified dentists and dental care professionals) The consultation included proposals to overcome financial barriers to further expanding ORE capacity in the longer term, using the flexibility given to the GDC in legislation introduced in March 2023. The new rules will come into effect from March 2024.

Dental performers list

In order to deliver NHS dental services, a dentist must be registered with the GDC and listed on the Dental Performers List (DPL) of the country in which they wish to practise. The England Performers List is held by NHS England. Each of the Devolved Governments has a Performers List, held by an equivalent organisation. The DPL provides assurance that all dentists are fit to provide NHS dental care, are suitably qualified, have up to date training, appropriate English language skills and have passed other relevant employment checks.

We have already made improvements to streamline and improve the DPL. On 1 April 2023, the Performers List Validation by Experience (PLVE) process was discontinued by NHS England. All DPL applicants who have not completed UK Dental Foundation Training are now managed by NHSE England in accordance with its policy document; Policy for Managing Applications to Join the England Performers Lists. This means all applicants who have not completed UK Dental Foundation Training are invited by NHS England to engage in a structured conversation that assesses whether they have the knowledge, skills, and experience to perform NHS primary dental services. In May 2023, the department introduced changes to the England Performers List regulations to allow NHS England to carry out this assessment. The change is intended to accelerate the process for overseas dentists to join the DPL and start working in the NHS.

In July 2023, the department introduced further reforms to the England Performers List regulations. The changes are intended to reduce bureaucracy and improve flexibility without compromising patient safety. The amended regulations came into force on the 18 September 2023.[7]

Dental therapy and hygiene

Dental care in England could not function without the vital contribution of its dental care professionals, including dental therapists, hygienists and nurses. As set out in the NHS Long Term Workforce Plan, we will expand dental therapy and dental hygiene undergraduate training places by 28% by 2028 to 2029 and expand training places by 40% from current levels to over 500 places by 2031 to 2032.

Dental therapists' scope of practice means that they can deliver much of the routine care that dentists provide so more therapists means more care for NHS patients. In addition to dental therapists and hygienists, we will also encourage greater numbers of dental nurses and clinical dental technicians into relevant education and training programmes.

On 11 January 2023, NHS England published guidance on enabling the whole dental team to work to their full scope of practice.

Dental care professionals (DCPs) such as dental therapists, hygienists and nurses are able to deliver treatment within their scope of practice directly to patients and have done so in the private sector. As part of these dental system improvement changes, we explored why the workforce was underutilised in the NHS sector to encourage the improve use of skill mix within NHS dentistry.

The Department and NHS England are satisfied that dental therapists and dental hygienists can provide direct access to NHS care where that care is within the GDC scope of practice, if they are qualified, competent, and indemnified to do so.

Furthermore, in August to September 2023, we consulted on changes to the Human Medicines Regulations which would enable dental therapists and dental hygienists to supply and administer some medicines without the need for a prescription from a dentist. These include local anaesthetics, fluoride varnish and certain antibiotics. This could enable these clinicians to deliver more care for patients using skills already within their scope of practice, whilst also improving the job satisfaction these professionals experience.

[7] The National Health Service (Performers Lists) (England) (Amendment) Regulations 2023 (legislation.gov.uk)

The proposed change will support dental hygienists and dental therapists in providing the right care to patients without unnecessary delays and add capacity in dental care teams.

We will respond shortly to the consultation on the proposals.

Expenses

As referenced in Chapter 5: Medical and Dental Staff Earnings, we implemented the overall uplift of 5.13% to dentists' remuneration for 2023 to 2024 (6% for pay elements and 3.23% for non-pay (expenses) elements), following the 51st report of DDRB. For clarity, we do not apply the DDRB recommendation on pay to the expenses uplift element of the contract. Expenses (costs) are uplifted in line with inflation at the same time each year.

Our position is that there is a strong rationale for using GDP deflators as a suitable measure of inflation to calculate expenses. The use of GDP deflator is consistent with other areas across the NHS. This is also in keeping with the way HMT sets budgets and therefore how the overall NHS mandate is calculated. We want a fair pay deal for both NHS staff and the taxpayer. This also means exercising fiscal discipline to make sure we protect taxpayers, manage public spending effectively and do not drive inflation up.

Table 61: Increase in Annual Contract Value to allow for a 6% uplift on pay and staff costs, and GDP deflator (3.23% as of the Autumn Statement 2022) on expenses from 1 April 2023.

Element	Weighting	Index	Source value	Weighted value
Income	46.60%	6.00%	DDRB	2.80%
Staff costs	22.00%	6.00%	DDRB	1.32%
Laboratory costs	6.00%	3.23%	GDP November 2022	0.19%
Materials	6.60%	3.23%	GDP November 2022	0.21%
Other costs	18.80%	3.23%	GDP November 2022	0.61%
Total	100.00%			5.13%

DHSC does not currently have the contractual levers to ensure that the full value of the pay uplifts delivered through NHS contracts is passed onto all General Dental Practitioners. As practices are private businesses, it falls to them to set their employee pay and conditions.

Any decisions on the expenses element of the uplift will be taken following the publication of the 52nd DDRB report, and after consultation with the sector.

General medical practitioners

Earlier chapters in this year's evidence include further detail on general medical practitioners, including workforce strategy, recruitment and retention, and earnings. This section looks specifically at the department's work to tackle the decline in the number of GP partners.

Tackling GP partnership decline

It is evident that the number of partners in general practice is decreasing. Table 63 below illustrates the general trend over time of falling GP partner numbers and rising numbers of salaried GPs as a proportion of the workforce.

Table 62: Doctors in general practice in England, FTE, by role, September 2018 to September 2023.

Practitioner type	September 2018	September 2019	September 2020	September 2021	September 2022	September 2023
All doctors in general practice	34,369	34,729	35,393	36,495	37,026	37,419
GP partners	19,293	18,462	17,641	17,059	16,750	16,342
Salaried GPs	8,115	8,496	9,133	9,752	9,865	10,065
GPs in training grade	5,880	6,547	7,454	8,576	9,470	10,116
GP retainers	121	186	228	254	252	272
GP regular locums	960	1,037	937	854	689	623

Source: General Practice Workforce, 30 September 2023, NHS England, October 2023, table 1a. Data includes estimates for practices that did not provide fully valid staff records.

NHSE's submission will contain further information on trends in numbers taking on contractor roles.

There are many factors that can deter GPs from taking on a partnership role such as higher workloads, or an increase in responsibility for managing income and expenditure.

The government commissioned a report on the 'Gender differences in uptake of partnership roles', which was published by the University of York in 2022. This qualitative study explores the factors that affect uptake of partnership roles, focussing particularly on gender differences. This study aimed to better understand the gendered barriers which

affect the career decisions in women GPs and, as a result, work to overcome these factors which deter partnership uptake.

The study found that a range of factors at individual, organisational and national levels influence the decisions of both men and women GPs around taking on a partnership role. The most commonly reported barriers were the desire for work-family balance (particularly relating to childcare responsibilities), workload pressures, greater level of responsibility associated with partnership roles, and financial investment risks. This study provides a useful insight into the factors affecting decisions to take up partnership roles, particularly for women. This puts us on a better footing in overcoming these barriers, using this as a foundation to better policy, and ultimately increase partnership uptake in general practice.

7. Total reward

Introduction to total reward

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

The total reward package in the NHS includes a generous holiday allowance, which goes up to 33 days annual leave per year on top of public holidays, sickness absence arrangements of up to 12 months of payment, access to a defined benefit pension scheme with an employer contribution rate of over 20%, enhanced parental leave, and support for learning, development, and career progression. These benefits are above the statutory minimum and exceed those offered in other sectors. Comparisons with the wider labour market should not just be limited to pay but include the full reward package.

The department has made a number of changes in the last year which are likely to have a positive impact on the reward package for doctors and dentists in the NHS. These include reforms to pension contributions, new retirement flexibilities, and measures to support clinicians impacted by pensions tax to continue to deliver their NHS work.

Over the last year, NHS England and NHS Employers have also furthered their guidance to employers to develop packages which support the recruitment, retention and motivation of staff.

Measuring the value of the package

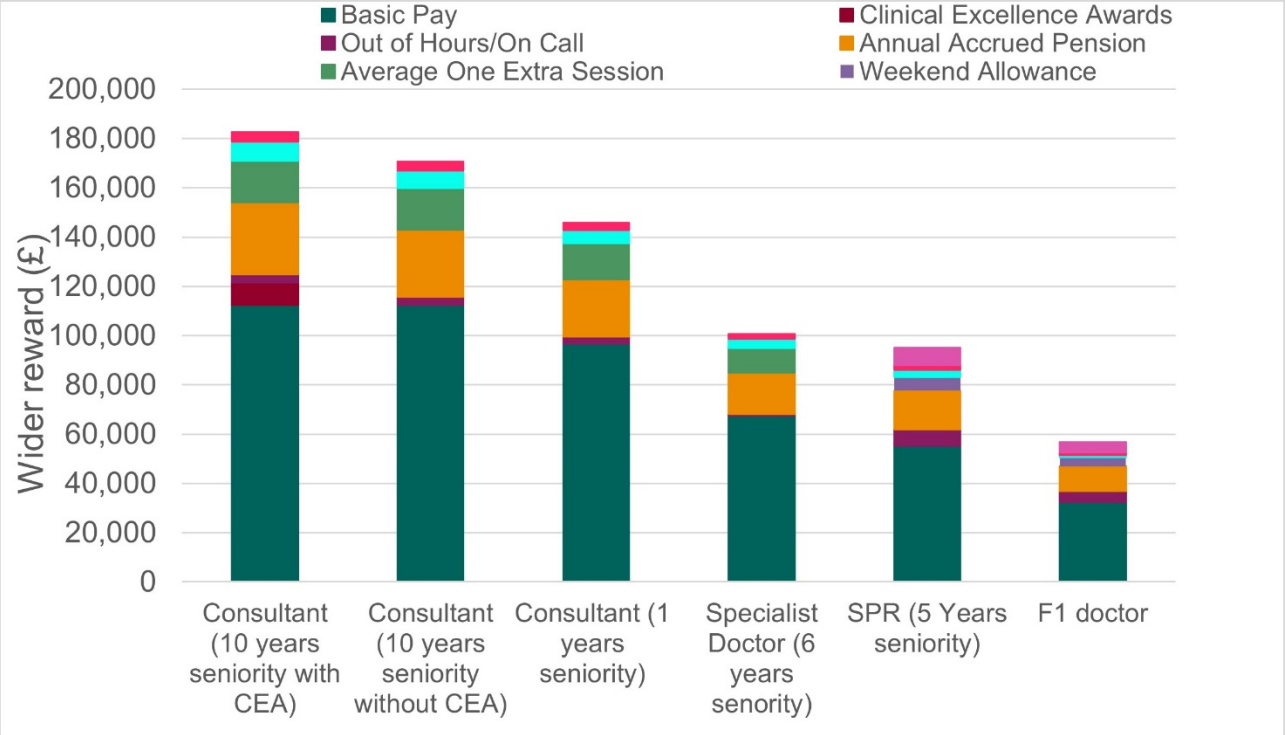
The department commissions the Government Actuary's Department (GAD) to measure the value of the total reward package for a range of medical roles, as shown in the chart below.

The elements included in the package are basic pay, annual accrued pension, additional annual leave value, Clinical Excellence Awards, average one extra session, additional sick leave, out of hours/on-call, weekend allowances and study leave value. Annual accrued pension is a measure of 2015 scheme pension, which is calculated as the pension accrued over the year multiplied by a factor of 20, less employee contributions.

It is important to note that the basic pay definition used for the analysis this year is mean annual basic pay per person, whereas in previous years this was per FTE. This change

was made for last year's analysis and has been retained for this year. This also applies for the trend analysis below.

Figure 20: Value of the total reward package for NHS doctors



The department also commissions GAD to provide analysis of the trend in wider reward for doctors over time. The chart below shows the split of total reward packages for NHS doctors between basic and other pay over the years 2021 to 2022, 2022 to 2023 and 2023 to 2024.

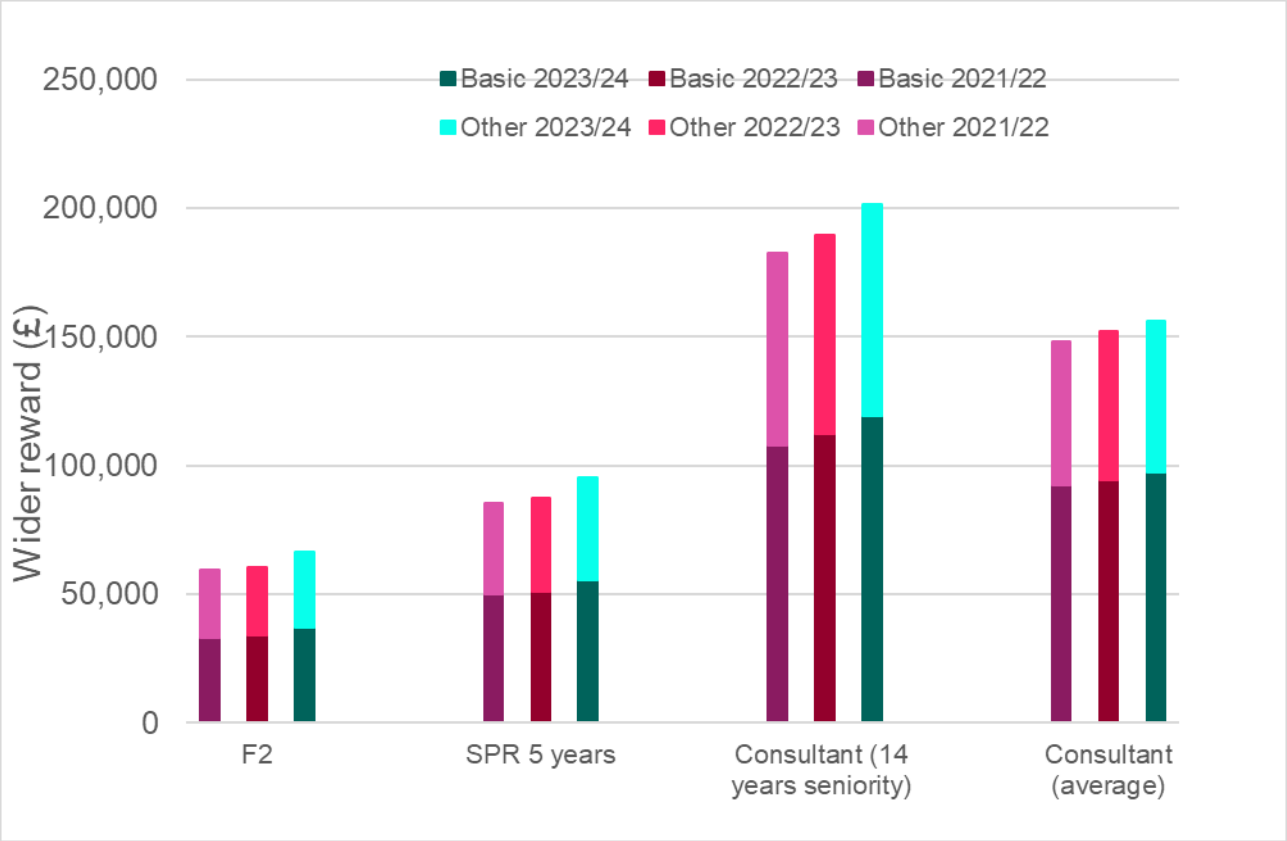
The analysis compares average reward at 30 September 2021, 30 June 2022 and 31 March 2023 with pay bands at 2021 to 2022, 2022 to 2023 and 2023 to 2024. This is appropriate and will only cause a negligible difference for the purpose of comparison. This is also consistent with the approach used in previous years and reflects the availability of the relevant data.

This shows that all the doctor roles considered as part of this analysis have experienced an increase in total wider reward in monetary terms over the period 2021 to 2022 to 2023 to 2024.

F2 doctors and SPR doctors experienced increases in total reward of around 11% between 2021 to 2022 and 2023 to 2024. In 2023 to 2024, the value of the reward package for consultants with 14 years' seniority increased by around 6% compared to the previous year, resulting in a total rise over the whole period of 10%. The value of the reward package for average consultants increased by around 3% in 2023 to 2024, resulting in a total increase of around 5% over the period 2021 to 2022 to 2023 to 2024.

For all of the roles considered, at least 38% of the total reward package is made up of non-basic pay.

Figure 21: Wider reward trend for NHS doctors over the period 2021/22 to 2023/24



In previous years' evidence to the DDRB, the department has commissioned GAD to provide analysis of reward across various NHS roles and private sector occupations. These calculations use the ONS datasets for salary and pension data. However, this year GAD has not been able to update this analysis for this year’s evidence as no new data has been released by the ONS since the information used last year.

Enhanced parental leave

As well as the total reward elements included in the analysis above, NHS staff with 12 months’ continuous service with one or more NHS employers are entitled to maternity, adoption and shared parental leave benefits above the statutory entitlement. GAD estimate that an average doctor in training in 2023 to 2024, calculated as having annual pay of £61,500, would be eligible to receive maternity pay of £25,000 in total. This includes £13,000 in excess of what they would be entitled to under the statutory maternity leave allowance.

This estimate is provided for illustrative purposes only and represents the additional value of NHS staff entitlement in excess of statutory maternity leave. Maternity pay depends on the individual's contractual entitlements and is calculated relative to the current statutory maternity pay entitlements. The figures have been rounded to the nearest £1,000.

Other benefits

Other than the national reward elements included in the above analysis, employers have the flexibility to enhance their local reward package, and many offer a range of benefits and discounts which have financial value to staff and may support recruitment and retention of staff and improve employee engagement.

Although the range of benefits offered varies across employers, some popular flexible benefits can include salary sacrifice schemes, options to buy and sell annual leave, and a range of discount vouchers. Some employers offer travel benefits such as season ticket loan and cycle to work scheme, as well as health and wellbeing benefits including discounted gym memberships. The blue light card is also available to all NHS staff at a cost of £4.99 for 2 years.

Many trusts have also partnered with third party providers offering staff up to 20% discount on shopping, insurance and travel. Staff may also be entitled to cashback on purchases at specified retailers of up to 12% using prepaid cards. Therefore, employees spending around £3,000 per year at a participating supermarket could offset spending by up to £360 (around 1% of basic pay on average). The overall value to staff can vary depending on the specific benefits options offered across employers and the level of benefits taken up, but GAD estimate these additional flexible benefits could be valued at up to 1% - 3% of basic pay on average across NHS employees.

Employers are stepping up this support to make benefits go further. NHS Employers has developed guidance to support employers when offering benefits to mitigate higher living costs and to highlight what is available. These benefits can include:

- housing and utilities - rental deposit schemes, home electronics salary sacrifice scheme, accommodation and rent subsidies;
- childcare - subsidised childcare, on-site nurseries, government tax free child support scheme;
- travel - free parking, transport season ticket loans, public transport subsidies, pay expenses weekly;
- food and leisure - free or subsidised meals on site, signposting to emergency service discount sites, access to free sanitary products;

- other financial support - saving schemes, will writing services, financial education workshops, budget planning guidance, early access to pay.

Flexible working and flexible retirement

'We work flexibly' is one of the elements on the People Promise, with a commitment to deliver this to staff by 2024 to 2025. This ambition is that all NHS staff should be offered the chance to work flexibly. Flexible working is a strong driver of retention and is an important factor in improving the mental health and wellbeing of staff. Programmes of work to improve the flexible working offer is evidenced through the improving score in this year's NHS Staff Survey results. The publication of both the NHS LTWP and the NHS Equality, Diversity and Inclusion Improvement plan earlier this year, will be important in the continued drive to improve access to flexible working.

NHS England have developed a range of flexible working interventions and resources nationally to support local organisation to adopt flexible working practices across their organisations. These include:

- A published flexible working definition and set of principles for all staff;
- Publication of 2 toolkits to support line managers in leading flexible workplaces for all and to help staff to prepare conversations in requesting it;
- Proactive work with several organisation to review their approaches to flexible working and to encourage implementation;
- Development of a simple cost calculator to help organisations identify potential costs savings by calculating turnover, recruitment and bank and agency expenditure;
- Support to organisations in the implementation of effective use of e-rostering systems, accelerating where possible;
- NHS England also encourages employers to implement the working carers passport to support timely, compassionate conversations about what support including flexible working arrangements would be helpful.

Supporting the NHS LTWP is the recently published NHS EDI Improvement Plan which sets out to improve the culture of the NHS workforce and to boost retention by addressing inflexible working practices that may deter people entering the workforce or leaving the workforce entirely.

The department envisages that those members who wish to take partial retirement (as described in the section on new retirement flexibilities below) will be able to agree with their employer a change to their working pattern, much like those who wish to work flexibly for other reasons. NHS Employers has produced guidance to help employers explore multiple ways in which this can be achieved for medical staff.

The NHS pension scheme

The NHS Pension Scheme remains a valuable part of the total reward package available to NHS staff and is one of the best pension schemes available.

Eligible NHS staff will now belong to one of the 2 existing schemes, both of which are defined benefit schemes. The final salary scheme, or legacy scheme, is made up of the 1995 and 2008 sections and is now closed to new members. All new staff join the 2015 scheme, a career average revalued earnings (CARE) scheme which provides benefits based on average earnings over a member's career. The key differences between the 2 schemes, other than the way benefits are calculated, are different normal pension ages and accrual rates, as shown in the table below.

Table 63: Comparison of retirement ages and accrual rates for members of the 1995 Section, 2008 Section and 2015 Scheme

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

The 2015 Scheme was introduced as part of wider reforms implemented by regulations made under the Public Service Pensions Act 2013. As part of these reforms, public service pension scheme members within 10 years of retirement were originally given transitional protection, and so remained in their legacy pension schemes. In December 2018, the Court of Appeal found this protection to be discriminatory against younger members. This has become known as the 'McCloud judgment'. The government accepted the judgment applies to other public service schemes, including the NHS Pension Scheme.

The public service pension schemes remedy (the 'remedy') for this discrimination has two parts, both of which have now been delivered. The first and prospective part closed the legacy public service pension schemes on 31 March 2022 and ensured equal treatment for all public service pension scheme members by moving all active members into the reformed public service pension schemes on 1 April 2022. The second and retrospective part of the remedy removed the effect of the transitional protections from 1 October 2023.

One key benefit of the 2015 Scheme is that for active members, the pension they earn is increased every April by the Consumer Price Index (CPI) in the year before, plus an additional 1.5%. This is known as ‘in-service revaluation’. This means that pension benefits more than keep up with rises in the cost of living. In April 2023, this rise was 11.6%.

The department keeps the rules of the pension scheme under review to ensure it continues to help the NHS attract and retain the staff needed to deliver high quality care for patients. In the past year it has made a number of changes in this area, including new retirement flexibilities for late career staff, and changes in relation to pension taxation.

Data from the NHSBSA shows that the median annual pension - taken as the pension at the 50th percentile - claimed by GPs (including assistants, locums, and principles) in the financial year 2022 to 2023 was £42,886.69. For medical doctors (non-specialists and specialists), this figure was £38,381.73. These figures include pensions taken on an age or Voluntary Early Retirement (VER) basis only.

It is important to note that the employment categories used by the NHSBSA in order to produce this data are historic and are selected by employers. We broadly understand that the GP categories correspond to salaried GPs, locum GPs and GP partners, and the medical doctor categories to those who are not consultants and those who are, but it remains possible that the category listed for each individual doctor may not always be accurate.

Due to the age profile of these members, it is likely that most of these doctors will have held the majority of their pension benefits in the 1995 Section, which features an automatic lump sum, with the option to commute more pension for additional lump sum. We understand that prior to the changes to pension tax announced at Budget in March 2023 (as discussed below) many doctors chose to commute more of their pension as a lump sum for tax reasons. For example, the median lump sum paid out to GPs in that year was £176,014.74 and to medical doctors £160,899.74. The automatic lump sum is not a feature of the 2015 scheme.

NHS pension projections

GAD calculates that scheme members can generally expect to receive around £3 to £6 in pension benefits for every £1 contributed.

Looking ahead, GAD have produced a series of pension projections, which are based on example members with existing service in the NHS Pension Scheme built up prior to 2023. These example members are assumed to have continuous membership in the scheme

from the point of joining, and to qualify in their respective fields in 2023. They assume that the example members remain in service and work full-time before retiring at age 65.

The GP partner and salaried GP examples are assumed to have joined the 2015 Scheme in 2018 aged 25 and to have qualified as GPs in 2023. The consultant example is assumed to have joined the 2008 Section in 2012 aged 25 before moving to the 2015 Scheme and qualifying as a consultant in 2023.

These projections are higher than those provided in previous years' evidence to the DDRB due to several factors:

- The updated pay profiles report higher pensionable pay than the pay profiles used in previous years' projections. For example, at age 55, the pay for partnered GPs is estimated to be around £158,000 whereas previously the GP pay was estimated to be £145,000. These estimates were calculated using GP earnings data published by NHS Digital. Higher pay is also seen across other employment groups.

- GAD has amended the approach used to be consistent with the consultants' pension projections it carried out for DHSC in August 2023. These projections therefore consider members who are newly qualified in 2023 and have past service during a period of pay restraint. They also allow for the pension tax changes introduced in the March 2023 Budget.

The figures are therefore not directly comparable with those produced for last year's evidence. We understand that they represent an upper estimate, as not all doctors will work full-time for their full career without any breaks. Some doctors may also take more time to complete GP or consultant level training.

The table below shows the total annual pension these example members could expect to receive, in today's monetary terms.

Table 64: Projected annual pensions for NHS doctors qualifying in their respective fields in 2023 and retiring age 65 (in today's monetary terms)

At retirement age	Year of joining the Scheme	Projected pension (pa)
GP partner	2018	£71,000
Salaried GP	2018	£56,000
Consultant	2012	£78,000

However, we expect that many NHS doctors will choose to commute some of their pension for a tax-free lump sum. The table below therefore shows the pension benefits the example members above could expect to receive, assuming that they commute 20% of their pension for a tax-free pension commencement lump sum (PCLS) at retirement, on current commutation terms (£12 lump sum per £1 of pension commuted), in today's monetary terms. These projected lump sums are within the maximum amount of £268,275 announced at the Spring 2023 Budget.

Table 65: Projected annual pensions and lump sums for NHS doctors qualifying in their respective fields in 2023 and retiring age 65 (in today's monetary terms)

At retirement age	Year of joining the Scheme	Projected residual pension (pa)	Projected PCLS
GP partner	2018	£56,000	£169,000
Salaried GP	2018	£44,000	£133,000
Consultant	2012	£62,000	£188,000

NHS pension scheme membership

The department continues to monitor scheme membership rates for HCHS doctors through ESR.

The table below shows the percentage of doctors, by grade, who were members of the scheme in June 2023, and in comparison to June 2022, June 2018 and June 2013.

This shows that whilst overall membership rates remain high, there have been reductions in the membership rates for doctors at some grades, most notably core training. We understand that this is mainly due to lower membership rates amongst doctors working in 'trust grades' which may be included in this category, where we have seen a substantial increase in the number of doctors employed in these roles. Of these doctors, many hold non-British nationality and we have previously seen that non-British staff typically have lower membership rates in the NHS pension scheme than those with British nationality. Further analysis of membership rates in June 2023 by nationality for doctors in training is included in the subsequent table.

Table 66: NHS Pension Scheme membership for HCHS doctors

Row Labels	June 2023	One Year Change	Five Year Change	Ten Year Change
Associate Specialist	90%	0%	-3%	-3%

Row Labels	June 2023	One Year Change	Five Year Change	Ten Year Change
Consultant	91%	0%	-1%	-5%
Core Training	80%	-6%	-11%	-14%
Foundation Doctor Year 1	91%	-2%	-4%	-5%
Foundation Doctor Year 2	88%	-4%	-5%	-8%
Hospital Practitioner / Clinical Assistant	70%	1%	-2%	-10%
Other and Local HCHS Doctor Grades	84%	4%	2%	-7%
Specialty Doctor	84%	-2%	-4%	-5%
Specialty Registrar	88%	-4%	-5%	-7%
Staff Grade	89%	-1%	-4%	-3%
Grand Total	88%	-2%	-4%	-7%

Table 67: NHS Pension Scheme membership for doctors in training in June 2023 by nationality

Nationality	Membership rate
European Union	88%
Rest of World Total	69%
United Kingdom Total	96%
Total	85%

NHS pensions claimed

We also monitor the number of pensions claimed each year, using data provided by the NHS Business Services Authority, the scheme administrator.

The tables below show the total numbers of GDPs, GPs, hospital dentists and hospital doctors claiming 1995 Scheme pension benefits, as well as the numbers of staff in these groups those claiming their pension benefits earlier than their normal pension age (NPA). This is known as taking voluntary early retirement (VER).

Table 68: NHS Pension awards for GDPs (1995 Section only)

Pension scheme year ending	All pension awards	VER pension awards	% VER of all pension awards
2008	490	193	39.4
2009	391	116	29.7
2010	468	177	37.8
2011	452	124	27.4
2012	454	151	33.3
2013	439	148	33.7
2014	412	138	33.5
2015	486	153	31.5
2016	380	121	31.8
2017	514	150	29.2
2018	459	108	23.5
2019	572	167	29.2
2020	562	156	27.8
2021	542	176	32.5
2022	497	116	23.3
2023	567	140	24.7

Table 69: NHS Pension awards for GPs (1995 Section only)

Pension scheme year ending	All pension awards	VER pension awards	% VER of all pension awards
2008	1137	245	21.5
2009	1324	280	21.1
2010	1513	347	22.9
2011	1346	407	30.2
2012	1343	503	37.5
2013	1186	494	41.7

Pension scheme year ending	All pension awards	VER pension awards	% VER of all pension awards
2014	1513	775	51.2
2015	1240	595	48.0
2016	912	457	50.1
2017	1349	710	52.6
2018	1155	518	44.8
2019	1228	567	46.2
2020	1212	509	42.0
2021	1156	469	40.6
2022	884	335	37.9
2023	1289	492	38.2

Table 70: NHS Pension awards for hospital dentists (1995 Section only)

Pension scheme year ending	All pension awards	VER pension awards	% VER of all pension awards
2008	53	9	17.0
2009	39	10	25.6
2010	67	12	17.9
2011	51	20	39.2
2012	63	16	25.4
2013	71	24	33.8
2014	48	12	25.0
2015	66	19	28.8
2016	62	25	40.3
2017	50	16	32.0
2018	74	28	37.8
2019	69	19	27.5
2020	70	15	21.4

Pension scheme year ending	All pension awards	VER pension awards	% VER of all pension awards
2021	64	13	20.3
2022	46	15	32.6
2023	61	10	16.4

Table 71: NHS Pension awards for hospital doctors (1995 Section only)

Pension scheme year ending	All pension awards	VER pension awards	% VER of all pension awards
2008	1313	137	10.4
2009	1404	147	10.5
2010	1611	186	11.5
2011	1838	248	13.5
2012	1769	270	15.3
2013	1475	315	21.4
2014	1760	334	19.0
2015	1678	356	21.2
2016	1789	374	20.9
2017	1871	390	20.8
2018	1816	334	18.4
2019	2060	343	16.7
2020	2198	409	18.6
2021	2199	388	17.6
2022	2271	354	15.6
2023	2588	459	17.7

NHS pension scheme contributions

Members and employers are required to pay towards the cost of benefits built up in the NHS pension scheme. At present employers contribute 20.6% of each member’s

pensionable earnings, plus a charge of 0.08% to fund the administration of the scheme. This is far more generous than most pension schemes offered in the private sector.

The current employer rate came into force on 1 April 2019 following the 2016 valuation, which required the employer contribution rate to increase from 14.3% to 20.6%.

Results from the 2020 valuation show an increase in benefit costs, requiring a 3.1 percentage point rise in the employer contribution rate to 23.7%. This figure has been confirmed by the Government Actuary's Department in their final 2020 valuation report. The updated employer contribution rate will apply from 1 April 2024. Further detail on this is set out in DHSC's response to the recent consultation on changes to the NHS Pension Scheme from 1 April 2024. This consultation ran from 26 October 2023 to 7 January 2024.

As part of this consultation, the department also outlined plans to deliver phase 2 of the ongoing review of member contributions in the NHS pension scheme. Member contributions are tiered according to pensionable earnings, with higher earners paying more than lower earners. However, the scheme has moved from final salary linked to a career average revalued earnings (CARE) model, and all members have been accruing CARE benefits from 1 April 2022. It is therefore an appropriate time to reform the member contribution structure.

Under the structure set out in the consultation, the number of tiers and range between the lowest and higher tier will be reduced. This means that the gap between some tier boundaries will be reduced. As part of the previous consultation process, it was decided that the move to the final 6-tier contribution structure would be staggered over 2 phases in order to give members time to adjust. The first phase implemented an 11-tier interim structure on 1 October 2022.

The consultation response confirmed that the following member contribution structure will apply from 1 April 2024. The reduction of the top rate to 12.5% taken alongside the pension tax changes, means that higher paid staff will receive significantly increased value form their pension contributions.

Table 72: NHS Pension Scheme member contribution threshold structure from 1 April 2024

Pensionable earnings thresholds	Contribution rate from 1 April 2024
Up to £13,259	5.2%
£13,260 to £26,831	6.5%

Pensionable earnings thresholds	Contribution rate from 1 April 2024
£26,832 to £32,691	8.3%
£32,692 to £49,078	9.8%
£49,079 to £62,924	10.7%
£62,925 and above	12.5%

New retirement flexibilities

As signalled in our plan for patients, over the past year, the department has introduced a package of new retirement flexibilities for doctors and dentists who are members of the 1995 section of the NHS pension scheme.

On 1 April 2023, the department abolished the rule that pension scheme members could only work up to 16 hours a week in the first month after returning from retirement without affecting their pension. Also on 1 April 2023, it removed the rule that prevented retired staff who return to NHS work from re-joining the scheme and building up more pension.

The department also made a new ‘partial retirement’ option available to staff on 1 October 2023 as an alternative to full retirement. This means that doctors and dentists are now able to draw down some or all of their pension whilst continuing to work and build up further pension, subject to a 10% reduction in their pensionable pay. An example is a consultant at the top of the pay scale who takes their 1995 section pension at 60, reduces their hours to 9 PAs and works until they are age 65. They would build up additional pension of nearly £11,000 per annum at today's values if taken at their state pension age. Previously, if they had taken their 1995 section pension at 60, they would have been unable to remain in the 2015 scheme. Under this example the consultant will also not be subject to either annual allowance (AA) or lifetime allowance (LTA) charges.

These new flexibilities will make retirement more flexible and help to support doctors with their work/life balance later in their careers.

At the same time, on 1 October, we amended the partial retirement rules for the 2008 section and the 2015 scheme so that members of these schemes can take up to 100% of their benefits and continue working if they wish. This will mean that the rules will be aligned across the 1995 section, 2008 section and the 2015 scheme.

Pension tax

As discussed in previous evidence submissions, the generosity of the NHS pension scheme and well-remunerated careers means that some senior doctors and dentists previously exceeded the annual allowance (AA) and lifetime allowance (LTA) for tax-free saving. The department is aware that experience of pension tax is important to the retention of doctors and dentists.

At the Spring Budget, the Chancellor announced that from 6 April 2023, the AA for tax-free pension saving would increase by 50% to £60,000 and the LTA would be first suspended and then removed. The minimum tapered annual allowance would also increase from £4,000 to £10,000 and the adjusted income threshold for the tapered annual allowance would increase from £240,000 to £260,000.

Estimates previously commissioned by the department based on projected pension scheme data indicated that around 22,000 senior NHS clinicians could have exceeded the previous £40,000 AA in 2023 to 2024, and that around 31,000 clinicians had reached at least 75% of the £1.073m LTA. The department's view therefore is that the pension tax changes announced at Budget will help to ensure that many experienced clinicians are not pushed out of the workforce for tax reasons.

For the minority of clinicians who will still receive AA charges, the ‘scheme pays’ facility allows them to meet the cost of a tax bill from the value of their pension benefits, without needing to find funds upfront. Where a member uses scheme pays, the member’s tax charge is paid through a deduction to their pension benefits at retirement.

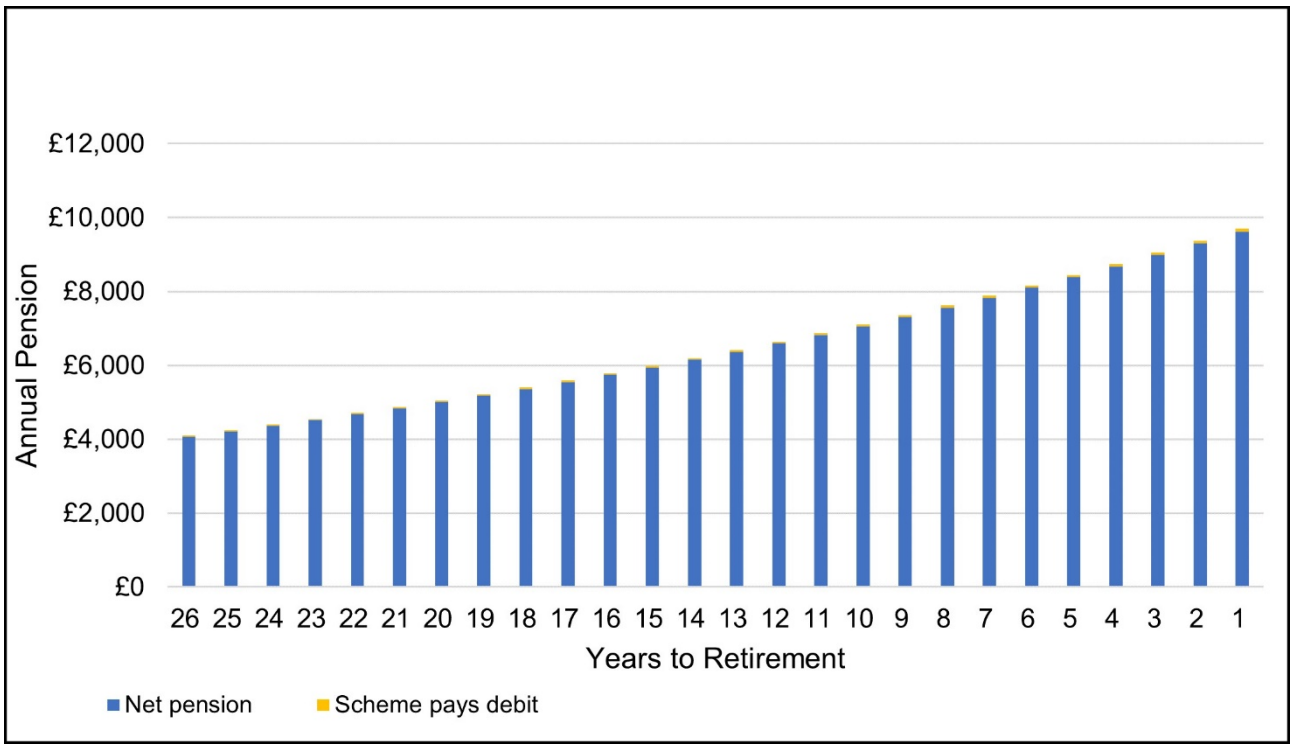
Analysis from GAD demonstrates that for most members scheme pays is a proportionate means of dealing with an AA charge, with the deduction to the member’s pension proportionate to the tax charge incurred. The analysis below shows that it may be a sound financial decision for clinicians to incur an AA charge and use scheme pays to deal with it, as in this case it will have a relatively small impact on the pension accrued. Although scheme pays will reduce the value of the pension accrued, the growth in benefits represents a good return on the contributions made.

The chart below considers a 43-year-old 2015 scheme member with pensionable pay of £195,000 and 4 years of service in the 2015 scheme. Over 2024 to 2025, the member could be expected to accrue pension of £9,700 pa at retirement age 68. This would be reduced by 1% to £9,600 pa once the scheme pays debit is applied. The graph below illustrates the progression up to retirement of pension benefits accrued and the AA charges incurred over a single year in the post-April 2023 AA regime.

This analysis uses 2020 valuation assumptions. Due to the increase in the AA at the March 2023 Budget, it was necessary to use an example with a higher pensionable pay

figure than in last year's analysis in order to produce an example member with an AA charge.

Figure 22: example growth in pension earned over year 2024 to 2025 for a member with 2015 Scheme benefits and pensionable pay of £195,000



To reduce the risk that senior doctors and dentists could face an AA tax charge as a consequence of the current high rate of CPI, the department also amended the revaluation date for career average pension benefits in the NHS Pension Scheme for scheme year 2022 to 2023 and future scheme years.

This moved the revaluation of career average accrued pension and earnings in a scheme year by 5 days, from 1 April, at the end of a tax year, to 6 April, at the start of the following tax year. The effect will be that the same rate of CPI will then be used for the revaluation and the calculation of pension benefit growth for AA purposes. This ensures that the annual allowance operates as intended in relation to NHS pensions and the high inflation environment does not create higher tax charges.

In addition, as announced at Spring Budget 2023, from this year open and legacy public service pension schemes for the same workforce will be considered linked for the purposes of calculating AA charges. This will allow members to offset any negative real growth in legacy scheme pension benefits against their AA, meaning that high earners will

have increased headroom against their AA in future. This is likely to be particularly beneficial for doctors and dentists who now have increased years of service in the 1995 Section as a result of the McCloud remedy.

Communicating the package

So that doctors and dentists can unlock the full value of their reward package, ensuring that they receive clear and accurate communications is important.

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

NHS pension scheme members also receive an annual benefit statement (ABS), which shows the current value of their scheme benefits. On 13 October 2023, the number of statements available was 2,734,642, with 337,043 views. In comparison, on 23 September 2022 the number of statements available was 2,812,443 and the number of views was 297,035.

The department commissions NHS Employers to provide advice, guidance, and good practice to the NHS on developing a strategic approach to reward, and communications with staff are coordinated by NHS England. NHS England and NHS Employers will provide further information on how individual employing organisations approach reward for their staff in their written evidence submissions.

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