Review Body on Doctors' and Dentists' Remuneration

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Fifty-Second Report 2024

Chair: Christopher Pilgrim

CP 1118

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Presented to Parliament by the Prime Minister
and the Secretary of State for Health and Social Care

Presented to the Scottish Parliament by the First Minister
and the Cabinet Secretary for Health and Social Care

Presented to the Senedd by the First Minister
and the Cabinet Secretary for Health and Social Care

Presented to the Northern Ireland Assembly by the First Minister,
Deputy First Minister and Minister of Health

By Command of His Majesty

July 2024

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Review Body on Doctors' and Dentists' Remuneration

The Review Body on Doctors' and Dentists' Remuneration was appointed in July 1971. Its terms of reference were introduced in 1998, and amended in 2003 and 2007, and are reproduced below.

The Review Body on Doctors' and Dentists' Remuneration is independent. Its role is to make recommendations to the Prime Minister, the Secretary of State for Health and Social Care, the First Minister and the Cabinet Secretary for Health and Social Care of the Scottish Government, the First Minister and the Cabinet Secretary for Health and Social Care of the Welsh Government, and the First Minister, Deputy First Minister and Minister of Health of the Northern Ireland Executive, on the remuneration of doctors and dentists taking any part in the National Health Service.

In reaching its recommendations, the Review Body is to have regard to the following considerations:

- The need to recruit, retain and motivate doctors and dentists.
- Regional/local variations in labour markets and their effects on the recruitment and retention of doctors and dentists.
- The funds available to the Health Departments as set out in the Government's Departmental Expenditure Limits.
- The Government's inflation target.
- The overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

The Review Body may also be asked to consider other specific issues.

The Review Body is also required to take careful account of the economic and other evidence submitted by the Government, staff and professional representatives and others.

The Review Body should also take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief and disability.

Reports and recommendations should be submitted jointly to the Prime Minister, the Secretary of State for Health and Social Care, the First Minister and the Cabinet Secretary for Health and Social Care of the Scottish Government, the First Minister and the Cabinet Secretary for Health and Social Care of the Welsh Government, and the First Minister, Deputy First Minister and Minister of Health of the Northern Ireland Executive.

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The Secretariat is provided by the Office of Manpower Economics.

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Executive summary

1. The Review Body on Doctors' and Dentists' Remuneration provides advice to ministers in the governments of the UK on the remuneration of all doctors and dentists employed by, or providing services to, the NHS in England, Scotland and Wales and the HSC in Northern Ireland. In this report, we make our recommendations for the 2024 pay round, covering the 2024-25 financial year.

2. The NHS is under significant pressure. Over 9 million people are waiting for treatment in the UK and activity has only just returned to pre-pandemic levels across secondary care, despite substantial growth in workforce numbers. To address these pressures, meet the needs of a growing population with more complex conditions, and improve patient care, the NHS needs to both expand and to become more efficient.

3. The Long Term Workforce Plan for England sets out the substantial growth in NHS staffing that will be needed over the next 15 years to meet this increasing demand, including a significant increase in medical and dental school places. It also looks to make the NHS workforce less dependent on international recruitment. Meeting the ambitions of the Plan will require medical and dental careers to maintain their attraction to future recruits, and the pay and reward package to enable the retention of experienced professionals in challenging and demanding roles.

4. The GP workforce is not showing the growth it needs to meet demand, although the numbers in training are increasing. Additional part-time working, especially among salaried GPs, increases the number of headcount GPs needed. Attracting dentists to NHS work is increasingly difficult, resulting in significant under-provision of NHS dentistry. Retention and recruitment across secondary care is in a stronger position this year.

5. Morale among the medical and dental workforces is poor, however, and has declined since the pandemic. There is widespread dissatisfaction among doctors and dentists with their working lives in general as well as increasing discontent with their level of pay. This is especially acute among doctors and dentists in training. Many of the issues impacting motivation and morale are not directly solvable with higher pay awards. We therefore continue to stress the need for these issues to be addressed outside the pay setting process through workforce planning and other actions to improve working conditions.

6. Industrial action has further damaged morale across the NHS workforce, weakened working relationships and increased workload, added to waiting list pressures, and been financially damaging. Most worryingly, it has had an impact on the volume and timeliness of care that the NHS has been able to provide to patients. The necessary redirection of management capacity and operational priorities to deal with industrial action has also slowed the pace of NHS reform.

7. We make our recommendations at a time of weak economic growth and falling inflation. However, this follows the economic instability and very high inflation of recent years. Average earnings growth remains at around 6 per cent, with pay settlements across the economy around 5 per cent.

8. We have been told by the UK Government that pay increases above 2 per cent will require reprioritisation from other areas of the NHS. In the other nations, health budgets are highly constrained. Despite this, governments have recognised the need to balance the enormous demand pressures on NHS budgets with the need to reward staff appropriately.

9. Balancing these factors, **we recommend a 6 per cent increase to the salary scales, pay ranges and the pay element of contracts from 1 April 2024**. This applies to: consultants; specialty, associate specialist and specialist (SAS) doctors and dentists; salaried dentists, including those working in Community Dental Services and the Public Dental Service; contractor general medical practitioners; salaried general medical practitioner pay ranges; and the pay element of dental contracts. This applies to all the nations of the UK.

10. We consider each part of our remit group separately. In doing this, we see that the issues outlined above are especially acute for doctors and dentists in training. Morale is very low, and this group has taken industrial action in England, Wales and Northern Ireland. Doctors and dentists in training face the costs of exams and the costs and disruption of regular relocation for training purposes and have little control over their working environment. We also see that this group has experienced a greater fall in relative pay compared to comparators across the economy over the medium term, and that this has been more pronounced for those in their earliest years of training. It is especially important to retain this group in the NHS workforce to become future specialists, consultants and GPs, and the NHS leaders of the future .We recognised many of these issues last year, when we made a higher pay award of 8.1 to 10.7 per cent for doctors and dentists in training, although note that actual earnings growth for this group over the last year has been held back, most likely by industrial action.

11. These factors again justify a higher pay uplift for doctors and dentists in training. Some of them, such as the costs of frequent job moves and exams, fall equally or more heavily on the most junior doctors. Therefore, we again recommend a flat-rate consolidated increase to pay in addition to the percentage uplift for all doctors and dentists. **We recommend a 6 per cent increase plus a consolidated uplift of £1,000 to the pay points for doctors and dentists in training from 1 April 2024.** This recommendation applies to England, Wales and Northern Ireland as we have not been asked to make a recommendation for Scotland for this group. This increase is worth 7.6 to 9.5 per cent on basic pay.

12. We expect contract uplifts to be sufficient for the full value of our recommendations to be reflected in earnings for contractor GPs at typical general practices, and for earnings for NHS/HSC work done by providing performer and associate dentists at typical dental practices. We are not confident this has been the case over the last two years. It is not clear that the current arrangements take sufficient account of recent high inflation. We urge governments to look for a better way of addressing this issue, possibly as part of wider contract reform.

13. Decisions about how to fund pay awards, whether from existing budgets or through increases to departmental budgets, remain a political choice that sits with the governments. It is important, however, that funding for pay awards does not continue to be reallocated from elsewhere in the health service as that could be detrimental to patient care and counter to longer-term objectives to reform and improve health services.

Chapter 1 Introduction and recommendations

The Review Body on Doctors' and Dentists' Remuneration

1.1 The Review Body on Doctors' and Dentists' Remuneration (DDRB) provides advice to ministers in the governments of the UK on the remuneration of all doctors and dentists employed by, or providing services to, the National Health Service (NHS) in England, Scotland and Wales and Health and Social Care (HSC) in Northern Ireland. In this report, we make our recommendations and observations for the 2024 pay round, covering the 2024-25 financial year.

1.2 We are governed by our terms of reference which are reproduced at the start of this report. We discuss our future terms of reference in chapter 6. Our annual pay review process begins with a programme of visits, where we meet members of our remit groups and local health service leaders in a variety of locations and healthcare settings across the UK. We take written and oral evidence from a range of organisations, including governments and trades unions, before making our recommendations. Following receipt of our recommendations, it is up to the governments to decide how to respond, and it is them, and the leaders of the health services they oversee, who ultimately implement annual pay uplifts for doctors and dentists.

Our remits for this year

1.3 Our remit letters from each of the four governments are in appendix A. We received our remit letter from the Secretary of State for Health and Social Care on 21 December 2023. It asked us to make recommendations on an annual pay award for all doctors and dentists in England. The letter noted that SAS doctors[1] on the 2021 contract were no longer in a multi-year pay deal and that independent contractor general medical practitioners were no longer subject to a five-year pay agreement.

1.4 The letter also pointed out that the government had been involved in talks with various medical groups. It said that the recent offer to consultants should not interfere with our recommendations for 2024-25 and that ongoing talks should also not impact on our recommendations.

1.5 In the absence of a Minister of Health, the Permanent Secretary and HSC Chief Executive wrote to us on 10 January 2024 asking for pay recommendations for doctors and dentists working in Health and Social Care in Northern Ireland.

1.6 The Minister for Health and Social Services wrote to us on 30 January 2024 asking for our advice and recommendations for medical and dental staff in Wales.

1.7 The Cabinet Secretary for NHS Recovery, Health and Social Care wrote to us on 5 March 2024 asking for our recommendations for all medical and dental staff in NHS Scotland for 2024-25, with the exception of junior doctors. The letter noted that a separate pay deal had been agreed with junior doctors [in 2023] which included a commitment to develop a pay bargaining system for junior doctors in Scotland, as well as a commitment to enter discussions to reform the junior doctors' contract. The letter also noted that the BMA Scottish Consultants Committee and Scottish Specialty and Specialist Committee would not participate in the DDRB process this year and wished to see the DDRB reformed. The Cabinet Secretary confirmed that he was seeking a recommendation for these groups and said the DDRB

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[1] Specialty, associate specialist and specialist doctors.

recommendations would be considered as part of any decision he made on pay uplifts for NHS Scotland.

Evidence

1.8 We received written and oral evidence from the following organisations which are parties to our process ('the parties'):
- The Department of Health and Social Care.
- The Scottish Government.
- The Welsh Government.
- The Department of Health (Northern Ireland).
- NHS England.
- NHS Employers.
- NHS Providers.
- The British Dental Association.
- The British Medical Association.
- The Hospital Consultants and Specialists Association.

1.9 Individual committees of the British Medical Association (BMA) submitted evidence. This included the General Practitioners Committees from all four nations and the sessional General Practitioners Committee, SAS Committees in England and Northern Ireland, and the Consultants Committee in England. The chairs of the BMA Scottish Consultants Committee and the BMA Scottish SAS Committee wrote to us in February to confirm that they would not be submitting evidence as part of the DDRB process and were instead seeking direct negotiations with the Scottish Government.

1.10 We also received written evidence from HM Treasury and the Association of Dental Groups.

1.11 We undertook eight visits in autumn 2023 across the four nations of the UK:
- Lancashire and South Cumbria Local Dental Committee.
- Avon Local Medical Committee.
- NHS England South West (postgraduate medical and dental education).
- University Hospitals North Midlands.
- Southern Health & Social Care Trust.
- Kingston Hospital.
- Hywel Dda University Health Board.
- NHS Forth Valley.

1.12 Across these visits, we held 15 discussion groups with consultants, SAS doctors and dentists, and doctors and dentists in training. We also held nine discussion groups with general medical practitioners (GPs) and general dental practitioners (GDPs) Our visits to the health boards in Wales and Scotland included discussion groups with contractor and salaried GPs and GDPs, as well as members of the Community Dental Service (CDS) in Wales and the Public Dental Service (PDS) in Scotland.

1.13 We also considered economic and workforce data prepared by our secretariat, policy developments from the governments, and broader research on the medical and dental workforces.

Our recommendations last year

1.14 Last year we recommended a 6 per cent increase to national salary scales, pay ranges and the pay element of contracts from 1 April 2023. This covered: consultants; SAS doctors and

dentists on old contracts in all four nations and those on reformed contracts in Scotland; salaried dentists working in the CDS and the PDS; contractor GPs in Scotland, Wales and Northern Ireland; salaried GP pay ranges; and the pay element of dental contracts. We commented that we expected that expenses uplifts for GPs and dentists to be sufficient for the full value of our recommendations to be reflected in earnings for contractor and salaried GPs at typical general practices and for earnings for NHS/HSC work done by providing performer and associate dentists at typical dental practices.

1.15 We also recommended that pay points for doctors and dentists in training be uplifted by 6 per cent plus £1,250. This increase was worth between 8.1 per cent and 10.7 per cent per cent on basic pay in England and Northern Ireland.[2]

1.16 Our third recommendation was that the new specialty doctor and specialist pay scales in England, Wales and Northern Ireland be increased by 3 per cent. This was in addition to the uplifts included in the multi-year deal.

Responses to our recommendations

1.17 The UK Government accepted our recommendations for England in full.[3] It said that the pay awards were above affordability but that it would fund them through prioritisation within existing departmental budgets and would protect frontline services. It planned to increase the main rate of the Immigration Health Surcharge to fund the award. The Department of Health and Social Care (DHSC) said the DDRB recommendations cost £1 billion above provision for 2023-24.

1.18 The Scottish Government accepted our pay recommendations for consultants, SAS doctors, GDPs and GPs.[4] However, it continued to negotiate separately with junior doctors and dentists, agreeing a 12.4 per cent increase for 2023.[5] There was also a commitment to a guaranteed minimum uplift of inflation for junior doctors for 2024-25, 2025-26 and 2026-27 and agreement to enter full contract negotiations from autumn 2023 with implementation by April 2026, with outcomes to include contract reform and a new pay review mechanism.

1.19 In August 2023, the Welsh Government Minister for Health and Social Services announced that medical and dental staff in Wales would receive a 5 per cent pay uplift for 2023-24, in line with the award made to those on Agenda for Change.[6] The Minister said that, without additional funding from UK Government, they were not in a position to offer any more. SAS doctors on the 2021 contracts received an uplift of 1.5 per cent in addition to the existing multi-year deal. This maintained parity with pay levels in England for this group, following an additional 1.5 per cent uplift (and 1.5 per cent non-consolidated payment) to salaried doctors and dentists in Wales in February 2023.

[2] Our 2023-24 recommendation for doctors and dentists in training was not accepted in Scotland or Wales.
[3] UK Parliament, *NHS Update Statement made on 13 July 2023.* https://questions-statements.parliament.uk/written-statements/detail/2023-07-13/hcws946
[4] Scottish Government, *Record pay award for NHS workers.* https://www.gov.scot/news/record-pay-award-for-nhs-workers
[5] Scottish Government, *Pay offer to Junior Doctors accepted.* https://www.gov.scot/news/pay-offer-to-junior-doctors-accepted
[6] Welsh Government, *Written Statement: NHS Pay award for Medical and Dental staff 2023/2024.* https://www.gov.wales/written-statement-nhs-pay-award-for-medical-and-dental-staff-2023-2024

1.20 Due to the lack of an executive, the Northern Ireland Government did not respond until February 2024, when the Minister for Health accepted our recommendations.[7] The pay increases had not yet been received at the time of writing our report.

1.21 NHS England said it funded systems in full to implement the pay award in 2023-24. Funding came from a review of investments in transformation programmes, including for recurrent financial pressures from the 2022-23 pay award. Additional funding was agreed with the DHSC specifically to cover the 2023-24 DDRB recommendations including a request for NHS England to contribute £100 million recurrently from its 2024-25 budget.

1.22 NHS Providers welcomed the 2023 pay award announcement, but noted the pay deal was below inflation, equating to a real-terms pay cut.

1.23 The British Dental Association (BDA) described the 2023 uplift as another real-terms pay cut and another blow to the long-term survival of the service. It said it was outrageous that two governments [Wales and Northern Ireland] had not accepted the DDRB's recommendations. It also highlighted that services costs for dental foundation training were not uplifted.

1.24 The BMA's General Practitioners Committee in Scotland said that GPs in Scotland were disappointed that in the face of severe workload and recruitment and retention challenges, the DDRB recommended a real-terms pay cut in its headline pay award recommendation. The General Practitioners Committee for England said the 6 per cent uplift to the other staffing expenses element of the contract funding went nowhere near far enough to address longstanding and recurrent below-inflation pay awards. The sessional GPs committee said 6 per cent did not go far enough to address the chronic below inflation pay awards recommended by the DDRB.

Timing of the pay round

1.25 NHS Providers said that the delayed announcement of pay awards was damaging to staff morale and their personal financial planning, as well as to trust financial planning. They said it was essential that the review process timeline was realigned to ensure NHS staff and trusts went into each financial year with clarity on what the pay award would be. NHS Employers also continued to be extremely concerned by the lack of progress in bringing our timetable back to normal, which would enable a return to prompt payment of the pay award at the beginning of the financial year. They said that delays were disrespectful to the NHS workforce and created an additional administration burden for employers.

1.26 The BDA said that the process for applying uplifts to dentists' contracts and salaries had been unacceptably and unnecessarily delayed. It said that implementation was then further delayed for GDPs by the need to determine the practice operating costs element. The GDP uplift was implemented from October 2023 in England, November 2023 in Scotland, January 2024 in Wales and after April 2024 in Northern Ireland. The BDA said there was a real impact on morale from this ongoing disregard for the profession. It said delayed uplifts also brought challenges to practices' financial sustainability and dentists' personal finances. There were also practical problems for GDPs where backdated payments needed to be made, particularly where individuals had retired or left the NHS.

[7] Northern Ireland Assembly, *Written Ministerial Statement Department of Health – Pay settlement for HSC staff.* https://www.niassembly.gov.uk/assembly-business/official-report/written-ministerial-statements/department-of-health---pay-settlement-for-hsc-staff

1.27 The BMA Northern Ireland SAS committee said that the continued occurrence of these delays, with or without an executive in place, undermined the DDRB's credibility and explained, in part, why confidence in the process was so low.

Industrial disputes

1.28 Consultants in England staged nine days of strike action between July and October 2023. An initial offer, with an overall additional cost of 3.45 per cent of the consultant paybill, was made by the government in November 2023 and rejected by members of the BMA and Hospital Consultants and Specialists Association (HCSA) in January 2024. A further offer was made in March 2024 and accepted by the unions. The agreement reformed the consultants pay scale to give fewer pay points and faster progression, ended the local clinical excellence award scheme with future funding incorporated into the pay scale offer, withdrew the BMA rate card, and made other changes around pay progression and parental leave.

1.29 Following an indicative strike ballot, an offer was made to SAS doctors and dentists in England in December 2023. This would have given additional pay uplifts of between 6.10 and 9.22 per cent from 1 January 2024 for those on the 2021 SAS contract. The offer was rejected by both BMA and HCSA members in March. The BMA England SAS Committee said this was because there was no uplift for those on the old SAS contracts.

1.30 A further offer was made to SAS doctors and dentists in England in May 2024, which offered the same uplift to those on the 2021 contracts, but an additional £1,400 uplift to those on the 2008 SAS contracts. This offer was accepted by BMA members in June. Both the consultants and SAS agreements were considered by the parties to be separate from the outcome of the DDRB process for 2024-25.

1.31 Doctors and dentists in training in England took 39 days of strike action between March 2023 and February 2024. Talks have been ongoing with the UK Government since October 2023, but no agreement has been reached. These talks moved to mediation in May but halted when the general election was called. The BMA junior doctors committee announced further strike action for 27 June to 2 July 2024.

1.32 Doctors and dentists in training in Wales took 10 days of strike action between January and March 2024. Planned strike action by consultants and SAS doctors and dentists in April was called off with all three groups entering negotiations with the Welsh Government following a mandate from the new First Minister. Offers were made in June after our recommendations were finalised, and therefore this report does not take them into consideration.

1.33 Doctors and dentists in training in Northern Ireland took three days of strike action in March and May 2024 and further strike action was scheduled for June. When confirming the 2023-24 uplift in February 2024, the Minister for Health in Northern Ireland said there were grounds for productive negotiations on a number of fronts, including: 2024-25 pay; potentially reforming the current junior contract in Northern Ireland; and addressing areas of concern on working conditions and other non-pay issues.[8] The Department of Health committed to further negotiations when there was a final settlement in the junior doctors dispute in England. Consultants in Northern Ireland voted in favour of taking industrial action in June 2024, and the Northern Ireland SAS committee also said it would also ballot members.

[8] Northern Ireland Assembly, *Written Ministerial Statement Department of Health – Pay settlement for HSC staff*. https://www.niassembly.gov.uk/assembly-business/official-report/written-ministerial-statements/department-of-health---pay-settlement-for-hsc-staff

Our comments

Evidence and participation in our process

1.34 The DDRB process is evidence based. Our consideration of written evidence, and the opportunity to hold oral evidence with the parties, are vital parts of our process and enable us to make balanced and informed recommendations. It was particularly regrettable this year that we did not receive written evidence on doctors and dentists in training from the BMA. This made our visits programme, where doctors were able to highlight aspects of their working lives, such as the working environment, support and workload, especially valuable.

1.35 As we said last year, the decision of some parts of the unions to not provide comprehensive evidence to our process means that the views and experiences of their members are not fully represented. We do not believe this is in their best interests and we encourage all parties to fully participate in the DDRB process next year.

1.36 The agreements made with unions representing consultants contained changes to the DDRB process, including our terms of reference, from the 2025-26 pay round. We welcome the commitment governments and unions have shown to the DDRB process through agreeing these changes which will inform our approach to next pay round. We discuss this further in chapter 6.

Timing of the round

1.37 Despite our raising concerns last year about the timing of our round, remit letters from each government were more than a month later this round, with remits received between 21 December 2023 and 5 March 2024. All of the governments submitted their written evidence later than last year, with government evidence received between 24 January 2024 and 5 March 2024. We held 13 oral evidence sessions with parties between 19 February and 29 April.

1.38 Parties and remit group members have raised genuine concerns about the impact of late pay awards. The delayed pay award is especially damaging to individuals during a period of significant increases to the cost of living. Our Chair wrote to the Prime Minister in February to raise our concerns about delays to government evidence and the subsequent damage to the pay setting process.

1.39 These issues were especially severe in Northern Ireland. Our Chair wrote to the Permanent Secretary of the Department of Health in Northern Ireland in November to express our concern about the damaging impact the delay to the pay uplift was likely to be having on the morale, recruitment and retention of medical and dental professionals. We are reassured that this was considered a priority when government was returned to Northern Ireland although we note that many HSC staff have still not received the pay uplift at the time of writing. Delays in implementing uplifts so that two fall in one financial year can also have significant tax implications, in particular increasing the likelihood of a pension annual allowance tax charge.

1.40 We encourage all parties, but especially governments, to work with us to set and meet a timetable that moves our process earlier. This year, the UK government asked us to report in May, but did not submit written evidence until 29 February. We received a substantial volume of valuable written and oral evidence this year, including significant amounts of late supplementary evidence, up to the end of April. We address a great breadth of issues in our work and are committed to a full and detailed consideration of the evidence. This process takes time and needs to be built into a future realistic timetable. Committing to an earlier

timetable in future will reinforce the need for evidence from all parties to be received timeously.

Our recommendations

Pay proposals from the parties

1.41 NHS Providers said that a meaningful pay increase for NHS doctors for 2024-25 was vital. In their pay survey: 15 per cent of members supported a pay uplift of 4 per cent; 43 per cent supported an uplift of 5 per cent; 24 per cent support an uplift of 6-9 per cent; and 9 per cent supported an uplift of over 10 per cent. There was no support for an uplift below 4 per cent. There was also some support for a targeted pay uplift for junior doctors and SAS doctors.

1.42 NHS Providers said it was important we consider the NHSPRB process that was running in parallel, due to the importance of multi-disciplinary teams in the delivery of patient care and services. They noted that some staff working at the top of Agenda for Change were working to a similar level as those under our remit, and that significantly differential pay awards could cause ill feeling across multi-disciplinary teams.

1.43 The BMA's general practitioners committees asked for: an above-inflation uplift in England; a 12.2 per cent uplift in Wales; an increase of inflation plus 3 per cent in Scotland, with an additional 3 per cent for contractors; an above-inflation uplift in Northern Ireland, and the inclusion of indemnity; and an above-RPI pay rise for salaried GPs across all four nations.

1.44 The BMA Northern Ireland SAS committee asked that any recommendation apply to SAS doctors on both the old and new contracts. The BMA England SAS committee asked for a series of above-inflation pay uplifts beginning in 2024-25 applying to both closed and open SAS grades. It also proposed the realignment of the 2008 and 2021 pay scales and a single pay spine (for specialty and specialist doctors) to better enable SAS doctors' career progression.

1.45 In oral evidence, the BMA England consultants committee said it was looking for a pay uplift of 6 to 8 per cent above CPI inflation to achieve pay restoration by 2026.

Factors in making our recommendations

1.46 We balance a number of different factors when making our recommendations on pay.

The broader context for the NHS

1.47 The NHS is under significant pressure. Despite substantial growth in workforce numbers, activity has only just returned to pre-pandemic levels, and over 9 million people are waiting for treatment across the UK. To address these pressures and meet the needs of a growing population with more complex conditions, the NHS needs to both expand and to become more efficient. Recruiting and retaining a skilled medical and dental 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.

1.48 The Long Term Workforce Plan for England pointed to substantial increases in NHS staffing that would be needed over the next 15 years to meet demand. This included a 60-100 per cent increase in medical school places and a 40 per cent increase in dental training places.

1.49 The NHS in England is required to deliver annual efficiency savings of at least 2.2 per cent each year, significantly higher than the 1 per cent that has historically been delivered. Public service healthcare productivity in England was 6.6 per cent lower in 2021-22 than in 2019-20. The Long Term Workforce Plan is predicated on an ambitious assumption of labour productivity

growth of up to 2 per cent a year. The NHS is also expected to become less reliant on international workers.

1.50 We note that the Long Term Workforce Plan is predicated on attracting increasing numbers into the medical and dental workforces and requiring more from NHS staff to deliver challenging efficiency targets. Delivering this will require the medical and dental professions in the NHS/HSC to remain attractive careers, and for staff morale and engagement to improve to a level where, supported by investment in technology, staff are motivated and incentivised to deliver.

The macroeconomic picture

1.51 Economic growth in the UK is weak, which constrains the government's ability to fund the public sector. Inflation has fallen sharply over the last 18 months, to 2.3 per cent in April 2024 on the consumer prices index, and is expected to be close to 2 per cent for the rest of the year. The labour market is showing signs of weakening, and much of the recent job growth has been driven by the health and social care sector. However, unemployment remains below the long-term average.

1.52 In making our recommendations, we consider trends in average earnings growth and pay settlements across the wider economy which indicate the typical increases being received by other employees and provide a useful reference point for our deliberations. Regular average earnings growth across the whole economy was around 6 per cent in the first quarter of 2024, and earnings growth at the top quartile of the earnings distribution, which is a better match for most of our remit group, was 4 to 5 per cent. Median pay settlements across the economy were at 5 per cent in the first quarter of 2024, with an interquartile range of 4 to 6 per cent.

Affordability

1.53 The DHSC told us that the 2021 Spending Review included 2 per cent in budgets for pay awards in 2024-25. It said that the financial pressures on the NHS settlement had become more pronounced in recent years due to unforeseen inflationary pressures, the lasting impact of COVID-19, the 2023-24 pay awards, and industrial action. These pressures had necessitated the reprioritisation of budgets for 2024-25.

1.54 NHS England said that pay awards needed to be fully funded, to deliver the mandated level of activity and investment in services. This included resolving pressures in the 2024-25 budget and agreeing the final budget with DHSC. It said that, if not supported by additional funding, further pay pressures were likely to result in difficult trade-offs during 2024-25 on staffing numbers and initiatives to support staff and would further impact on the ability of the NHS to deliver on its key strategic priorities of reducing the elective backlog, improving emergency care and improving access to primary care.

1.55 NHS Providers said that it was essential that the 2024-25 pay award was fully funded by central government to avoid either cuts to local NHS budgets, or further cuts to national improvement and transformation programmes. They said that funding pay uplifts by raiding frontline budgets could have significant operational implications and scaling back vital medium and long-term transformation spend (e.g. on frontline digitisation) would only make it harder to improve patient care.

1.56 In oral evidence, HM Treasury told us that funding pay awards higher than the amount budgeted for could raise the risk of increased borrowing and higher interest rates. An uplift above 2 per cent would lead to difficult decisions and trade-offs with other priorities.

1.57 None of the Scottish, Welsh or Northern Ireland governments gave us an indication of an affordable pay uplift. The Scottish Government said the health and care system was under extreme pressure as a result of the ongoing impacts of COVID-19, Brexit, inflation, and the UK Government's spending decisions. It said that pay and workforce must be explicitly linked to both fiscal sustainability and to reform, in order to secure the delivery of effective public services. Key to this was ensuring that plans for 2024-25 were affordable.

1.58 The Welsh Government said that providing a figure for an appropriate pay award would be against the principles of an independent pay review body. However, it said its financial situation was extremely challenging and any recommendations should take into account pressures on the overall budget.

1.59 The Department of Health in Northern Ireland anticipated that the future funding position would not significantly improve. In such a context, there would be no capacity to afford a meaningful pay uplift in 2024-25 without implementing corresponding cuts to services.

1.60 Affordability remains one of the key factors that we must consider when making recommendations, alongside the other considerations included in our terms of reference, including recruitment, retention and motivation. The affordability evidence provided to us by the governments represents crucial information for our recommendations but does not serve as a limiting factor, as we have demonstrated over a number of years.

1.61 In particular, we need to consider the impact of our recommendations on health funding more broadly and understand the implications for the rest of the health service and patient care. Our recommendations will need to be funded by reducing spend in other areas of the NHS, by reallocating funding from other areas of public spending, by increasing borrowing, or by increasing taxation. While these are decisions for government, we cannot responsibly ignore them.

1.62 We note that our recommendations last year necessitated reallocation from other NHS priorities. We would be particularly concerned about any reallocation that reduces investment in the transformation of the NHS and damages its ability to deliver longer term reforms, invest in measures to improve productivity, or reduce initiatives to invest in staff and the working environment which, in turn, impact morale and patient care.

1.63 We are also aware of the damaging cost that industrial action is having on the NHS – financially, on patients, on staff, and on the ability of leaders to focus on broader service improvements. NHS England estimated that the direct cost of industrial action by doctors was more than £1.5 billion in 2023-24.

Recruitment and retention

1.64 Recruitment remains strong across most of the remit group, with workforce numbers increasing across secondary care. We do, however, see an increased reliance on international recruitment. Just over half of those joining the medical register in 2022 had a non-UK primary qualification. The reliance on international recruitment is especially acute in filling specialty training places in general practice and psychiatry. This is at the same time as an increasing number of doctors are taking time out of training, although often remaining in the NHS workforce.

1.65 The numbers of doctors and dentists working in primary care shows a different path to secondary care. Full-time equivalent numbers of GPs have seen limited medium-term growth, of 2 per cent over five years in England, despite strong evidence of substantial increases in

demand for primary care. There are falls in the number of dentists providing NHS services in England, Scotland and Wales. There is strong and concerning evidence that NHS dentistry is increasingly unattractive, and this is impacting the amount of care that patients are able to receive from the NHS and causing substantial damage to overall dental heath provision.

1.66 We have seen growth in workforce numbers among hospital doctors over the last year, ranging from 0.5 per cent in Northern Ireland to 5.1 per cent in England. Since December 2019, just before the pandemic, the medical and dental secondary care workforce has grown by between 11.2 per cent in Northern Ireland and 22.1 per cent in Wales. Workforce growth has been much weaker in primary care especially when considering full time equivalent numbers rather than headcount. There are fewer dentists providing NHS services in England, Scotland and Wales than prior to the pandemic. The full-time equivalent number of GPs has seen small falls in Scotland and Wales over the last year, while England has seen notable falls in the number of GP partners.

Trends in relative pay

1.67 We examine current and long-term trends in pay for doctors and dentists as they relate to recruitment, retention and motivation, in line with our terms of reference. We are cognisant of long-term developments in our remit group's position within the overall earnings distribution, their real-terms pay level, and how their pay compares to comparator professions. We do not, however, believe it is our role to ensure that pay for our remit group retrospectively tracks inflation, or any other measure, irrespective of the broader recruitment and retention or NHS contexts. We note that earnings have grown by less than inflation, in particular since 2020, but that most parts of our remit group have kept up with earnings growth for employees across the economy at a similar level of earnings.

1.68 Doctors and dentists in training, particularly foundation doctors in England, have seen weak earnings growth over the last year, of 1.3 to 4.4 per cent, despite our 2023 recommendation last year of an 8.1 to 10.3 per cent uplift, which may be due to industrial action and a fall in additional working hours. More significantly, doctors and dentists in training have seen their earnings fall relative to the overall earnings distribution by more than other parts of our remit group since 2010, particularly during the early years of training.

Motivation and morale

1.69 The issues of motivation and morale are of particular concern to us this year. While the NHS Staff Survey for England showed slightly better results for medical and dental staff in 2023 than in 2022, they remained much worse than in 2019 and 2020, and the slight improvement recorded in 2023 for medical and dental staff was less marked than that for NHS staff as a whole. We have heard explicit concerns in evidence and on visits about the paucity in basic amenities and poor quality of support for medical staff in their workplaces such as: access to hot meals, late rota changes, unavailability of transport, and safe parking following late night shifts.

1.70 As we said last year, many of the issues driving the challenges to motivation and morale are not directly solvable with higher pay awards. We therefore continue to stress the need for these issues to be addressed outside the pay setting process through workforce planning and other actions to improve working conditions. However, pay serves as an important signifier of value and can exacerbate a feeling amongst the medical and dental workforce that they are neglected and undervalued. This can in turn make staff feel they no longer wish to put in the additional discretionary effort on which the NHS/HSC depends, and low morale can reduce the quality of patient care and overall productivity.

1.71 In particular, we notice the poor quality of working life that is experienced by doctors and dentists in training including issues such as delayed communication on placement locations in addition to many of the problems listed above. While many of these issues have been recognised, progress in addressing them has been limited. This should be a priority in future talks between governments and doctors and dentists in training.

The industrial relations context

1.72 The substantial costs of industrial action go beyond the immediate and concerning impact on patients. There are significant financial costs – NHS England has estimated that the cost of industrial action by doctors was more than £1.5 billion in 2023-24 – and opportunity costs in terms of management capacity and the redirection of operational priorities. Delays in resolving industrial action have affected morale across the workforce, damaged working relationships, increased workload and added to waiting list pressures.

1.73 We understand the strike action taken over the past year is a result of the high levels of discontent that doctors have with their pay and working lives, in particular doctors and dentists in training, and are an expression of poor morale. One of the key demands from the unions is the restoration of pay to 2008 levels in real terms.

Differences across nations

1.74 Our remit covers all four nations of the UK and we receive separate evidence on each. The labour market for medical and dental staff is both a UK-wide and an international one. When making our recommendations, however, we are cognisant of differences between the nations of the UK, in terms of the economy, the labour market, health services and government policies. We are sensitive to flows of medical and dental staff between nations, and any differences between pay and other terms, and wish to avoid an unnecessary internal market. Unwarranted pay differentials across nations are likely to create inefficient competition for specialists, and a sense of unfairness as individuals are paid differently for doing the same job.

1.75 We consider the differential positions on affordability, recruitment and retention, motivation and morale across the nations each year to see if a differential approach is required. Our recommendations this year cover all four nations of the UK.

Broader developments in reward

1.76 Our recommendations typically focus on base pay, but this is only one part of a much broader reward package for doctors and dentists that includes pay supplements and allowances, leave, additional benefits, pensions, working conditions, job security, career development, and organisational culture. All of these affect recruitment, retention, motivation and morale. In a number of these areas, such as structured career and pay progression, job security, international mobility, and pensions, medical careers compare positively to other highly qualified roles in the private sector.

1.77 The issue of pension taxation in particular has for several years been of major concern, especially to senior doctors and dentists. Both the annual allowances and the lifetime allowance have reduced incentives to work extra hours or to stay in employment. The changes to pension taxation announced in last year's budget represent a significant improvement to the total reward package for higher earners including many in the medical workforce, and should have a positive impact on the retention of experienced doctors and dentists. Furthermore, the additional flexibilities brought into the NHS pension scheme should support both partial retirement and retire and return. The rollout of the McCloud remedy is,

however, creating a degree of uncertainty over pension values, in particular around pension taxation.

1.78 We also note the one percentage point reduction in employee pension contributions for higher earners in the NHS scheme, which directly increases take-home pay.

Our recommendations

1.79 We make our recommendations considering all the factors within our terms of reference. We are also aware that negotiations are ongoing for a number of groups across different nations of the UK. We make our recommendations on the basis that the 2023-24 pay rates, as set out in our appendix, are in place, and the agreed changes to pay for consultants in England from 1 March 2024 and for SAS doctors and dentists in England from 1 April 2024 have been implemented. We also recommend on the basis that our 2023 recommendations have been fully implemented in Northern Ireland.

1.80 We understand that this situation may have changed by the time governments make their decisions and this report is published, and that this may impact how they respond to our recommendations. In particular, the Welsh Government made additional offers to junior doctors, SAS doctors and consultants after our recommendations were finalised. These are not considered in our report.

1.81 This year has been particularly complex, with many groups in our remit voting for industrial action and further negotiations with the different governments. Although inflation has significantly reduced, cost of living pressures remain. While recruitment and retention in most areas is relatively strong, we continue to hear that doctors and dentists are planning to leave the NHS/HSC, and morale is poor and has fallen since the pandemic. In that context, the ambitions of the Long Term Workforce Plan look challenging. To meet them will require the pay and reward package to both attract future recruits to medical and dental careers and enable the retention of experienced professionals in challenging and demanding roles.

Consultants

1.82 In making our pay recommendation for consultants, we observe that the number of consultants has seen substantial growth over the last decade across all nations, which has been maintained over the last year, with annual growth in the number of consultants ranging from 1.6 per cent in Scotland to 3.6 per cent in England. The leaving rate for consultants in England has also improved, falling to 4.8 per cent in the year to September 2023, down from 5.5 per cent a year earlier.

1.83 However, we note that the Long Term Workforce Plan looks to increase the number of consultants in England by almost 50 per cent by 2036-37 to meet projected demand. It is clear that consultants play a central role in terms of delivering healthcare and reducing waiting lists, and therefore these positive recent trends in workforce data will need to be maintained to meet the ambitions of the Plan.

1.84 Consultants in England took nine days of strike action in 2023, and there since has been agreement with the government on reform to the consultants' contract. This was worth around an additional 3.5 per cent of the paybill and represents additional earnings growth for this group, as well as enhanced future pay progression. The agreement makes significant progress to reducing the length of the pay scale and the time taken to reach the maximum and should impact positively on the gender pay gap over time. Other nations may wish to consider similar reforms.

1.85 Earnings growth for consultants in England has been lower than inflation over the medium term but has kept pace with the 99th percentile of the earnings distribution for all employees. The significant changes to pension flexibilities and to pension taxation over the last year should give stronger incentives for late-career consultants to stay in work and to work additional sessions.

1.86 We note that staff survey data for England showed small improvements in engagement, job satisfaction and workload measures for consultants, albeit from a low level. However, the most recent staff survey shows further declines in satisfaction with pay.

SAS doctors and dentists

1.87 For SAS doctors and dentists in England, Wales and Northern Ireland, there has been a lack of movement to the new contract, and recognised disincentives to do so. The recent agreement in England addresses these issues. We would encourage Wales and Northern Ireland to make similar reforms.

1.88 In considering a pay recommendation for this group, we note that leaving rates for specialty and associate specialist doctors in England have fallen over the last year and pay for SAS doctors has remained in line with comparators. However, career development, recognition and inclusion are major issues for this group. This has been recognised by employers and we would hope that plans to address this, including the creation of new specialist roles, will be implemented.

1.89 Again, there is a need to ensure that pay supports recruitment and retention to remain strong in order to meet the ambitions set out in the Long Term Workforce Plan. We are conscious this part of our remit group includes a higher proportion of internationally qualified doctors who may be less likely to remain in the UK over the longer term.

Locally employed doctors and dentists

1.90 We have seen substantial growth in the number of hospital doctors employed on local contracts, especially in England. This is linked to both the increasing number of UK graduates taking longer periods away from training after completing their foundation years and the increasing number of international medical graduates joining the workforce who do not initially meet the criteria to take consultant or SAS roles.

1.91 There is encouraging evidence from the GMC that locally employed doctors often move into postgraduate training or onto SAS contracts. We also welcome the commitment in the recent SAS agreement in England to a joint piece of work to better understand the make-up of the locally employed workforce (including their contractual terms and needs) and enable locally employed doctors to move to permanent SAS contracts.

1.92 As we said last year, parties should work together to understand what can be done to maximise the contribution that locally employed doctors can make to NHS services, and to ensure their equitable and consistent treatment. This better understanding of local employed doctors should then lead to action to improve recruitment, retention, motivation, training and career progression for this group, therefore ultimately improving services and patient care.

1.93 We understand that the majority of locally employed doctors are on terms and conditions which mirror national contracts and pay scales. Therefore, their annual uplifts mirror those applied to national contracts.

General medical practitioners

1.94 There is increasing demand for GP services, growing workloads and high public concern in recent years over access to GPs. There are an increasing number of appointments being delivered in general practice, up from 1.3 million per working day in April 2023 to 1.4 million per working day in April 2024 in England (a 7.8 per cent increase), although a growing proportion are carried out by another primary care professional rather than a GP. Across all nations, there have been moves to increase the use of multidisciplinary teams in general practice.

1.95 The number of full-time equivalent GPs has shown only small increases across England and Scotland, well below the numbers previously identified as a target. Headcount numbers have shown a small increase in Northern Ireland, while the number of full-time equivalent GPs has seen a small fall in Wales. This is in contrast to substantial growth in the number of hospital doctors, and raises significant concerns around a shortfall of GPs relative to increasing demand. We note the need for recruitment incentives for GPs to work in rural areas in several parts of the country. Increased part-time working, especially among salaried GPs, increases the total number of GPs needed to meet demand.

1.96 There has been a significant expansion of GPs in training across all nations. In England, the number of (headcount) GPs in training grew by 6.5 per cent in the year to December 2023, and by 67.1 per cent over the previous five years which is part of a longer-term trend. This has been supported by international recruitment. These trainees should increase the number of GPs in the future.

1.97 However, we have seen a fall in the number of GP partners in England, of 2.2 per cent over the year to December 2023 and of 15.1 per cent over five years in full-time equivalents. The proportion of qualified permanent GPs working as salaried rather than partner GPs in England has increased from 37 to 46 per cent over the last five years. This raises concerns about the future sustainability of the existing GP partnership model.

1.98 We are concerned about two emerging possibilities facing general practice in the UK. Firstly, a risk that increasing numbers of patients choose private GPs due to difficulties accessing NHS services. Secondly, that GPs might be more attracted to taking on private patients to meet this demand, therefore reducing access to NHS GP services. As a consequence, general practice in the future could start to face some of the challenges of provision seen with dental services. We will be monitoring this issue and would like to receive any evidence that helps us understand if demand for general practice is being pushed to the private sector and our forward-looking concerns are justified.

1.99 Earnings for contractor GPs have shown strong growth up to 2021-22, boosted by COVID-19 payments, and have kept up with inflation. Salaried GP earnings have also seen real terms growth in England, Scotland and Wales. We note the increase in part-time working among salaried GPs at the same time as real earnings growth. The BMA has pointed to high workloads as the driver of less than full time working.

1.100 GPs have consistently raised the issue of high increases to expenses over the last two years which have not been matched by increases in funding, in particular for energy. Given the lag in the availability of earnings data, and the unclear impact of COVID-19 payments, it is hard to discern what the recent path of earnings has been. COVID-19 payments will have largely fallen out of 2022-23 earnings, which we will be considering next year. We will then want to review the longer-term trend closely to look at the relative position of GP earnings.

General dental practitioners

1.101 Over a number of years we have expressed our increasing concern about the continuing severe difficulties in access to NHS/HSC dentistry across the UK, and the consequences for the oral and overall health of patients. In England, Scotland and Wales there are fewer dentists providing NHS services than in 2019-20. The number of NHS dentists in Northern Ireland has seen a small increase in the short term and is unchanged over the medium term. Despite reported high demand from patients, NHS activity has not returned to pre-pandemic levels. There has also been a reduction in NHS working hours across all nations with dentists moving to private work. We heard on visits this was not only more profitable but could be more attractive to newly qualified associates as they are able to practice a wider range of skills such as cosmetic dentistry.

1.102 While dentists have seen earnings growth in 2020-21 and 2021-22, given the decreasing amount of NHS work performed this is likely due to increased income from private work. Earnings growth for GDPs has been above our recommendations in recent years. This may be due to contractual differences, varying levels of COVID-19 support, or changes in the balance of the NHS and private work. This makes trying to make a single appropriate pay uplift recommendation especially challenging. Dentists have made clear to us that they have seen a significant increase in costs since 2021-22, which has not been met by contractual uplifts.

1.103 The Dental Recovery Plan for England recognises some of the issues and makes limited plans to expand access and increase the level of dental provision. We are particularly concerned that the impact of our recommendations on the recruitment and retention of dentists in the NHS may be limited in light of the need for broader contract reform.

Community and Public Dental Services

1.104 Despite our request last year, we received a disappointing lack of evidence on workforce trends, recruitment and retention for the Community Dental Services and the Public Dental Services. This is an important service delivering care to an increasing population of vulnerable patients and the lack of evidence makes it hard to us to make appropriate targeted pay recommendations. We do, however, see evidence of a decline in engagement and job satisfaction, and an increase in workload pressures. We would like to explore the workforce issues for this important service in more detail next year.

Our pay recommendations

1.105 Considering all these factors, **we recommend a 6 per cent increase to the salary scales, pay ranges and the pay element of contracts from 1 April 2024**. This applies to: consultants; SAS doctors and dentists; salaried dentists, including those working in Community Dental Services and the Public Dental Service; contractor general medical practitioners; salaried GP pay ranges; and the pay element of dental contracts. This applies to all the nations of the UK.

Recommendation 1

We recommend a 6 per cent increase to salary scales, pay ranges and the pay element of contracts from 1 April 2024.

This recommendation applies to the following groups in all four nations of the UK:

- Consultants.
- Specialty, specialist and associate specialist (SAS) doctors and dentists.
- Salaried dentists, including those working in Community Dental Services and the Public Dental Service.
- Contractor general medical practitioners.
- Salaried GP pay ranges.
- The pay element of dental contracts.

Doctors and dentists in training

1.106 We have not seen particularly strong evidence of widespread recruitment or retention issues for doctors and dentist in training, with specific locality and specialty issues being addressed through targeted pay, international recruitment, and directing the availability of training posts across the country. There has been strong growth in the number of doctors and dentists in training in England, Scotland and Wales over the last year, although not in Northern Ireland.

1.107 However, there was a notable 9.3 per cent fall in the number of applicants to study medicine in 2023 compared to 2022. This may reflect a negative impact from the industrial action, as young people consider their future careers. By contrast, there was a marked and continued increase in the numbers applying to study dentistry. The Long Term Workforce Plan in England requires a substantial expansion in the number of medical and dental students. Starting salaries are likely to be important in maintaining the attractiveness of the medical and dental professions in order to deliver on these ambitions.

1.108 There is an increasing tendency for doctors to take time out between foundation and core/specialty training, and to take a longer period out. Reasons for this are varied, including personal fulfilment, taking a break, improving health and physical/mental wellbeing and career exploration. Many doctors are continuing to work in the NHS, on local contracts or as locums during this time. There is no evidence that doctors are dropping out of the medical workforce altogether at an increasing rate.

1.109 There does however appear to be an increasing mismatch between the available specialty training places and the doctors that wish to take these places. Increasing numbers of core and specialty training places are being filled by international medical graduates, in particular in the harder-to-fill specialties such as psychiatry and general practice. Meanwhile, doctors are dropping out of training to reapply for the specialty that they want.

1.110 We see a clear and compelling need to incentivise doctors and dentists to complete training, to work on trainee salaries rather than as locums, and to aspire to become consultants in the future. Pay is an important element of this.

1.111 Doctors and dentists in training received a higher pay award last year than other groups, worth 8.1 to 10.7 per cent in England and Northern Ireland, above pay awards across the rest of the public sector. However, earnings growth has been low, in England at least, probably due to industrial action and fewer additional hours.

1.112 Doctors in training have seen slower earnings growth than all employees at the same level of earnings since 2010. Medical and dental graduates remain substantially higher paid than graduates in other disciplines, but lower than directly comparable professional roles. In addition, the relative position of the earnings of doctors and dentists in training compared to the distribution of earnings of other employees remains lower than in the past, in particular at foundation years 1 and 2. In contrast, pay for SAS grades and consultants has remained consistent or has slightly improved relative to comparator groups over the same period.

1.113 Doctors and dentists in training in Scotland agreed a higher pay increase (12.4 per cent) than any other medical group last year. There has not been industrial action in Scotland over the last year. The Scottish Government is not seeking recommendations for junior doctors this year.

1.114 We are aware of the high levels of discontent among this workforce, as evidenced by strike action in England, Wales and Northern Ireland. Motivation and morale indicators for junior doctors are more negative than for other medical groups but show a small improvement in the latest survey. Satisfaction with pay is very low, and there is concern about wider working conditions. We also understand that doctors and dentists in training continue to experience considerable disruption and costs from the need to rotate posts and relocate, as well as additional costs such as for exams.

1.115 We note the particular working environment pressures facing doctors and dentists in training, the poor morale, the increasing tendency to drop out of training, the very high disruption and costs that this group faces from job rotations, and the fall in relative earnings compared to the broader economy for this group. Consequently**, we recommend a 6 per cent increase plus a consolidated uplift of £1,000 to the pay points for doctors and dentists in training from 1 April 2024**. This recommendation applies to England, Wales and Northern Ireland. This increase is worth 7.6 to 9.5 per cent on basic pay.

Recommendation 2

We recommend a 6 per cent increase plus a consolidated uplift of £1,000 to the pay points for doctors and dentists in training in England, Wales and Northern Ireland from 1 April 2024.

1.116 We recommend that locally employed doctors receive the same uplift as the national contract that their employment arrangement mirrors, otherwise a 6 per cent uplift.

1.117 Full details of our recommended pay rates are in appendix B.

Expenses

1.118 Contractor GPs and GDPs have strongly expressed to us the significant increase in costs they have faced over the last two years, which has not been matched by increases in their NHS funding. The latest earnings and expenses data only covers the period up to and including 2021-22, and so we are unable to say whether sufficient allowance was made for any growth in expenses in 2022-23 and 2023-24. The data that we do have, up to 2021-22, show income growth for both these groups has kept up with inflation over a five-year period and been significantly ahead of both our recommendations and earnings for other medical and dental groups. However, we recognise that income figures for 2020-21 and 2021-22 may have been inflated in the short-term by payments relating to COVID-19 or, in the case of dentistry, a reduction in expenses due to lower activity caused by COVID-19.

1.119 One of the problems with the current uplift process for England, which uses the forecast GDP (gross domestic product) deflator, is that there is no correction mechanism for when the forecast is significantly different to the out-turn, as happened in 2023-24 when the contract uplift was based on a projected figure of 3.23 per cent, while the latest estimate of the GDP deflator is 6.54 per cent. In the other nations, contracts have typically been uprated in line with the earnings element of the contract, which takes no account of the longer-term trends in the costs of providing care.

1.120 We expect uplifts to be sufficient for the full value of our recommendations to be reflected in earnings for contractor GPs at typical general practices, and for earnings for NHS/HSC work done by providing-performer and associate dentists at typical dental practices. We are not confident this has been the case over the last two years. It is not clear that the current arrangements have taken sufficient account of recent high inflation. We will be looking closely at the earnings and expenses data for 2022-23, due to be published in the summer of 2024, to see how GP and dental incomes changed for that year, relative to our recommendation that they should increase by 4.5 per cent.

1.121 Until 2014, the DDRB made recommendations on the size of increased contract payments, such that it generated income growth of a particular value after accounting for any change in expenses faced by contractors. However, the quality and timeliness of data for net incomes and expenses meant that often the actual changes in net incomes did not match those intended by the DDRB. As a result, the DDRB stopped making recommendations in this way and started to make recommendations on the desired change in net incomes leaving the parties to discuss/negotiate/agree the appropriate increase in contract payments after taking account of the expenses faced by contractors.

1.122 The current processes for setting expenses have not been set out clearly to us. As we have said before, this process should be agreed between the parties. What we have heard suggests that parties have been unable to agree a robust methodology that takes appropriate account of changes in the level of expenses faced by contractors. We would like to hear from governments next year about the approaches they have taken, with the outcomes clearly set out, and any assessment they have made of the effectiveness of these approaches. We would also like to hear from the BMA and the BDA on how they think contract uplifts can best reflect the expenses faced by GP and dental contractors.

1.123 The structure of the costs faced by GP and dental contractors differs. For example, staff costs account for 58 to 72 per cent of GP contractor costs but only 31 to 35 per cent of costs for dental contractors, while material and other costs account for a larger share of dental expenses than those for GPs. It may well be that a different approach is needed for each group.

1.124 We would urge governments to look for a better way of addressing this issue, possibly as part of wider contract reform.

Consultant reward schemes

1.125 The four nations are in very different places on clinical excellence awards, discretionary pay, and other consultant reward schemes. The recent agreement for consultants in England ends the local clinical excellence award scheme so we do not need to make a recommendation. The Scottish Government has said it is not making any new distinction awards as they do not align with its progressive pay principles. Discretionary points are still available. It has said it is not seeking any recommendation from us on distinction awards or discretionary points. The Welsh Government has said it wishes to remove commitment awards. Clinical excellence awards in Northern Ireland remain suspended although there are proposals to reintroduce them.

1.126 In our last four reports, we have declined to make a recommendation that uplifts should be applied to consultant reward schemes, as a result of concerns over the schemes' equity and effectiveness. They have also all been frozen in value since at least 2018. The national clinical impact awards for England and Wales show disproportionate awards going to men and to those from a white ethnic background, although outcomes have generally shown improvement and we welcome this progress.

1.127 The DHSC asked us to allow the reformed national clinical impact scheme further time to be fully implemented and embedded before any further uplift was recommended. Both the BMA and the HCSA said that the freezing in value of awards meant they were worth a diminishing amount over time.

1.128 We will not be making a recommendation on consultant reward schemes this year. We would like to receive further evidence on the effectiveness of the clinical impact award scheme, including its impact on patient care and productivity, and further reassurance on its equity, before we make a recommendation. We will be looking to do this next year. We would also like to see the other nations complete the reforms of their schemes and provide a clear statement on their future reward policies for discretionary pay for consultants.

Costs of recommendations

1.129 We estimate that implementing our recommendations will add £1.2 billion to the substantive HCHS paybill in England, against a total DHSC Resource Departmental Expenditure Limit in 2024-25 of £165.8 billion. We estimate that they will add £90 million to the paybill in Scotland, £90 million to the paybill in Wales, and £40 million to the paybill in Northern Ireland.

1.130 Decisions about how to fund pay awards for our remit group, whether from existing budgets or through increases to departmental budgets, remain a political choice that sits with the governments. It is, however, difficult to separate pay and workforce costs from the recognised need to improve productivity and the working environment in support of the overall aim to improve health outcomes. We are therefore increasingly concerned that decisions to continue to reallocate funds from elsewhere in the health service to fund pay awards could be detrimental to patient care and counter to longer-term objectives to reform and improve health services.

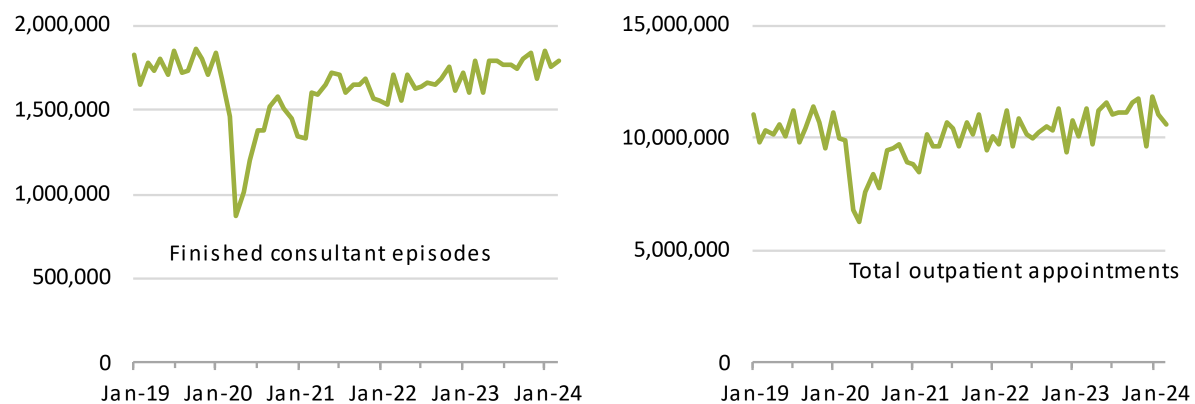
Chapter 2 Wider context

2.1 This chapter considers the wider context for our recommendations including the economy and the labour market, health spending and affordability, industrial action, healthcare productivity, workforce planning, workforce equalities, and developments in pensions.[9]

2.2 The NHS is under significant pressure. Overall activity has only just returned to pre-pandemic levels (see figure 2.1). Waiting lists have been at record levels due to both increased demand and lower activity since 2020. In March 2024, there were 7.54 million patients waiting for treatment in England, down slightly from a peak of 7.75 million in August 2023. Of these, 4.1 per cent (309,300) had been waiting for over a year, down from 8.8 per cent (436,100) in March 2021 but up from levels close to zero seen before the pandemic.

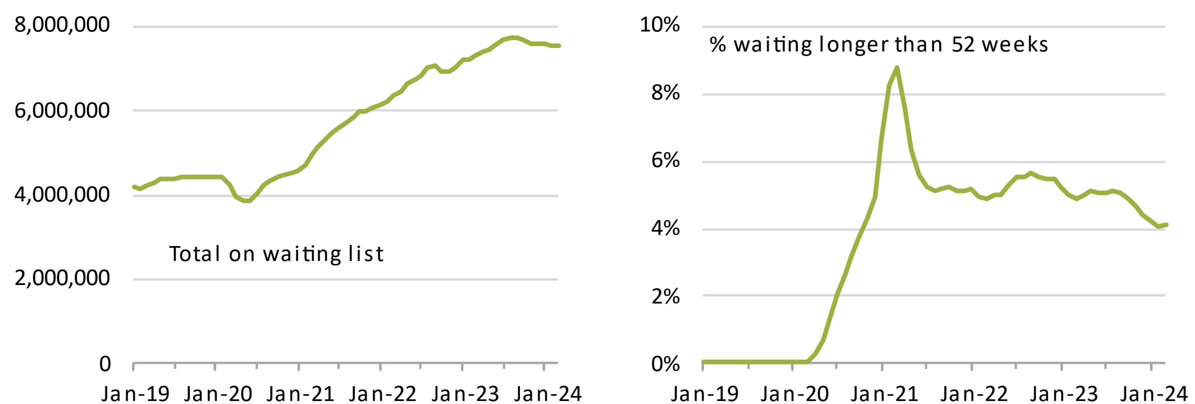
2.3 In Scotland, there were 534,000 ongoing patient waits at the end of March 2024, an increase of 10 per cent since the end of March 2023 and double the number in March 2020. In Wales, the total waiting list stood at 769,000 in March 2024, 5 per cent higher than a year earlier, and 68 per cent higher than in March 2020. In Northern Ireland, waiting lists continue to increase: the waiting list stood at 341,910 patients in December 2023, an increase of 10 per cent from a year earlier and 42 per cent higher than in December 2019.

Figure 2.1: Finished consultant episodes and total outpatient appointments, England, 2019 to 2024



Source: NHS England, Hospital Episode Statistics.

Figure 2.2: Number of patients waiting for treatment and proportion waiting over one year, England, 2019 to 2024



Source: NHS England, Recovery of Elective Activity Management Information.

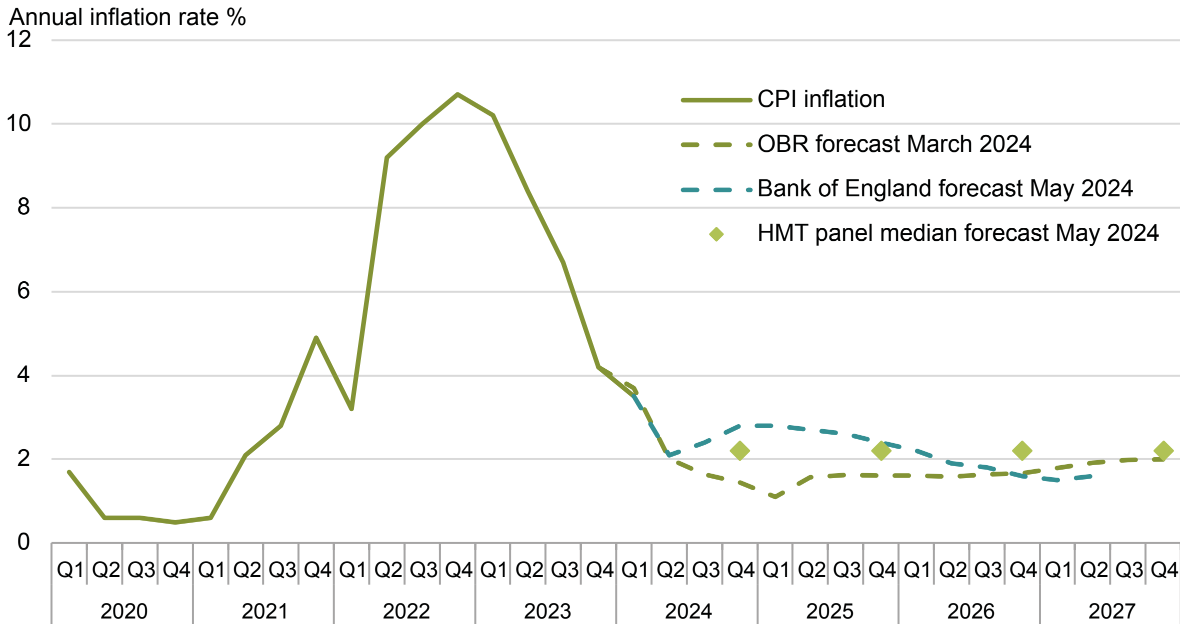
[9] This chapter contains data published up to the end of May 2024.

The economy and the labour market

2.4 UK economic growth was weak in 2023, at 0.1 per cent overall for the year, with the economy moving into a technical recession in the second half of 2023. Gross domestic product was estimated to have increased by 0.6 per cent in the first quarter of 2024 and was forecast to be weak but positive over the rest of 2024.

2.5 Inflation has fallen sharply over the last 18 months, with the Consumer Prices Index (CPI) rate at 2.3 per cent in April 2024, down from 8.7 per cent in April 2023 and from a peak of 11.1 per cent in October 2022. CPIH inflation (the CPI including owner occupiers' housing costs) was at 3.0 per cent and the Retail Prices Index (RPI) rate was at 3.3 per cent in April 2024. Energy prices, which had been the main driver of higher inflation, have fallen sharply in recent months. CPI inflation is forecast to be close to 2 per cent for the rest of 2024 (see figure 2.3).

Figure 2.3: CPI inflation and forecasts, 2020 to 2027



Source: ONS, CPI inflation, quarterly (D7G7); Office of Budgetary Responsibility (OBR), *Economic and fiscal outlook*, March 2024, Bank of England, *Monetary Policy Report*, May 2024, HM Treasury, *Forecasts for the UK economy*, May 2024.

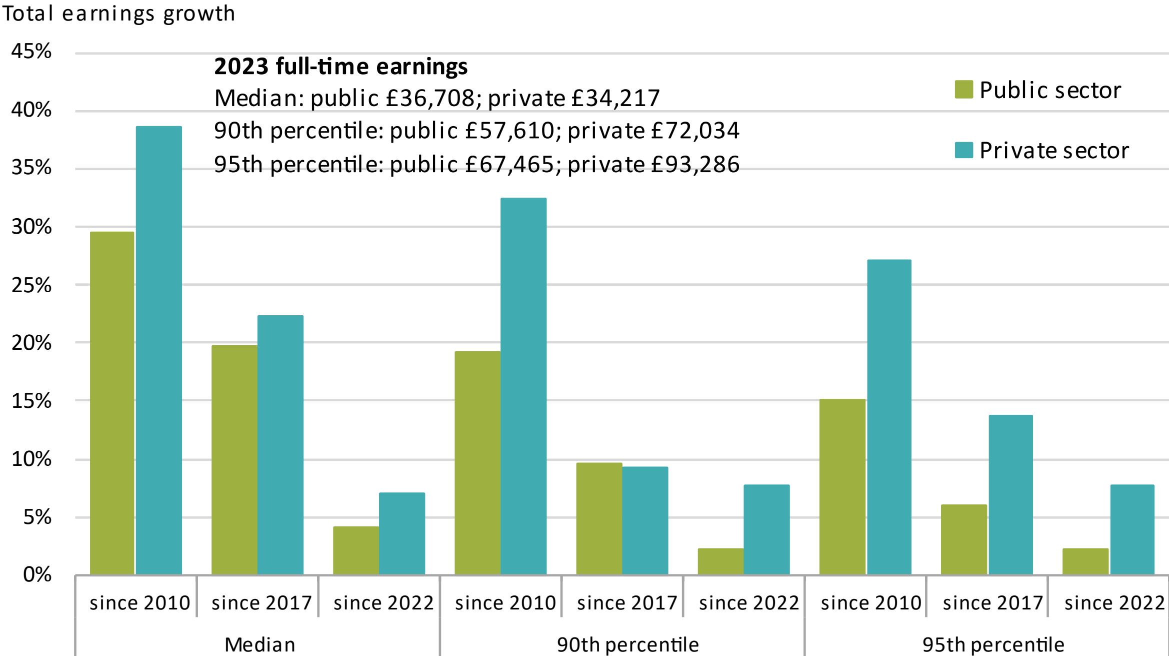
2.6 The evidence on the labour market presents a mixed picture. Pay as you earn (PAYE) real time information indicated that the number of employees on payrolls in April 2024 was 30.2 million, up 129,000 (0.4 per cent) over the year but down 102,000 over the three months to April. According to the Labour Force Survey, the overall level of employment was 33.0 million in the first quarter of 2024, down 204,000 over the year. The Office for National Statistics (ONS) recorded 898,000 job vacancies in the three months to April 2024, a notable fall from the peak at 1.30 million in May 2022, although still higher than the longer-term average. The largest number of job vacancies were in health and social work (160,000), retail and wholesale (116,000) and accommodation and food services (107,000). The unemployment rate was 4.3 per cent in the first quarter of 2024, up from 4.0 per cent a year earlier but still at an historically low level.

2.7 Whole economy annual average weekly earnings growth was at 5.7 per cent in the first quarter of 2024. Regular earnings growth (i.e. excluding bonuses) was at 6.0 per cent – 6.3 per cent in the public sector and 5.9 per cent in the private sector.

2.8 We pay particular attention to earnings at the upper end of the wage distribution, which includes the more highly paid members of our remit group. PAYE data on earnings showed that earnings growth over the last year was stronger in the lower half of the earnings distribution and weaker at the top end. Annual earnings growth was 7.8 per cent at the 25th percentile in the year to February 2024; 6.3 per cent at the median; 5.1 per cent at the 75th percentile; 4.6 per cent at the 90th (and 99th) percentile; and 3.8 per cent at the 95th percentile.

2.9 Annual Survey of Hours and Earnings (ASHE) data also show lower earnings growth for higher earners, and that public sector earnings growth has been lower than the private sector (see figure 2.4). Comparisons of changes in earnings over time are sensitive to the base year chosen. Since 2010, full-time earnings growth at the median has been 38.5 per cent in the private sector and 29.5 per cent in the public sector. At the 95th percentile, earnings growth since 2010 has been 27.2 per cent in the private sector but just 15.1 per cent in the public sector.

Figure 2.4: Full-time earnings growth in the public and private sectors, 2010 to 2023

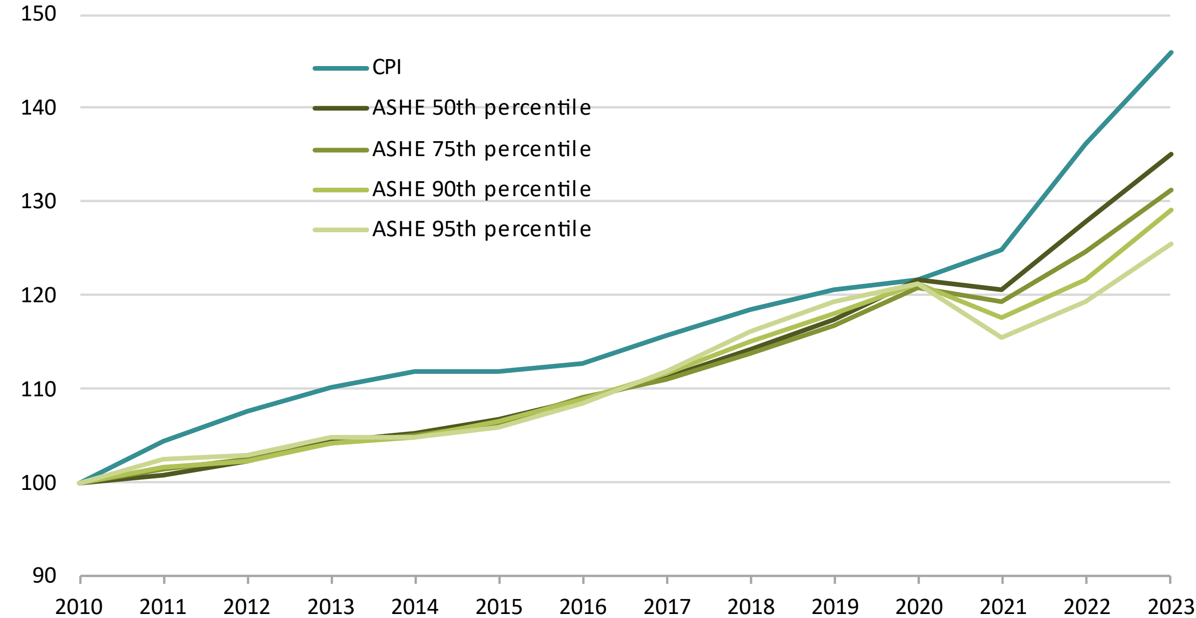


Source: ASHE.

2.10 Earnings have grown by less than inflation for all employees since 2010, and in particular since 2020 (see figure 2.5).

2.11 Pay settlement medians were at 6 per cent in 2023. Data for the first quarter of 2024 show a fall to around 5 per cent. Brightmine (formerly XpertHR) reported a median pay award of 4.9 per cent for the three months to April 2024; the Incomes Data Research (IDR) median was 5.0 per cent for the three months to April 2024; and the Labour Research Department (LRD) reported a median of 5.0 per cent for all employees for the three months to April 2024.

Figure 2.5: ASHE 50th, 75th, 90th and 95th percentiles of full-time employees and CPI index, 2010 to 2023



Source: ONS, ASHE, CPI.

Health spending and affordability

2.12 In its economic evidence to the pay review bodies, HM Treasury said that 2024-25 would be the tightest year of this Spending Review period, with departments having faced significant headwinds since budgets were set, driven by inflation, pay, and an array of department-specific pressures including the continued impacts of COVID-19 on the NHS.

2.13 HM Treasury said that price levels were forecast to be 12 per cent higher in 2024-25 than when departmental budgets were set at the 2021 Spending Review, due to stronger and more persistent inflation. This meant that departments' budgets were around £10 billion lower in real terms in 2024-25 than in 2022-23, in contrast to the real terms increase of 1 per cent a year planned in 2021.

2.14 HM Treasury said that departments were generally funded for pay awards of 3 per cent in 2022-23 and 2 per cent in 2023-24, while actual review body awards were around 5 per cent in 2022-23 and around 6 per cent in 2023-24. This equated to spending around £10 billion more on pay in 2024-25 than planned at the 2021 Spending Review for pay review body workforces alone, even before 2024-25 awards were considered.

2.15 HM Treasury said that departments were already having to reprioritise and find efficiencies to enable funding to be available for pay awards this year. Public sector expenditure on pay had increased from 49 per cent of total resource expenditure in 2021-22 to 53 per cent in 2022-23. It said that each 1 percentage point of review body pay awards would cost an estimated £1.8 billion in 2024-25. Increased spending on pay either reduced available room in budgets for non-pay expenditure, including funding for frontline services provision, or necessitated further borrowing which would increase pressures on interest rates. HM Treasury said that, given the reprioritisation towards pay already made to deliver 2022-23 and 2023-24 awards, the scope for further savings within departments' budgets was limited.

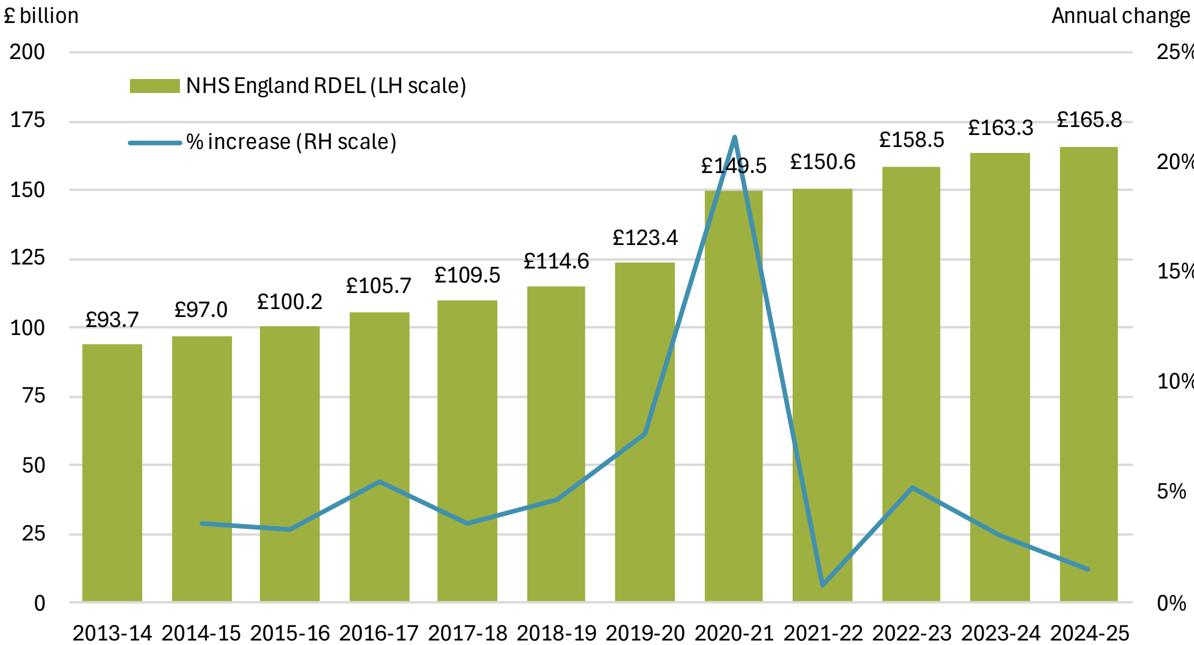
2.16 The Department of Health and Social Care (DHSC) said that the 2021 Spending Review had included 2 per cent in budgets for pay awards in 2024-25. It said that the financial pressures on the NHS settlement since the Spending Review had become significantly more pronounced due to unforeseen inflationary pressures, the lasting impact of COVID-19, the 2023-24 pay awards, and industrial action. This was despite some additional funding since the 2021 Spending Review, including the financial package announced in November 2023, providing an additional £800 million. These pressures had necessitated the reprioritisation of budgets for 2024-25. The DHSC recognised in oral evidence that recommendations on pay should balance the need for industrial peace and a growing workforce with the challenging financial landscape.

2.17 Mandate funding for NHS England was set to increase by 1.5 per cent in 2024-25. Staffing costs accounted for 45.6 per cent of NHS England resource funding in 2022-23, unchanged over the medium term.

2.18 NHS England said that the NHS budget would be worth 3.8 per cent less in real terms in 2024-25 than in 2021-22. It said that financial pressures on NHS services had been exacerbated by ongoing industrial action. Additional non-recurrent funding for integrated care boards (ICBs) was announced in November 2023 in response to the financial and operational pressures of industrial action. This meant diverting planned spend away from technology budgets, international recruitment, and wider capital budgets, with capital spending switched to resource spending.

2.19 NHS England said that the NHS also needed to deliver annual efficiency savings of at least 2.2 per cent each year, which was significantly higher than the circa 1 per cent a year the NHS had historically delivered. In total, ICBs were seeking to make £7.8 billion of savings in 2023-24.

Figure 2.6: Mandate funding for NHS England, 2013-14 to 2024-25



Source: DHSC.

Note: NHS England Revenue Departmental Expenditure Limits (RDEL) cash excluding ringfenced spending.

2.20 NHS Providers said that it was essential that the 2024-25 pay award was fully funded by central government to avoid either cuts to local NHS budgets, or further cuts to national

improvement and transformation programmes. They said that funding pay uplifts by raiding frontline budgets could have significant operational implications and scaling back vital medium and long-term transformation spend (e.g. on frontline digitisation) would only make it harder to improve patient care.

2.21 The Scottish Government said the budget for health and social care was £19.5 billion in 2024-25, which it said was a real terms uplift. It said that, despite this, the system was under extreme pressure as a result of the ongoing impacts of COVID-19, Brexit, inflation, and the UK government's spending decisions. Health boards across Scotland would receive an almost 3 per cent uplift in funding, bringing their total budget to £14.2 billion, which included over £10 billion for NHS staff. The paybill was estimated to have grown by £163 million (8.5 per cent) over 2023-24.

2.22 The Institute for Fiscal Studies (IFS) said that overall healthcare funding in Scotland for 2024-25 was expected to be 6.7 per cent higher in cash terms than the initial plans set out in the May 2022 Resource Spending Review, but only 0.7 per cent higher in real terms.[10]

2.23 The Scottish Government did not publish a public sector pay policy alongside the 2024-25 Budget and it was made clear in oral evidence that a position on affordability for the 2024-25 pay award had not yet been set.

2.24 The Welsh Government said that the draft resource budget for health and social services in 2024-25 was £11.3 billion, an 8.7 per cent increase (in nominal terms) on the final resource budget of £10.4 billion for 2023-24.

2.25 The Department of Health in Northern Ireland said in written evidence that no budget had been set yet for 2024-25. It said that the budgetary and political uncertainty had obvious consequences for pay planning and policy. It anticipated that the future funding position would not significantly improve. In such a context, there would be no capacity to afford a meaningful pay uplift in 2024-25 without implementing corresponding cuts to services.

2.26 The Northern Ireland Executive published its 2024-25 budget on 25 April 2024.[11] Allocated funding for the Department of Health increased from £7,261 million in 2023-24 to £7,716 million in 2024-25, an increase of 6.3 per cent. The Finance Minister said that the budget underlined the Executive's commitment to health with it receiving over half (51.2 per cent) of the total amount allocated to departments for day-to-day costs, including £34 million to tackle waiting lists.

Impact of industrial action

2.27 Doctors and dentists in training in England took 39 days of industrial action between March 2023 and February 2024. A further five-day strike was planned to start at the end of June. Consultants in England took nine days of strike action between July and October 2023. Doctors and dentists in training in Wales took 10 days of strike action between January and March 2024. Doctors and dentists in training in Northern Ireland took strike action in March, May and June 2024.

2.28 NHS England estimated that the cost of industrial action by doctors was more than £1.5 billion in 2023-24. This included the costs of having to secure staff cover on strike days and catching

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[10] IFS, *The IFS Scottish Budget Report – 2024–25.* https://ifs.org.uk/publications/ifs-scottish-budget-report-2024-25

[11] *Written Ministerial Statement – Public Expenditure – Budget 2024-25.* https://www.finance-ni.gov.uk/publications/written-ministerial-statement-public-expenditure-budget-2024-25

up on activity that had been rescheduled. Responding to the strike action impacted on the operational and management capacity to plan and deliver productivity through transformation.

2.29 NHS Providers said that trust leaders had lost valuable leadership and managerial headspace and time for strategic planning due to industrial action, and planning for the strikes had a big impact on the delivery of operational priorities.

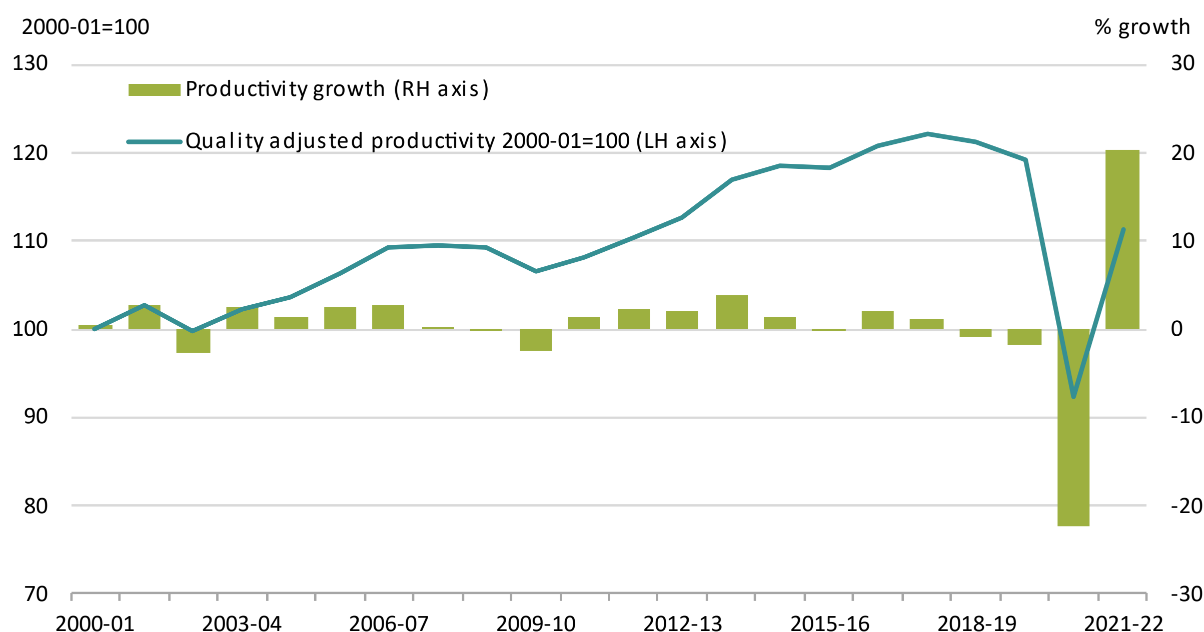
2.30 NHS Employers said that the planning and preparation needed for managing ongoing industrial action had had a significant impact on the organisational capacity of employers, with resources diverted to manage reduced activity by doctors and organise local cover. This additional activity had restricted the ability of employers to deliver planned improvements. The financial cost of additional sessions for existing staff and agency/bank staff had been significant and not separately funded. These financial pressures had reduced opportunities for employers to recruit substantive staff.

2.31 NHS Providers said that delays in resolving industrial action had affected morale. Industrial action had also had an impact on relationships between trust leaders and staff. NHS Employers reported growing concerns for the wellbeing of staff due to prolonged periods of industrial action causing unsustainable pressure on workloads. They also said this had had a serious impact on morale and had led to the deterioration of relationships between staff groups.

Healthcare productivity

2.32 According to the ONS, public service healthcare productivity in England increased by 20.3 per cent in 2021-22, following a fall of 22.4 per cent in 2020-21. This reflected an increase in output while inputs remained broadly constant. Quality adjusted output increased by 19.6 in 2021-22, while total inputs fell by 0.6 per cent in 2021-22 as expenditure on goods and services to support healthcare services through the pandemic fell slightly, following an increase of 24.2 per cent in 2020-21.

Figure 2.7: Public service healthcare productivity, England, 2000-01 to 2021-22



Source: ONS. Public service productivity, healthcare, England: financial year ending 2022.

2.33 Public service healthcare productivity in England was 6.6 per cent lower in 2021-22 than in 2019-20. Between 2000-01 and 2021-22, healthcare productivity grew by 11.2 per cent, an average of 0.7 per cent a year. This compares to 20.1 per cent in the whole economy over the period.

2.34 The IFS said that, in England, hospitals had 15.8 per cent more consultants, 24.6 per cent more junior doctors, 19.5 per cent more nurses and health visitors, and 18.5 per cent more clinical support staff in January to July 2023 than in January to July 2019.[12] However, in the first nine months of 2023, hospitals had 4.3 per cent fewer emergency admissions and 1.3 per cent fewer non-emergency admissions than over the same period in 2019. They carried out 1.8 per cent more outpatient appointments and 0.8 per cent more treatments from the waiting list than in 2019. The IFS pointed out that this means the number of patients treated per staff member has fallen substantially.

2.35 The DHSC said that, as a result of the COVID-19 pandemic, there were large backlogs for elective care due to issues such as the direct effects of managing COVID-19, delays to discharge and longer non-elective lengths 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.

2.36 The Institute for Government (IfG) and Public First explored the reasons why hospital activity did not increase in line with funding or staffing, pointing to issues around patient flow, staffing and management.[13] The slow flow of patients through hospitals was identified as the most immediate cause of the productivity problems exacerbated by delayed discharges due to a lack of available care outside the hospital system.

2.37 Outpatient activity had dropped relative to staffing: the number of attended outpatient appointments fell by 2.6 per cent between 2019 and 2022, while overall headcount increased by 11.1 per cent. This was linked to stalled diagnostic testing. There was also a risk that general medical practitioners (GPs) making fewer referrals – in part to address hospital capacity concerns – were creating a hidden backlog by allowing treatable conditions to deteriorate and possibly leading to more unplanned admissions. The report pointed to the UK’s long-standing minimal capital spending on healthcare relative to other countries.

2.38 The IfG and Public First considered that the composition and morale of NHS staff could be exacerbating the problem. Despite a big increase in the overall number of doctors and nurses, the balance looked to have shifted towards less experienced practitioners, who may be less able to speed up patient flow. There had also been an increase in staff churn which was disruptive in hospitals: the overall leaver rate increased from 10.7 per cent in the year to December 2019 to 12.5 per cent in the year to September 2022. A lack of ward nurses and managers at the most critical points for patient flow was identified. Low morale, burnout, backlogs, the use of agency staff and the ongoing pay dispute were also highlighted.

2.39 They also said that the NHS was chronically undermanaged and that managers had insufficient ability and freedom to make consistent decisions. The report concluded that more capacity, a more stable and supported workforce, and greater clarity on objectives and finances from the government were all needed.

[12] IFS, *Is there really an NHS productivity crisis?* https://ifs.org.uk/articles/there-really-nhs-productivity-crisis

[13] IfG, *The NHS productivity puzzle: Why has hospital activity not increased in line with funding and staffing?* https://www.instituteforgovernment.org.uk/publication/nhs-productivity

2.40 The DHSC acknowledged there was a system challenge of meeting the efficiency and productivity savings set out in the last Spending Review, as well as refining and implementing plans to deliver labour productivity growth of up to 2 per cent a year, as set out under the Long Term Workforce Plan. It acknowledged that was significantly higher than the 1 per cent a year the NHS had historically achieved. It noted that the current settlement required the NHS to deliver annual efficiency savings of at least 2.2 per cent each year.

2.41 The DHSC said that productivity improvements going forward needed 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 staff, and reducing the administrative burden on clinicians through technological advancement, such as artificial intelligence and robotic process automation.

2.42 NHS Providers questioned whether the assumptions in the Long Term Workforce Plan, of 1.5-2 per cent productivity growth a year, would be achievable. NHS Employers said this was a very stretching target and that even to achieve the lower end of the range would require major investment in technology, innovation and capital.

2.43 The IfG has noted that, in contrast to secondary care, the number of appointments that GPs delivered reached a record level in 2022-23, with GPs providing 162.3 million appointments, 0.2 per cent more than in 2021-22 and 5.3 per cent more than in 2019-20.[14] This was despite the fall in the number of fully qualified permanent GPs. Other practice staff were also delivering record numbers of appointments, with 163.3 million provided in 2022-23, an increase of 11.6 per cent compared to 2021-22 and 19.5 per cent compared to 2019-20. This was a far greater increase than the number of GP appointments because of the increase in direct patient care staff. Both GPs and other practice staff had increased the number of appointments delivered per FTE, with GPs (excluding trainees) delivering 9.5 per cent more appointments per FTE in the 12 months to September 2023 than in the 12 months to September 2019 and other practice staff providing 10.0 per cent more.

2.44 In the 2024 Spring Budget, the UK government announced an additional £0.9 billion a year of capital departmental spending, over the three years from 2025-26 to 2027-28, for a public sector productivity programme focused on the NHS. It said the NHS productivity plan would double investment in NHS technological and digital transformation, including upgraded MRI scanners, the roll out of universal electronic patient records, and a reduction in the time frontline workers spent on administrative tasks. It said this would help unlock £35 billion in cumulative productivity savings from 2025-26 to 2029-30.

Workforce planning

The Long Term Workforce Plan

2.45 NHS England published the *NHS Long Term Workforce Plan* in June 2023.[15] It adopted a 15-year timeframe, using 2022 as the starting point and running until 2036-37. It included a significant reassessment of NHS demand, driven by an aging population with multiple morbidities, that would need to be met by an expansion in workforce supply. It was organised

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[14] IfG, *Performance Tracker 2023: General practice.* https://www.instituteforgovernment.org.uk/publication/performance-tracker-2023/general-practice

[15] NHS England, *NHS Long Term Workforce Plan.* https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/

around three themes: training new staff, retaining existing staff, and reforms to improve productivity.

2.46 The Plan estimated that domestic education and training overall would need to increase by 50 to 65 per cent by 2030-31. More than £2.4 billion would be invested over the next six years, to support a 27 per cent increase in training places by 2028-29. The required increase in medical school places was estimated to be 60 to 100 per cent, meaning there would need to be 12,000 to 15,000 places by 2030-31. This expansion would begin by increasing the number of medical school places from 7,500 in 2022 to 10,000 by 2028-29.

2.47 The Plan said that there would need to be a 45 to 60 per cent increase in the number of GP specialty training places by 2033-34, with the aim of increasing the number of places from 4,000 in 2022 to 6,000 by 2031-32. The first expansion of 500 places would take place in 2025-26. There would also need to be expansions to foundation and specialty training, commensurate with the growth in undergraduate places.

2.48 Under the Plan, training programmes for dentists would expand by 40 per cent by 2031-32; this would lead to the number of dental training places increasing from 809 to 1,133.

2.49 Investment in domestic education and training was expected to lead to the NHS becoming less reliant on international workforce supply in the medium to long term. It was expected that the proportion of joiners to the NHS who were recruited internationally would fall from 24 per cent to 9.0-10.5 per cent by 2036-37. There was expected to be a significant reduction in international recruitment for doctors, though this was dependent on the level of productivity growth.

2.50 Funding has been provided for 200 medical degree apprenticeship places in pilots running from 2024-25. The ambition in The Plan was to expand this to up to 400 places by 2026-27. Subject to evaluation, the aim was to have 2,000 students training on this route by 2031-32, with more than 850 medical degree apprenticeships by 2028-29.

2.51 A pilot internship model for newly qualified doctors was proposed, which would involve graduating six months earlier and entering a six-month remunerated internship programme. NHS England would also work with medical schools and the General Medical Council to develop four-year undergraduate medical degrees. New medical schools and additional medical school places would be focused in the geographic areas with the greatest staff shortfalls, and a higher proportion of graduates would carry out their postgraduate training in the areas with the greatest shortages.

2.52 The Plan was predicated on an ambitious labour productivity assumption of up to 2 per cent a year (with a range of 1.5-2 per cent). This was based on reducing the administrative burden through technological advancement and better infrastructure, care being delivered in more efficient and appropriate settings, and using a broader range of skilled professionals, upskilling and retaining staff.

2.53 The IFS looked at the potential implications of the workforce plan for NHS funding.[16] It said that the Plan implied annual NHS budget increases of around 3.6 per cent a year in real terms (or 70 per cent in total by 2036-37). It said it implied real-term increases in the NHS wage bill of around 4.4 per cent a year. It also said that increasing the size of the workforce so rapidly

[16] IFS, *Implications of the NHS workforce plan Green Budget 2023 – Chapter 8.* https://ifs.org.uk/publications/implications-nhs-workforce-plan

would likely require NHS wages to become more generous in real terms and potentially match or even exceed growth in wages in the rest of the economy.

2.54 In evidence, parties broadly welcomed the Long Term Workforce Plan, but raised a number of issues. NHS Employers said that investment would be needed in local infrastructure and capacity to support the significant increase in workplace learning and education to deliver the Plan. They noted that the focus on new and different roles, as well as a shift back to more generalist roles, was seen as key to delivering transformation and services. They said it would be important that a pay system and associated terms and conditions supported this focus.

2.55 NHS Providers said that questions remained about how the Plan would be funded and implemented across its 15-year lifespan. NHS Providers noted that the Plan did not set out any ambitions for pay and total reward.

2.56 Both the Hospital Consultants and Specialists Association (HCSA) and the British Dental Association (BDA) noted the lack of detail around undergraduate and specialty training, with particular concerns around training capacity.

Workforce planning in Scotland

2.57 The Scottish Government said that NHS boards and health and social care partnerships were asked to complete three-year workforce plans in 2022, taking into account their current workforce, including a gap analysis comparing projected demand with current workforce capacity, and their assessment of workforce needs to fill any identified gaps. The plans were published late in 2022. The Scottish Government said it had been reviewing the three-year workforce planning process and would implement a refined process this year.

2.58 The IFS said that the Scottish Government's health and social care workforce plan only aimed to increase NHS staffing by 1 per cent over the five years from 2022, compared to 20-21 per cent growth under the workforce plan for England over the same period.[17] It suggested that Scotland was likely to need to either increase staffing numbers and spending by more than planned increases, find ways to boost productivity significantly faster than was being planned in England, or live with a relative deterioration in NHS service quality.

Workforce planning in Wales

2.59 The Welsh Government said that the challenge of recruiting to particular specialties needed to be addressed through workforce planning and recruitment initiatives as well as changing the way roles were designed.

Workforce planning in Northern Ireland

2.60 The Department of Health in Northern Ireland published *Health and Social Care Workforce Strategy 2026: Delivering for Our People* in 2018, with a target implementation of 2026. This modelled the number of medical and dental school and specialty postgraduate training places. The Department said that a rolling programme of medical specialty workforce reviews was ongoing. The strategy's second action plan was published in June 2022.

[17] IFS, *Scottish Budget: Healthcare spending, staffing and activity Scottish Budget.* https://ifs.org.uk/publications/scottish-budget-healthcare-spending-staffing-and-activity

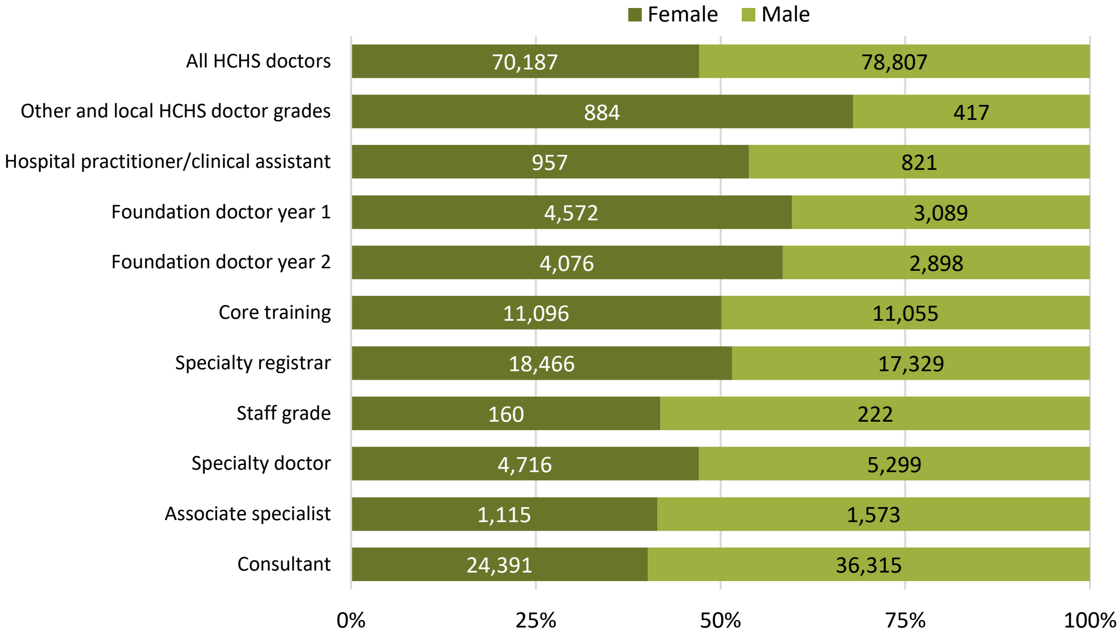
Workforce equalities and diversity

Secondary care

2.61 In December 2023, 47 per cent of medical and dental Hospital and Community Health Services (HCHS) staff in England were female. Although a majority of doctors and dentists in training were female, in the more senior positions, just 41 per cent of associate specialists and 40 per cent of consultants were female.

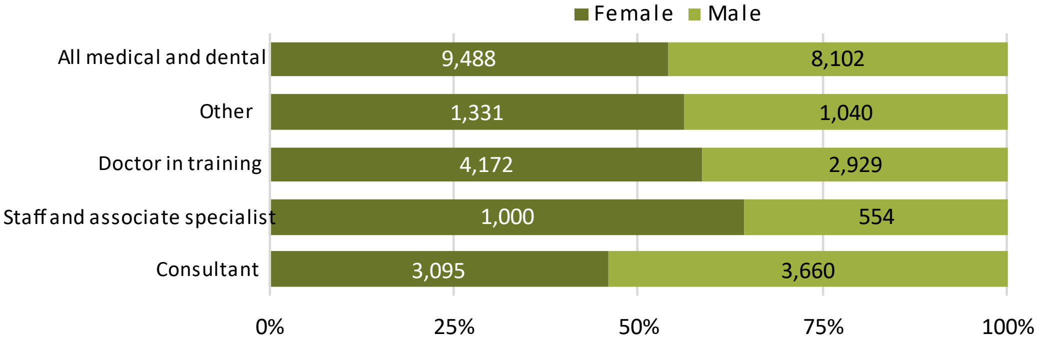
2.62 The proportion of medical and dental staff that were female increased by 1.8 percentage points, to 47.1 per cent, between September 2019 and December 2023. There was an increase in the percentage of foundation year 1, foundation year 2, core trainees, associate specialists and consultants that were female, but a fall in the percentage of specialty registrars that were female.

Figure 2.8: HCHS doctors and dentists, by gender and grade, England, December 2023, headcount



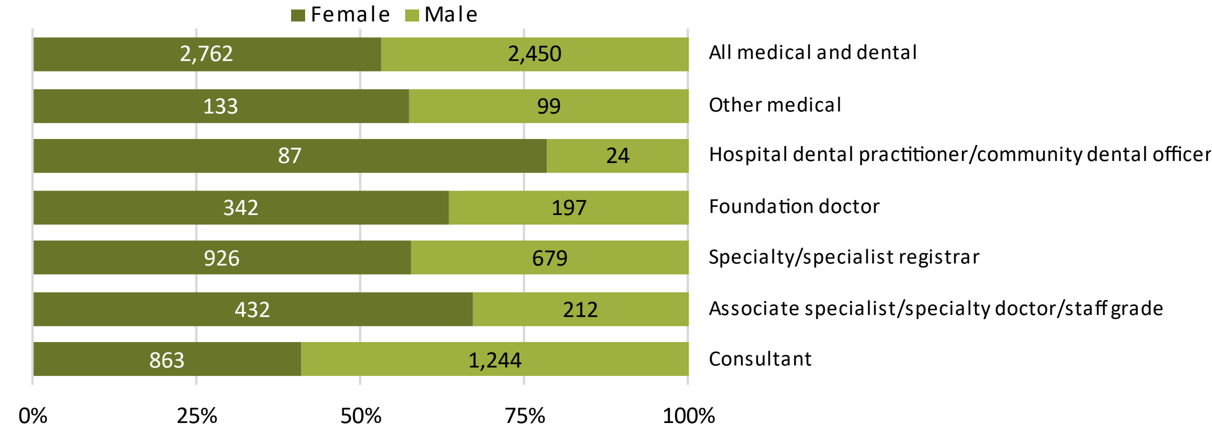
Source: NHS England.

Figure 2.9: HCHS doctors and dentists, by gender and grade, Scotland, December 2023, headcount



Source: NHS Education for Scotland.

Figure 2.10: Health and Social Care doctors and dentists, by gender and grade, Northern Ireland, March 2023, headcount



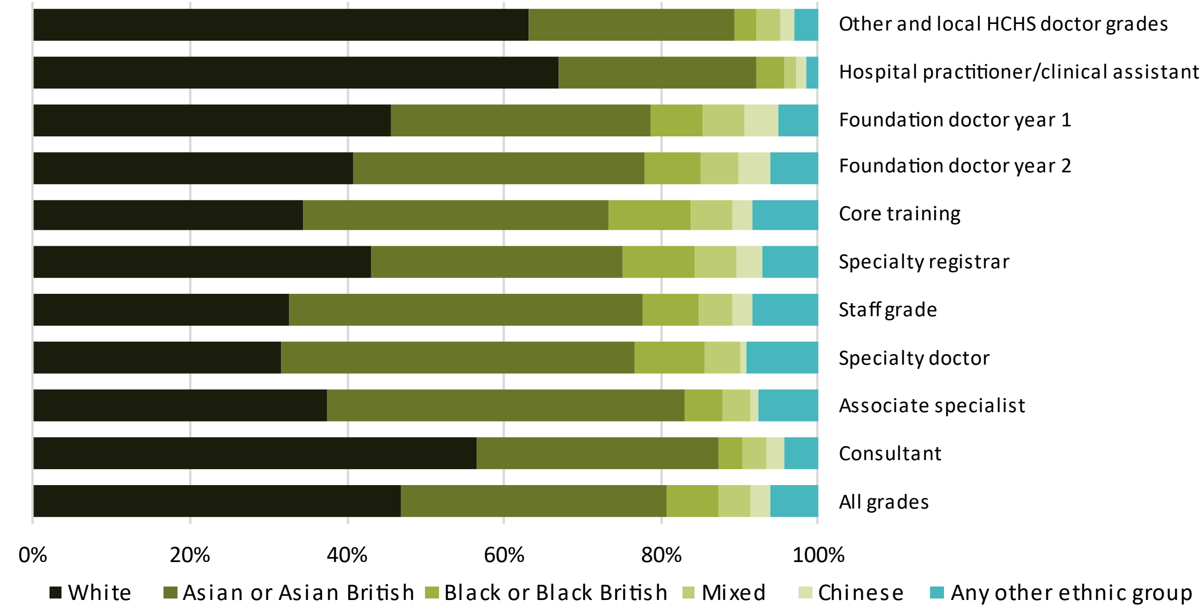
Source: Northern Ireland health and social care workforce census.

2.63 In Scotland, 53.9 per cent of medical and dental staff were female in December 2023. At all grades a majority of medical and dental staff were female, except at consultant, where 45.8 per cent were female. The proportion of staff that were female increased by 1.2 percentage points (from 52.8 per cent to 53.9 per cent) between 2019 and 2023.

2.64 In Northern Ireland, 53.0 per cent of medical and dental staff were female in 2023. At all grades a majority of staff were female, except at consultant, where 41.0 per cent were female. The proportion of staff that were female increased by 6.7 percentage points (from 46.3 per cent to 53.0 per cent) between 2019 and 2023.

2.65 In Wales, 46.0 per cent of medical and dental staff were female in September 2023, an increase from 45.7 per cent in September 2022.

Figure 2.11: HCHS doctors and dentists, by ethnicity and grade, England, December 2023, headcount



Source: NHS England.

2.66 In December 2023, 46.9 per cent of medical and dental staff in England were White; 33.8 per cent were Asian or Asian British; 6.4 per cent were Black or Black British; 4.1 per cent had mixed ethnicity; 2.7 per cent were Chinese; and 6.0 per cent were from any other ethnic group.

2.67 Between September 2019 and December 2023, the proportion of medical and dental staff that were Asian or Asian British, Black or Black British, Chinese, mixed ethnicity, or any other ethnic group all increased, while the proportion that were White decreased. Broken down by grade, the largest falls in the percentage of White staff, and the largest increases in the percentage of staff from all other ethnic groups, were in the least senior grades: foundation year 1; foundation year 2; and core training. The smallest changes were in the composition of staff were at the more senior levels: consultant and associate specialist/specialist.

2.68 In Wales, in September 2023, 35.4 per cent of medical and dental staff were White, 17.5 per cent were Asian/Asian British, 3.4 per cent were Black/African/Caribbean/Black British, 1.7 per cent were from mixed/multiple ethnic groups, and 4.0 per cent were from other ethnic groups. However, for 38.0 per cent of medical and dental staff there was no information on ethnicity. Compared with September 2022, the percentage of White staff fell by 2.5 percentage points, and the percentage of staff for whom there was no information increased by 2.7 percentage points, otherwise there was little change over the period.

2.69 In December 2023, 2.9 per cent of medical and dental staff in England said that they were disabled, compared with 6.0 per cent of all NHS staff. Foundation year 1 (6.1 per cent) and foundation year 2 (6.0 per cent) doctors were more likely to say they were disabled than other medical and dental grades. There was no disability data for 20.3 per cent of HCHS doctors and dentists, compared with 14.4 per cent of all NHS staff. Between September 2019 and September 2023, there was an increase in the percentage of HCHS doctors at all grades saying they were disabled, and an increase in the percentage saying they were not disabled, as the percentage of HCHS doctors with no known disability status fell from 28.4 per cent to 20.3 per cent.

2.70 In December 2023, 72.3 per cent of medical and dental staff in England were heterosexual or straight; 1.8 per cent were gay or lesbian; 1.1 per cent were bisexual; 0.1 per cent were undecided; 0.1 per cent said their sexual orientation wasn't listed; and for 24.8 per cent no information was available. Information on sexual orientation was more likely to be available for doctors and dentists in training than for more senior colleagues. Information on sexual orientation was available for a greater percentage of the workforce at all medical and dental grades in December 2023 (75.2 per cent) than in September 2019 (63.1 per cent).

2.71 In December 2023, 23.9 per cent of medical and dental staff in England had Christian beliefs; 16.0 had Islamic beliefs; 14.3 per cent were Atheists; 10.2 per cent were Hindus; and for 28.6 per cent no information was available. Compared with NHS staff as a whole, doctors and dentists were more likely to be Muslims and Hindus, but less likely to be Christians. The percentage of doctors and dentists for which there was no information on religious belief fell from 39.9 per cent in September 2019 to 28.6 per cent in December 2023.

General practice

2.72 The number of female GPs has increased at a far greater rate than the number of male GPs. Between 2016 and 2023, the number of female FTE regular GPs in England increased by 18 per cent compared with a 3 per cent increase in the number of male regular GPs. In December 2023, female FTE regular GPs made up 53.3 per cent of the total, up from 49.8 per cent in December 2016. Female GPs are much more likely to work part time: in December 2023 it

took 112 male headcount GPs to generate 100 male FTE GPs and 135 female headcount GPs to generate 100 female FTE GPs.

2.73 A similar pattern has been seen in the other nations. In Scotland, the proportion of headcount GPs that were female increased from 55 per cent in 2015 to 62 per cent in 2023. In Northern Ireland, the proportion of headcount GPs that were female increased from 45 per cent in 2013 to 60 per cent in 2023.

2.74 Average earnings of female contractor GPs were lower than those of male contractor GPs in each nation in 2021-22, by 21 per cent in both Scotland and Wales, 20 per cent in Northern Ireland, and 19 per cent in England. It is important to note that this does not take account of working hours. The pre-tax income gap narrowed in each nation between 2017-18 and 2021-22, except in Wales where there was little change.

2.75 Average earnings of female salaried GPs in 2021-22 were lower than those of male salaried GPs: by 22 per cent in Wales; 25 per cent in both England and Scotland, and 37 per cent in Northern Ireland. In all nations except Wales, the gap between male and female average incomes narrowed between 2017-18 and 2021-22.

General dental practitioners

2.76 The proportion of general dental practitioners (GDPs) providing NHS work in England that were female increased from 50 per cent in 2018-19 to 54 per cent in 2022-23. Similarly, in Scotland, the proportion of GDPs that were female increased from 47 per cent in March 2013 to 55 per cent in March 2023. In Wales, the share of NHS dentists that were female increased from 42 per cent in 2010-11 to 51 per cent in 2022-23. In Northern Ireland, the share of NHS dentists that were female increased from 47 per cent in 2010 to 59 per cent in 2023.

2.77 In England and Scotland, average pre-tax incomes of female providing-performer dentists were lower than those of male providing-performers in 2021-22, by 19 per cent and 14 per cent respectively. In Wales, in 2021-22, average pre-tax incomes for female providing-performer dentists were 2 per cent higher than those for male providing-performers. Again, this does not take account of working hours.

2.78 Average pre-tax incomes of female associate dentists in 2021-22 were lower than those of male associates: by 26 per cent in England; 24 per cent in Scotland, and 23 per cent in Wales. In each nation, the gap between male and female average incomes was little changed between 2019-20 and 2021-22.

Pensions

2.79 The March 2023 Budget increased the pension annual allowance from £40,000 to £60,000 from April 2023. The Budget also changed the rules around the taper. The minimum annual allowance increased from £4,000 to £10,000. The adjusted income limit (where the taper cuts in) increased from £240,000 to £260,000. There was no change to the threshold income limit, which remained at £200,000. This allowed individuals to benefit by up to £13,500 a year in reduced annual allowance tax charge.

2.80 The lifetime allowance was also removed from April 2023. The lifetime tax charge was levied at 25 per cent of the value of pension pots over £1.073 million. Its removal was potentially highly valuable for those whose pension pots are worth more than £1.073 million at retirement, which includes many of the higher earners in our remit group.

Pension developments in England and Wales

2.81 Employers' contribution to the NHS pension scheme increased from 20.6 to 23.7 per cent from 1 April 2024. Employee contributions also changed to a six-tier contribution structure where the top band (where most doctors and dentists will be) reduced from a contribution rate of 13.5 per cent (at £75,633 and above) to 12.5 per cent (at £62,925 and above).

2.82 A package of new retirement flexibilities for members of the 1995 section of the NHS pension scheme in England and Wales has been introduced. 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 was abolished from 1 April 2023. The rule that prevented retired staff who return to NHS work from re-joining the scheme and building up more pension was also removed.

2.83 A new partial retirement option was made available to staff from 1 October 2023 as an alternative to full retirement. Pension scheme members are now able to draw down some or all of their pension while continuing to work and build up further pension, subject to a minimum 10 per cent reduction in their pensionable pay. The partial retirement rules for the 2008 section and the 2015 scheme were also amended so that members could take up to 100 per cent of their benefits and continue working if they wish. The rules were aligned across the 1995 section, 2008 section and the 2015 scheme.

2.84 Additional changes aligning the CPI for benefit revaluation with calculations for pension taxation mitigated the impact of the annual allowance on members from the 2022-23 tax year.

2.85 NHS Employers welcomed the changes which they said had helped employers to retain staff who would otherwise have left the pension scheme, reduced their working commitments, or retired to avoid substantial tax charges. They said that the overall flexibility provided by pension tax changes, combined with partial retirement and retire-and-return options, benefited both members and employers in terms of retention.

2.86 NHS Employers remained of the view that introducing greater flexibility over the level of contributions members paid into the scheme was key to ensuring the NHS pension scheme remained attractive and valuable to all staff. They said allowing members to pay a lower level of contribution to the scheme for a proportionately lower pension in return could help to encourage more members to join the scheme and access a broader reward package from their employer. NHS Employers said they would welcome the opportunity to explore ways of combining flexible pension accrual with recycling unused employer contributions for all staff.

2.87 NHS Providers also welcomed the increased pension flexibilities, as well as the increase to the annual allowance and the abolition of the lifetime allowance. Trust leaders commented that the £60,000 annual allowance remained too low and were concerned that the decision to abolish the lifetime allowance could be reversed following a general election.

2.88 The HCSA welcomed the pension tax changes, including the ability to offset negative growth in one NHS pension scheme against positive growth in another. It noted that the McCloud judgment meant individuals may not have a clear view of how much work they were able to do without incurring disproportionate charges. It said that, once the remedy had been applied and doctors informed of how they were affected, it would then be possible to measure the impact of the pension changes on behaviours.

2.89 The HCSA said it was important for policymakers to understand that the creation of uncertainty or fear around pension taxation greatly impacted behaviours. It noted with caution proposals to bring back the lifetime allowance, albeit with the caveat that doctors would be excluded from this tax.

2.90 The HCSA was also concerned by divergence in approach from NHS trusts on partial retirement. It described the requirement to drop pensionable pay by 10 per cent as an arbitrary restriction that incentivised doctors to cut back on working hours. It said some trusts had mitigated this by providing means to make part of the pay non-pensionable, to allow doctors to continue working at full capacity if they wish, while drawing pension. The HCSA's position was that NHS Employers should compel all trusts to offer this provision to retain senior doctors.

2.91 Overall, 88 per cent of hospital doctors and dentists in England were members of the pension scheme in June 2023, down 2 percentage points over the year and 7 percentage points over 10 years. The falls were highest among those in core training. The DHSC said this was mainly due to lower membership rates among doctors working in trust grades, which might be included within core training, many of whom held non-British nationality. For doctors and dentists in training from the UK, membership was 96 per cent but 69 per cent for those not from the UK or EU.

Table 2.1: NHS pension scheme membership for the HCHS workforce, England, June 2023

	June 2023	One-year change	Five-year change	Ten-year change
Consultant	91%	0%	-1%	-5%
Associate specialist	90%	0%	-3%	-3%
Specialty doctor	84%	-2%	-4%	-5%
Staff grade	89%	-1%	-4%	-3%
Specialty registrar	88%	-4%	-5%	-7%
Core training	80%	-6%	-11%	-14%
Foundation doctor year 2	88%	-4%	-5%	-8%
Foundation doctor year 1	91%	-2%	-4%	-5%
Hospital practitioner/ clinical assistant	70%	1%	-2%	-10%
Other and local HCHS doctor grades	84%	4%	2%	-7%
All HCHS doctors	88%	-2%	-4%	-7%

Source: DHSC.

Pension developments in Scotland

2.92 The Scottish Government said that the changes to the annual allowance and moves to abolish the lifetime allowance were welcome and would support staff retention by removing most senior doctors and dentists from the impact of pension tax. It said that pension tax had previously been identified as a barrier to senior clinicians remaining in the workforce and from working more hours due to the risk of incurring a significant pension tax charge.

2.93 Retirement flexibilities (pensionable employment and partial retirement), which were already available to those in the 2008 and 2015 pension schemes in Scotland, were extended to the 1995 scheme from April and October 2023.

2.94 To protect lower-paid staff, the Scottish Government delayed implementation of reform to member contribution rates for more than two years. However, it was acknowledged that there were concerns about the retention of senior doctors both in the workforce and in the pension scheme as a result of Scotland falling behind the rest of the UK in the implementation of these contribution changes. A revised contribution structure has been introduced which aimed to strike a balance between flattening the contribution structure, protecting the take-home pay of lower and middle earners, and the affordability of the scheme. The phased implementation of these changes began on 1 October 2023, which included a reduction in the highest contribution rate, for those earning over £68,223, from 14.7 per cent to 13.7 per cent. An increase in the employer contribution rate from 20.9 to 22.5 per cent was required from 1 April 2024.

Pension developments in Northern Ireland

2.95 The changes to the annual allowance and the abolition of the lifetime allowance, as well as the adjustment of the CPI revaluation date, were broadly welcomed by the Department of Health in Northern Ireland. It hoped that members might be more inclined to remain within the HSC and the HSC pension scheme given these changes.

2.96 The Department was consulting on a package of new retirement flexibilities including pensionable re-employment, partial retirement and removal of the 16-hour rule. These flexibilities had been designed to offer staff increased options at the end of their careers, so they could partially retire or return to work seamlessly and continue building pension after retirement if they wished. It was hoped these flexibilities would offer members a greater degree of flexibility around how they took their pension benefits as well as providing an important boost to HSC capacity.

2.97 The Department was also working to introduce guidance to allow HSC employers to offer employer contribution recycling where, when a member dropped out of the scheme either entirely or for one contract, they received the money which their employer would have spent on pension contributions as income net any additional costs.

Our comments

The economy and the labour market

2.98 Inflation has fallen sharply over the last 18 months, to 2.3 per cent in April 2024 on the CPI measure, and was expected to be close to 2 per cent for the rest of the year. Members of our remit group will, however, be continuing to experience the higher costs of living from the inflation of the last two years.

2.99 Economic growth in the UK is weak, which constrains the government’s ability to fund the public sector. The labour market is showing signs of weakening, and much of the recent job growth has been driven by the health and social care sector. Although rising, unemployment remains well below its long-term average.

2.100 In making our recommendations, we consider trends in average earnings growth and pay settlements across the wider economy which indicate the typical increases being received by other employees and provide a useful reference point for our deliberations. Regular average earnings growth across the whole economy was around 6 per cent in the first quarter of 2024, and earnings growth at the top quartile of the earnings distribution, which is a better match for most of our remit group, was closer to 4-5 per cent. Median pay settlements across the

economy were at 5 per cent in the first quarter of 2024, with an interquartile range of 4 to 6 per cent.

Health funding and affordability

2.101 There is no doubt that the scope for affording pay increases within existing health budgets is extremely tight with ongoing pressures from inflation, waiting lists, and previous pay uplifts. Before many of these pressures unfolded, the Spending Review 2021 was set to allow for a 2 per cent pay award for 2024-25 in England. Reprioritisation from other areas of the health budget was necessary following the 2023-24 pay awards. We note the concerns from NHS Providers that if a pay award is not fully funded this year there is a risk of either cuts to local NHS budgets, or further cuts to national improvement and transformation programmes which support long-term productivity growth. We also note that additional funding has been found for further pay uplifts for consultants and SAS doctors in England, and an offer was made to doctors and dentists in training.

2.102 In oral evidence, governments recognised the need to balance the enormous demand pressures on NHS budgets with the need to reward staff appropriately and the risk and subsequent costs of further industrial action. The DHSC told us that the costs of industrial action in the NHS in 2023-24 was £1.7 billion and observed that a pay award that was too low could reignite disputes that had been successfully resolved. The NHS in England is already required to deliver annual efficiency savings of at least 2.2 per cent each year, significantly higher than the 1 per cent that has historically been delivered. In Scotland, Wales and Northern Ireland, the pressures on health budgets are evident, although we were not given a clear picture on the affordability of pay uplifts.

Long Term Workforce Plan

2.103 The publication of the Long Term Workforce Plan for England is an important and positive step forward and we welcome it. This is a central step in addressing recruitment and retention for our remit group and the rest of the NHS workforce and assessing whether medical and dental staffing is sustainable in the medium and long term. It will require substantial future funding commitments from the government to be delivered.

2.104 We would hope to see detailed action plans, specific to individual workforces, as well as ongoing monitoring, in future years. In particular, there needs to be more detailed planning around the demand for medical specialties in the NHS, and how this matches the current ambitions of doctors in training. The Plan predicts a decreasing reliance on internationally qualified doctors. Given the increasing dependence on this group in recent years, it is important to set out how this will be achieved.

2.105 Many parties have suggested that the productivity targets required by the Plan are unrealistic. The reasons for the recent apparent decline in healthcare productivity are complex and multifaceted. Health productivity is also hard to assess and focuses on short-term measurable outputs. Productivity gains typically require members of the workforce to deliver more, and they may be assisted by technological improvements to deliver this. It is important to set out how structural changes to the workforce and the delivery of care might best deliver these productivity targets.

2.106 Significant concerns have also been raised about whether the trainers and training infrastructure is sufficient to deliver current training needs, even before this substantial expansion to training places. We would like to see a greater focus on whether appropriate

reward and incentives are in place for experienced members of the medical and dental profession to deliver this training.

2.107 There was no discussion of pay levels in the Plan, and no party has indicated to us how the pay system might support the planned substantial expansion to the medical and dental workforces. The medical and dental professions will need to remain attractive to prospective applicants and appropriate incentives will need to be in place to direct doctors and dentists in training to the specialties and localities where they are needed.

2.108 Concerns have not been raised about whether the expansion in medical and dental places will lead to a reduction in the quality of trainees. However, the expansion of medical and dental school places, and the new ways of delivering these qualifications, should provide opportunities to increase the diversity of the workforce. In particular, we would like to see scope for increasing the social diversity of medical and dental trainees.

2.109 The medical and dental labour markets across the four nations are interdependent, and we would like a greater understanding of how the Long Term Workforce Plan in England affects the other nations and how workforce planning can be complementary across the UK. In particular, we would welcome updates on the progress of workforce plans from all nations in evidence next year.

Workforce equalities

2.110 The medical and dental workforces have seen significant advances in equality and diversity over a short period of time. Overall, there is close to a gender balance in medical and dental staff in the secondary care workforce; and the proportion of women is likely to increase further as over half of doctors in training are women. Women have become the majority in primary care workforces.

2.111 We have seen significant increases in the proportion of the secondary care workforce that are from a non-white background, likely supported by increasing international recruitment. We have also seen increases in both the number of medical and dental staff who are disabled and in the proportion of staff who are reporting their disability status.

2.112 We have received a disappointing lack of evidence on the gender pay gap in secondary care this year. Given the very positive developments in this area recently, with the Mend the Gap report and the recent consultant pay restructuring in England, we would like to receive more evidence on gender pay gaps across the secondary care workforce next year. We would also like to be updated on progress on ethnicity pay gap reporting, which was not addressed in evidence this year.

2.113 We would like to receive evidence on the socio-economic background of the medical and dental workforces, and how the expansion of training places might be used as an opportunity to increase socio-economic diversity.

Pensions

2.114 The NHS pension scheme continues to be more generous than for comparators in the private sector. The last year has seen significant changes to pension taxation, making the regime considerably more beneficial for higher earners, and reforms to enable greater flexibility around retirement. We have been told by parties previously that pension taxation and the structure of the pension scheme were discouraging additional work and incentivising earlier retirement. The recent changes should incentivise senior doctors and dentists to continue working rather than taking full retirement. It has been too soon this year to see any clear

impact in the data, and we hope this would be closely monitored in the near future. We have also heard on our visits that the pension taxation regime had stopped consultants from taking on additional programmed activities; we would like to see data on how this trend has changed over time.

2.115 The one percentage point reduction in the employee pension contribution rate for higher earners also provides a boost to take-home pay for most of our remit group.

2.116 We note the small falls in pension scheme membership. We might expect membership to grow again among the consultant workforce following the pension taxation changes that make it more valuable to stay in the scheme. The fall in pension scheme membership among those in core training in England is starker, at 11 percentage points over five years and 14 percentage points over 10 years. While the DHSC has reported that this is related to the increase in international recruits, the BMA have pointed to the cost of living and the high level of employee pension contributions. This group are missing out on a significant part of the overall reward package and we think it is important to explore this further in evidence next year.

Chapter 3 The Hospital and Community Health Service workforce

3.1 Hospital and Community Health Service (HCHS) doctors and dentists are those directly employed by NHS trusts and foundation trusts in England, NHS boards in Scotland, health boards in Wales, and HSC trusts in Northern Ireland. This includes doctors and dentists in training,[18] specialty, associate specialist and specialist (SAS) doctors and dentists, and consultants, as well as doctors and dentists employed on local contracts. Salaried dentists working in the Community Dental Services or Public Dental Services, most of whom are also part of the HCHS workforce, are discussed in chapter 5.

Workforce

3.2 The full-time equivalent (FTE) medical and dental HCHS workforce showed strong growth in the year to December 2023 (see table 3.1). The workforce growth was especially strong in England (5.1 per cent in the year to December 2023) and Wales (4.2 per cent in the year to December 2023) but weaker in Northern Ireland (1.9 per cent in the year to December 2023).[19]

Table 3.1: HCHS doctors and dentists by nation, FTE, December 2023

	England	Scotland	Wales	Northern Ireland
Total	139,656	15,723	8,233	4,791
Annual growth	*+5.1%*	*+2.6%*	*+4.2%*	*+0.5%*
Doctors and dentists in training	70,292	6,737	4,220	2,056
Annual growth	*+6.0%*	*+2.7%*	*+5.2%*	*-0.4%*
SAS doctors and dentists	11,639	1,240	974	564
Annual growth	*+7.7%*	*+2.2%*	*+5.2%*	*+2.0%*
Consultants	56,255	6,137	2,974	1,972
Annual growth	*+3.6%*	*+1.6%*	*+2.4%*	*+2.2%*

Source: NHS England, NHS Education for Scotland, Stats Wales, Department of Health Northern Ireland.

Note: Data for Northern Ireland is from March 2022 and 2023.

3.3 Since December 2019, just before the pandemic, the medical and dental HCHS workforce has grown by 23,000 (19.2 per cent) in England, by 2,000 (14.9 per cent) in Scotland, by 1,500 in Wales (22.1 per cent) and by 500 (11.2 per cent) in Northern Ireland.

3.4 Data for England shows especially strong growth in the number of core trainees, of 13.3 per cent in the year to December 2023. Locally employed doctors (LEDs) and clinical fellows are included in this group and are probably responsible for much of the growth, given there was a smaller increase (of 7.4 per cent) in the number of foundation doctors and an increase of just 1.3 per cent in the number of specialty registrars.

3.5 The Department of Health and Social Care (DHSC) said that, on average in 2022-23, 7 per cent of the medical workforce in England were employed on trust grades and could be described as locally employed doctors. A further 13 per cent of the workforce were on contracts which were closed to new entrants. The General Medical Council (GMC) published separate data on

[18] We have consistently used the term doctors and dentists in training, rather than junior doctors, to cover those in foundation training, core training, and specialist training, including registrars, in our reports. We are happy to adopt the term which is considered most accurate by the parties.

[19] Table 3.1 uses data from March 2023 for Northern Ireland as the workforce breakdown is only published once a year.

locally employed doctors in England and Wales for the first time last year.[20] This showed that the number of locally employed doctors more than doubled from 11,046 in 2014 to 22,576 in 2021.

3.6 The DHSC noted that the previous concerns that the post-COVID-19 period would see a significant reduction in consultant numbers had not been realised.

3.7 Participation rates among the HCHS workforce in England (the ratio of FTE to headcount) remained high, at 94 per cent in 2023 (96 per cent for men and 92 per cent for women), unchanged over the decade. This indicates that there has not been an overall increase in part-time working.

Table 3.2: Participation rates of HCHS doctors and dentists, England, December 2023

Group	Participation rate (ratio of FTE to headcount)			Percentage point change over past decade*		
	All	**Male**	**Female**	**All**	**Male**	**Female**
All HCHS doctors	94%	96%	92%	0%	0%	0%
Consultant	93%	94%	90%	-2%	-2%	0%
Associate specialist	89%	94%	82%	1%	0%	2%
Specialty doctor	89%	94%	83%	4%	2%	7%
Staff grade	91%	93%	89%	12%	5%	25%
Specialty registrar	95%	98%	93%	-1%	-1%	-1%
Core training	98%	99%	97%	-1%	-1%	-2%
Foundation doctor year 2	99%	100%	99%	0%	0%	0%
Foundation doctor year 1	100%	100%	99%	0%	0%	0%
Hospital practitioner/ clinical assistant	36%	37%	35%	8%	10%	7%
Other and local grades	64%	64%	64%	-1%	1%	-1%

Source: NHS England.

*Change over decade for men and women uses data at September 2013.

3.8 NHS England said that the number of doctors training less than full time had increased from 11.8 per cent in March 2018 to 19.6 per cent in March 2023. The Department of Health in Northern Ireland said there had been an increase in the number of trainees working less than full time from 14.2 per cent in August 2022 to 16.4 per cent in August 2023.

Undergraduate medical training

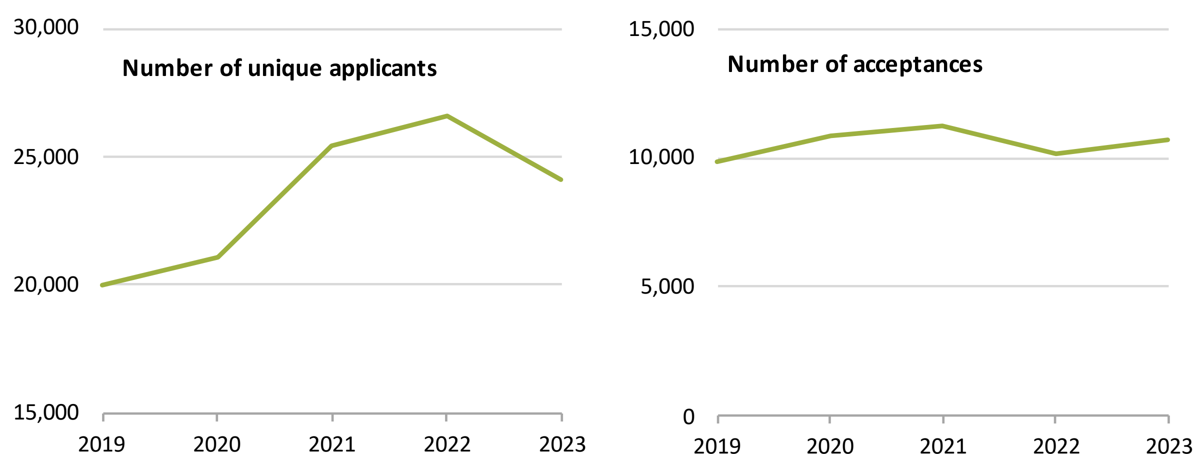
3.9 In 2023 there were 24,150 applicants to study medicine across the UK, a fall of 9.3 per cent from 2022. This follows an increase in the number of applicants in each of the three previous years. Despite the fall in 2023, the number of applicants remained 21.0 per cent higher than in 2019 (pre-COVID-19).

3.10 In 2023 there were 10,710 acceptances to study medicine, an increase of 5.5 per cent from 2022. In 2020 and 2021 the numbers accepted on to courses was higher than expected, because of the increase in A-Level grades that resulted from centre-assessed grading, but this

[20] GMC, *The state of medical education and practice in the UK: workforce report 2023*. https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk/workforce-report

was followed by a 10.1 per cent fall in the numbers accepted onto courses in 2022. The number accepted to study medicine in 2023 was 8.3 per cent higher than in 2019.

Figure 3.1: Number of applicants and acceptances for medicine degrees, UK, 2019 to 2023



Source: UCAS.

3.11 There was not a marked change in the proportion of students coming from overseas – between 2019 and 2023 the UK-domiciled share of: applicants increased from 77 per cent to 78 per cent of the total; and acceptances increased from 88 per cent to 89 per cent of the total.

3.12 The DHSC said there were an additional 1,500 medical school places a year for domestic students in England between 2018 and 2020, taking the total number of medical school places to 7,500 each year. It said the expansion was completed in September 2020 and delivered five new medical schools in England. The DHSC said there were 205 additional medical school places allocated for the 2024-25 academic year.

3.13 The Scottish Government said that a medical undergraduate intake of 1,417 for 2023-24 was approved, a 67 per cent increase on the 2015-16 intake of 848. Its 2021 Programme for Government committed to increasing medical school places by 500 over the lifetime of the Parliament, while also doubling the number of available widening access places.

Workforce planning

3.14 The NHS Long Term Workforce Plan estimated the required increase in medical school places to be 60 to 100 per cent, meaning there would need to be 12,000 to 15,000 places by 2030-31. This expansion would begin by increasing the number of medical school places from 7,500 in 2022 to 10,000 by 2028-29.

3.15 The Plan said there would need to be expansions to foundation and specialty training, commensurate with the growth in undergraduate places. Overall, the Plan projected up to 46 per cent growth in SAS, locally employed doctors, and doctors in training over period 2021-22 to 2036-37. The supply of consultants in England was projected to increase from the baseline of 53,000 in 2021-22 to 67,000 in 2026-27 and 82,000 in 2036-37. This was expected to meet projected demand of 75,000 to 78,000 in 2036-37.

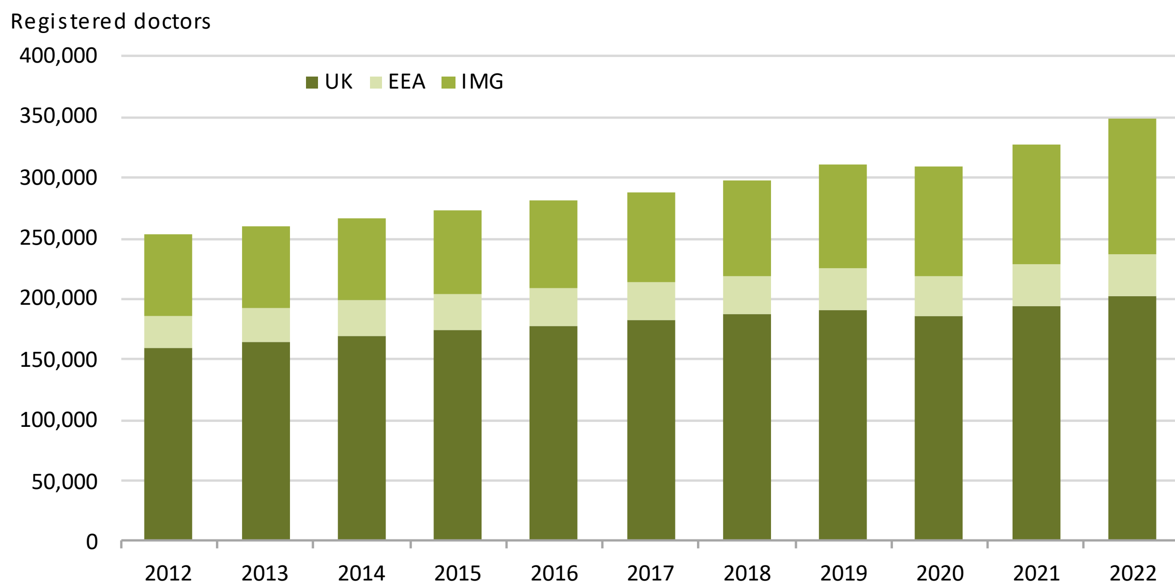
3.16 NHS England noted that consultants were drawn from domestic supply and international medical graduates (IMGs) through postgraduate training or SAS routes and that domestic supply, the primary source of consultants, was finite. It said that, while medical student places were growing, it would take at least 10 years for this to translate into senior doctors.

3.17 NHS England noted that the timeline for trainees to achieve their Certificate of Completion of Training was likely to still be affected by the elective experience missed during the pandemic. It said this would be impacting on short-term consultant supply.

International recruitment

3.18 GMC data show that, since 2018, the number of doctors joining the medical register 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 (52 per cent of the doctors who joined the UK workforce). Overall, there was a 38 per cent increase in registered doctors over the decade (see figure 3.2). The proportion of registered doctors with a UK PMQ fell from 63 per cent in 2012 to 58 per cent in 2022.

Figure 3.2: Registered doctors by region of primary medical qualification, 2012 to 2022



Source: GMC.

3.19 The DHSC acknowledged that the growth in the medical workforce had mainly been driven by an increase in international recruitment. Over a third (35.1 per cent) of medical hospital and community health staff had a non-UK nationality in December 2023 (7.5 per cent EU/EEA, 27.5 per cent rest of the world).

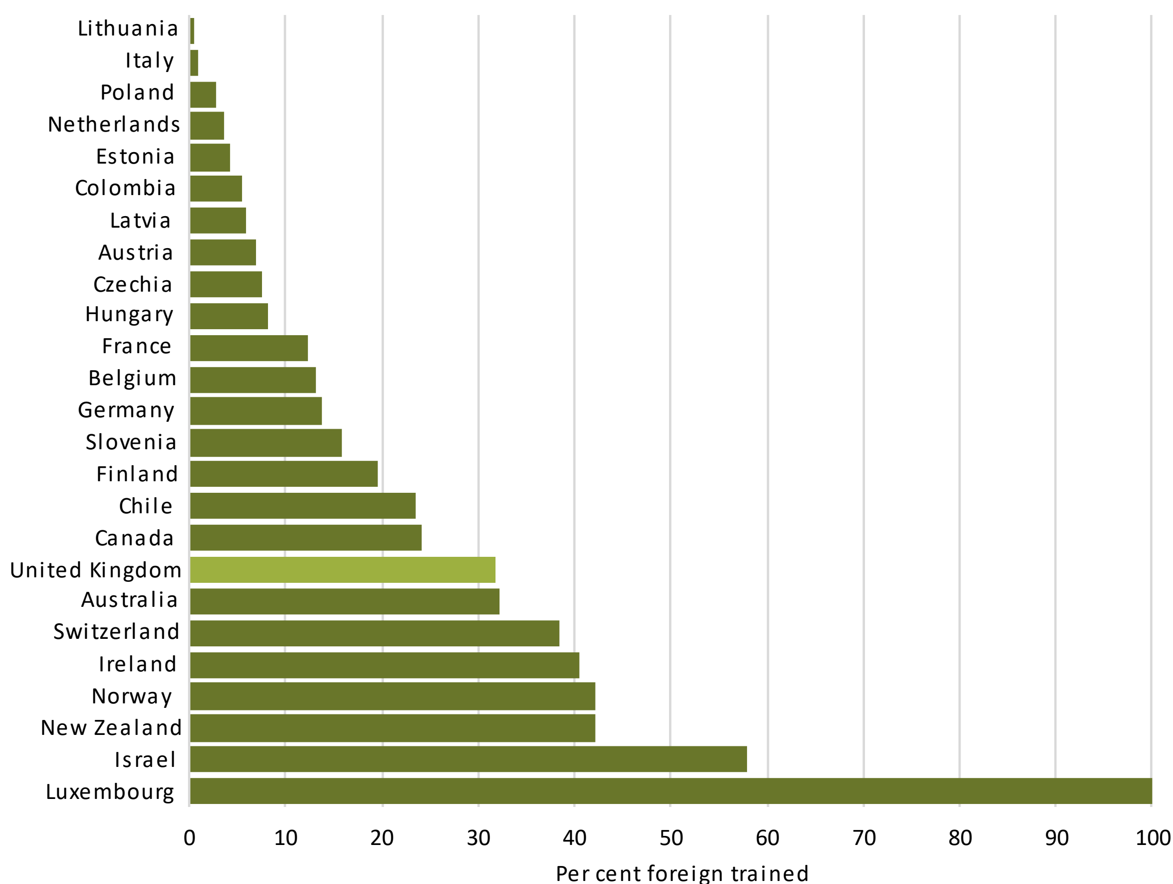
3.20 The DHSC said that there had been an increasing proportion of IMG joiners entering postgraduate training or SAS and locally employed roles. In 2022, there were over 42,500 IMGs licensed as SAS or locally employed doctors which was 19,200 (83 per cent) more than in 2017. Additionally, there were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

3.21 Non-UK graduates made up around half of doctors working in general practice training posts, and a quarter of specialist training posts in England in 2022. The DHSC expected the use of overseas doctors to fill training posts to fall when the 1,500 medical school place expansion of 2018 to 2020 started to enter core, GP, or run-through training from 2025. However, it said that over 1,000 international graduate doctors were likely to be required to fill the current number of specialty training posts, despite the 1,500 medical school place expansion. The

Long Term Workforce Plan forecast that the expansion of medical school places would support a reduction in internationally recruited doctors.

3.22 Compared to other countries, 32 per cent of UK doctors were foreign trained in 2021 (slightly higher than in 2010 when the percentage was 30), towards the upper end of the range of countries (see figure 3.3). The UK proportion was much higher than that of other large European countries, but similar to that for other English-speaking countries, such as Ireland, Australia and New Zealand.

Figure 3.3: Percentage of doctors that are foreign trained, 2021



Source: OECD.

3.23 The GMC said that, in 2022, in England and Wales, the proportion of licensed doctors who gained their PMQ outside the UK was greater than in Northern Ireland and Scotland. These doctors made up 39 per cent of licensed doctors in England and 36 per cent in Wales but represented only 19 per cent of licensed doctors in Scotland and 17 per cent in Northern Ireland. The Scottish Government told us that internationally qualified doctors made up a large and increasing proportion of those joining the medical workforce: 29 per cent of doctors joining the Scottish workforce in 2022 were IMGs or EEA graduates, compared to 16 per cent in 2015.

3.24 Of the 15,000 internationally qualified doctors who joined the GMC register in 2022, doctors from India or Pakistan were the most numerous, with 2,402 and 2,372 doctors joining respectively, meaning the two countries accounted for 16 per cent each of the non-UK graduate joiners in 2022. Doctors from Nigeria were the next largest non-UK graduate contributor of doctors to the UK workforce, with 1,616 doctors joining the UK register in 2022, up from 181 doctors in 2014.

3.25 The GMC said that four out of ten doctors joining its register by the IMG postgraduate qualification route had left within four years. It said that doctors joining through the IMG sponsorship route tended to stay in the UK workforce for a shorter period. It said this was expected, given that doctors who joined the UK workforce through this route often did so on a fixed-term arrangement, after which they generally left.

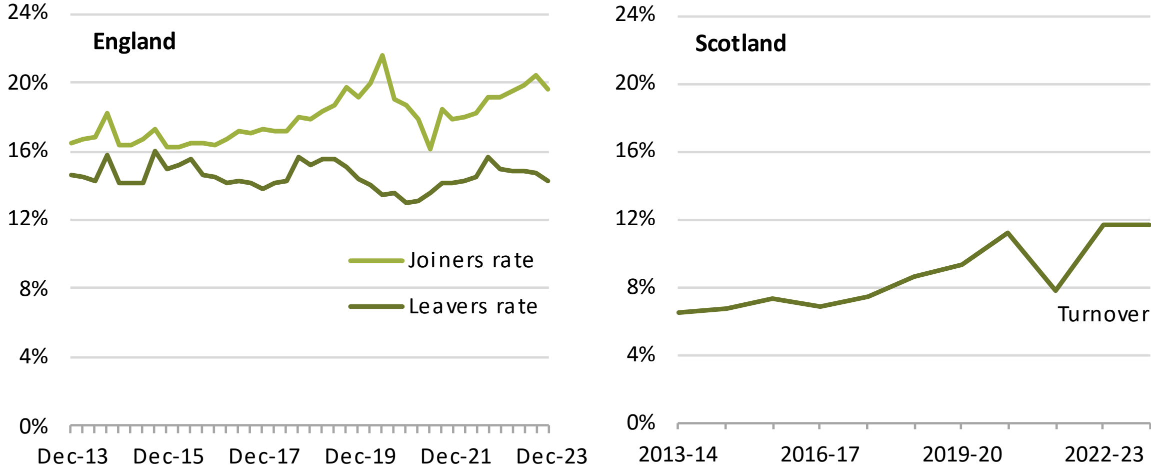
3.26 NHS Providers said that the current overreliance on overseas recruitment was unsustainable. They agreed with the ambition set out in the Long Term Workforce Plan to make international recruitment more sustainable by strengthening national pipelines. NHS Providers were concerned about the negative impact of changes to the immigration health surcharge and increases to visa fees announced in July 2023 and by their framing as necessary to ensure a pay uplift for NHS and other public sector workers.

Recruitment and retention

3.27 The FTE joining rate for all hospital medical and dental staff in England was 19.6 per cent in the year to December 2023, an increase from 19.1 per cent on the previous year. The leaving rate for all hospital and medical staff in England was 14.3 per cent in the year to December 2023, a reduction from 15.0 per cent in the previous year. The stability index, which measures the percentage of staff there at the start of the year who do not leave during the year, was 85.4 per cent in December 2023, up from 84.8 per cent in the previous year.

3.28 The turnover data for Scotland has been on an upwards trend since 2015-16, increasing from 6.8 per cent in 2015-16 to 11.2 per cent in 2019-20. The turnover rate dipped in 2020-21, affected by COVID-19, but increased again in 2021-22, reaching a new peak of 11.7 per cent, where it has remained in 2022-23.

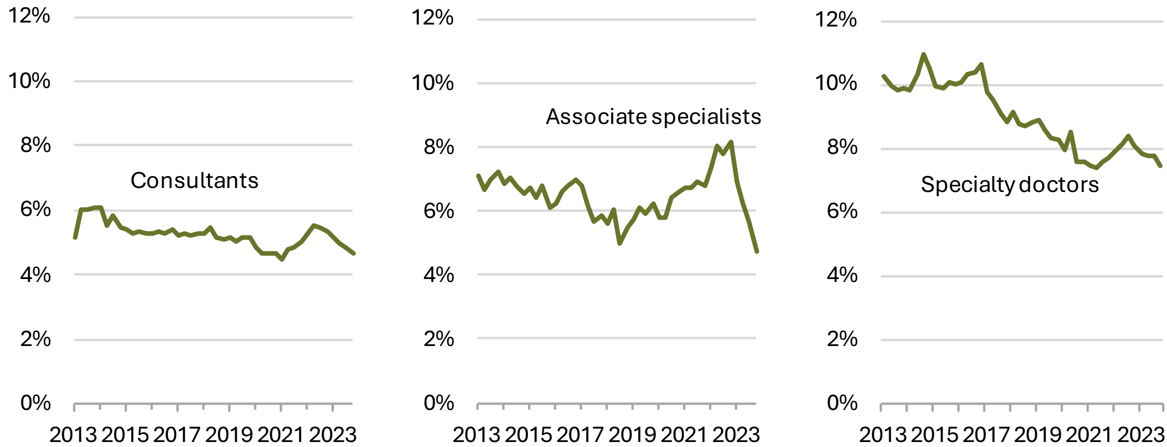
Figure 3.4: Joiners and leavers rates for HCHS doctors in England and medical and dental turnover in Scotland, 2013 to 2023



Source: NHS England, NHS Education for Scotland.

3.29 The leaving rate for consultants in England was 4.7 per cent in the year to December 2023, down from 5.3 per cent a year earlier. The leaving rate for associate specialists in England was 4.7 per cent in the year to December 2023, down from 8.2 per cent a year earlier. The leaving rate for specialty doctors in England was 7.5 per cent in the year to December 2023, down from 8.1 per cent a year earlier.

Figure 3.5: Leaver rates, England, consultants, associate specialists and specialty doctors, 2013 to 2023



Source: NHS England.

3.30 NHS England said that, since March 2023, vacancies had grown faster for consultants than other staff groups. At July 2023, consultant vacancies were at their highest level (10.6 per cent) in at least five years. It said that ongoing investigative work suggested that both the electronic staff record and provider workforce returns under-reported the actual number of consultant vacancies. NHS England said that some geographies and specialties found it hard to recruit the consultants they needed, which could affect patient care and increase the use of bank and agency staff to cover consultant vacancies.

3.31 There were 436 consultant vacancies in Scotland in December 2023, a slight reduction from 439 in the previous quarter, but an increase from 413 in the same quarter a year earlier. In December 2023, the consultant vacancy rate in Scotland was 6.8 per cent, an increase from 6.5 per cent a year earlier.

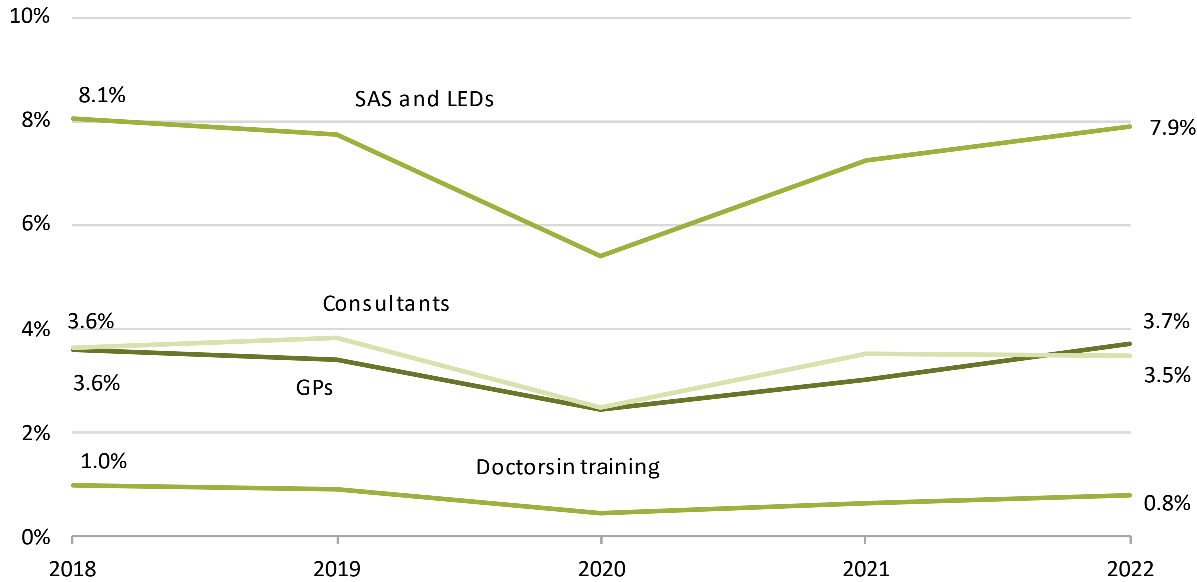
3.32 The number of consultant vacancies in Northern Ireland was usually in a range between 100 and 150 between 2017 and 2022. In 2023, the number of consultant vacancies increased, peaking at 192 in June 2023, before falling back to 182 in September 2023 and 160 in December 2023.

3.33 The GMC monitors the number of leavers from its register each year (see figure 3.6). In 2022, 3.5 per cent of specialists (consultants) left the register, the same rate as before the pandemic. The figure was much higher for SAS and locally employed doctors, at 7.9 per cent. This group includes a higher proportion of internationally qualified doctors. Less than 1 per cent of doctors in training left the register in 2022.

3.34 In the NHS staff survey for England, there was a small fall, from 24.4 per cent in 2022 to 23.9 per cent in 2023, in the proportion of medical and dental staff considering leaving the NHS. For doctors and dentists in training there was an increase, from 20.6 per cent in 2022 to 22.5 per cent in 2023.

3.35 The DHSC provided data on the number of hospital doctors and dentists taking their pension as well as the numbers claiming their pension benefits earlier than their normal pension age (voluntary early retirement). The proportion of doctors taking early retirement had remained fairly stable over time – 17.7 per cent of all retirements in 2023 were early retirements, compared to 18.4 per cent in 2018.

Figure 3.6: Leaving rate of registered doctors, UK, 2018 to 2022



Source: GMC.

3.36 NHS Providers noted that workforce shortages were the key limiting factor in efforts to bring down waiting lists and deliver high quality patient care. They said that retention of senior doctors was particularly concerning in this regard, as they were ultimately responsible for determining a patient's care.

3.37 NHS England also said that retention of doctors in late-stage careers was a key concern. It said that doctors were choosing to leave the NHS for various reasons: workplace pressures, lack of opportunities to work flexibly, and issues relating to pension taxation. NHS England published guidance on retaining doctors in late-stage career in June 2023.[21] This made 10 recommendations for systems and employers to consider when supporting doctors in late career in secondary care to stay in the NHS.

3.38 NHS England said that consultants were retiring at an average age of 60 years, six years before the current state pension age. This average age had been relatively static since at least 2018-19. It said that retaining consultants past the age of 60 would help maintain an essential part of the medical workforce, at a point when they had significant experience that could both benefit patients and be shared with colleagues.

3.39 The Northern Ireland Department of Health said there was anecdotal evidence to suggest the new Sláintecare model in the Republic of Ireland, offering much higher medical and dental salaries than within the HSC, was leading to a number of doctors resigning and taking up posts in Ireland. There were reports of 13 medical staff moving to Sláintecare in 2023, plus one further successful applicant who turned down an offer to take up a post in the Republic of Ireland. Basic pay for a consultant was €214,113 to €257,193 for a 37-hour week under Sláintecare in 2023 compared to £94,127 to £126,907 for a 40-hour week in Northern Ireland. While there was a Northern Ireland-wide scheme to pay a recruitment and retention premium of up to 10 per cent to consultants, no trusts reported using it, although some were considering it.

[21] NHS England, *Retaining doctors in late stage career guidance*. https://www.england.nhs.uk/long-read/retaining-doctors-in-late-stage-career

3.40 The British Dental Association (BDA) said that the failure to award a pay uplift, the absence of clinical excellence awards, and the growing differential in pay with the Republic of Ireland were all causing recruitment and retention difficulties for hospital dentists in Northern Ireland.

Use of temporary staffing

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

3.42 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 were regularly monitored for compliance and effectiveness, aimed to reduce cost and give greater assurance of quality.

3.43 NHS England said that reducing agency spending across the NHS to 3.7 per cent of the total paybill was a priority. It said that increasing demand and vacancies were driving the use of temporary staffing (both agency and bank) in NHS trusts, with a spend of £6.6 billion at the end of 2022-23.

3.44 Medical and dental agency spend as a share of overall temporary staffing in NHS trusts fell from 60 per cent in 2017-18 to 44 per cent in 2022-23. NHS England said this reflected an increase in the proportion of temporary medical and dental shifts procured through a bank: from 18 per cent in 2017-18 to 56 per cent in 2022-23, while agency shifts had decreased from 82 per cent in 2017-18 to 44 per cent in 2022-23.

3.45 The Welsh Government said that agency spend on medical and dental staff in Wales was £83.1 million in 2022-23. It was forecast to fall by 8.8 per cent to £75.8 million in 2023-24.

3.46 The Department of Health in Northern Ireland said that high vacancy levels meant there was a continued reliance on locums and agency workers to support service delivery. It said that locum doctors did not provide the same level of stability and consistency in services and they were much more expensive than substantive staff. Medical and dental agency/locum expenditure totalled £114.9 million in 2022-23, an increase of 11.9 per cent on 2021-22. Trusts reported working hard to reduce off-contract locum appointments.

Use of the BMA rate card

3.47 The British Medical Association (BMA) published a rate card in 2022 which set advisory rates of pay for extra-contractual activity at various times of the day and week. The DHSC said that the BMA-advised rate for extra-contractual work for consultants on a weekday between 7am and 7pm was £161 an hour, over three times the average hourly rate of pay. It said the advised rate increased to £269 an hour for work overnight.

3.48 NHS Providers said that the majority of respondents to their pay survey were not paying BMA rate card rates: 93 per cent for juniors, 91 per cent for SAS doctors and 85 per cent for consultants. The consultant rate card was reported as having a higher financial impact than the SAS or junior doctor rate cards.

3.49 The BMA withdrew the rate card as part of the recent agreement for consultants in England but reserved the right to reintroduce it if there was a future industrial dispute. NHS Providers welcomed the withdrawal of the consultant rate card but were concerned that there was no agreement on a national framework for overtime payments and said this was a missed opportunity for a national resolution. NHS Employers said that rates had been discussed at joint local negotiating committees and they were continuing to work collaboratively with neighbouring trusts and across their local Integrated Care System to agree on rates to minimise competition between organisations.

3.50 The Welsh Government said that the BMA had issued consultant, SAS, and junior doctor rate cards which had not been agreed with the Welsh Government or NHS Wales Employers. It said the BMA rate card had been presented by some doctors as a standard they expected to be remunerated when working extra contractual hours. It said these rates were considerably higher than those currently being paid across NHS Wales and higher than those of the original Welsh Government rate card.

3.51 An All-Wales Rate Card Group had been established with the aim of agreeing and producing an equitable and fair rate card for additional shifts and to clarify where those rates should be applied.

Doctors and dentists in training

Foundation training

3.52 The recruitment of trainee doctors is predominantly undertaken on a UK-wide basis. All eligible applicants are allocated a place on the two-year programme. The UK Foundation Programme said that 9,702 eligible applicants were allocated to a foundation school for 2024, an increase of 12.1 per cent from the 8,655 allocations in 2023.[22]

3.53 The Welsh Government said that the number of foundation posts (years 1 and 2) had increased from 660 to 900 over the last five years.

3.54 The Scottish Government said there were 954 established foundation year 1 training places in 2023-24. It projected that it would need to increase its foundation establishment by approximately 219 posts (23 per cent) by 2026-27 to accommodate sequential expansions at undergraduate level. This included 48 additional foundation year 1 posts for 2024-25. The Scottish Government said that the new foundation posts would provide an opportunity both to support fragile rotas and to innovate.

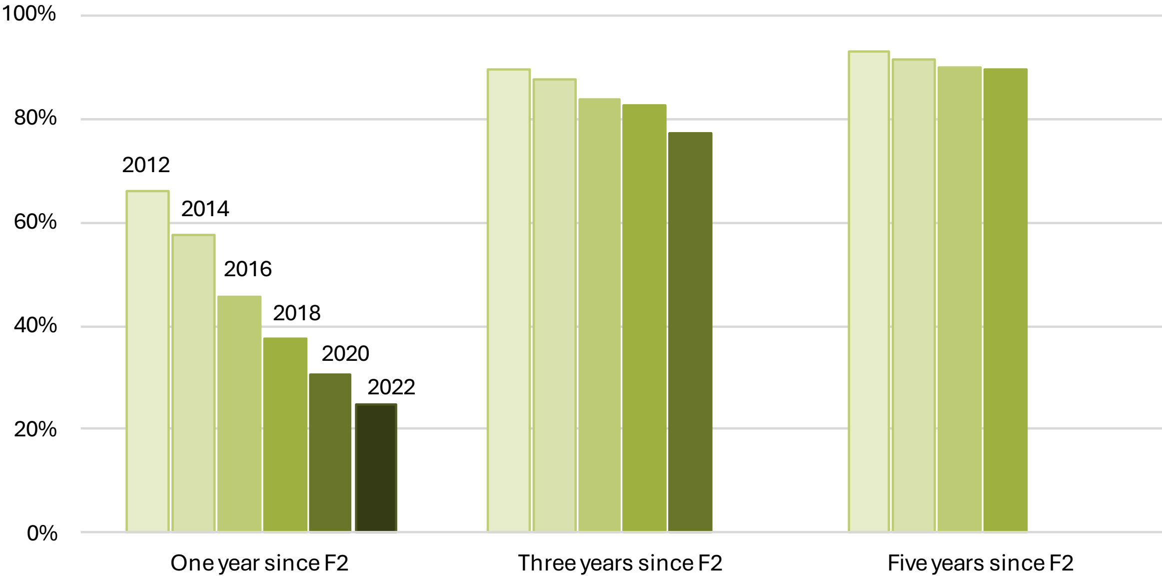
3.55 The Department of Health in Northern Ireland said that the number of foundation places for August 2023 was increased from 252 to 294 to meet university output. Due to the number of withdrawals, only 249 new foundation year 1s started in August 2023, less than in the previous year. More than half of the 46 withdrawals were from Republic of Ireland graduates taking up an internship in the Republic of Ireland.

Time out of training

3.56 Data from the GMC show that a growing proportion of trainees completing their second year of foundation training do not go straight into core/specialty training, and that these breaks are increasing in length. In 2012, 66 per cent of doctors completing foundation year 2 continued straight into core/specialty training. In 2022, this was 25 per cent.

[22] UK Foundation Programme, *UK Foundation Programme.* https://foundationprogramme.nhs.uk/

Figure 3.7: Proportion of doctors in training each year following completion of foundation year 2, 2012 to 2022



Source: GMC.

3.57 Furthermore, 89 per cent of doctors completing foundation year 2 in 2012 were in training three years later; for the 2020 cohort this was 77 per cent. Five years after completing foundation year 2 in 2018, 90 per cent of doctors had returned to training. This compared to 93 per cent of those completing foundation year 2 in 2012.

3.58 Research commissioned by the GMC into the reasons why doctors took time away from training found that the majority (87 per cent) had chosen to take time away from training and only 13 per cent did so after not having received their desired core/specialty training offer.[23] The motivation to take time away was for a variety of personal and professional reasons including improving physical and mental wellbeing and not having secured a training post.

3.59 NHS Employers said that many employers approved of time out of training initiatives, such as NHS England's out of programme pause initiative, but wished to see the number of training posts increased, to counteract concerns around a reduction in rota staffing levels.

Core and specialty training

3.60 Data from NHS England indicated an overall fill rate of 99 per cent at core training/specialist training level 1 and 85 per cent at higher levels of specialist training. There were shortfalls in recruitment to general practice and core psychiatry specialty training for 2023 (with fill rates of 84 and 78 per cent) although further recruitment was underway to fill the remaining vacancies with a later start date.

3.61 The Welsh Government said there had been increases in the number of core and specialty training posts of 80-90 a year over the last three years, with fill rates remaining high (above 90 per cent) at core level. It said there was more variability in fill rates across different specialty

[23] Church H, Agius S, Jenkins L (2023), *The post-foundation training break ('F3'): evaluating its impact on postgraduate medical training,* https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/the-post-foundation-training-break-evaluating-its-impact-on-postgraduate-medical-training

areas at higher training levels partly relating to expansion of post numbers within Wales and partly to equivalent expansions and resultant competition in other UK nations.

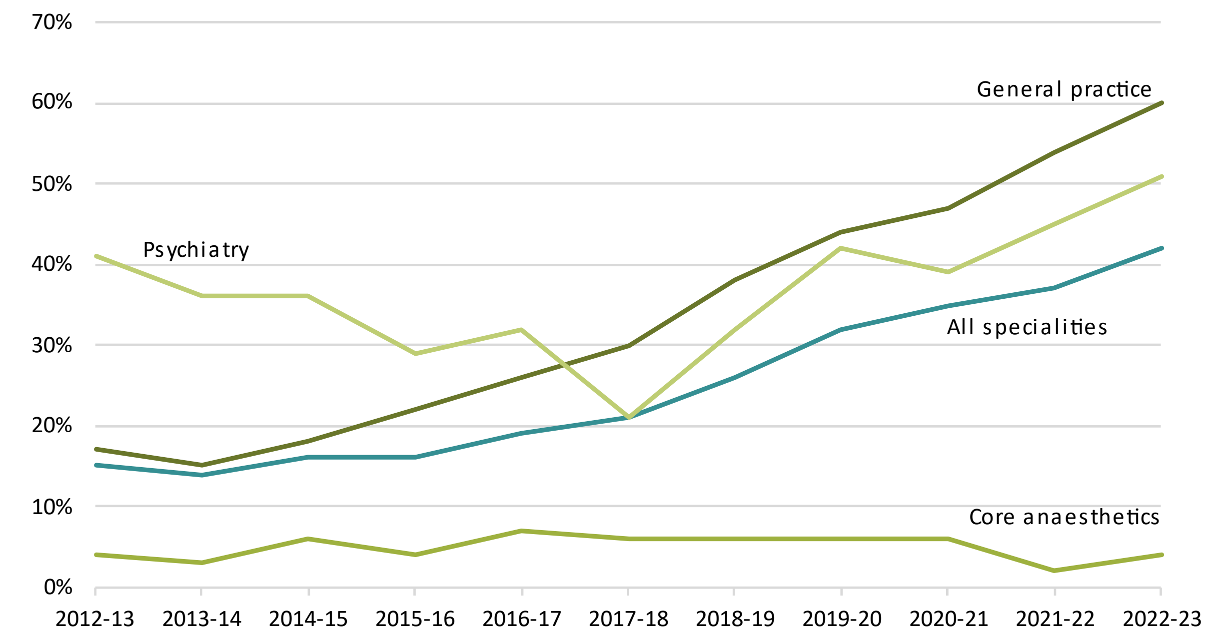
3.62 A total of 1,137 core and specialty training posts were advertised in Scotland last year and 1,061 (93.3 per cent) were filled by July 2023, similar to a year earlier. The Scottish Government said that 878 expansion posts had been created since 2014 across a range of medical specialties. Of these, 153 were approved in November 2023, the largest annual expansion to date, and would be recruited to from 2024 onwards. Any unfilled vacancies were passed to health boards to fill using locums or other solutions such as clinical development fellowship posts which had been growing in popularity as an alternative to progressing directly into specialty training after completing foundation year 2.

3.63 In Northern Ireland, there was a vacancy rate of 12 per cent across all medical training roles in August 2023, up from 11 per cent in August 2022 and 8 per cent in August 2021.

International recruitment to medical training

3.64 NHS England said the proportion of doctors with a non-UK PMQ recruited to specialties immediately post foundation had risen steadily. In the academic year 2022-23, they represented 40 per cent of all new starters at the entry level to core or run-through specialty training. In general practice, they represented 60 per cent of all new starters, and 51 per cent in core psychiatry.

Figure 3.8: Proportion of core training/specialist training 1 with a non-UK primary medical qualification, England, 2012-13 to 2022-23



Source: NHS England.

3.65 NHS England said that two changes had coincided to alter the balance of UK and non-UK PMQ postgraduate medical trainees in specialty training. First, the growing proportion of UK doctors taking a break between completing foundation training and moving into core training programmes. Second, changes to visa requirements which meant that more doctors from overseas were both willing and able to apply to training posts.

3.66 The Department of Health in Northern Ireland said that, among current doctors and dentists in training, 57 per cent qualified in Northern Ireland, 25 per cent in other parts of the UK, 14 per cent were internationally qualified, and 4 per cent qualified in the Republic of Ireland. There were 270 trainees requiring visa sponsorship, including 101 new trainees from August 2023. Of the 270, 21 per cent were from Nigeria, 18 per cent from Malaysia, 14 per cent from Pakistan, 9 per cent from the Sudan, and 7 per cent from India.

Flexible pay premia

3.67 Flexible pay premia are recruitment and retention payments designed to support recruitment to general practice training, hard-to-fill training programmes such as emergency medicine, psychiatry, histopathology and oral-maxillofacial surgery, and for clinical academic trainees. Flexible pay premia were worth £2,956 to £9,693 a year for doctors in training in England in 2023-24.

3.68 August 2023 fill rates for each of the specialties with a flexible pay premium are shown in table 3.3. General practice, core psychiatry and histopathology all had fill rates over 90 per cent. A number of higher specialty training programmes across emergency medicine, psychiatry, histopathology and oral-maxillofacial surgery had lower fill rates.

Table 3.3: Specialty training programmes with flexible pay premia, England, August 2023

Training programme	Premium	Posts	Accepts	Fill rate %
General practice ST1-4	£9,693	3,433	3,427	99.8
Emergency medicine ST4+	£2,956 to £7,881*	86	34	39.5
Oral & maxillofacial surgery ST3+	£2,956 to £7,881*	23	13	54.2
*Psychiatry***				
Core psychiatry CT1	£3,941	450	449	99.8
General psychiatry ST4+	£3,941	148	122	82.4
Child and adolescent psychiatry ST4	£3,941	52	37	71.2
Forensic psychiatry ST4	£3,941	30	21	70.0
Medical psychotherapy ST4	£3,941	8	8	100.0
Old age psychiatry ST4	£3,941	65	51	78.0
Psychiatry of learning disability ST4	£3,941	35	14	40.6
Histopathology				
Histopathology ST1+	£4,729	96	96	100.0
Chemical pathology ST3	£4,729	6	5	83.3
Diagnostic neuropathology ST3	£4,729	10	1	10.0
Paediatric and perinatal pathology ST3	£4,729	6	2	33.3

Source: DHSC, NHS Employers.

*Depending on length of training programme.

** £2,956 for four-year higher training programmes.

3.69 The DHSC said that pay was not the only factor influencing choice of specialty. It said it was hard to evaluate the success of flexible pay premia without fully understanding the reasons why trainees chose their specialties, and the choices they would have made had the payments not been available. It said that a whole system perspective of ensuring appropriate recruitment to all specialties also needed to be considered. NHS Employers said they supported a review of the hard-to-fill specialties, to provide an updated picture and identify if some were no longer appropriate or whether additional categories were needed.

3.70 NHS England said that the Distribution of Medical Specialty Training Programme aimed to address health inequalities by reviewing and aligning specialty training placements to the areas of greatest need across England. The first tranche of training posts in three high-fill specialties – haematology, cardiology, and obstetrics and gynaecology – started in August 2022. It said that addressing distribution for the other medical specialties had been allocated into phases and would be explored to align with further expansion over the next 10 to 15 years. Postgraduate deans were looking at the distribution of doctors within their own footprints, to ensure better regional distribution to remote and rural systems. NHS England said it was aware that trainees in rural Cornwall, for example, had to pay London prices for accommodation. It said this deterred trainees from settling in such areas long term. NHS England also supported a number of priority programmes in areas of England that found it difficult to attract and retain trainees through the foundation and specialty recruitment processes.

Contract reform

3.71 The contract for doctors and dentists in training in England was reformed from 2016. Under the 2016 contract, doctors and dentists in training in England receive pay for additional hours at plain time (i.e. 1/40th of basic pay), up to a maximum of 48 hours worked. There are a number of additional payments: a 37 per cent premium for hours worked between 21.00 and 07.00; 3 to 15 per cent for those rostered to work between one-in-eight and one-in-two weekends; and an 8 per cent on-call allowance.

3.72 The 2002 contract in Wales, Scotland and Northern Ireland uses a banding system, which reflects: the number of additional hours worked; the degree to which these hours are unsociable; the on-call commitment; and the workload. The premium ranges from 20 per cent for those working 40-48 hours a week/least antisocially to 100 per cent for those working more than 56 hours a week/most antisocially. The 2023-24 pay agreement for doctors and dentists in training in Scotland included a commitment to contract reform.

3.73 In oral evidence, the Department of Health in Northern Ireland said that it would like to bring junior doctors on to a modernised contract that did not focus on the frequency of the rota but offered a higher basic salary with additional allowances, with similarities to the England model.

Earnings and pay comparability

3.74 We receive separate earnings data for foundation year 1, foundation year 2, core training and registrars in England. In the year to December 2023:

- Average earnings per head for foundation year 1 were £37,519, 1.3 per cent higher than a year earlier. Basic pay per head was 2.3 per cent higher and non-basic pay was 2.1 per cent lower than a year earlier.
- Average earnings per head for foundation year 2 were £44,974, 3.6 per cent higher than a year earlier. Basic pay per head was 4.4 per cent higher and non-basic pay was 1.5 per cent higher than a year earlier.
- Average earnings per head for core trainees were £58,040, 3.7 per cent higher than a year earlier. basic pay per head was 4.1 per cent higher and non-basic pay was 2.4 per cent higher than a year earlier.
- Average earnings per head for registrars were £65,755, 4.4 per cent higher than a year earlier. Basic pay per head was 5.8 per cent higher and non-basic pay was 0.7 per cent higher than a year earlier.
- Non-basic pay made up 23-26 per cent of earnings.

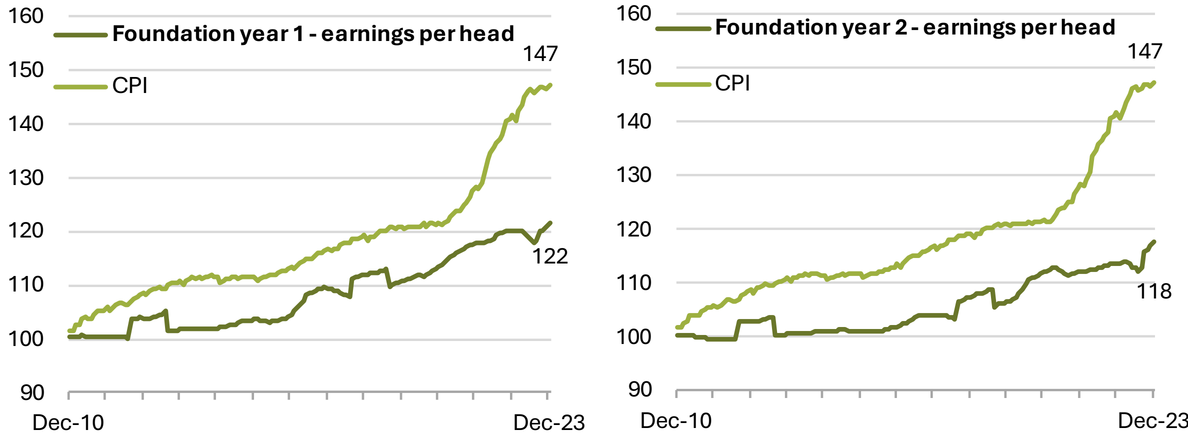
3.75 This earnings growth is considerably lower than our recommendation last year of an 8.1 per cent increase for registrars, rising to 10.3 per cent for foundation year 1. The reasons for this may include lost pay due to strike action as well as a reduction in additional working hours for foundation doctors in particular.

3.76 In 2022-23, average total pay per FTE for doctors in training in Scotland was £71,862. Non-basic pay made up 45 per cent of earnings.

3.77 Comparisons of changes in earnings and prices over time are sensitive to the base year chosen. Between the year to September 2010 and the year to December 2023, the Consumer Prices Index (CPI) increased by 47 per cent.[24] Over the same period:

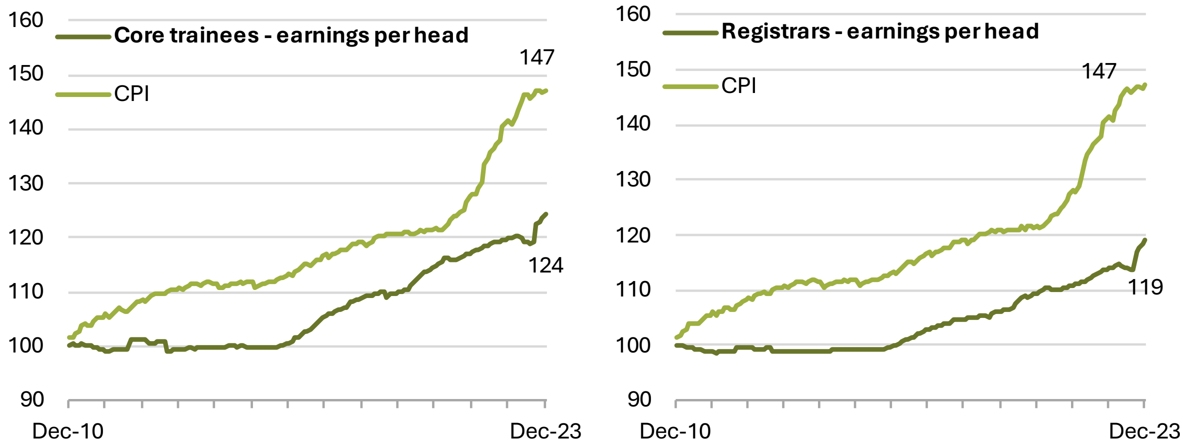
- Foundation year 1 earnings per head in England increased by 22 per cent.
- Foundation year 2 earnings per head in England increased by 18 per cent.
- Core trainee earnings per head in England increased by 24 per cent.
- Registrar earnings per head in England increased by 19 per cent.

Figure 3.9: Foundation doctors, change in average earnings per person and CPI, England, December 2010 to December 2023, September 2010=100



Source: OME analysis of NHS England and ONS data.

Figure 3.10: Core trainees and registrars, change in mean average earnings per person and CPI, England, December 2010 to December 2023, September 2010=100



Source: OME analysis of NHS England and ONS data.

[24] The earnings data series begins in 2010.

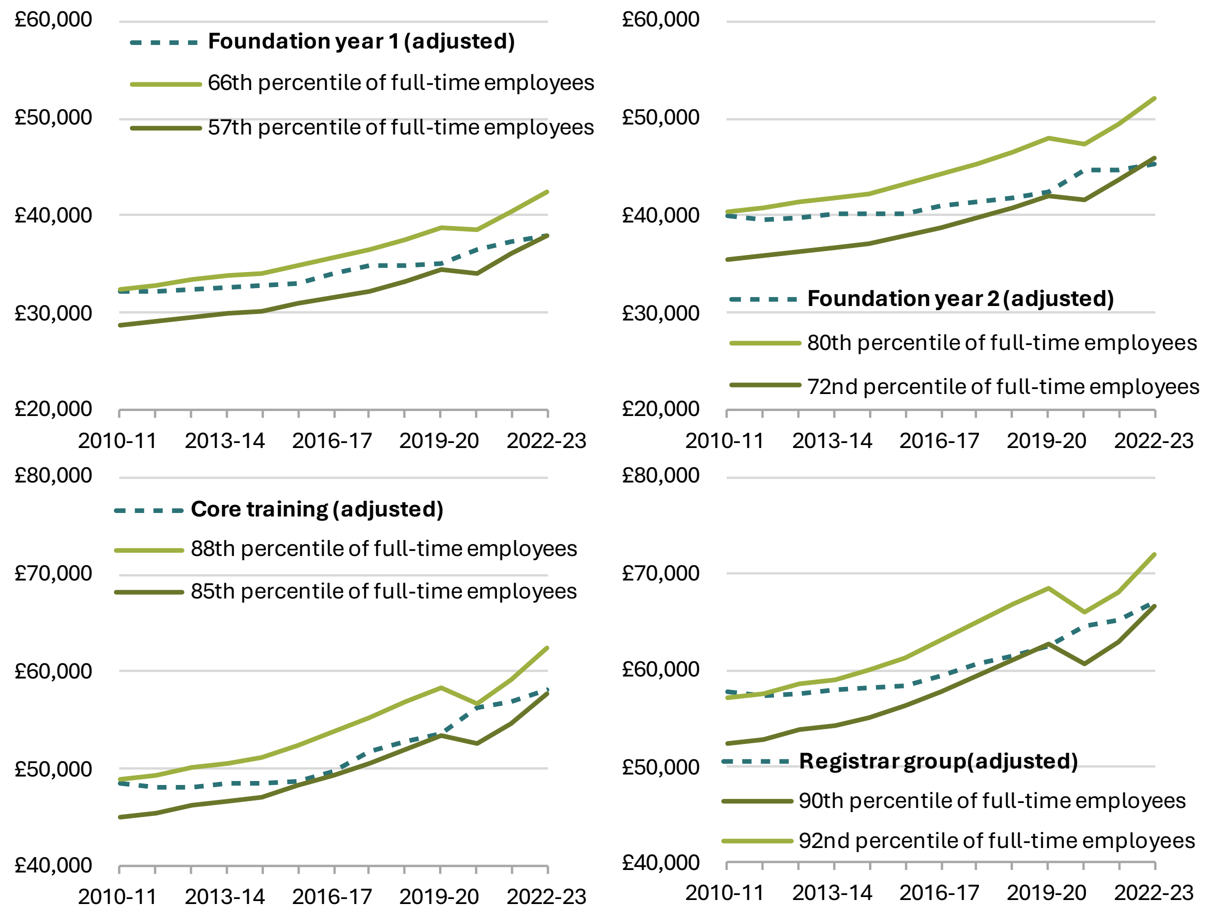
3.78 Between the year to September 2015 and the year to December 2023, the CPI increased by 32 per cent. Over the same period:

- Foundation year 1 earnings per head in England increased by 18 per cent.
- Foundation year 2 earnings per head in England increased by 16 per cent.
- Core trainee earnings per head in England increased by 24 per cent.
- Registrar earnings per head in England increased by 20 per cent.

3.79 In each case, most of the difference over the period occurred in the two most recent years as inflation increased sharply. As set out in chapter 2, earnings have grown by less than inflation for all employees since 2010, and in particular since 2020.

3.80 Average earnings per FTE for foundation year 1 in England were just below the 66th percentile of all full-time earnings in 2010-11 (see figure 3.11). By 2019-20, average earnings for foundation year 1 had fallen back towards the 57th percentile and, despite moving back towards the 66th percentile in 2020-21, average earnings fell back to the 57th percentile in 2022-23.

Figure 3.11: Average total earnings per FTE of doctors in training, England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2022-23



Source: OME analysis of NHS England and ASHE data.

Note: Earnings for doctors are average annual basic pay per FTE, added to non-basic pay per head data, adjusted by a factor that reflects the ratio between FTE and headcount estimates of basic pay.

3.81 Average earnings per FTE for foundation year 2 in England were just below the 80th percentile of all full-time earnings in 2010-11. By 2019-20, average earnings of foundation year 2 had

fallen back in line with those of the 72nd percentile and, despite moving back towards the 80th percentile in 2020-21, average earnings fell back below the 72nd percentile in 2022-23.

3.82 Average earnings per FTE for core trainees in England were just below the 88th percentile of all full-time earnings in 2010-11. By 2015-16, average earnings of core trainees had fallen back in line with those of the 85th percentile and, despite moving back towards the 88th percentile in 2020-21, average earnings returned to the 85th percentile in 2022-23.

3.83 Average earnings per FTE for registrars in England were just above the 92nd percentile of all full-time earnings in 2010-11. By 2019-20, average earnings of registrars had fallen back in line with those of the 90th percentile and, despite moving back towards the 92nd percentile in 2020-21, average earnings returned to the 90th percentile in 2022-23.

3.84 Earnings for foundation doctors in England are behind some market comparators (legal, finance, pharmaceutical and veterinary), in line with actuarial equivalents, and ahead of academic roles. Registrar earnings in England are behind equivalent actuarial, legal, finance and pharmaceutical roles, but ahead of academic and veterinary equivalents.

Figure 3.12: Inter-quartile range of total earnings of foundation year 1 doctors, England, compared with professional comparator groups, matched by job size to market data, 2023

Figure 3.13: Inter-quartile range of total earnings of foundation year 2 doctors, England, compared with professional comparator groups, matched by job size to market data, 2023

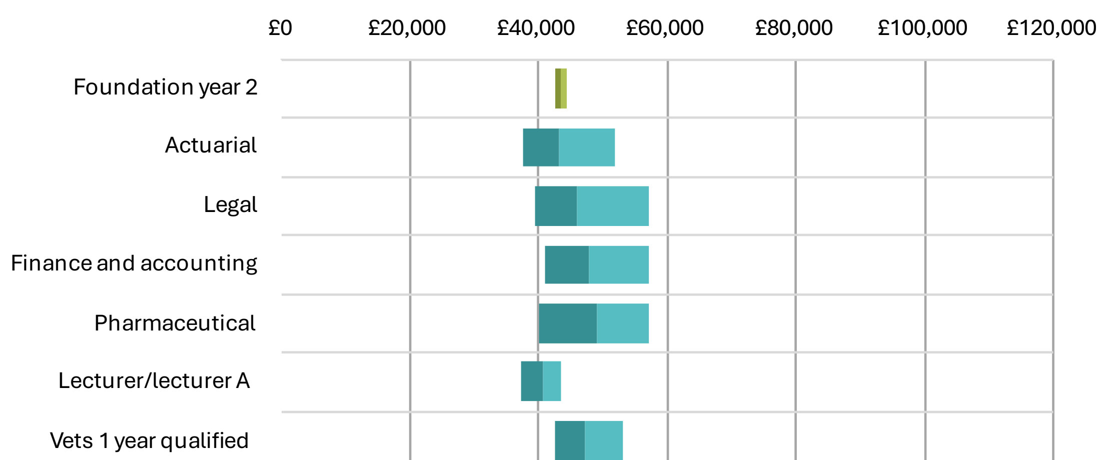
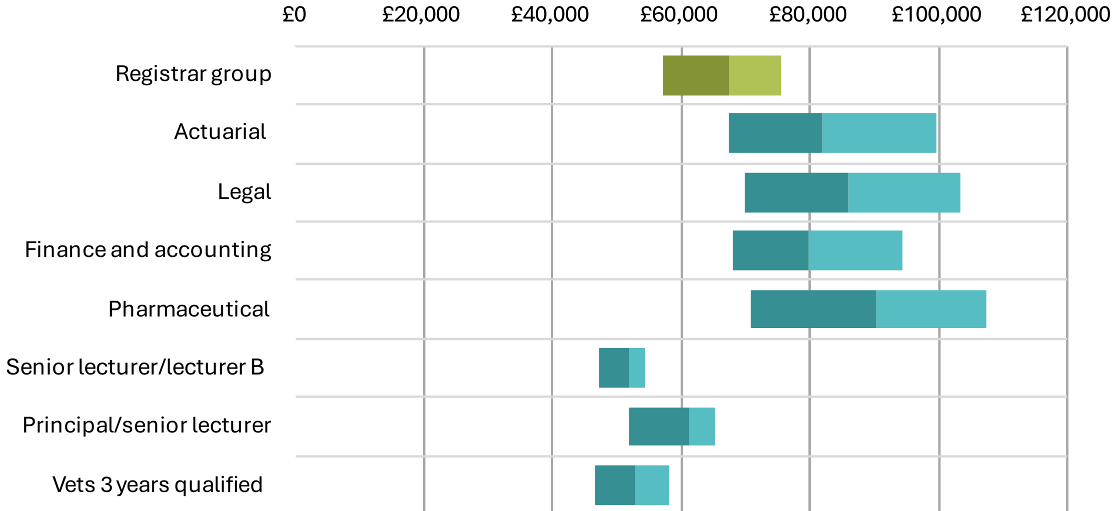


Figure 3.14: Inter-quartile range of total earnings of registrars, England, compared with professional comparator groups, 2023



Source (figures 3.12 to 3.14): OME analysis of data from Kornferry; Universities and Colleges Employers Association; The Society for Practising Veterinary Surgeons; NHS England; ONS.

Notes: Pay for other professions in figures 3.12 to 3.14 is on a full-time equivalent basis, whereas that for doctors and dentists is on a headcount basis, and so is lower than it would be on an FTE basis. Individual medical and dental roles are matched by job size to market data.

3.85 Longitudinal Education Outcomes (LEO) data show that, in 2020-21, median earnings for those with a medical and dentistry degree one year after graduation (£39,400) were substantially higher than even upper quartile earnings for any other subject. Similarly, median earnings for medical and dental students three years after graduation (£49,300) were higher than the upper quartile for any other subject. Three years after graduation, median earnings for all other subjects were well below one-year earnings for medical and dental graduates. This earnings differential over other degree subjects is maintained to at least ten years after graduation, with only economics coming close.

3.86 The Hospital Consultants and Specialists Association (HCSA) said that pay for physician associates and anaesthetic associates should be a factor in setting pay for doctors and dentists in training.[25] It said that junior doctor pay should be set sufficiently high to reflect the additional responsibilities beyond the scope of a physician or anaesthetic associate. The HCSA said this was a huge concern for morale.

Working lives

3.87 The HCSA highlighted a broken rotation system for doctors in training, where employers rarely complied with their contractual obligations such as providing rotas in good time or ensuring accuracy of payslips.

3.88 NHS England confirmed in April that all employers were required to ensure they provided work schedules to doctors in training at least eight weeks in advance and finalised duty rosters six weeks in advance, as per the current contract.[26] It said it would support this

[25] Physician associate roles are on Agenda for Change, usually starting on band 7 (£43,742 to £50,056) after qualification, with a standard 37.5-hour working week with the need to work flexibly over a seven-day period. The physician associate base salary is higher than the base salaries for foundation (1 and 2) doctors, but the deficit narrows as doctors enter core training, and is reversed as time in core training continues.

[26] NHS England, *Improving the working lives of doctors in training.* https://www.england.nhs.uk/long-read/improving-the-working-lives-of-doctors-in-training/

commitment by ensuring that information regarding incoming doctors was provided to organisations within the required 12-week time frame and with improved accuracy. It also said it would improve rota management by exploring the opportunities technology offered to move towards greater self-rostering, so doctors had greater control over their lives while meeting the needs of the service. It said that, where rota changes were required with less than six weeks' notice, the doctors in training impacted should be involved in creating the new rota and pre-existing leave arrangements must be accommodated.

3.89 The Department of Health in Northern Ireland said that a single lead employer now employed all doctors and dentists in training across HSC and coordinated their rotations. The main benefit for the trainees was that they had one employer throughout their training and so only needed to complete new start paperwork once. This assisted with statutory entitlements such as maternity leave and avoided them having to be processed as a leaver after each placement.

Locally employed doctors

3.90 We do not have official data on the number of locally employed doctors or their earnings as they are not a distinct group within the payroll data. It is likely that many count as being in core training, as they are on the same pay rate. This group has shown strong growth in England in recent years. In December 2023, the number of core trainees in England was 21,624 FTE, an increase of 13.3 per cent from a year earlier, 61 per cent from December 2019 (pre COVID-19), and 148 per cent (12,915) higher than a decade earlier. Locally employed doctors and clinical fellows are included under this heading and are probably responsible for much of this growth, given there has not been a substantial increase in the number of foundation year doctors over the period.

3.91 For the first time last year, the GMC was able to provide separate data on SAS doctors and locally employed doctors in England and Wales. This showed that the number of locally employed doctors more than doubled from 11,046 in 2014 to 22,576 in 2021.

3.92 The GMC said that growth in the number of locally employed doctors was linked to both the increasing number of UK graduates taking longer periods away from training after completing their foundation years and the increasing number of international medical graduates joining the workforce who did not initially meet the criteria to take consultant or SAS roles.

3.93 The GMC said that almost two-thirds (65 per cent) of doctors with local contracts had been licensed for less than five years and just over a third (35 per cent) had held a licence for five years or more. About half of them were UK graduates, while the other half were non-UK graduates.

3.94 The HCSA said that local contracts often appealed to those with caring responsibilities as they gave stability without the turbulence of rotations and long commutes. It suggested the trend of doctors in training taking time out for local roles was illustrative of how impractical the training pathway could be for many doctors. NHS Employers highlighted examples of bespoke working patterns which could not have been easily achieved using national contracts.

3.95 The DHSC said that further work was underway to understand more about locally employed doctors, why employers were using them and the specific roles they undertook. It said this would help inform decisions around any future strategic action to further support doctors employed on local contracts.

3.96 The Scottish Government noted that clinical development fellowship posts had been growing in popularity recently as an alternative to progressing directly into specialty training after completing foundation year 2.

3.97 The Northern Ireland Department of Health said the main reason for employing doctors on local contracts were filling gaps in the training programme and/or lack of recurrent funding for the posts. Trusts were typically using terms and conditions that mirrored national contracts.

3.98 One trust in Northern Ireland reported that the recruitment of clinical fellows contributed to significant savings for the trust, reducing the need for agency locums and addressing training gaps. It said these were high quality doctors who wanted to take a year out of training and who were seeking to improve the quality of their work experience in advance of future applications to specialty training.

3.99 The Welsh Government did not provide any evidence on locally employed doctors.

Contracts for locally employed doctors

3.100 The DHSC said that the majority of locally employed doctors were employed on terms and conditions which mirrored national contracts and national pay scales. Therefore, their annual uplifts would also mirror those applied to national contracts. NHS Employers said that rules had been tightened in the visa application process, which now listed the 2016 pay scales as the expected rate of pay. They said this was a key driver for employers moving their local contracts to mirror the 2016 terms.

3.101 NHS Employers said that local variations of these contracts would remove references to training but generally retain pay structures and rota rules. They said that, as pay progression for doctors in training was linked to progression through training grades, this could create a lack of pay progression for local doctors employed for multiple years. This might create retention challenges.

Career development

3.102 The GMC said that the retention of international medical graduate doctors in local roles was improving and that increasing proportions were entering postgraduate training. It said that, of the IMGs who joined as locally employed doctors in 2014, 37 per cent had left after four years; that decreased to 20 per cent for the 2018 cohort.

3.103 The GMC said that considerable proportions of international medical graduates who joined as locally employed doctors went on to enter formal postgraduate training within the first four years of being licensed. This proportion almost doubled between 2014 and 2018, from 22 per cent of the 2014 cohort being in postgraduate training three years after joining, to 41 per cent of the 2018 cohort.

3.104 NHS Employers noted that retention could be a challenge, with many locally employed doctors leaving within the first 12 months of their contract. In most cases this was to enter postgraduate training. This created a constant cycle of recruitment and induction which generated a large administrative and financial burden for employers. NHS Providers commented in oral evidence that some doctors on local contracts had been moved onto SAS contracts to both support the service and retain the individual.

3.105 NHS Providers said there was an issue around encouraging locally employed doctors to take up SAS roles because, while basic rates of pay were higher for SAS doctors, pay for additional hours, on-call and night supplements tended to be lower so that overall pay dropped.

3.106 The Long Term Workforce Plan said that locally employed doctors were a huge asset to the NHS. It said they generally undertook more junior roles, requiring direct or indirect supervision. The Plan said there was a commitment to working with partners to review medical career pathways and identify ways to better support postgraduate career progression for this group, including routes to progress their careers into high demand specialties such as cancer.

3.107 One aspect of the recent agreement with SAS doctors in England was a commitment to a joint piece of work to better understand the make-up of the LED workforce (including their contractual terms and needs) and to enable locally employed doctors to move to permanent SAS contracts where this was in everyone's best interests. There was also an agreement to promote the statutory right of locally employed doctors with four or more years of continuous service on successive fixed-term contracts to be made permanent.

SAS doctors[27]

Contract reform

3.108 In 2021, governments in England, Wales and Northern Ireland implemented near-identical new contracts for SAS doctors and dentists. These reforms were agreed in referenda of BMA members. A reformed specialty doctor contract with a shorter pay spine was introduced alongside a new, more senior specialist grade. Doctors and dentists could practice with more autonomy within the specialist grade, and it was introduced with the intention of providing improved opportunities for development and progression within the SAS framework.

3.109 The agreement covered the three years from 2021-22 to 2023-24 and included 3 per cent investment in pay for each of the three years. Pay spines were restructured at the same time, so that some, including those at the bottom of the pay spine, received significantly more than 3 per cent a year, while others received less. The new contract also extended the definition of plain time, from 7am to 7pm to 7am to 9pm on weekdays. Moving onto the new specialty doctor contract was optional for those already employed under the old contract, but compulsory for new starters.

3.110 The evidence highlighted two main issues with the pay structure for SAS doctors and dentists in England, Wales and Northern Ireland:

- The relative position of the 2008 and 2021 specialty doctor pay spines i.e., some of the pay points for the closed contract were higher than equivalent points on the open contract.
- The relative position of the top of the 2008 specialty doctor pay spine and the bottom of the 2021 specialist pay spine. Those at the top of the pay spine for the 2008 specialty doctor contract could face a drop in pay on promotion to specialist doctor.

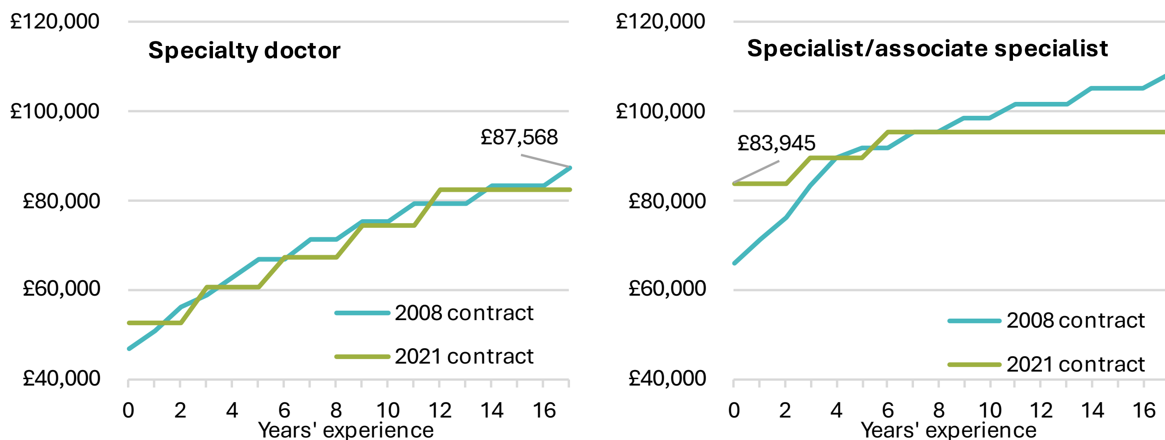
3.111 In May 2023, around half of SAS doctors in England were on 2021 contracts. Only around one quarter of specialty doctors on the 2021 contract had transferred from the 2008 contract, a further quarter had moved from the trainee grade, and the rest were new joiners. In Wales, just over half of SAS doctors were on the 2021 contracts. In Northern Ireland, only a small proportion of SAS doctors had transferred to the new contract.

[27] This group comprises doctors and dentists on national contracts in non-consultant roles, who are also not actively undertaking postgraduate training. The two contracts for this group that are open to new entrants are for specialty and specialist doctors and dentists, but the group also includes a number of closed grades: associate specialists, staff grade doctors and dentists and senior clinical medical officers.

3.112 The DHSC said that the number of transfers to the 2021 contracts was much lower than hoped. It said this situation could raise equal pay concerns and potentially impact recruitment. It also put at risk its ambitions to improve SAS doctors' morale and feelings of being valued.

3.113 The BMA SAS England Committee said that many doctors would be required to take a basic pay cut if they moved to the new contract. The Committee said the three main reasons for SAS doctors not transferring were: the long-term financial position being better on the old contract; the potential drop in pay; and the new definition of plain time.

Figure 3.15: Pay scales for specialty and specialist/associate specialist doctors, England, 2023-24



Notes: Does not include further uplift from 1 April 2024. The 2023-24 specialty/specialist pay scales (2021 contract) in Northern Ireland are the same as England. The specialty doctors pay scale in Wales is £12 to £18 above the England scale and the specialist pay scale in Wales is £18 to £21 above the England scale (2021 contract).

3.114 New contracts for SAS doctors in Scotland were implemented on 1 December 2022. The new contracts were broadly similar to those in England, Wales and Northern Ireland but were introduced without a multi-year deal. The new specialty doctor pay spine was higher than the old at every pay point. The new contract also did not change the definition of unsocial hours. The Scottish Government said that uptake of the new arrangements was excellent, with over 80 per cent of specialty doctors choosing to move to the new contract.

3.115 The pay scale for specialty doctors on the new contract in Scotland in 2023-24 was 9.2 to 14.7 per cent above the England, Wales and Northern Ireland equivalent. The pay scale for specialist doctors on the new contracts was 5.0 per cent higher in Scotland than in England, Wales or Northern Ireland at all points.

Specialist doctors

3.116 The DHSC said that the number of specialist posts in England had steadily increased since the new grade was introduced in April 2021, with 817 specialist posts in May 2023. It said the increase in specialist roles continued to outstrip attrition of associate specialist roles in England, meaning that in 2022-23 the number of specialist/associate specialist roles grew by just under 9 per cent.

3.117 The DHSC said that just over 40 per cent of doctors in specialist roles had moved from the specialty doctor grade. Around 8 per cent had moved from the doctors in training grade and 11 per cent from the consultant grade. It said this suggested that the grade was fulfilling its intended role as a route for development for specialty doctors and as an alternative career path for medical staff.

3.118 NHS Employers said that funding for specialist roles needed to be secured locally, to meet service delivery requirements, and employers had experienced difficulties with this. NHS England said the introduction of the specialist grade gave flexibility to both employers and senior doctors: employers could create specialist roles that best provided the skill mix they required, and doctors had an alternative senior grade to consultant, so long as they met the entry requirements. As such, it said the reformed SAS grades had an important role in the medium to long term in continuing to provide attractive flexible career routes as the aspirations of doctors in training changed.

3.119 The BMA SAS England Committee said that, with thousands of doctors still sitting at the top of both specialty doctor pay scales, the expansion of the specialist grade needed to be sped up. It says that a single pay spine, with set criteria to progress to the specialist grade, was the best way of achieving this.

3.120 The Scottish Government said it was still early days for introducing the specialist role. A number of posts had been created and NHS Boards were planning to use this grade further.

3.121 The Welsh Government noted that, while the number of doctors being appointed to the new specialist grade continued to increase, the take up of these posts from existing SAS doctors remained much lower than anticipated when the new contract was introduced, pointing to the lower starting salary for the specialist role compared to the top of the 2008 specialty doctor pay scale.

3.122 The Department of Health in Northern Ireland said that trusts were exploring how to use the new specialist grade, but the creation of posts had been limited. In oral evidence, we were told that trusts had been reluctant to introduce specialist posts or reconfigure the medical workforce without direct funding from the Department.

Table 3.4: Gap between the maximum of the specialty doctor pay scale and the minimum of the 2021 specialist pay scale, 2023-24

	New contract	Old contract
England	£1,545	-£3,623
Scotland	-£2,570	-£1,211
Wales	£1,545	-£4,782
Northern Ireland	£1,545	-£4,049

Note: A positive figure means the minimum of the 2021 specialist pay scale is above the maximum of the old/new specialty doctor pay scale. This does not include the further uplift from 1 April 2024 in England.

3.123 Across all nations, the top pay point of the old specialty doctor pay scale for 2023-24 was higher than the starting pay for a specialist (see table 3.4). This could mean that there is no financial benefit to specialty doctors achieving promotion.

3.124 NHS Employers said that this gap remained until the specialist doctor gained four years' experience in the grade. It said that an overlap of the pay scales was not something that was intended following the introduction of the new contracts but was a consequence of higher pay awards being applied to those on the closed 2008 specialty doctor contract. This had been resolved with doctors being placed at various points on the specialist pay scale, including the top. NHS Employers published guidance last year advising employers to apply a short-term non-pensionable recruitment and retention premium to affected doctors.

Pay agreement in England

3.125 Following a ballot for industrial action and an earlier rejected offer, agreement was reached with SAS doctors and dentists in England in June 2024. Effective from 1 April 2024, it uplifted pay points on the 2021 contract by between 6.10 and 9.22 per cent. The starting salary for a specialty doctor increased from £52,530 to £55,825. Pay for those on pre-2021 contracts increased by £1,400. There was also agreement to withdraw the BMA rate card for SAS doctors in England.

Figure 3.16: Relative position of the 2008 and 2021 specialty doctor pay scales, England

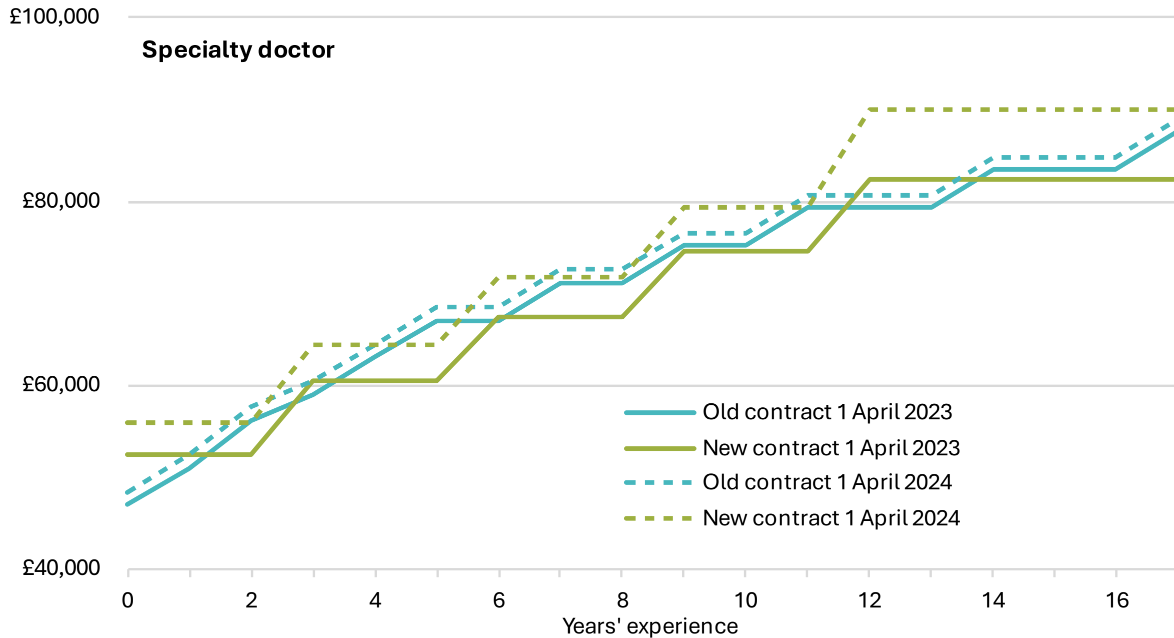
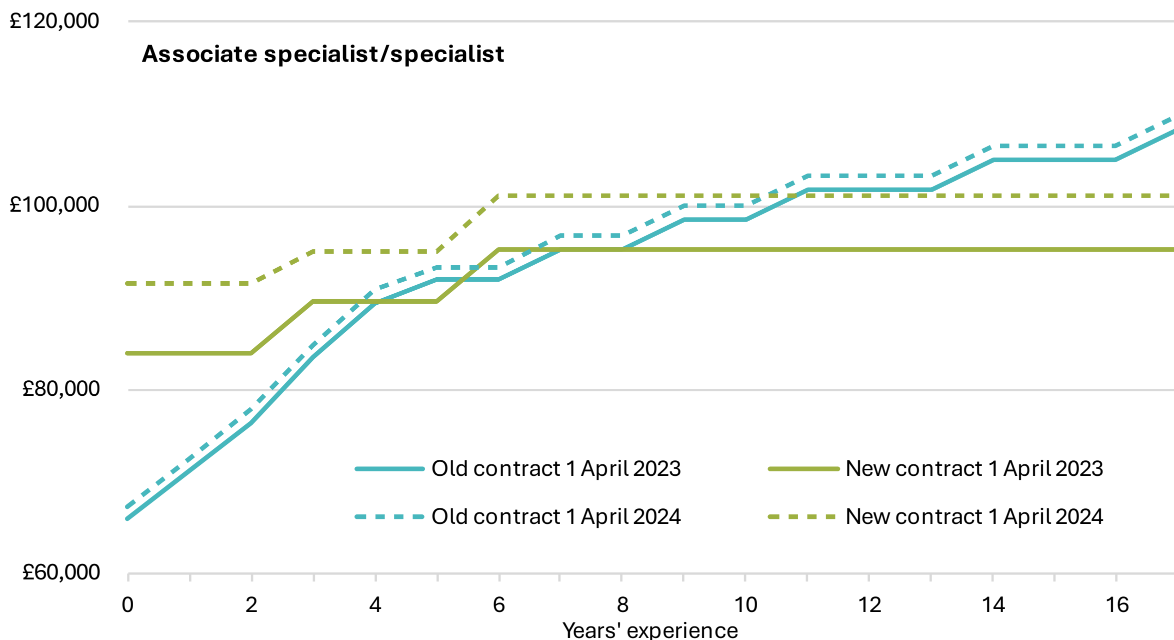


Figure 3.17: Relative position of the 2008 associate specialist and the 2021 specialist doctor pay scales, England



3.126 There are still six pay points where specialty doctors on the 2021 contracts in England will earn less than those on the closed contracts (see figure 3.16). There will be no-one on the lowest pay points of the old pay scale as it has been closed to new entrants since 2021.

3.127 The agreement took pay for the 2021 specialist grade to above the 2008 associate specialist grade except for the top pay points for associate specialists with over 11 years of experience (see figure 3.17). Specialist doctors reach the top of the pay scale after six years.

3.128 As part of the deal, the DHSC, NHS Employers, NHS England and the BMA agreed three priority actions to support the career development and progression of SAS doctors. The first was to develop advice and guidance specifically to support career progression for SAS doctors. The second was to explore what national levers are available to encourage, establish and embed specialist roles in order to provide career development opportunities for SAS doctors. This included:

- The creation of guidance to employers recommending that:
  - Vacant associate specialist roles are converted into specialist role vacancies.
  - Specialist roles are advertised internally within trusts first to give local specialty doctors more opportunities to progress within their trust.
  - SAS advocates have an opportunity to review relevant vacancies and make the case for them to become specialist roles.
- A piece of research into why more specialist roles are not being created and the establishment of a project board, with representation from the DHSC, NHS Employers, NHS England and the BMA, to consider the recommendations and how these could be implemented.

3.129 The third action was to ensure that, for specialty doctors undertaking a specialist doctor role, the acting up clause (which already existed in the SAS terms and conditions of service) is properly utilised.

3.130 It remained a shared commitment for the DHSC, NHS Employers, NHS England and the BMA to support career progression opportunities for all SAS doctors. This was expected to take the form of a programme of work that reviewed how employers could create more specialist posts in their organisation, creating more career progression opportunities for SAS doctors.

3.131 There was recognition that career development for a SAS doctor was not limited to progression from specialty doctor to specialist – for example, a SAS doctor might wish to become a consultant. Accordingly, there was agreement to promote job planning, so that SAS doctors were able to work optimally, with access to the appropriate opportunities, and to collaborate on a piece of work with the objective of helping SAS doctors to progress through the portfolio pathway.

3.132 It was the government's expectation that there would be a shared interest and endeavour to encourage SAS doctors in England to understand the value of moving to the new contracts.

Earnings and pay comparability

3.133 In the year to December 2023:

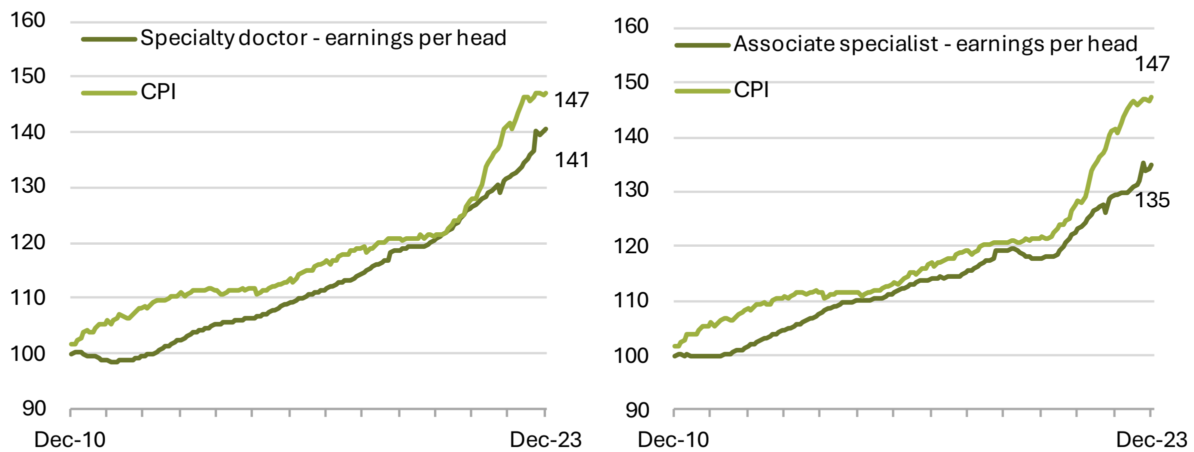
- Average earnings per head for specialty doctors in England were £80,444, 6.6 per cent higher than a year earlier.
- Average earnings per head for specialists/associate specialists in England were £106,341, 4.2 per cent higher than a year earlier.
- Non-basic pay made up 19-20 per cent of earnings.

3.134 In 2022-23, average total pay per FTE for staff grade doctors in Scotland, which includes specialist doctors and associate specialists, was £89,754. Non-basic pay made up 19 per cent of earnings.

3.135 Between the year to September 2010 and the year to December 2023, specialty doctor earnings per head in England increased by 41 per cent, compared with an increase in the CPI of 47 per cent over the same period. Associate specialist earnings per head in England increased by 35 per cent. Most of the difference over the period has occurred in the two most recent years as inflation increased sharply.

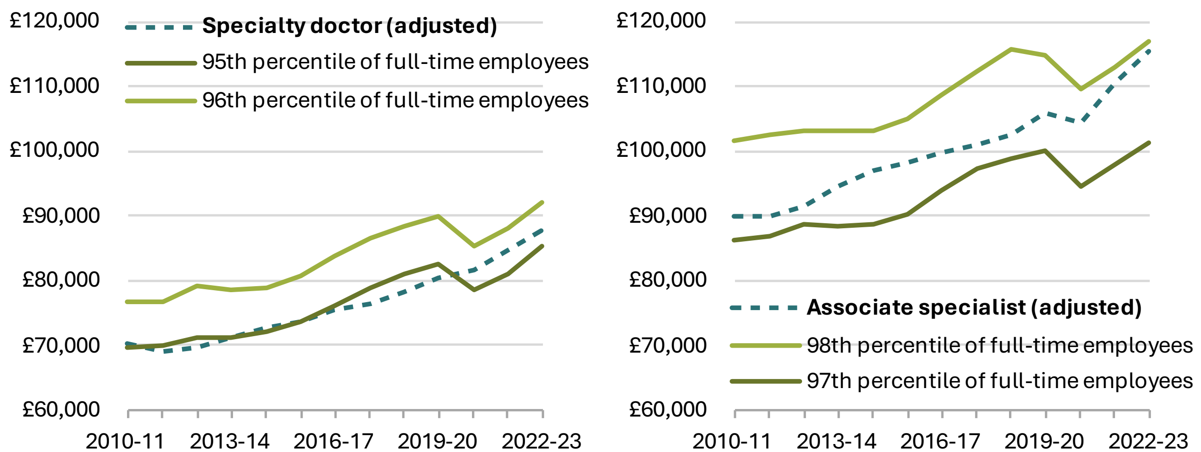
3.136 Between the year to September 2015 and the year to December 2023, specialty doctor earnings per head in England increased by 32 per cent, compared with an increase in the CPI of 32 per cent over the same period. Associate specialist earnings per head in England increased by 23 per cent.

Figure 3.18: Specialty doctors and specialists/associate specialists, England, change in average earnings per person and CPI, December 2010 to December 2023, September 2010=100



Source: OME analysis of NHS England and ONS data.

Figure 3.19: Average total earnings per FTE of SAS doctors, England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2022-23



Source: OME analysis of NHS England and ASHE data.

Note: Earnings for SAS doctors are average annual basic pay per FTE, added to non-basic pay per head data, adjusted by a factor that reflects the ratio between FTE and headcount estimates of basic pay.

3.137 Average earnings per FTE for specialty doctors in England were broadly in line with the 95th percentile of all full-time earnings between 2010-11 and 2015-16. Average total earnings for specialty doctors fell below earnings at the 95th percentile between 2016-17 and 2019-20, before moving back above that benchmark each year since 2020-21.

3.138 Average earnings per FTE for specialists/associate specialists in England have been consistently between the 97th and 98th percentile of all full-time earnings. After falling back towards the 97th percentile between 2015-16 and 2018-19, specialist/associate specialist average earnings moved closer to the 98th percentile in each year since 2019-20.

3.139 Specialty doctors in England have similar earnings to other professional comparators (actuarial, legal, finance/accounting, pharmaceutical) and earn more than their veterinary and academic comparators. Associate specialist/specialist doctors in England earn more than their veterinary and academic comparators, but less than their other professional comparators (actuarial, legal, finance/accounting, pharmaceutical).

Figure 3.20: Inter-quartile range of total earnings of specialty doctors, England, compared with professional groups, matched by job size to market data, 2023

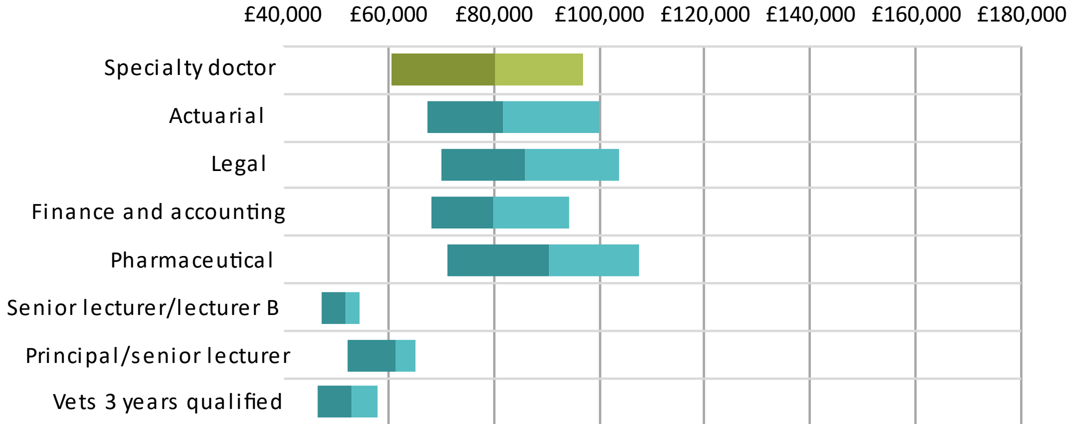
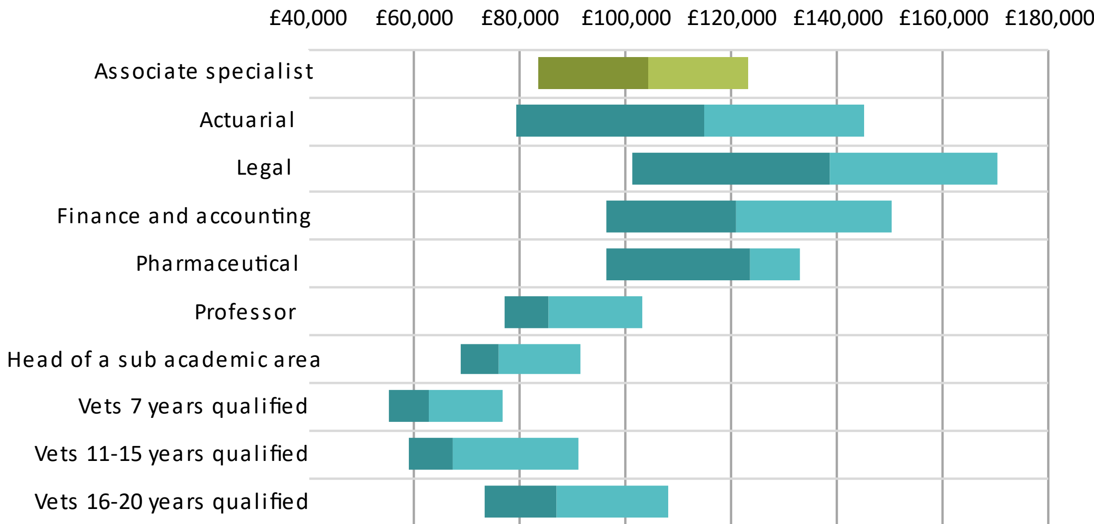


Figure 3.21: Inter-quartile range of total earnings of associate specialist/specialist doctors, England, compared with professional groups, matched by job size to market data, 2023



Source (figures 3.20 and 3.21): OME analysis of data from Kornferry; Universities and Colleges Employers Association; The Society for Practising Veterinary Surgeons; NHS England; ONS.

Notes: Pay for other professions is on a full-time equivalent basis, whereas that for doctors and dentists is on a headcount basis, and so is lower than it would be on an FTE basis. Individual medical roles are matched by job size to market data.

Career development

3.140 The Long-Term Workforce Plan for England said that SAS doctors formed an increasing proportion of the medical workforce, including at a senior level. It said that, traditionally, these roles predominantly focused on clinical service provision, although feedback from this group indicated their growing desire for greater opportunities in a non-patient facing capacity, such as leadership, mentoring, and education and training. The Plan committed to support SAS doctors to have a better professional experience, by improving equitable promotion and ensuring options for career diversification.

3.141 The HCSA drew attention to the work on improving careers by the SAS Collective. This included calls for: access to an educational supervisor; access to professional development opportunities; opportunities to become specialists; opportunities to be educators; extended roles in leadership and management open to all substantive medical staff; and that all locally employed doctors employed for more than two years within one trust should be offered the opportunity to transfer to the appropriate SAS contract.

Working lives

3.142 On our visits, SAS doctors told us they felt unfairly treated compared to other groups of doctors, that they did not feel recognised and were struggling with career development. We were told that very few specialist roles were being created leaving many SAS doctors at the top of the specialty doctor pay scale.

3.143 The BMA England SAS committee told us in oral evidence that SAS doctors suffered bullying and harassment, and poor treatment because of their grade. SAS doctors' career and pay progression was stunted. Similarly, the BMA Northern Ireland SAS committee told us in oral evidence that SAS doctors felt bullied, undermined and overlooked by consultants. They felt constantly excluded which led to disillusionment.

Consultants

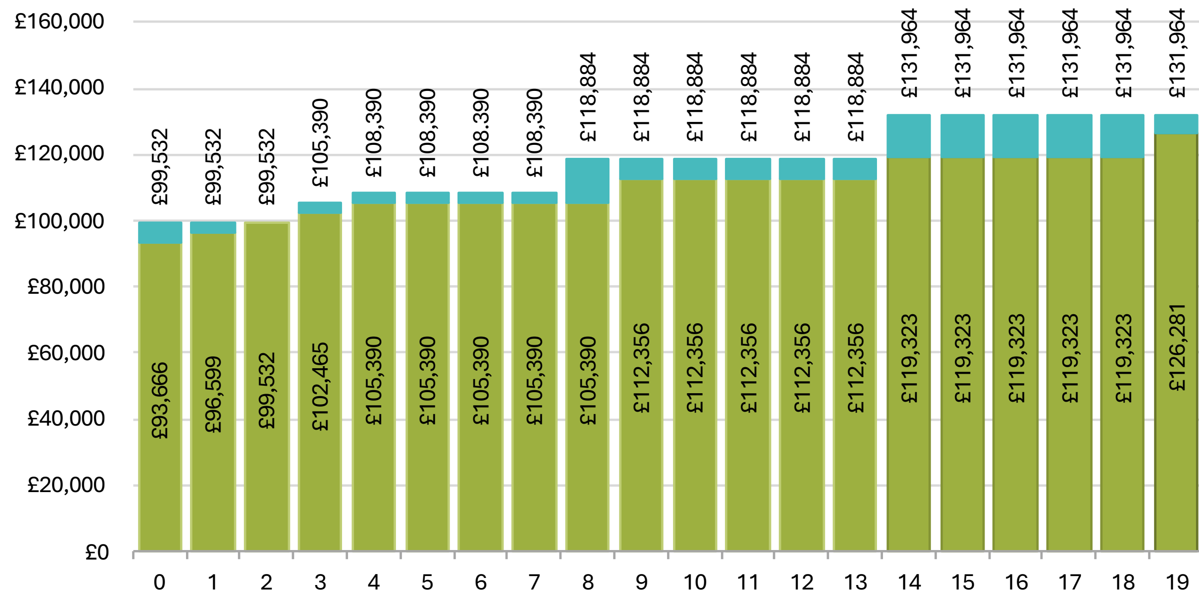
Agreement in England

3.144 The Government negotiated an agreement with consultants in England during 2023-24 following strike action. The DHSC said this focused on modernisation of the pay scale, better linking it to performance, and addressing equalities issues within the current structure, alongside productivity enhancing initiatives. The number of pay points was reduced from eight to five, and the time taken to reach the top pay point was reduced from a minimum of 19 to 14 years. The changes were effective from 1 March 2024.

3.145 Increases to individual pay points ranged from zero to 12.8 per cent. All consultants will benefit substantially over their career. Including the DDRB-recommended 6 per cent from 1 April 2023, this equated to uplifts of between 6.0 per cent and 19.6 per cent over the course of 2023-24.

3.146 The agreement increased the starting salary for a consultant in England to £99,532. Consultants are on this salary for a minimum of three years. The next pay point of £105,390 is for one year, the third pay point of £108,390 is for four years. A consultant will reach the top pay point of £131,964 after a minimum of 14 years with no further progression.

Figure 3.22: Uplifts to the consultant pay scale in England



3.147 The agreement moved funding for new local CEAs into basic pay. This meant it became consolidated, pensionable, and subject to uplifts. This represented around 1.5 percentage points of the cost of the uplifts to pay points. The overall cost was estimated at 4.95 per cent of the consultant paybill in the earlier version of the offer made in November (which did not have the uplifts to pay points 4 to 7 but would have been effective two months earlier), 3.45 percentage points of which was new money.

3.148 New arrangements will be introduced to ensure that there is a clearer link between pay progression and evidence of skills, competencies and experience. The DHSC said that progression between pay points was based on existing provisions (which were not always enforced). It said there were already requirements to: engage in job planning; make a reasonable effort to meet commitments and objectives; participate satisfactorily with appraisal; meet commitments around private practice; and to have no active disciplinary or capability issues. A new criterion for progression was that consultants needed to have engaged and participated in statutory and mandatory training (or, where this was not achieved for reasons beyond the doctor’s control, to have made every effort to do so).

3.149 The BMA England Consultants Committee said that, due to the limited additional investment available, it was not able to achieve as much reform as it would have liked. It said the time to reach the top pay point remained too long, at 14 years, and there were still too many pay points. It believed further reform was required, to result in a two or three-point structure with the top reached after around five years.

3.150 NHS Employers said that that the reforms sought to create opportunities for better productivity and efficiency, more effective performance management and a reduction in some equalities risks across the consultant workforce.

3.151 The DHSC have advised that it is likely that the positive impact on the gender pay gap from this agreement will take some time to be realised because it gave higher uplifts at the top of the scale (where there are higher proportions of males) than the bottom (where there are higher proportions of females). The benefit to the gender pay gap comes from reducing the number of pay points and the length of time to reach the top of the scale, so over time it

should reduce the disadvantages currently experienced by female consultants. The deal was welcomed very positively by Professor Dame Jane Dacre and her team.

Contract reform

3.152 The DHSC said that, even with the agreement, there remained elements of the consultants' contract that were out of line with the modernised contracts of other NHS workforces. It said it would be interested in pursuing a full programme to reform the contract in the future.

3.153 NHS Employers said that their priorities for any wider contract reform, above the pay scale changes agreed, had remained consistent for a number of years, and included: modernising terms and conditions to make sure that they were fit for purpose under a changing NHS, and provided greater consistency and alignment with other reformed medical contracts and staff groups where appropriate; and removal of the opt-out clause that allowed consultants the right to refuse non-emergency work after 7pm and before 7am, to allow for more flexible deployment of the consultant workforce according to service needs.

3.154 The Welsh Government said that reform of the pay scales, including the removal of commitment awards, was essential in being able to demonstrate fair pay and to ensure recruitment and retention of consultants to services across NHS Wales.

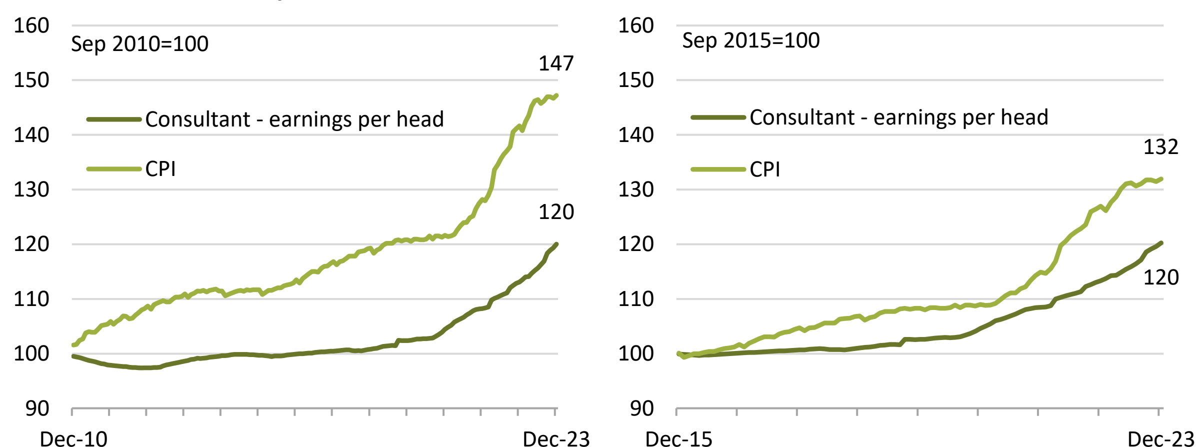
3.155 The Department of Health in Northern Ireland said there had been no real progress made on consultant contract reform.

Earnings and pay comparability

3.156 In the year to December 2023, average earnings per head for consultants in England were £133,858, 6.1 per cent higher than a year earlier. Non-basic pay made up 24 per cent of earnings. In 2022-23, average total pay per FTE for consultants in Scotland was £143,864. Non-basic pay made up 26 per cent of earnings.

3.157 Between the year to September 2010 and the year to December 2023, consultant earnings per head in England increased by 20 per cent, compared with an increase in the CPI of 47 per cent over the same period. Between the year to September 2015 and the year to December 2023, consultant earnings per head increased by 20 per cent, compared with an increase in the CPI of 32 per cent over the same period. Much of the difference over the period has occurred in the last two years as inflation increased sharply.

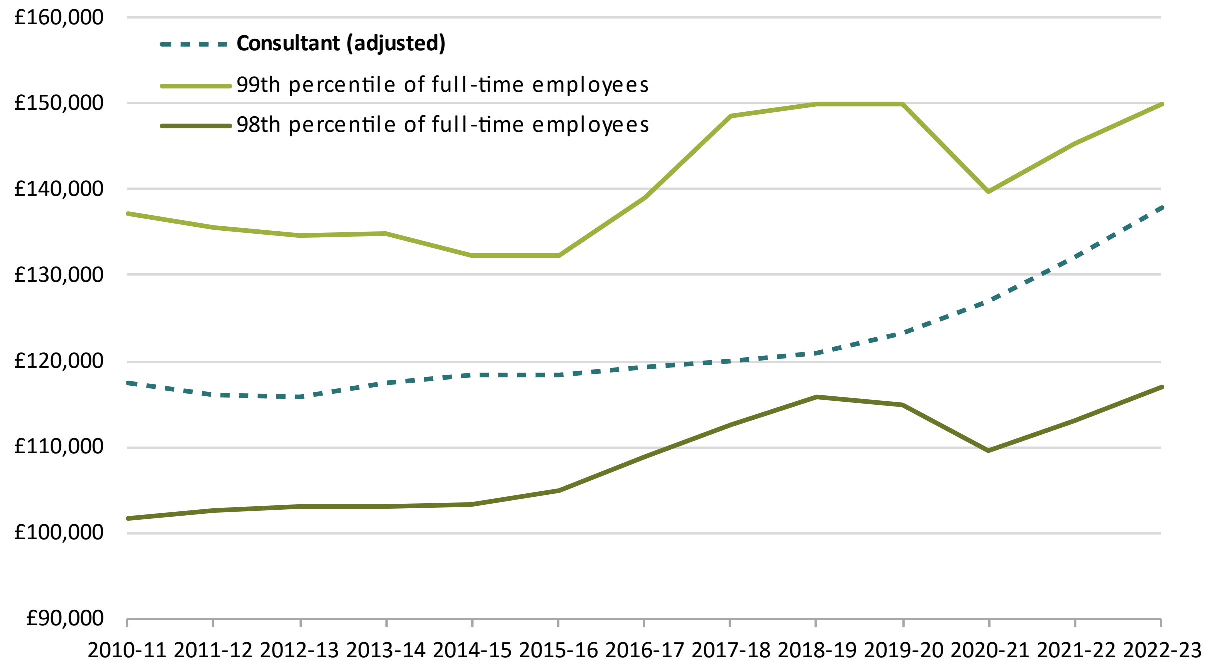
Figure 3.23: Consultants, change in average earnings per person and CPI, England, December 2010 to December 2023, September 2010=100



Source: OME analysis of NHS England and ONS data.

3.158 The BMA England Consultants Committee said the value of the consultant pay scale had fallen by 20.6 per cent in real terms between 2008-09 and 2022-23 (or 31.7 per cent using the Retail Prices Index (RPI) rather than the CPI). Including the highest value of a clinical impact award, maximum consultant reward had fallen by 39.6 per cent in real terms between 2008-09 and 2022-23 (or 48.0 per cent using the RPI).

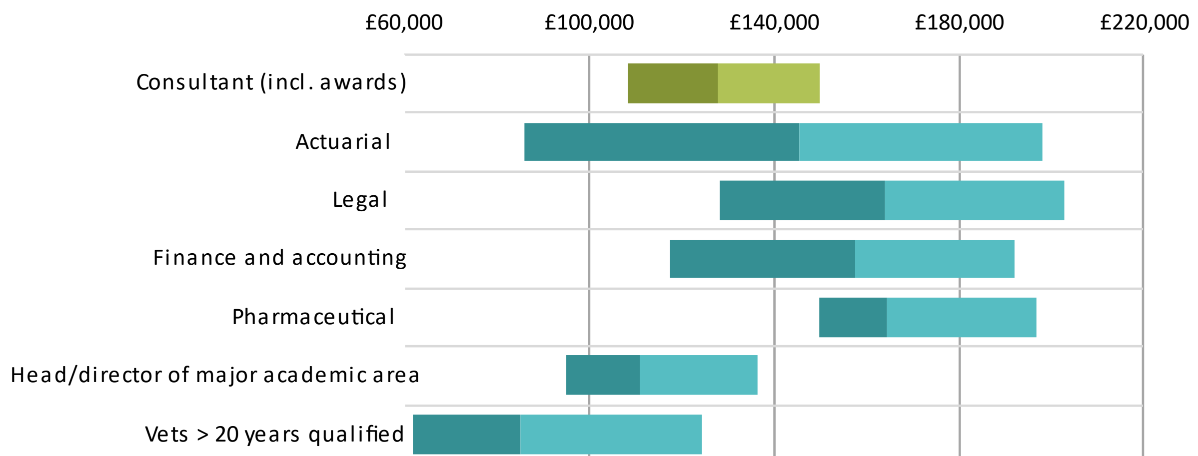
Figure 3.24: Average total earnings per FTE of consultants, England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2022-23



Source: OME analysis of NHS England and ASHE data.

Note: Earnings for consultants are average annual basic pay per FTE, added to non-basic pay per head data, adjusted by a factor that reflects the ratio between FTE and headcount estimates of basic pay.

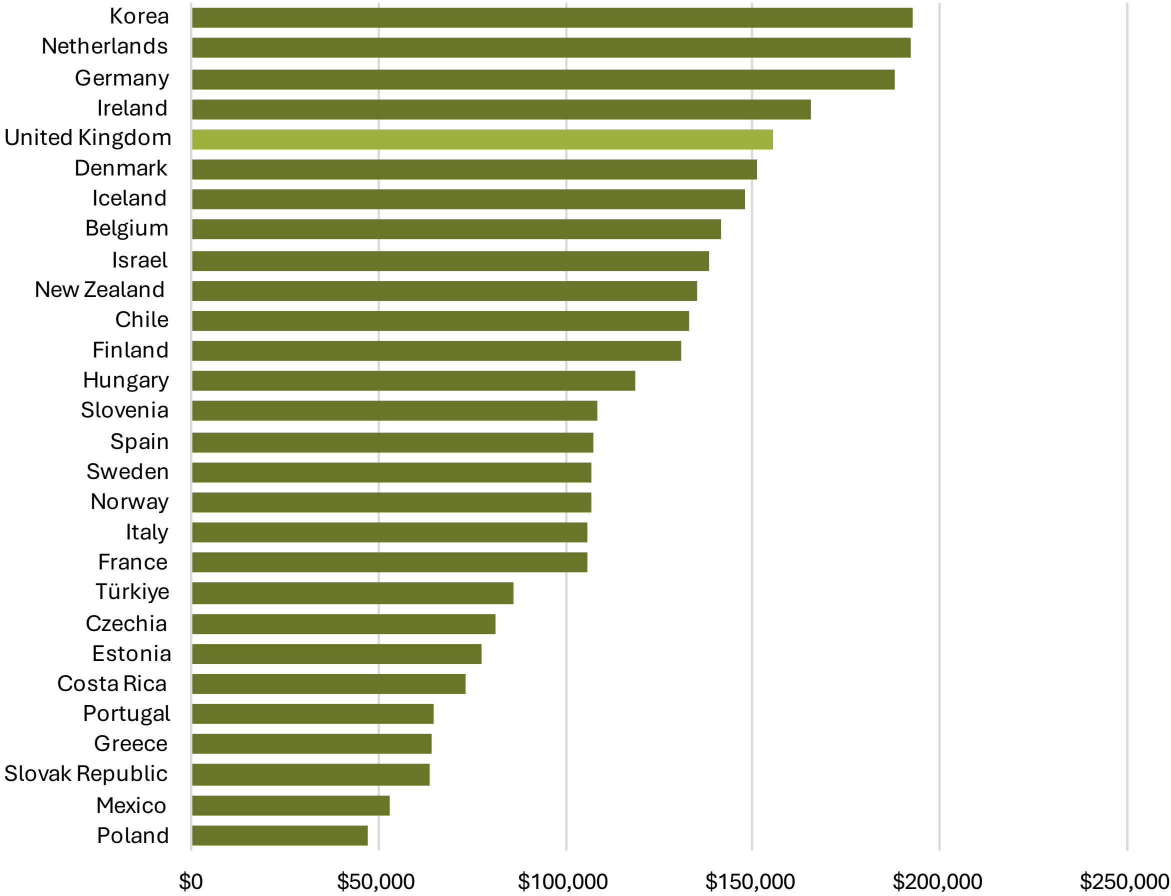
Figure 3.25: Inter-quartile range of total earnings of consultants, England, compared with professional comparator groups, matched by job size to market data, 2023



Source: OME analysis of data from Kornferry; Universities and Colleges Employers Association; The Society for Practising Veterinary Surgeons; NHS England; ONS.

Notes: Pay for other professions is on a full-time equivalent basis, whereas that for consultants is on a headcount basis, and so is lower than it would be on an FTE basis. Individual medical and dental roles are matched by job size to market data.

Figure 3.26: Remuneration of specialists, 2021



Source: OECD.

Notes: The data has been converted to a common currency ($US) using purchasing power parities. Data is not available for some English speaking OECD countries, such as Australia, Canada and the USA.

3.159 Since 2010-11, average earnings per FTE consultant have been consistently between the 98th and 99th percentile of all full-time earnings. Between 2015-16 and 2018-19, consultant average earnings fell back to the 98th percentile, although this has since reversed, as between 2018-19 and 2022-23 consultant average earnings continued to grow while earnings at the 98th and 99th percentiles showed little or no growth.

3.160 Consultants earn more than their veterinary and academic comparators, but less than their other professional comparators (actuarial, legal, finance/accounting and pharmaceutical).

3.161 Organisation for Economic Co-operation and Development (OECD) data for the remuneration of 'specialists' across a range of countries in 2021 showed that remuneration for UK consultants was towards the top of the range within the OECD, behind just Korea, Netherlands, Germany and Ireland.[28]

Clinical excellence awards, clinical impact awards, commitment awards, distinction awards and discretionary points

3.162 Each nation runs a different system of discretionary pay for consultants, with typically a lower and a higher award scheme: local clinical excellence awards (CEAs) and national clinical impact

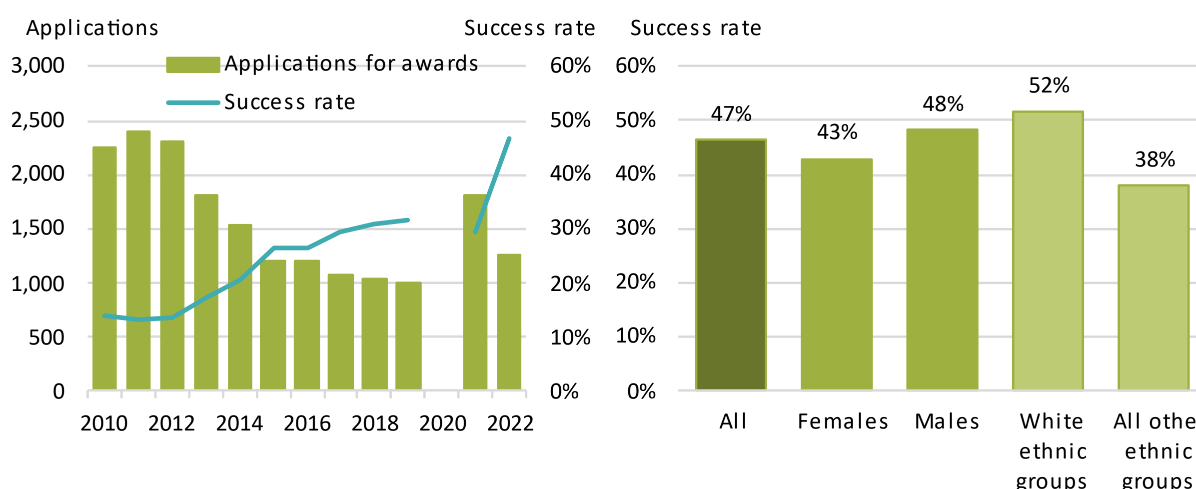
[28] Although OECD use 'specialists' as the descriptor, these are consultants. The UK data uses consultant earnings in England. Data is not available for some English speaking OECD countries, such as Australia, Canada and the USA.

awards (CIAs) in England; commitment awards and national CIAs in Wales; a paused CEA scheme in Northern Ireland; and discretionary points and distinction awards in Scotland, the latter of which are no longer being awarded.

National clinical impact awards in England and Wales

3.163 National CIAs were introduced from April 2022 for consultants in England and Wales. Up to 600 awards are available in England each year and 37 in Wales.[29] They are worth £20,000, £30,000 or £40,000 In England and Wales, as well as a £10,000 award in Wales. Awards are non-pensionable and held for five years.

Figure 3.27: Applications and success rates for new national clinical impact awards, England and Wales



Source: ACCIA.

3.164 In 2022, there were 1,267 applications for new awards: 1,186 in England and 81 in Wales. A total of 590 new awards were granted – 553 in England and 37 in Wales, resulting in an overall success rate of 46.6 per cent in England and 45.6 per cent in Wales. Just over half (54.7 per cent) of new awards were given to applicants with no previous award.

3.165 In 2022, 67.1 per cent of awards granted were to men and 30.7 per cent to women, meaning men had a higher success rate of 48.4 per cent, compared to 42.9 per cent for women. The success rate gap between males and females widened 1.2 percentage points from the 2021 awards. The Advisory Committee on Clinical Impact Awards (ACCIA) said there was also an over-representation of white ethnic groups, both in applications and in success rates.

3.166 The DHSC said that, while the indications on the impact of the reforms on broadening access to awards were positive, the reformed scheme had only operated for one full round, and it therefore asked the DDRB to allow the reformed scheme further time to be fully implemented and embedded before any further uplift is recommended.

3.167 The BMA said that the changes to the national CIA scheme had a negative impact on total compensation. It said the changes prevented younger applicants (who were more likely to be female and were more ethnically diverse) from ever holding a pensionable CEA. It said that

[29] ACCIA, *Advisory Committee on Clinical Impact Awards*. https://www.gov.uk/government/organisations/advisory-committee-on-clinical-impact-awards

consultants needed to forfeit their pensionable (pre-2018) local CEA if they successfully applied for a national CIA, making it financially disadvantageous.

Local clinical excellence awards in England

3.168 Under the recent consultants' agreement in England, the contractual right to access an annual local CEA round ceased. The funding for new local CEAs was moved into basic pay. This did not impact non-consolidated awards which had been issued for more than one year.

3.169 NHS Providers welcomed the reforms to local CEAs. Trust leaders had previously noted an opportunity, with local CEAs paused during the pandemic, for the scheme to end and for the funding to be moved into base pay for consultants, particularly as a result of the negative impact they had on the gender pay gap.

Discretionary points and distinction awards in Scotland

3.170 Scotland has discretionary points and distinction awards for consultants. No new distinction awards have been made since 2010 and there has been no progression through the scheme. Current award holders continue to receive their award and they are still subject to five-year reviews. The value of the distinction awards and discretionary points has not increased since 2010.

3.171 The Scottish Government said that no new distinction awards had been made as these did not align with its progressive pay principles. The availability of new discretionary points increased in line with the number of consultants in post. The Scottish Government said there was no evidence to suggest that an adverse impact had resulted from the freezing of the value of distinction awards and discretionary points. It said it was not seeking any recommendations from the DDRB on distinction awards or discretionary points.

Commitment awards in Wales

3.172 Instead of a local CEA scheme, Wales has commitment awards. They are available to all consultants after three years at the top of the consultant pay scale who demonstrate their commitment through satisfactory job plan reviews. They are then eligible at three-yearly intervals, until they have achieved eight award levels. Each level is worth an amount annually which is permanent and pensionable. A consultant can hold a national CIA and a commitment award at the same time.

3.173 The Welsh Government said that reform of the pay scales, including removal of commitment awards, was essential in being able to demonstrate fair pay and to ensure recruitment and retention of consultants.

Clinical excellence awards in Northern Ireland

3.174 The CEA scheme in Northern Ireland has paused since 2011, with no new awards made since 2009-10; existing awards continue to be paid where applicable. A new draft scheme has been proposed which the Department of Health said would broaden access and make the application process fairer and more inclusive. Subject to the results of a consultation, the number of levels of awards will reduce from twelve to six with the three higher awards run by the Department of Health and the three lower awards run by employers. It was proposed that there would be a five-year award period for higher awards and a three-year period for lower awards.

3.175 While the recipients of the paused current scheme were consultants and the new scheme has been based on the consultant population, the consultation also sought views on expanding

the awards scheme to other senior medical staff, such as SAS doctors. The consultation said that the cost of the scheme once at steady state would be £6.7 million; £3.2 million of this would be from the funds released from the legacy scheme and a further £3.5 million in new money. The Department of Health said the proposed scheme would require a further allocation of funds for which ministerial approval would be required.

Motivation and morale

3.176 The NHS Staff Survey for England showed slightly better results for medical and dental staff in 2023 than in 2022. However, the results for 2023 remained much worse than in 2019 and 2020, and the slight improvement recorded in 2023 for medical and dental staff was less marked than that for NHS staff as a whole.

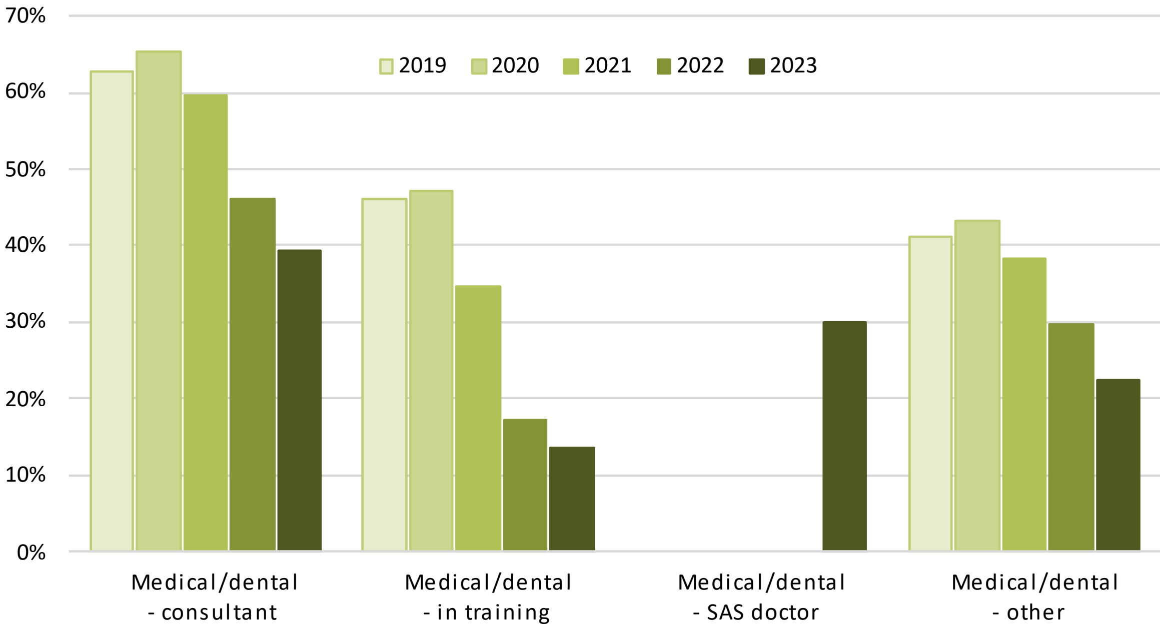
3.177 Compared with 2022, there were small increases in the percentages of medical and dental staff saying that: they were looking forward to going to work; were enthusiastic about their job; felt their line manager and their organisation valued their work; and that they would recommend their organisation as a place to work. There were also small reductions in the percentage saying that: they had considered leaving the NHS; and had experienced harassment, bullying or abuse from patients, relatives or the public. Doctors and dentists in training saw a similar trend to all medical and dental staff with a small improvement in 2023, but results for this group were typically more negative than for all medical and dental staff.

3.178 Compared with 2022, there were increases in the percentage of medical and dental staff saying that: they could meet the conflicting demands on their time; there were adequate supplies and staff for them to do their job properly; and that they were able to achieve a good balance between work and home life. There were also reductions in the percentage saying that: they had felt unwell as a result of work-related stress; and that they felt burnt out because of work. There was a small reduction in the percentage of staff saying that they had worked unpaid hours over and above those contracted, and a small increase in the percentage saying they had worked paid hours over and above those contracted.

3.179 While the results saw a small improvement, doctors and dentists in training were more likely than other groups to report that they felt unwell as a result of work-related stress (48.9 per cent of doctors and dentists in training compared to 43.5 per cent of all medical and dental staff), and that they felt burnt out because of work (38.9 per cent of doctors and dentists in training compared to 32.4 per cent of all medical and dental staff). Doctors and dentists in training were less likely to report that they achieved a good balance between work and home life: 35.8 per cent of doctors and dentists in training compared to 42.0 per cent of all medical and dental staff.

3.180 The survey showed a further decrease in satisfaction with pay. In 2023, 32.1 per cent of medical and dental staff said they were satisfied or very satisfied with their pay, a decrease of 5 percentage points from 36.6 per cent in 2022, and a decrease of 25 percentage points from 2020. This contrasts with all NHS staff, of whom 31.2 per cent said they were satisfied with their pay in 2023, an increase from 25.6 per cent in 2022, and a reduction from 36.5 per cent in 2020. By grade, 39.3 per cent of consultants, 30.0 per cent of SAS doctors and just 13.6 per cent of doctors and dentists in training reported being satisfied with their pay.

Figure 3.28: HCHS doctors, satisfaction with pay by grade, England, 2019 to 2023



Source: NHS Staff Survey.

3.181 Prior to COVID-19, sickness absence for doctors in England averaged just under 1.5 per cent, compared with just under 4.5 per cent for all NHS staff. Since the spring of 2020, sickness absence rates have generally been higher. The latest data to December 2023, show a 12-month average sickness rate for HCHS doctors of 1.8 per cent, compared with 5.0 per cent for all NHS staff. In the 12 months to December 2023, there were 922,000 HCHS doctor days lost to sickness absence, a reduction from 1,056,000 in the 12 months to December 2022.

3.182 The BDA identified a number of specific issues affecting motivation and morale from its survey of members working in hospital settings: low staffing levels/reduced clinical capacity; unrealistic workloads; poor leadership and management; poor working conditions; and a toxic workplace culture.

Pensions

3.183 Data from the DHSC showed a decline in pension scheme membership among doctors and dentists in training. Overall, 91 per cent of foundation year 1 doctors in England were members of the NHS pension scheme in June 2023, 88 per cent of foundation year 2 doctors, 80 per cent of those in core training, and 88 per cent of specialty registrars.

3.184 Pension scheme membership among those in core training had declined by 14 percentage points over 10 years. While this might be driven by cost-of-living pressures, the DHSC said it was mainly due to lower membership rates among locally employed doctors, where there had been a substantial increase in numbers. Of these doctors, many held non-British nationality and, while 96 per cent of UK doctors were members of the pension scheme, only 69 per cent of those with a non-UK or EU nationality were in the pension scheme.

3.185 The DHSC reported that 91 per cent of consultants were in the NHS pension scheme in June 2023, unchanged on the year but down 5 percentage points over the previous 10 years. The changes to pension taxation should give higher-paid doctors and dentists more incentive to stay in the NHS pension scheme.

Impact of pension taxation changes

3.186 On our visits we were told that there had been a notable fall in consultants' willingness to work additional hours since the pandemic, which had not been reversed by the recent changes to pension taxation. Pension taxation was much less of an issue than previously, except for concerns that it might change again.

3.187 NHS Employers reported staff taking early retirement, reducing their work commitments, and a reluctance to apply for promotions or take on additional work and responsibilities due to pension taxation. NHS England said that the reforms to pension tax would likely mean fewer doctors deciding to leave the NHS for this reason as most, but not all, were no longer subject to pension tax charges.

3.188 The Scottish Government said that the changes to the annual allowance and moves to abolish the lifetime allowance were welcome and would support staff retention by removing most senior doctors and dentists from the impact of pension tax. It said that pension tax had previously been identified as a barrier to senior clinicians remaining in the workforce and from working more hours.

Our comments

Recruitment and retention, motivation and morale

3.189 Recruitment and retention for medical and dental staff in secondary care appears to be robust, given the strong growth in workforce numbers across all groups and nations over the medium term, and falling leaver rates. We observe, however, the recent decline in applications to medical degrees, and the increasing reliance on international medical graduates to fill less popular training places, which are concerning in the context of the aspirations of the Long Term Workforce Plan. Medicine needs to remain an attractive career to support the future expansion of health services. Vacancy rates remain high in some areas, which may reflect increasing demand. We would like to better understand the barriers to filling these vacant roles. We would expect spend on temporary medical staffing to have increased in 2023-24 to cover for industrial action.

3.190 We would also like to hear more about any ongoing impact from Sláintecare and flows of doctors and dentists between Northern Ireland and the Republic of Ireland.

3.191 While there were small improvements in motivation and morale across medical and dental staff in the latest NHS survey, they remain at a low level, and the improvement for medical and dental staff was less marked than that for NHS staff as a whole. Along with increasing dissatisfaction with pay, and poor working conditions, poor morale has contributed to the recent willingness to take industrial action. We note that indicators of engagement, job satisfaction and workload remain worse for doctors and dentists in training than for all medical and dental staff.

Doctors and dentists in training

3.192 There is clearly increasing dissatisfaction with working lives and worsening morale among doctors and dentists in training in particular. This group experiences significant disruption and costs from frequent job moves during their training years. The need to bear the costs of exams alongside this has also been highlighted to us. Just 14 per cent of doctors and dentists in training reported being satisfied with their pay, a further fall since last year and significantly worse than other parts of the medical workforce.

3.193 Earnings data shows that doctors and dentists in training have not seen the growth in earnings that we would have expected to follow from our pay recommendation in 2023-24 of 6 per cent plus £1,250 on all pay points, equating to between 8.1 and 10.3 per cent in England. This is especially the case for foundation doctors. This is likely due to reduced income during strike action, increased part-time working, or a reduction in additional working hours.

3.194 We have taken particular note that the relative position of the earnings of doctors and dentists in training compared to the distribution of earnings of other employees remains lower than in the past, especially at foundation years 1 and 2. In contrast, pay for SAS grades and consultants has remained consistent or slightly improved compared to comparator groups over the same period.

3.195 It is clear that those in training are responding to heightened work pressures and a poor working environment by increasingly moving to less-than-full-time working and taking time out of training. We have heard explicit concerns in evidence and on visits about the paucity in basic amenities and poor quality of support for medical staff in their workplaces such as: access to hot meals, late rota changes, and the unavailability of transport or safe parking following late night shifts. This is in addition to the need to frequently move or commute long distances due to training rotations. We understand that the recent industrial action is caused by multiple factors, alongside pay, and we hope all parties can work together to improve the working lives of this important group.

3.196 There has been little progress on contract reform for doctors and dentists in training in Scotland, Wales or Northern Ireland, despite commitments from the governments to address this. We understand contract reform is part of ongoing discussions and we would hope to see developments on this in the coming year.

3.197 We recognise the growing trend of doctors and dentists in training to take time away from training when they have completed the foundation stage, and for longer. While this practice is not a bad thing, the reasons for it are mixed and it will delay the time for someone to become a consultant. With the growing number of medical students across all nations, it is important that the reasons are understood to facilitate workforce planning.

Locally employed doctors

3.198 We note the increasing cohort of locally employed doctors, who are typically doctors that are taking time out of training or recent international recruits. It is important to support career progression and development for these doctors and we welcome the proposals under the recent SAS agreement to better understand the make-up of the locally employed workforce and to enable locally employed doctors to move to permanent SAS contracts.

3.199 The current inability to separate locally employed doctors from the wider medical and dental workforce in the workforce data is a concern. Without this information at a national level, their role in the workforce cannot be fully understood and appropriate career plans developed. We would like to hear more from all parties about how this group can be better identified. It will then be possible to explore how the increased use of locally employed doctors, and turnover in these roles, impacts on patient care and broader productivity.

SAS doctors and dentists

3.200 There have been clear structural issues created by the different SAS contracts and the lack of take up of the new contract in England, Wales and Northern Ireland. The slow progress in introducing specialist roles, despite this being a key part of career development in the new

SAS contract, is disappointing. We are pleased to see these issues addressed in the recent agreement with SAS doctors in England and would hope that similar action can be taken in Wales and Northern Ireland. We would like to understand better where these specialist roles have been created and how they are being used to improve service delivery.

3.201 We note that leaving rates for specialty and associate specialty doctors in England have fallen over the last year. Pay for SAS doctors has remained in line with comparators. We also observe, however, the specific issues around career development and bullying and harassment experienced by this group. This might be addressed through greater use of the SAS advocate role.

Consultants

3.202 The restructuring in the recent consultants pay deal for England reduces the number of pay points and the time taken to reach the top of the scale. This is a positive development, and we would hope to see the gender pay gap reduce over time as a result. This creates a disparity with other nations which may wish to consider similar reforms. We would also like to see the scope for further contract reform explored, in particular how it can improve service delivery.

3.203 Substantial concerns have been raised in the past over pension taxation among this group. The recent reforms mark a significant increase in total remuneration for consultants. Along with reforms to the pension scheme that enable individuals to retire and return to work, we would hope to see improved retention of senior doctors and dentists.

Consultant reward schemes

3.204 The four nations are in very different places on clinical excellence awards, discretionary pay, and other consultant reward schemes. The schemes are at different stages of progress towards reform, and some are closed to new applicants.

3.205 In our last four reports, we have not recommended that uplifts be applied to consultant reward schemes, as a result of concerns over the schemes' equity and effectiveness. They have all been frozen in value since at least 2018.

3.206 The recent agreement for consultants in England ends the local CEA scheme. Therefore, a separate recommendation on local CEAs is not needed and this funding will, by default, be uprated in line with the consultants' pay uplift. The Scottish Government has said it is not making any new distinction awards as they do not align with its progressive pay principles. Discretionary points are still available, but the Scottish Government said it was not seeking any recommendation from us on distinction awards or discretionary points.

3.207 Clinical excellence awards in Northern Ireland remain suspended although there is a commitment to reintroduce then. The Welsh Government has said it wishes to remove commitment awards.

3.208 The national clinical impact awards scheme for England and Wales continues to show disproportionate awards going to men and to those from a white ethnic background. The DHSC has asked us to allow the reformed national CIA scheme further time to be fully implemented and embedded before any further uplift is recommended. Both the BMA and the HCSA have said that the freezing in value of awards means they are worth a diminishing amount over time. We are cognisant of this and would like to see further evidence on both the equity and effectiveness of the scheme so we can reconsider the value of awards next year.

Chapter 4 General medical practitioners

4.1 This chapter considers general medical practitioners (GPs). General practice services are typically delivered by partnerships of GPs that own their practices and run them as private businesses and employ salaried GPs as well as other staff such as receptionists and healthcare professionals. Some practices are owned and operated by other NHS/HSC organisations, and GPs also work in other parts of the NHS/HSC, including out of hours services. Doctors become GPs after five years of postgraduate medical training, comprising the two-year foundation programme and three years' general practice training. Doctors in general practice training are also discussed in chapter 3.

General practice workforce

4.2 In December 2023, there were 36,657 regular full-time equivalent (FTE) GPs in England including those in training. This was 1.8 per cent higher than a year earlier and 9.9 per cent higher than five years earlier. There were 26,826 qualified permanent FTE GPs (excluding those in training) in England in December 2023, an increase of 0.5 per cent from a year earlier but a fall of 2.2 per cent over five years.[30]

4.3 In England, the headcount of GPs has increased more quickly than the number of FTEs. This means it takes a greater number of headcount GPs to generate the same number of FTE GPs. In December 2016, it took 122 headcount qualified permanent GPs to generate 100 FTE qualified permanent GPs. By June 2020, this had increased to 129 headcount qualified permanent GPs, and by December 2023 had increased further, to 133.

4.4 Within the population of qualified permanent GPs, there has been a difference in the growth of GP partners and salaried GPs. In December 2023, there were 16,217 FTE qualified permanent partner GPs in England, a fall of 2.2 per cent from a year earlier and 15.1 per cent over five years. In December 2023, there were 10,333 FTE qualified permanent salaried GPs, an increase of 4.8 per cent from a year earlier and 25.9 per cent over five years.[31]

4.5 In England, GP partners had a participation rate (the ratio of FTE to headcount) of 86 per cent at December 2023, compared to 63 per cent for salaried GPs. The change in the composition of the workforce means a larger number of GPs (on a headcount basis) are required to generate a given number of FTE GPs.

Table 4.1: GPs, England, December 2023

	Headcount	Annual growth	FTE	Annual growth
All regular GPs	45,638	2.4%	36,657	1.8%
Qualified permanent GPs	35,738	1.3%	26,826	0.5%
Partner GPs	18,939	-2.2%	16,217	-2.2%
Salaried GPs	16,369	5.8%	10,333	4.8%
GPs in training	10,065	6.5%	9,831	5.6%
GP retainers	665	7.1%	276	8.6%
Locums	1,540	-3.7%	661	-1.3%

Source: NHS England.

Note: Regular GPs includes all GPs except locums. Qualified permanent GPs excludes locums and GPs in training.

[30] Regular GPs includes all GPs except locums. Qualified permanent GPs includes all GPs except locums and GPs in training.
[31] Partner GPs are referred to as performers in Scotland and principals in Northern Ireland. These are all also referred to as contractor GPs.

4.6 The Department of Health and Social Care (DHSC) said that there were many factors that could deter GPs from taking on a partnership role, such as higher workloads or an increase in responsibility for managing income and expenditure. Research indicated that the most commonly reported barriers were the desire for work-family balance (particularly relating to childcare responsibilities), workload pressures, the greater level of responsibility associated with partnership roles, and financial investment risks.[32]

4.7 The number of regular locum GPs in England has been falling. Over the five years to December 2023, the number of headcount locums fell by 36 per cent and the number of FTE locums fell by 29 per cent.

4.8 In March 2023, there were 4,474 (headcount) qualified GPs in Scotland, a fall of 0.9 per cent over the year, and an increase of 1.7 per cent over four years. FTE numbers fell by 0.4 per cent over the year and by 4.0 per cent over four years. Performer GPs in Scotland (equivalent to partner GPs in England) had an average 0.82 full-time equivalent in 2023, while salaried GPs had an average 0.66 full-time equivalent.

Table 4.2: GPs, Scotland, March 2023

	Headcount	Annual growth	FTE	Annual growth
All qualified GPs	4,474	-0.9%	3,478	-0.4%
Performers	3,196	-1.8%	2,624	-1.2%
Salaried	1,248	2.3%	828	1.2%
Retainers	51	-16.4%	26	-2.6%

Source: General Practice Workforce Survey 2023, NHS Education for Scotland, December 2023.

Notes: Excludes GPs in training. Retainers are qualified GPs on the performers list with caring responsibilities which prevent them committing to a more substantive GP post.

4.9 In December 2023, there were 1,841 FTE GPs employed in Wales, 1.6 per cent lower than a year earlier. Between December 2022 and December 2023, the number of FTE GP practitioners fell by 1.9 per cent while the number of FTE GP registrars fell by 0.6 per cent.

Table 4.3: GPs, Wales, December 2023

	Headcount	Annual growth	FTE	Annual growth
All GPs	2,522	2.1%	1,841	-1.6%
Practitioners	2,032	2.5%	1,422	-1.9%
Retainers	27	0.0%	11	-4.5%
Registrars	463	0.4%	409	-0.6%

Source: StatsWales.

Note: Practitioner GPs covers partner/contractor GPs and salaried GPs.

4.10 The British Medical Association (BMA) General Practitioners Committee Wales (GPC Wales) said that, while the GP headcount in Wales had plateaued, the number of FTE GPs working at practices had decreased by 25 per cent, from 1,901 in 2013 to 1,430 in 2023.

4.11 In 2023, there were 1,448 qualified GPs in Northern Ireland, 2.0 per cent more than a year earlier and 9.4 per cent more than five years earlier. Of these, 1,175 (81.1 per cent) were

[32] Laura Jefferson, et al., *Exploring gender differences in uptake of GP partnership roles: a qualitative mixed-methods study.* https://pubmed.ncbi.nlm.nih.gov/37365008/

principal GPs, down from 1,190 (89.9 per cent) in 2018. The number of salaried GPs increased from 117 in 2018 (8.8 per cent) to 261 in 2023 (18.0 per cent).

Table 4.4: GPs, Northern Ireland, 2023

	Headcount	Annual growth
All qualified GPs	1,448	2.0%
Principals	1,175	-0.4%
Salaried	261	16.0%
Retainers	12	-14.3%

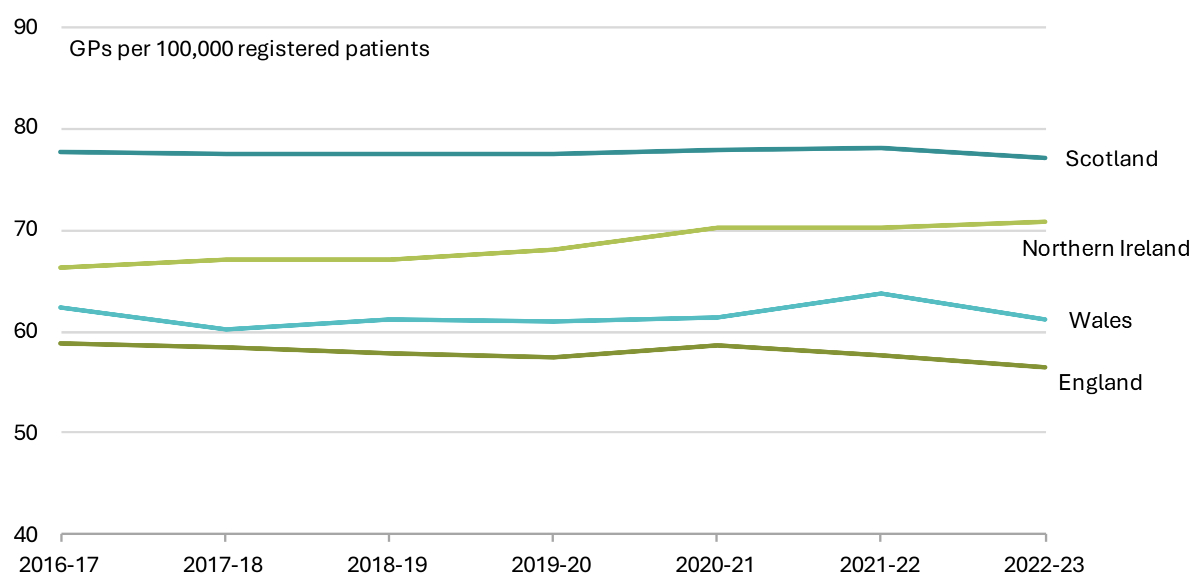
Source: Department of Health Northern Ireland.

4.12 The Department of Health in Northern Ireland said that falling working hours meant that there had been a reduction of more than 5 per cent in the number of FTE GPs between 2018-19 and 2021-22. It said there was evidence that the number of General Medical Services (GMS) sessions being filled by this workforce had decreased.

4.13 The BMA General Practitioners Committee Northern Ireland (GPC Northern Ireland) said that, while the headcount number of GPs in Northern Ireland was growing, there was no data on working hours. It said that self-reported data from GPs to the Northern Ireland Medical and Dental Training Agency suggested that there was a reduction in whole-time equivalent GPs between 2018-19 and 2021-22.

4.14 The number of (headcount) GPs per 100,000 registered patients has been falling in England, Scotland and Wales. In 2022-23, the number of GPs per 100,000 registered patients was: 77.1 in Scotland; 70.9 in Northern Ireland; 61.1 in Wales; and 56.4 in England. Between 2016-17 and 2022-23, the number of GPs per 100,000 registered patients increased in Northern Ireland (by 6.8 per cent) but fell in Scotland (by -0.8 per cent), Wales (-1.9 per cent) and England (-4.2 per cent).

Figure 4.1: GPs (headcount) per 100,000 registered patients, 2016-17 to 2022-23



Source: General Medical Services for Northern Ireland, Family Practitioner Services Information Unit.

General practice training

4.15 There has been strong growth in the number of GPs in training. In England, the number of GPs in training grew by 6.5 per cent in the year to December 2023, and by 67.1 per cent over the previous five years, from a headcount of 6,022 in December 2018 to 10,065 in December 2023. Over this five-year period, the proportion of trainees in England with a primary medical qualification from outside the UK/European Economic Area increased sharply, from 21 per cent in December 2018 to 43 per cent in December 2023, with a corresponding reduction in those with a primary medical qualification from the UK, from 75 per cent to 51 per cent.

4.16 Successful applicants who commit to GP training for three years in Targeted Enhanced Recruitment Scheme (TERS) localities are offered a one-off £20,000 salary supplement, funded by NHS England. The scheme was designed to test whether additional financial incentives attracted trainees to areas facing the severest recruitment pressures.

4.17 The number of TERS places in England was expanded from 500 to 800 in 2022-23, accounting for 20 per cent of the 4,000 GP specialty training places available nationally. NHS England said that TERS had proved successful in attracting GP trainees to areas with the most significant recruitment challenges and that it might also be making GP training more attractive to prospective trainees, helping fill the target of 4,000 training placements. It said that caution should be exercised in the evaluation of TERS, however, as longitudinal tracking was required to ascertain if TERS trainees remained in an area after qualification and it was still a relatively new scheme.

4.18 In Scotland, all 273 posts advertised in general practice specialty training in 2023 were filled, a 2.6 per cent increase from the same stage in 2022, when 266 posts were filled from 268 advertised. The Scottish Government said that the number of general practice specialty training places had been increased to support its commitment to have 800 additional GPs in post by 2027. In 2016, 100 extra places were created and a further 35 places were added in 2023. Another 35 expansion posts had been approved for 2024.

4.19 The Scottish Government said it offered TERS bursaries to GP trainees who agreed to take up post in locations which were historically hard-to-fill and/or in remote and rural locations, where fill rates had been lower in the past. The one-off payment was made to trainees as a lump sum on taking up the post, and in return they agreed to complete the three-year training programme in that location. In total, 94 bursary posts were filled in 2022 and 112 in 2023. A further 50 would be funded in 2024-25, with the Scottish Government noting that fill rates were at 100 per cent. It said that priority would be given to posts in the most remote and rural parts of the country.

4.20 The Welsh Government said that the GP specialty training programme had been significantly expanded over the past three years. The recruitment target of 160 new GP trainees each year had consistently been exceeded between 2019 and 2022, with 175 GP trainees in 2022, although this was a fall of 3.8 per cent from 2021.

4.21 Financial incentives for GP training in Wales were introduced in 2017. The targeted incentive scheme provides £20,000 to GP trainees who take up a training post in north Wales, Ceredigion, Pembrokeshire or Powys. The Welsh Government said that these training schemes historically had low fill rates, of less than 75 per cent over a five-year period. Trainees receive £10,000 on commencing their training, with the second payment made after they complete one year of practice in the incentivised region following completion of their training. This scheme was extended to Carmarthenshire from August 2023.

4.22 The Department of Health in Northern Ireland said that number of GP training places increased from 65 in 2015-16 to 111 in 2018-19 and 121 in 2022-23, an overall increase of 86 per cent. The Department said that, given the uncertainty around future budgets, it was not in a position to commit to maintain the 121 places beyond 2023-24. The number of trainees who completed GP training in Northern Ireland and obtained a Certificate of Completion of Training increased from 65 in 2018-19 to 78 in 2022-23.

4.23 GPC Northern Ireland welcomed the uplift to the number of GP training places but noted that it took an additional recruitment round to fill these places last year. It had concerns that the number of GP trainees who intended to practice in Northern Ireland at the end of their training was not increasing in line with trainee places.

Long Term Workforce Plan

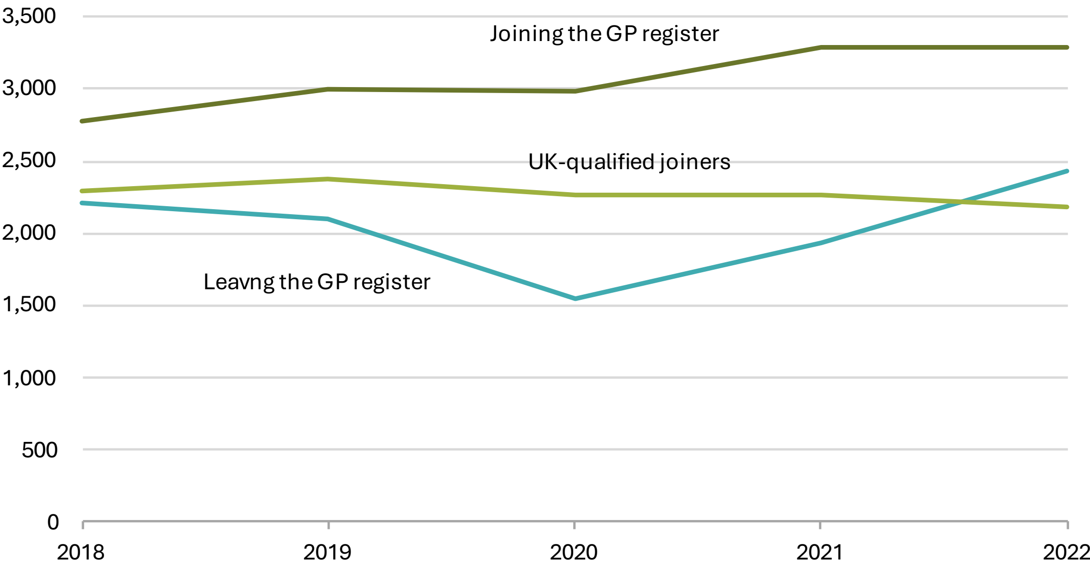
4.24 The Long Term Workforce Plan for England projected the supply of GPs (including GPs in training) in England to increase from the baseline of 36,000 in 2021-22 to 39,000 in 2026-27, 46,000-48,000 in 2031-32 and 50,000-53,000 in 2036-37.

4.25 The Plan projected a 45 to 60 per cent increase in the number of GP specialty training places in England by 2033-34, with the aim of increasing the number of places from 4,000 in 2022 to 6,000 by 2031-32. The first expansion of 500 places would take place in 2025-26 to coincide with the first cohort of graduates following the expansion of medical school places that took place in 2018 reaching the end of the foundation programme.

Recruitment and retention

4.26 Data from the General Medical Council (GMC) showed that 3,295 GPs joined the register in 2022, compared to 2,430 leavers. Of those joiners, a third (33.6 per cent) were non-UK graduates. This compared to 17.5 per cent in 2018. The GMC said this was largely due to international medical graduates completing their GP training in the UK, rather than joining from abroad with recognised GP qualifications. In 2022, 3.7 per cent of GPs left the GMC register, up from 3.0 per cent in 2021 and 2.5 per cent in 2020.

Figure 4.2: Numbers joining and leaving the GMC GP register, 2018 to 2022



Source: GMC, *The state of medical education and practice in the UK Workforce report 2023*.

4.27 The DHSC said it continued to work with NHS England to boost the recruitment of GPs, address the reasons why doctors left or reduced their working hours, and encourage them to return to practice. GPC England drew attention to a drastic drop in availability for both locum and salaried GP posts since autumn 2023.

4.28 The DHSC said that recent reforms to pensions – around taxation, retire and return, and partial retirement – would support existing GPs to continue contributing their expertise for longer and incentivise those who had retired to return to practice.

4.29 The proportion of GPs in England taking voluntary early retirement (before age 60) fell from 52.6 per cent in 2017 to 38.2 per cent in 2023. DHSC said that average retirement ages for GPs had not changed significantly in recent years. NHS England said that the proportion of medical staff who retired due to reaching their normal retirement age, and then chose to return to work two months after retirement, increased from 39.2 per cent in April 2018 to 52.9 per cent in April 2023.

4.30 The Scottish Government said it was still running its GP recruitment campaign as part of its commitment to increase the number of GPs in Scotland by 800 by 2027. The campaign sought to encourage GPs from the rest of the UK to relocate to Scotland, highlighting the flexible, supportive, collaborative and multi-disciplinary working environment available. Work was underway to develop a rural workforce recruitment strategy by the end of 2024.

4.31 The Scottish Government said that new GPs in Scotland in remote, rural or deprived areas were eligible for a golden hello payment. Golden hellos could also be paid to new GP performers if the local health board believed the practice was experiencing significant difficulties around recruitment and retention. The payments were £5,000 (minimum) for recruitment difficulty; £10,000 for remoteness or rurality; and £7,500 to £12,500 for deprivation.

4.32 Seniority payments are made to GPs in Scotland to reward experience, based on years of service: £600 a year after six years; £5,129 a year after 21 years; £10,258 a year after 36 years; and a maximum of £13,900 a year at 47 years. The annual bill for seniority payments to GPs was £16.9 million in 2021-22, unchanged on the previous year.

4.33 The Welsh Government said that a number of positive steps had been taken to keep GPs in the profession, with incentives offered to support doctors to continue working in general practice as they approached retirement or wished to undertake other commitments. The Partnership Premium Scheme was introduced on 1 October 2019 as an incentive for GPs to take up partner roles with payments based on clinical sessions undertaken. Annual payments for 2022-23 totalled £6.2 million. The Welsh Government said that existing incentive schemes for recruitment and retention would be reviewed over the coming year.

4.34 The Department of Health in Northern Ireland said it had taken a number of actions to support the GP workforce. Initiatives included the Attract, Recruit, Retain scheme which provided additional financial and practical support to practices seeking to recruit GPs in hard to recruit areas; the GP Induction and Refresher Scheme; and the GP Retainer Scheme.

4.35 The Department said that ongoing challenges with GP retention and recruitment across Northern Ireland meant that multi-disciplinary team (MDT) practitioners were key in helping to meet rising demand in the primary care setting. It said that feedback from senior GPs indicated that these practice-based MDT roles had been critical in stabilising GP services in these areas and averting further practice closures.

Access to GP services

4.36 There were approximately 1.4 million appointments with general practices in England every working day in April 2024, up by 7.8 per cent from April 2023. The number of daily appointments has increased from 1.2 million in April 2021, as has the number of daily appointments with a GP (as opposed to other health professionals). However, the proportion of all general practice appointments that were with GPs declined, from 50.8 per cent in September 2021, to 48.0 per cent in September 2022, and 44.6 per cent in September 2023, as the role of other health professionals in GP practices continued to develop. There was an increase in the proportion of appointments that were face-to-face, from 60.5 per cent in September 2021, to 68.1 per cent in September 2022, and 70.6 per cent in September 2023. However, there was a decline in the proportion of appointments that took place within seven days of the appointment being made, from 73 per cent in September 2021, to 68 per cent in September 2022, and 66 per cent in September 2023.

4.37 The GP Patient Survey for England was generally less positive in both 2022 and 2023 than previous years. There were reductions in satisfaction with: the overall experience; the out of hours service; and the experience of making an appointment. There were changes in the way patients accessed practice services, with a decline in the percentage of people able to see/speak to their GP of choice and an increase in the percentage of patients seeing a healthcare professional other than a GP.

Earnings for contractor GPs

4.38 Earnings data for contractor (partner/principal) GPs and salaried GPs comes from His Majesty's Revenue and Customs (HMRC) and the most up to date data available is for 2021-22. In 2020-21, average taxable income for contractor GPs grew strongly in each of the four countries, by between 8.8 per cent (Scotland) and 16.6 per cent (England). We were told last year that these increases were related to actions taken during the COVID-19 pandemic, such as delivering the vaccine programme, and that they would only be maintained to some extent into 2021-22 and beyond.

4.39 In 2021-22, however, average taxable incomes for contractor GPs in England, Scotland and Northern Ireland were higher again than in 2020-21, by 8.0 per cent, 3.6 per cent and 2.7 per cent respectively. In Wales, average taxable incomes for contractor GPs in 2021-22 were 5.4 per cent lower than in 2020-21 but remained 7 per cent higher than in 2019-20. Overall, this means that in 2020-21 and 2021-22, after adjusting for inflation, average taxable incomes for contractor GPs were at their highest for over a decade in each of the four countries.

Table 4.5: Contractor GPs, pre-tax income, 2021-22

	England	Scotland	Wales	Northern Ireland
Mean (average)	£153,400	£119,500	£115,900	£119,500
Median	£141,600	£114,300	£112,200	£110,800
Lower quartile	£108,500	£92,400	£86,700	£89,900
Upper quartile	£183,500	£141,300	£139,500	£136,300
Lowest 10%	£82,200	£74,300	£68,200	£69,800
Highest 10%	£236,300	£167,100	£165,500	£163,300

Source: NHS England.

Note: Pre-tax income is gross earnings minus expenses.

4.40 In 2021-22, pre-tax incomes of contractor GPs in England were higher than in other nations. Median pre-tax incomes in Scotland, Wales and Northern Ireland were between £110,800 and £114,300, compared with £141,600 in England. There was a substantial range in contractor GP incomes within each nation.

Figure 4.3: Contractor GPs, average income before tax, nominal and adjusted by CPI, England, Scotland, Wales, Northern Ireland, 2010-11 to 2021-22

Source: OME analysis of NHS England and ONS data.

Note: Earnings not adjusted for hours worked.

4.41 Mean nominal pre-tax incomes for contractor GPs in 2020-21 and 2021-22 were at their highest levels since at least 2002-03 in England and Northern Ireland, and since 2003-04 in Scotland (when the data series begins in each nation). Adjusted by the Consumer Prices Index (CPI), average pre-tax incomes for contractor GPs were at their highest levels since 2006-07 in England. Scotland, Wales and Northern Ireland all saw small real terms falls between 2020-21 and 2021-22 but pre-tax earnings have seen growth in real terms since 2008-09 in Scotland, 2010-11 in Wales and 2010-11 in Northern Ireland.

4.42 The pre-tax income estimates are produced on a headcount basis and take no account of hours worked. NHS England estimates show that the number of FTE contractor GPs in September 2021 was 0.858 of the headcount number of contractor GPs, down from 0.866 a year earlier. Applying this ratio to the income estimates gives an estimated FTE mean pre-tax income for contractor GPs in England in 2021-22 of £178,700 rather than £153,400 on a headcount basis, a 9.0 per cent increase from 2020-21.

4.43 DDRB recommended a 3 per cent uplift for 2021-22 for contractor GPs in Scotland, Wales and Northern Ireland. Average pre-tax incomes for contractor GPs generally grew by more than the DDRB recommendation between 2016-17 and 2021-22. Over the period as a whole, the increase in average pre-tax incomes in each of the nations (between 24 per cent and 46 per cent) was greater than the DDRB recommendations (13 per cent).

Table 4.6: Changes to average pre-tax income for GP contractors by nation compared with DDRB recommendations, 2016-17 to 2021-22

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	Increase over the period
DDRB recommendation	1.0%	1.0%	2.0%	2.5%	2.8%	3.0%	**13%**
England	4.5%	3.5%	3.4%	3.8%	16.6%	8.0%	**46%**
Scotland	1.5%	2.5%	8.8%	4.7%	8.8%	3.6%	**34%**
Wales	3.3%	3.4%	6.4%	2.4%	12.6%	-5.4%	**24%**
Northern Ireland	-1.6%	3.2%	-1.2%	7.9%	12.4%	2.7%	**25%**

Note: The DDRB recommendations applied to contractor GPs in England for 2016-17, 2017-18 and 2018-19 only. From 2019-20 onwards they were covered by a multi-year deal. The cell is shaded green when average income grew by less than the DDRB recommendation.

4.44 NHS England noted that earnings growth for contractor GPs in England was significantly above the maximum uplift of 2.1 per cent agreed in the contract for 2021-22 (1.8 per cent for 2020-21), which it said was likely due mainly to the additional funding provided during the second year of the pandemic for the delivery of the COVID-19 vaccination programme.

4.45 The BMA General Practitioners Committee England (GPC England) said that over half of respondents to its survey of practices (60 per cent) said that they were cutting partner income, with an average reported decrease in contractor/partner income for 2022-23 of 23 per cent. It said that payments to practices for the COVID-19 vaccination programme in 2020-21 and 2021-22 provided a financial cushion which helped practices weather the inflationary storm. It said that the NHS payments to practice dataset showed a fall of approximately 80 per cent in COVID-related payments in 2022-23. The value of COVID-19 payments to general practice in England between 2020-21 and 2022-23 is set out in table 4.7.

Table 4.7: NHS payments to general practice, England, 2020-21 to 2022-23

	2019-20	2020-21	2021-22	2022-23
NHS payments to general practice (exc COVID-19) £ million	9,377	9,684	10,076	10,230
NHS payments to general practice (inc COVID-19) £ million	-	10,022	10,883	10,395
COVID-19 payments £ million	-	339	807	165
COVID-19 payments (% of NHS payments (exc COVID-19)	-	3.5%	8.0%	1.6%

Source: NHS England, NHS Payments to General Practice.

Earnings for salaried GPs

4.46 In 2020-21, average taxable income for salaried GPs grew by between 8.1 per cent and 9.7 per cent in Wales, Northern Ireland and Scotland, but less strongly, by 2.0 per cent, in England. In 2021-22, average taxable incomes for salaried GPs in both England and Wales were higher than in 2020-21, by 4.8 per cent and 7.2 per cent respectively. In Scotland and Northern Ireland, average taxable incomes for salaried GPs in 2021-22 were lower than in 2020-21, by 0.6 per cent and 4.4 per cent respectively, but remained 9 per cent and 4 per cent higher than in 2019-20.

Table 4.8: Salaried GPs, pre-tax income, 2021-22

	England	Scotland	Wales	Northern Ireland
Mean (average)	£68,000	£71,900	£70,400	£58,600
Median	£62,700	£66,200	£64,100	£55,200
Lower quartile	£46,800	£51,300	£50,000	£39,300
Upper quartile	£83,000	£83,400	£84,900	£69,200
Lowest 10%	£33,900	£40,000	£34,700	£31,100
Highest 10%	£105,900	£106,200	£117,200	£88,700

Source: NHS England.

Note: Pre-tax income is gross earnings minus expenses.

4.47 In 2021-22, pre-tax incomes of salaried GPs in Northern Ireland were lower than those in other countries in the UK. Median pre-tax incomes in England, Scotland and Wales were between £62,700 and £66,200, compared with £55,200 in Northern Ireland.

Figure 4.4: Salaried GPs, average income before tax, nominal and adjusted by CPI, England, Scotland, Wales, Northern Ireland, 2010-11 to 2021-22

Source: OME analysis of NHS England and ONS data.

Note: Earnings not adjusted for hours worked.

4.48 Mean nominal pre-tax incomes for salaried GPs in England and Wales in 2021-22 were at their highest levels since at least 2006-07. After adjusting for CPI inflation, average taxable incomes for salaried GPs in England and Wales were at their highest for a decade. In Scotland, there was a fall in nominal and real earnings between 2020-21 and 2021-22 for salaried GPs, but

real earnings in 2021-22 were above the 2008-09 level. Salaried GPs in Northern Ireland also saw a fall in both nominal and real average taxable incomes in 2021-22. After adjusting for inflation, average taxable incomes in Northern Ireland have fallen since 2016-17.

4.49 The number of FTE salaried GPs in England in September 2021 was 0.639 of the headcount number of salaried GPs, down slightly from 0.641 in the previous year. Applying this ratio to the income estimates gives an estimated FTE mean pre-tax income for salaried GPs in England in 2021-22 of £106,500 rather than £68,000 on a headcount basis, a 5.1 per cent increase from 2020-21.

4.50 The DDRB recommended a 3.0 per cent uplift to the salaried GP pay range for 2021-22, for salaried GPs in England, Scotland, Wales and Northern Ireland. Average pre-tax incomes generally grew by more than the DDRB recommendation between 2016-17 and 2021-22. Over the period as a whole, the increase in average pre-tax incomes in each of the nations (between 22 per cent and 36 per cent) was greater than the DDRB recommendations (13 per cent).

4.51 The DHSC said that there did not appear to be a clear link between agreed government uplifts to pay and changes in average earnings for GPs. It said that, as independent contractors, it was for GP partners to determine uplifts in pay for themselves and their employees. NHS England noted that the 4.8 per cent earnings growth for salaried GPs was above the DDRB recommended uplift for 2021-22 of 3.0 per cent and offset the 0.8 per cent shortfall in earnings growth against the 2.8 per cent DDRB recommendation for 2020-21.

Table 4.9: Changes to average pre-tax incomes for salaried GPs by nation compared with DDRB recommendations, 2016-17 to 2021-22

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	Increase over the period
DDRB recommendation	1.0%	1.0%	2.0%	2.5%	2.8%	3.0%	**13%**
England	1.3%	3.2%	3.8%	5.0%	2.0%	4.8%	**22%**
Scotland	6.9%	1.8%	3.5%	1.2%	9.7%	-0.6%	**24%**
Wales	3.9%	-3.0%	12.1%	4.1%	8.1%	7.2%	**36%**
Northern Ireland	16.9%	2.5%	-2.8%	2.5%	8.5%	-4.4%	**24%**

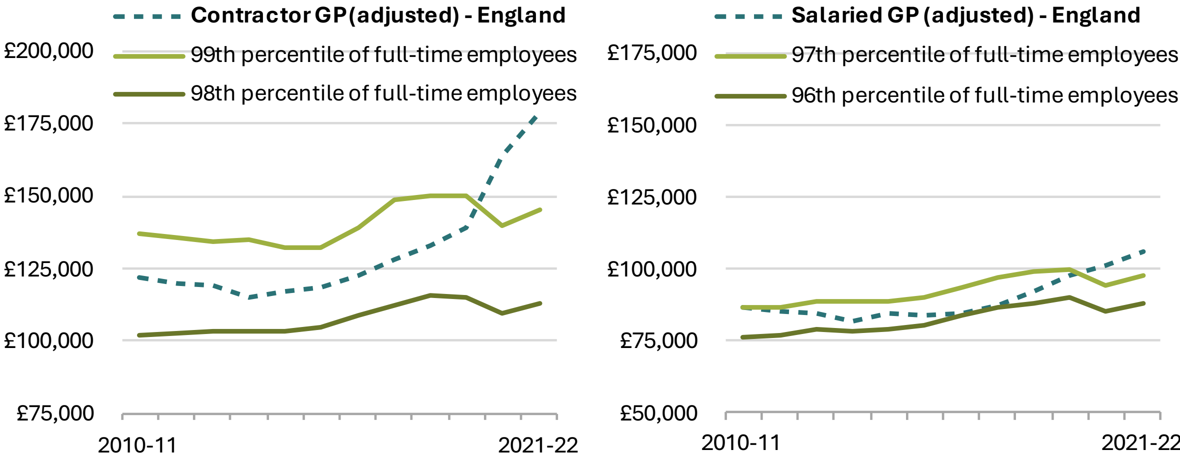
Note: The cell is shaded green when average income grew by less than the DDRB recommendation.

Pay comparisons

4.52 After adjusting for full-time equivalence, contractor GP incomes before tax were between the 98th and 99th percentile of all full-time employee earnings between 2010-11 and 2019-20 but have moved well above the 99th percentile since 2020-21. Salaried GPs incomes before tax were between the 96th and 97th percentile of all full-time employee earnings between 2010-11 and 2019-20 but have moved above the 98th percentile since 2020-21.

4.53 At median earnings, contractor GPs earned more than all their professional comparators. Salaried GPs earned less than their professional comparators, but these comparisons are affected by the high level of part-time working among salaried GPs, as data in figures 4.6 and 4.7 for comparator professions is on an FTE basis, while GP pay is on a headcount basis and is therefore lower than the FTE equivalent.

Figure 4.5: Average income before tax of contractor and salaried GPs in England compared with the distribution of earnings of full-time UK employees, 2010-11 to 2021-22



Source: OME analysis of data from NHS England and ONS.

Note: Earnings are adjusted for full-time equivalence.

Figure 4.6: Interquartile range of total earnings of contractor GPs, England, compared with professional groups, matched by job size to market data, 2023

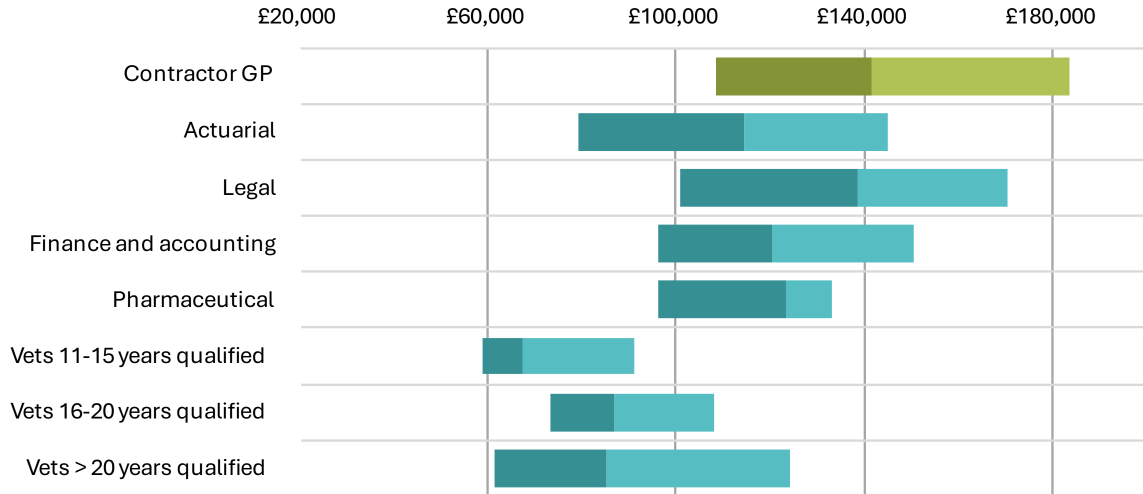
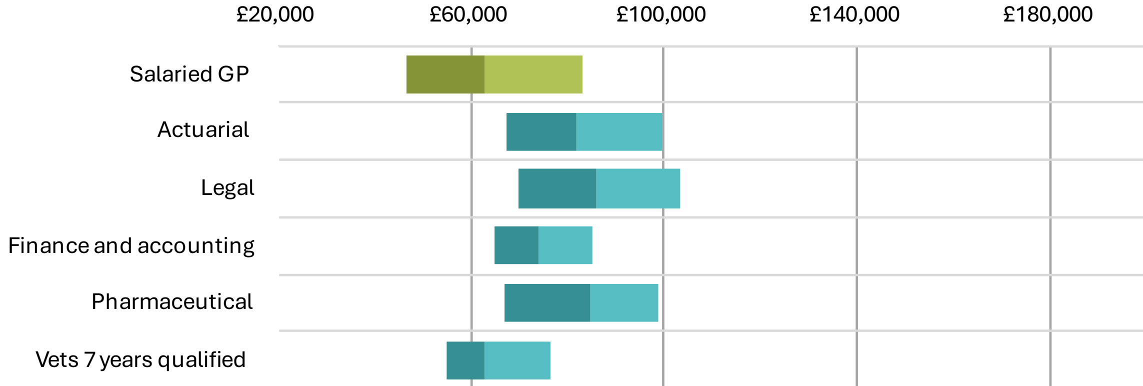


Figure 4.7: Interquartile range of total earnings of salaried GPs, England, compared with professional groups, matched by job size to market data, 2023



Source (figures 4.6 and 4.7): OME analysis of data from Kornferry; The Society for Practising Veterinary Surgeons; NHS England; ONS.

Notes: Pay for comparator professions is on an FTE basis, while GP pay is on a headcount basis and is therefore lower than the FTE equivalent; this is especially significant for salaried GPs. GP earnings are from 2021-22, while comparator earnings are from 2023. Individual medical roles are matched by job size to market data.

4.54 The BMA Sessional General Practitioners Committee (GPC Sessional) said that the pay range [£68,974 to £104,086 in England] for salaried GPs did not accurately reflect market rates, with both the minimum and maximum of the range falling short by £9,000 on average in England. In July 2023, the BMA published a recommended pay range of £78,514 to £113,626.[33]

GP earnings by gender

4.55 Average earnings of female contractor GPs were lower than those of male salaried GPs in each nation in 2021-22, by 21 per cent in both Scotland and Wales, 20 per cent in Northern Ireland, and 19 per cent in England. The pre-tax income gap narrowed in each nation between 2017-18 and 2021-22, except in Wales where there was little change. This data does not adjust for working hours.

Table 4.10: Contractor GPs income before tax, by gender and nation, 2017-18 to 2021-22

		2017-18	2018-19	2019-20	2020-21	2021-22
England	Male	£125,600	£130,000	£134,300	£156,100	£168,100
	Female	£97,300	£101,200	£106,400	£125,200	£136,300
	Difference	*-23%*	*-22%*	*-21%*	*-20%*	*-19%*
Scotland	Male	£107,800	£117,200	£120,800	£131,400	£135,900
	Female	£80,800	£88,700	£94,400	£103,200	£107,300
	Difference	*-25%*	*-24%*	*-22%*	*-21%*	*-21%*
Wales	Male	£111,000	£118,800	£122,300	£135,600	£130,400
	Female	£87,700	£93,300	£96,100	£109,100	£103,200
	Difference	*-21%*	*-21%*	*-21%*	*-20%*	*-21%*
Northern Ireland	Male	£107,900	£104,500	£113,800	£126,500	£128,900
	Female	£79,600	£81,400	£87,400	£100,000	£103,300
	Difference	*-26%*	*-22%*	*-23%*	*-21%*	*-20%*

Source: NHS England.
Note: Does not adjust for working hours.

Table 4.11: Salaried GPs income before tax, by gender and nation, 2017-18 to 2021-22

		2017-18	2018-19	2019-20	2020-21	2021-22
England	Male	£75,100	£76,900	£79,800	£81,100	£83,100
	Female	£52,600	£55,000	£58,000	£59,200	£62,500
	Difference	*-30%*	*-28%*	*-27%*	*-27%*	*-25%*
Scotland	Male	£85,200	£85,900	£85,400	£93,000	£89,200
	Female	£55,800	£57,000	£58,600	£65,000	£66,900
	Difference	*-35%*	*-34%*	*-31%*	*-30%*	*-25%*
Wales	Male	£62,800	£68,200	£72,800	£80,500	£84,300
	Female	£49,200	£55,700	£57,800	£61,100	£65,400
	Difference	*-22%*	*-18%*	*-21%*	*-24%*	*-22%*
Northern Ireland	Male	£92,900	-	£70,100	£85,100	£83,500
	Female	£51,800	£51,500	£53,900	£55,400	£52,300
	Difference	*-44%*	-	*-23%*	*-35%*	*-37%*

Source: NHS England.
Note: Does not adjust for working hours. Sample size is too small for male earnings in Northern Ireland.

[33] BMA, *A new recommended pay range for salaried GPs in England.* https://www.bma.org.uk/pay-and-contracts/pay/gp-pay/a-new-recommended-pay-range-for-salaried-gps-in-england

4.56 Average earnings of female salaried GPs in 2021-22 were lower than those of male salaried GPs: by 22 per cent in Wales; 25 per cent in both England and Scotland, and 37 per cent in Northern Ireland. In all nations except Wales, the gap between male and female average incomes narrowed between 2017-18 and 2021-22. Again, this data does not adjust for working hours.

Expenses

4.57 Expenses accounted for around two-thirds of gross earnings for contractor GPs in England and Wales, and 55-56 per cent of gross earnings in Scotland and Northern Ireland in 2021-22. The bespoke contract arrangements for GMS across the four nations will account for some of the differences in gross earnings and expenses.

Table 4.12: Contractor GPs, average gross earnings, expenses and pre-tax income, 2021-22

	England	Scotland	Wales	Northern Ireland
Gross earnings	£482,400	£269,000	£325,800	£258,300
Expenses	£329,000	£149,500	£209,800	£143,200
Income before tax (average)	£153,400	£119,500	£115,900	£119,500
Expenses % of gross earnings	68%	56%	64%	55%

Source: NHS England.

4.58 On our visits, GPs told us that expenses were a key issue and contract uplifts did not cover rising costs, with particular pressures coming from energy bills, wages for practice staff, especially to meet the National Living Wage, and other costs such as labs, cleaning and materials.

4.59 GPC England highlighted a number of areas where costs had increased by much more than the uplift in the contract since 2019-20 in particular: the National Living Wage; salaried GP pay uplifts; staffing expenses; employers national insurance; and energy costs. GPC Wales said that rising expenses presented a real and existential challenge to the sustainability and viability of practices.

4.60 GPC England ran a snapshot survey of practices finances from December 2023 to January 2024. Around 600 individual practice sites completed the survey, which it said represented approximately 10 per cent of practices in England. The survey indicated that, between October 2022 and October 2023, the median practice saw: a 9.0 per cent increase in staffing spend; a 10.8 per cent increase in spend on salaried GPs; a 7.7 per cent increase in non-GP practice staff spend; and a 4.1 per cent increase in spend on locums. The survey said that two in three practices (64 per cent) were concerned about their short and long-term viability.

4.61 The Royal College of Nursing told us that it surveyed 1,500 members working in general practice in April 2024: 44 per cent had not received a pay rise for 2023-24 at all, and 77 per cent had not received the full pay rise. Of those who had received a pay rise, 19 per cent had not received pay backdated to April 2023.

GP contracts in England

4.62 A five-year framework for general practice was agreed between NHS England and GPC England in 2019. Funding for the core practice contract, including GP contractor pay, was fixed for the five-year period at the outset.

4.63 The DHSC said that spending on general practice services increased by 31.4 per cent in cash terms between 2017-2018 and 2021-2022, from £10.3 billion to £13.5 billion. In real terms, spending increased by 19.2 per cent over the period. GPC England said that uplifts to the global sum during the five-year framework cumulatively amounted to 12.5 per cent.

4.64 NHS England said that the number of practices had decreased by 11.3 per cent over the last five years, from 7,137 in 2018 to 6,334 at September 2023. Practice closures fell from 197 in 2018-19 (0.6 per cent of all practices) to 64 in 2022-23 (0.2 per cent of all practices). Of these 64, 42 were mergers with another practice.

4.65 NHS England said that uplifts to contractor GP pay, salaried staff pay (including for salaried GPs) and other practice (non-pay) expenditure under the five-year contract were calculated as follows:

- The proportions of the national GP practice contract value attributable to each element to be uplifted (that is, contractor pay, salaried staff costs and other practice expenses) were calculated based on data from the GP earnings and expenses estimates.
- The uplifts for each element of the contract were then calculated by multiplying the percentage uplift agreed for that element by the proportion of the contract value.

4.66 We understand that, for 2023-24, the staffing elements of the contract were increased by 6 per cent and the expenses element was increased by 3.23 per cent, in line with the gross domestic product (GDP) deflator forecast made by the OBR in November 2022.

4.67 NHS England and the DHSC have been in consultation with GPC England about the GP contract for 2024-25. NHS England said there would be an increase in investment of £259 million taking overall contract spend to £11,864 million in 2024-25 [a 2.2 per cent increase].[34] This included:

- A planning assumption of 2 per cent pay growth for contractor GPs, salaried GPs, and other practice staff.
- A planning assumption of 2 per cent pay growth uplift to the overall Additional Roles Reimbursement Scheme.
- 1.68 per cent inflation, in line with the November 2023 [forecast] gross domestic product deflator.
- 0.38 per cent population growth.

4.68 BMA GP members in England voted to reject the contract changes in March.[35] NHS England said it would like to reconvene to understand the funding envelope in light of the government's response to our recommendations for 2024-25.

GP contracts in Scotland

4.69 A new contract was introduced for GMS in Scotland in 2018. The Scottish Government said that the 2018 GMS contract aimed to:

- Improve access for patients.
- Address health inequalities and improve population health, including mental health.
- Provide financial stability for GPs.
- Reduce GP workload through the expansion of primary care MDTs.
- Increase support for GPs and GP infrastructure.

[34] NHS England, *Arrangements for the GP contract in 2024/25.* https://www.england.nhs.uk/publication/arrangements-for-the-gp-contract-in-2024-25

[35] BMA, *GP contract 2024/25 changes referendum.* https://www.bma.org.uk/our-campaigns/gp-campaigns/contracts/gp-contract-202425-changes

- Increase transparency on general practice funding, activities and workforce to assist strategic planning, commissioning and delivery of primary care services.
- Make general practice a more attractive profession for existing GPs, junior doctors and undergraduate medical students.

4.70 The Scottish Government said that one of the core aspects of the contract was the new funding model as it recognised that an appropriate and secure level of income was a prerequisite to attracting GPs to the profession and ensuring the future sustainability of general practice.

4.71 The Scottish Government said that the new contract was being introduced in two phases. Phase one included:

- A new workload formula to better match resource to demand.
- Additional investment of £23 million to allow most practices to gain from the new funding formula, while the remaining practices received an income guarantee to protect their income level to ensure no practice was destabilised.
- A GP partner whole time equivalent minimum earnings expectation from April 2022. This meant that no GP would receive less than £93,824 NHS income a year (including pension contributions) for a whole-time post. This would be uplifted in line with DDRB recommendations.

4.72 Phase 2 depended on a further vote from the profession and would include:

- Introducing an income range for GP partners comparable to consultants.
- Directly reimbursing practice expenses e.g. staffing costs.

4.73 The Scottish Government said that a key change in the 2018 contract was that GPs would become more involved in complex care and system wide activities, necessitating a refocusing of GP activity. GPs were expected to be less involved in more routine tasks, with these tasks being delivered by other health professions in the wider primary care MDT.

4.74 The Scottish Government said that, since 2018, it had significantly expanded the multi-disciplinary primary care workforce, with total staff of 4,731 FTE working in MDT services at March 2023, including physiotherapy, pharmacy and phlebotomy. It said this was freeing up practice time to focus on more complex community care, reducing referrals into secondary care, streamlining inefficient practice processes, creating upskilling training pipelines for staff, and encouraging self-management.

4.75 The Scottish Government said there were 911 GP practices in Scotland at 1 October 2022 and 83 per cent were on the national GMS contract. The number of practices in Scotland had decreased by 9 per cent from 997 practices in 2012. The Scottish Government said this reflected a trend towards larger practices with more GPs serving a larger number of patients. The BMA General Practitioners Committee Scotland (GPC Scotland) said that the proportion of practices run directly by health boards had increased from 4.5 per cent of all practices in 2013 to 6.6 per cent in 2023.

4.76 There was a 6.5 per cent uplift to practice staff expenses (in line with Agenda for Change in Scotland) and a 6 per cent uplift to wider practice expenses (in line with assumed CPI). This included £8.3 million funding to cover population growth in 2022-23.

GP contracts in Wales

4.77 There were 383 active GP practices in Wales at 31 March 2023, down from 389 a year earlier. A new unified contract for GMS came into effect on 1 October 2023. The Welsh Government

said that the GMS role in Wales was changing, with greater emphasis on GPs doing what only they could do, and a wider multi-professional team providing support both within the practice and the community. The contract set out the key services all individual GP practices needed to provide while some supplementary services were moved to health boards to deliver.

4.78 GPC Wales said that Welsh Government spending on general practice as a proportion of overall NHS Wales spending had fallen from 8.7 per cent of expenditure in 2005-06 to 6.1 per cent in 2020-21. GPC Wales said GMS contracts that were handed back by partners required direct management by health boards in many cases, which came at a much higher cost per patient.

4.79 The BMA said the overall funding increase in 2023-24 was £20 million, representing 4.4 per cent of the GMS contract value of £450 million. This included a 5 per cent pay uplift for practice staff.[36] GPC Wales said that this did not counter the increase in practice costs or staffing expenses. It said that the 5 per cent uplift to staff pay would virtually erode the entirety of the GP pay element in the financial settlement. It said that contractor GPs would receive less than a 1 per cent uplift to their actual pay in 2023-24.

GP contracts in Northern Ireland

4.80 The Department of Health in Northern Ireland said there were 317 GP practices in Northern Ireland at 31 March 2023, a reduction of two (0.6 per cent) since 2022 and 33 (9.4 per cent) since 2014. There were 13 instances of practices returning their contracts during 2022-23 and five (up to September 2023) in 2023-24. New arrangements, in some cases trusts taking on practices, had been found for all contracts that had been handed back and no practices had closed.

4.81 The Northern Ireland Audit Office said that, while there could be a number of factors behind the decision to hand back a contract, stakeholders had said that concerns around securing sufficient clinical workforce, financial concerns, and reducing numbers of GPs wanting to take on the financial risk were common factors.[37] The Department noted the significant risk potential practice closures represented to the wider Health and Social Care system.

4.82 The Department said it had been agreed that work would be undertaken on a longer-term, strategic approach to the funding model for GMS and the contract that underpinned those arrangements.

4.83 The Department said that GPs received a 6 per cent uplift in funding for 2023-24. This was in line with the DDRB recommendation on pay. Changes to the GMS contract in Northern Ireland for 2024-25 were agreed in May 2024. This included £5 million for GP indemnity, pending identification of the long-term model for future provision, and a £33.9 million increase to core global sum payments.[38] The GPC Northern Ireland said indemnity had been a “chill factor” when attempting to recruit GPs to Northern Ireland as they were expected to fund insurance costs of upwards of £8,000 a year.

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[36] BMA, *Focus On: Welsh GMS Contract Financial Uplift 23/24.* https://www.bma.org.uk/media/coojzxkn/bma-focus-on-contract-financial-uplift-2324.pdf

[37] Northern Ireland Audit Office, *Access to General Practice in Northern Ireland.* https://www.niauditoffice.gov.uk/publications/access-general-practice-northern-ireland

[38] Department of Health, *Swann welcomes 24/25 GP contract.* https://www.health-ni.gov.uk/news/swann-welcomes-2425-gp-contract

Workload and wellbeing

4.84 We do not have staff survey data for GPs. The GMC's 2023 report on workplace experiences found that 38 per cent of GPs were satisfied in their work in 2022, compared with 50 per cent of all doctors and down from 51 per cent of GPs in 2021.[39] In terms of workload, GPs reported more high-intensity days (78 per cent) than other doctors (63 per cent on average) and fewer low-intensity days (3 per cent compared to 8 per cent for all doctors).

4.85 The DHSC said that diversifying the workforce by increasing the number of primary care professionals would help to reduce GP workload, free up capacity for GPs to focus on what only GPs could do, and deliver more appointments. It expected this to improve retention of GPs who were increasingly citing high workloads as reasons for reducing their hours or leaving the workforce.

4.86 GPC England said that trying to replace salaried GPs with non-GP clinical staff, who were not adequately trained or licensed to perform the full range of GP tasks or activities, and who needed to be supervised by a GP, was a false economy for which patients and the public would suffer in the medium to long term.

4.87 GPC Sessional said that the workload in general practice was increasingly unmanageable, with salaried GPs working overtime amounting on average to an additional 25 per cent of their contracted hours.

4.88 GPC Scotland said that in a recent survey on GP wellbeing, over one in four GPs (28 per cent) described their workload as unmanageable while 85 per cent reported that they struggled to cope with work either some or all of the time and that this was impacting their physical and mental wellbeing. GPC Northern Ireland said that workloads were increasing, exacerbated by a growing and ageing population.

GP trainers' grant

4.89 NHS England said that one of the biggest challenges to the delivery of expansion targets was training placement capacity and that a shortage of educators and supervisors would hinder efforts to expand GP numbers. The DHSC said that, with the expansion of GP specialty training places, maintaining the current cohort of GP trainers and ensuring that it remained an attractive option was critical in supporting the increasing trainee pipeline, and growing the number of doctors in general practice.

4.90 GPC England said that the plans to continue to increase the number of GPs remained at high risk of failing if the underfunding of registrar placements was not properly addressed. It said that the national commitment to extend the time it took to train in general practice would also inevitably require more GP trainer capacity, so the grant needed to sufficiently incentivise practices to continue or become training practices.

4.91 The DHSC and NHS England both said that the expansion of roles across primary care and the increase of GP specialty training places had intensified the role of GP trainers and their workload. NHS England said that consistent feedback in every region was that the balance of workload to remuneration was the main reason for practices and doctors deciding not to join the training community and that, without additional increase in remuneration to retain those

[39] GMC, *The state of medical education and practice in the UK Workplace experiences 2023.* https://www.gmc-uk.org/-/media/documents/somep-workplace-experiences-2023-full-report_pdf-101653283.pdf

in the role and incentivise others to join, the existing issues with training and GP expansion would be compounded.

4.92 According to the GMC's *National Training Survey*, 52 per cent of trainers were at high or moderate risk of burnout and 32 per cent said their work frustrated them to a high or very high degree.[40] The GMC's workplace experience report said that 63 per cent of GPs with a training role were struggling with their workload compared to 53 per cent of GPs who did not hold such a role.[41]

4.93 In the Royal College of General Practitioners *Fit for the Future: Reshaping general practice infrastructure in England* report, 47 per cent of general practice staff said their practice had a shortage of educators/supervisors, limiting their capacity to take on GP trainees or other learners, while 84 per cent said a lack of physical space limited their practice's ability to take on GP trainees or other learners.[42]

4.94 The DHSC said that GP trainer grants had a 6 per cent uplift applied in 2023-24. NHS England said that GP trainers were included in the GP educators pay scale and it was expected that any uplift to this scale would automatically apply to them.

4.95 GPC Scotland said that practice training grants in Scotland did not increase in value each year and therefore the incentive they offered to practices to train new GPs eroded year on year. It said that these grants sat outside the practice reimbursements set out in the Statement of Financial Entitlements.

Our comments

GP workforce

4.96 Despite increasing demand for GP appointments, and high public concern in recent years over access to GPs, we have seen very low growth in the number of full-time equivalent GPs, with a 2.2 per cent fall over the last five years in the number of FTE permanent qualified GPs in England for example. This is in significant contrast to the growth in the number of consultants. In particular, the number of GP partners is falling. This may raise issues over the future sustainability of the existing GP partnership model. Further, while the number of salaried GPs is increasing, this group are increasingly likely to work part time, limiting the overall increase in capacity.

4.97 It appears that the substantial growth in demand for general practice services is being met by increasing GP workloads and by greater use of other health professionals working within GP settings. However, despite these developments, patient satisfaction is falling, with a decline in the proportion of people able to see/speak to their GP of choice, and there are reports of increases in the use of private GP services.

[40] GMC, *National Training Survey 2023 results.* https://www.gmc-uk.org/-/media/documents/national-training-survey-2023-initial-findings-report_pdf-101939815.pdf

[41] GMC, *The state of medical education and practice in the UK, Workplace experiences, 2023* https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk/workplace-report

[42] RCGP, *Fit for the Future: Reshaping general practice infrastructure in England.* https://www.rcgp.org.uk/getmedia/2aa7365f-ef3e-4262-aabc-6e73bcd2656f/infrastructure-report-may-2023.pdf

4.98 We note the recent BMA position that GPs should have the ability to treat patients privately in the same way that other clinicians can.[43] This would be a change from the current position where, unlike general dental practitioners, GPs are only allowed to offer private appointments to individuals who are not their patients.

4.99 We are concerned about two emerging possibilities facing general practice in the UK. Firstly, a risk that increasing numbers of patients choose private GPs due to difficulties accessing NHS services. Secondly, that GPs might be more attracted to taking on private patients to meet this demand, therefore reducing access to NHS GP services. As a consequence, general practice in the future could start to face some of the challenges of provision seen with dental services. We will be monitoring this issue and would like to receive any evidence that helps us understand if demand for general practice is being pushed to the private sector and our forward-looking concerns are justified.

4.100 We welcome the strong growth in the number of GPs in training which should increase the future workforce, although we note both the heavy reliance on international recruitment to fill training places in England and the need for recruitment incentives for training places in some rural areas across the UK. To sustain this future workforce, it will be important to understand the retention rates for international recruits and those given incentives to work in rural areas. It would also be instructive to better understand the effectiveness of the recruitment incentives.

4.101 Our evidence base on recruitment and retention for general practice is weaker than for secondary care: we would like to see close tracking of joiners and leavers from the GP workforce, and a measure of GP job vacancies. GMC data show the number of UK-qualified joiners to the GP register was below the number of leavers in 2022. Internationally qualified doctors are supporting the overall number of GPs. There is also some evidence of a recent fall in the recruitment of salaried (and locum) GPs; we would like to understand this better.

4.102 It is concerning to see sharp falls in the number of GPs who were satisfied in their work in 2022, compared to both a year earlier and compared to other doctors, and GPs experiencing more 'high-intensity' days at work than other parts of our remit group. We hope to hear more detail next year about the impact on morale and workload of the increased capacity in the wider primary care workforce, and whether it begins to address these issues.

Earnings and expenses

4.103 GP partner/contractor earnings have shown strong growth for the most recent two years of data (for 2020-21 and 2021-22). Incomes were still being boosted by COVID-19 payments in those years. We note the broad range of earnings across contractor GPs which may reflect the variation in business models.

4.104 It is significant that earnings for GPs have kept up with inflation over the last decade (with the exception of salaried GPs in Northern Ireland) after expenses have been taken into account. This contrasts with falls in real earnings for hospital doctors over the same period. Full-time equivalent earnings for partner GPs are high relative to consultants. Both contractor and salaried GPs (in England) saw earnings growth in 2020-21 and 2021-22 above that of other full-time employees. This is in contrast to hospital consultants. Average earnings for

[43] Pulse, *Remove contractual restrictions on GPs seeing patients privately, say UK LMCs.* https://www.pulsetoday.co.uk/news/lmcs-conferences/remove-contractual-restrictions-on-gps-seeing-patients-privately-say-uk-lmcs/

contractor GPs in England moved above the 99th percentile of all full-time employees in 2021-22.

4.105 We note the increase in part-time working among salaried GPs at the same time as real earnings growth. However, the BMA has said that salaried GPs are working overtime amounting on average to an additional 25 per cent of their contracted hours. Contractor earnings have grown while overall numbers have fallen. We would like to better understand the link between earnings and decisions to become a contractor GP.

4.106 However, the latest earnings data is for 2021-22, which is now over two years old. Given these delays on earnings data at a time of particularly high inflation, and the unclear impact of COVID-19 payments, it is hard to discern what the more recent path of earnings has been and to judge whether the trend of the last decade is now changing.

4.107 COVID-19 payments will mainly have fallen out of the 2022-23 data, which we will consider next year. Governments are using a range of approaches to uplifting expenses, such as the GDP (gross domestic product) deflator forecast, our recommendations, and affordability. None of these relate closely to the actual expenses incurred by GPs, nor do they look back to see whether contract uplifts have been adequate to meet past expenses. We note, in particular, the GDP deflator forecast significantly underestimated the actual turnout in 2023-24. GPs have consistently raised the issue of high increases to expenses over the last one to two years, which in their view have not been matched by increases in funding through contracts. Again, the picture will become clearer in our report next year. At that point, we are likely to want to review the longer-term trend closely to look at relative positions in earnings.

4.108 Scotland has gone further than the other nations on contract reform for GPs. It would be helpful to understand the effectiveness of the reforms so far, and to review if the aims of the reforms are being delivered.

Chapter 5 Dentists

5.1 Our remit covers all General Dental Practitioners (GDPs) and salaried dentists providing NHS/HSC services including dentists working in the Community Dental Services (CDS) in England, Wales and Northern Ireland and the Public Dental Service (PDS) in Scotland.[44]

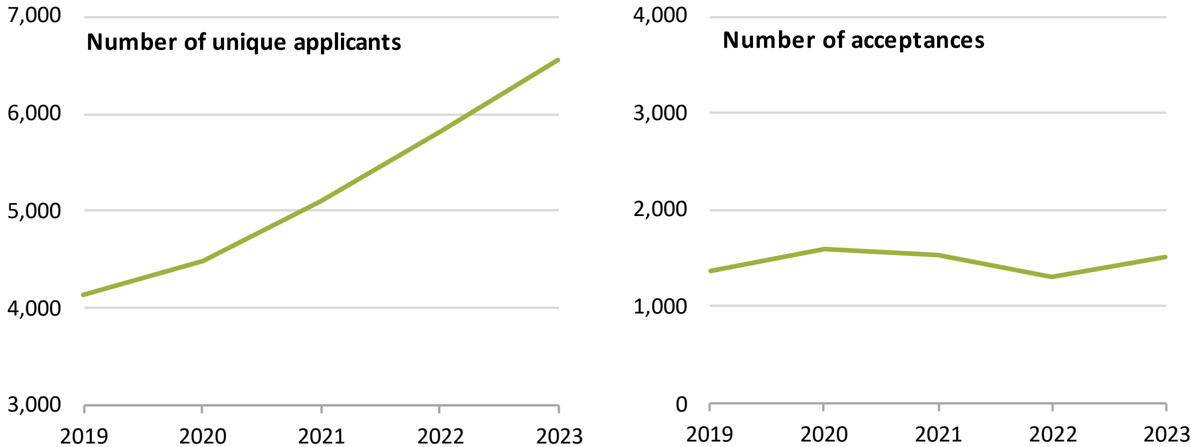
Dental training

5.2 There were 6,565 applicants to study undergraduate dentistry across the UK in 2023, an increase of 12.7 per cent from 2022. Following four years of consecutive growth, the number of applicants to study dentistry was 59 per cent higher than in 2019.

5.3 There were 1,505 acceptances to study dentistry in 2023, an increase of 14.9 per cent from 2022. In 2020 and 2021, the numbers accepted on to courses was higher than expected, because of the increase in A-level grades that resulted from centre-assessed grading, but this was followed by a 15.2 per cent fall in the numbers accepted onto courses in 2022. However, the numbers accepted on to courses to study dentistry in 2023 remained 9.1 per cent higher than in 2019.

5.4 The undergraduate admissions data do not show a marked change in the proportion of students coming from overseas to study dentistry: between 2019 and 2023 the UK-domiciled share of applicants increased from 89 per cent to 91 per cent; acceptances increased from 93 per cent to 94 per cent.

Figure 5.1: Number of applicants and acceptances for dentistry degrees, UK, 2019 to 2023



Source: UCAS.

5.5 Postgraduate dental training includes a one-year foundation programme spent in primary care, which is mandatory for dentists wishing to participate in the NHS/HSC; dental foundation trainees are not employed on the main contract for doctors and dentists in training and are not generally considered to be part of the trainee workforce while in dental foundation training. Most dentists then leave training to work in practice-based dentistry, either in the NHS or in the private sector, although those that wish to work in the hospital sector undertake dental core and specialty training programmes after this. Hospital dental

[44] While terminology differs between the nations of the UK, GDPs delivering NHS/HSC services are generally split into two categories. Dentists that hold a contract in their own right with the NHS/HSC to provide services are referred to as providing-performer or principal dentists. Dentists that deliver NHS services under a contract held by another body, which can be a limited company or a providing-performer partnership, are referred to as performer-only or associate dentists. Associate dentists usually practise as subcontractors.

trainees are typically employed on the main contract for doctors and dentists in training and included in statistics for doctors and dentists in training.

5.6 NHS England said that postgraduate dental training places had consistently been filled, or close to filled, across all training programmes. The fill rate for dental core training year 1 in England was 75 per cent in 2023, with a shortfall of 73 trainees. Fill rates for years 2 and 3 were 81 per cent. Only 1 per cent resigned from post during core training in 2023.

5.7 In Wales, Health Education and Improvement Wales (HEIW) had developed an offer to encourage future dental trainees to complete their foundation year in dental practices across rural Wales, rather than more popular urban areas. In addition to a £5,000 salary uplift, dentists taking up the offer would be provided with enhanced academic and wellbeing support for the duration of the programme.

5.8 The Department of Health in Northern Ireland said there were 30 foundation dentistry placements in Northern Ireland; 22 dental core training posts; and 10 specialty training posts. It said that Republic of Ireland graduates continued to be attracted to Northern Ireland for dental training particularly at foundation level.

5.9 According to a destination survey completed in August 2022, 71 per cent of foundation dentists stayed within Northern Ireland. The figure remaining reduced as they progressed to specialty training level with many core trainees moving to other regions as there were a limited number of specialty training posts in Northern Ireland.

5.10 The Department said that the number of dental graduates was set to bulge in the next two years reflecting the increased intake during the pandemic. This could mean that the foundation training programme in Northern Ireland was under pressure to increase placements. The Department noted that Northern Ireland had never had sufficient placements to accommodate all Queen's University Belfast graduates.

5.11 The Department said that dental core training in Northern Ireland had a 73 per cent fill rate (16 out of 22 posts filled). It said that one reason given for the low rate was a pay disparity with other regions, with Northern Ireland trainees starting on a lower point on the scale and therefore remaining at a comparatively lower salary on the various progression points. The disparity increased further as trainees progressed into specialty programmes and made it less attractive to remain in Northern Ireland beyond foundation.

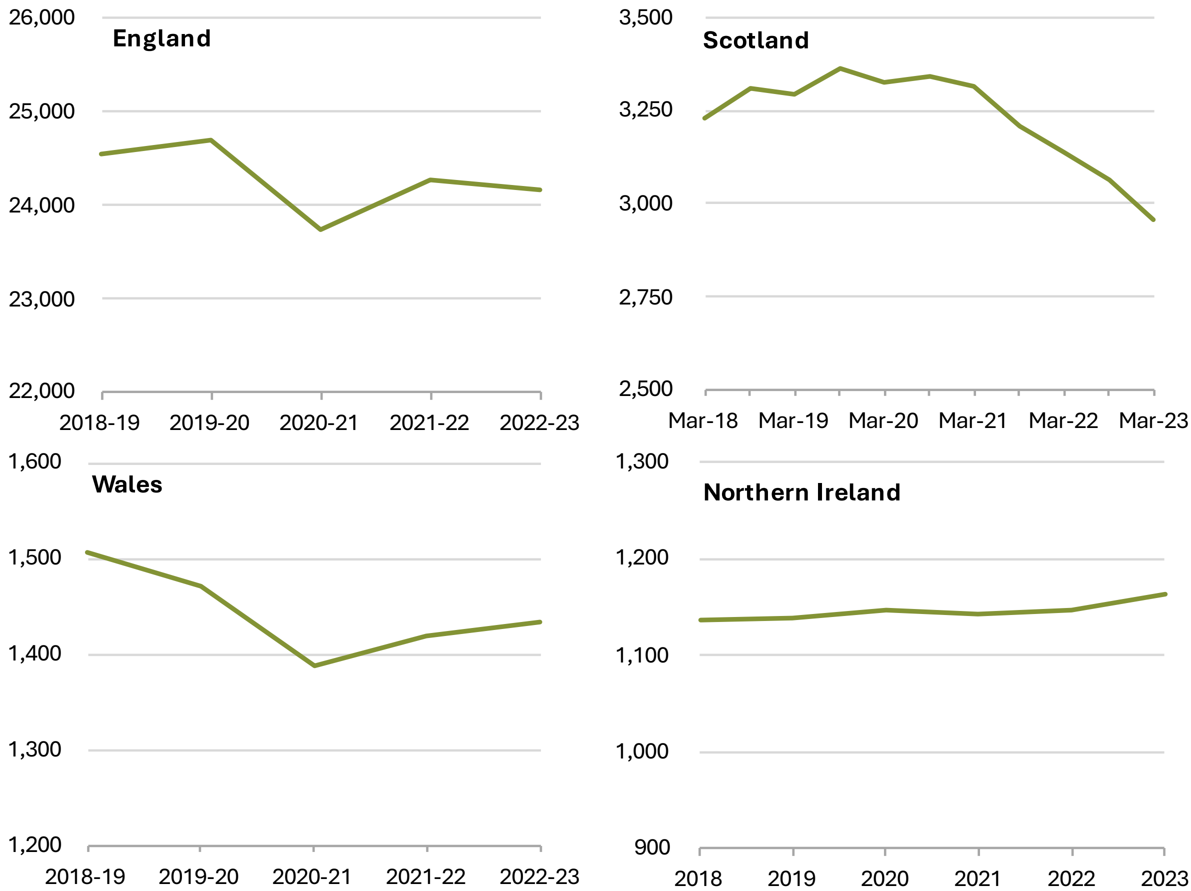
Dental workforce

5.12 The latest data for England, Scotland and Wales all show fewer dentists providing NHS services than prior to COVID-19. The numbers in England and Wales show some pick up since 2020-21, but not by enough to recover the losses through COVID-19. Dental numbers for Scotland have continued to fall into 2023 and at a greater pace than previously reported. Dental numbers in Northern Ireland held up through COVID-19.

5.13 In the year to 31 March 2023, there were 24,151 dentists providing NHS services in England, a fall of 121 (0.5 per cent) from 24,272 a year earlier. The number of dentists providing NHS services in the year to 31 March 2023 was 533 (2.2 per cent) lower than the peak recorded in the year to 31 March 2020.

5.14 In 2022-23, 81 per cent of dentists providing NHS services in England were associates and 19 per cent were principals or providing-performers. This compares to 80 per cent and 20 per cent in 2018-19.

Figure 5.2: NHS dentists, 2018 to 2023



Source: NHS England, NHS Education for Scotland, Stats Wales, Department of Health Northern Ireland.

5.15 NHS England said that the fall in the number of dentists providing NHS activity in 2022-23 was not a significant movement, but it was concerned that dentists were delivering less NHS care than the equivalent number would have done pre-pandemic. It noted that delivery of contracted activity in 2023-24 had not returned to pre-pandemic levels, with the number of unique patients seen around 86 per cent of pre-pandemic levels.

5.16 At 31 March 2023, there were 2,954 non-hospital dentists providing NHS services in Scotland, a fall of 184 (5.9 per cent) from a year earlier and 411 (12.2 per cent) since September 2019.

5.17 In 2022-23, there were 1,434 dentists providing NHS services in Wales, an increase of 14 (1.0 per cent) from a year earlier but still 72 (4.8 per cent) below the peak recorded in 2018-19. HEIW was developing a workforce plan for dentistry.

5.18 In 2022-23, there were 1,163 dentists providing dental health services in Northern Ireland, an increase of 17 (1.5 per cent) from a year earlier. The number of health service dentists increased strongly between 2010 and 2020, fell slightly in 2021 before increasing again in 2022 and 2023.

5.19 In 2022-23, there were 42.7 dentists providing NHS services per 100,000 population in England, a fall from 42.9 a year earlier, and below the peak of 43.9 in 2019-20. In 2023, there were 55.3 dentists providing NHS services per 100,000 population in Scotland, a fall from 58.9 a year earlier and below the peak of 63.2 in September 2019. In 2023, there were 60.4

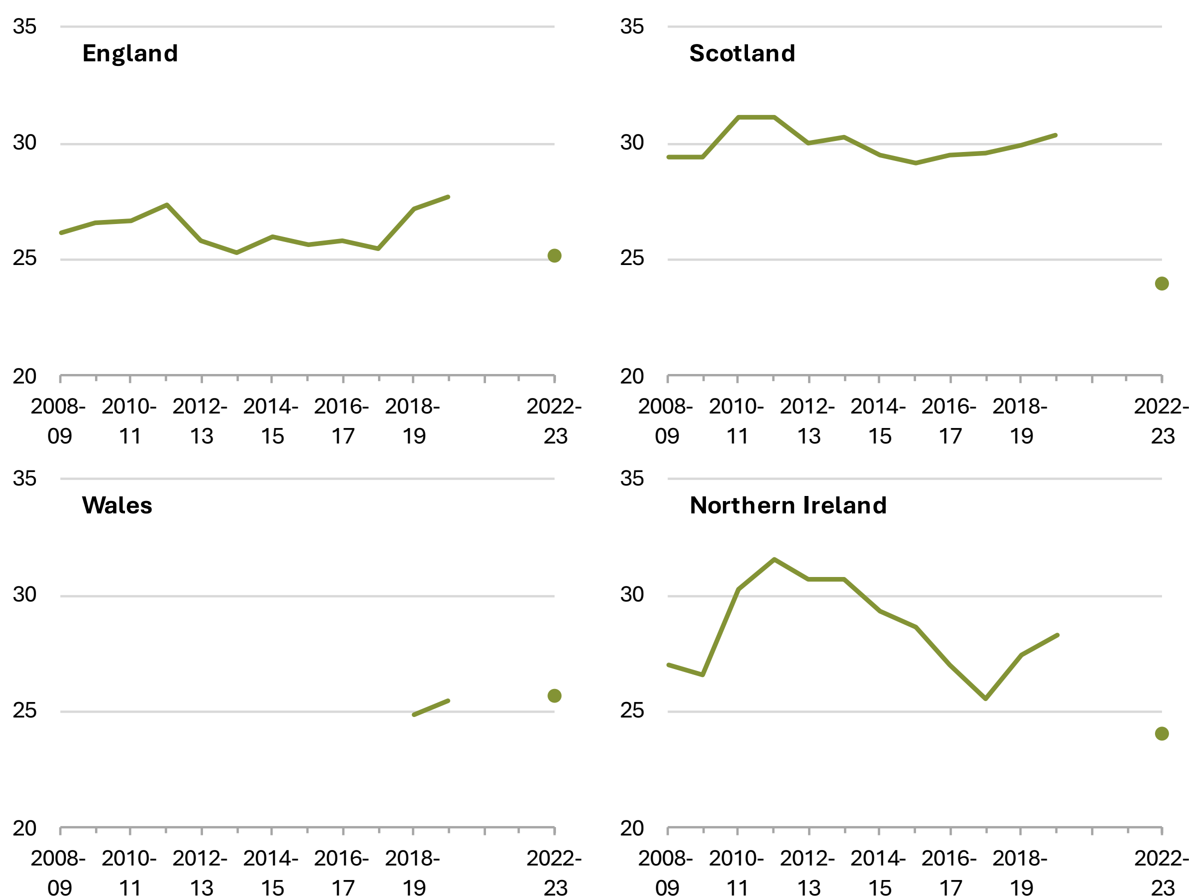
dentists per 100,000 population in Northern Ireland, up from 59.7 in 2022 and unchanged from 2018.

Working hours

5.20 The dental working patterns survey for 2022-23 was published in April 2024 for the first time since 2019-20.[45] This covers all dentists who have done some NHS work. The average weekly working hours (across NHS and private work) of principal dentists in 2022-23 were: 43.1 in Wales; 41.4 in Northern Ireland; 41.1 in England; and 39.9 in Scotland. Compared with 2019-20, the average working hours had declined in England, Scotland and Northern Ireland but had increased in Wales.

5.21 The average weekly working hours of associate dentists varied little between nations: 34.0 in Wales; 33.9 in Scotland; 33.7 in England: and 33.6 in Northern Ireland. Compared with 2019-20, the average number of hours worked fell in all countries: by 2.1 hours in Scotland; 1.1 hours in England; 1.0 hour in Wales; and 0.3 hours in Northern Ireland.

Figure 5.3: Average weekly hours on NHS/health service work, principal dentists, 2008-09 to 2022-23



Source: NHS England, Dental Working Patterns Survey.

Note: This survey was not undertaken in 2020-21 or 2021-22.

5.22 The proportion of time spent on NHS work by principal dentists in 2022-23 was: 61.2 per cent in England; 60.1 per cent in Scotland; 59.6 per cent in Wales; and 58.1 per cent in Northern

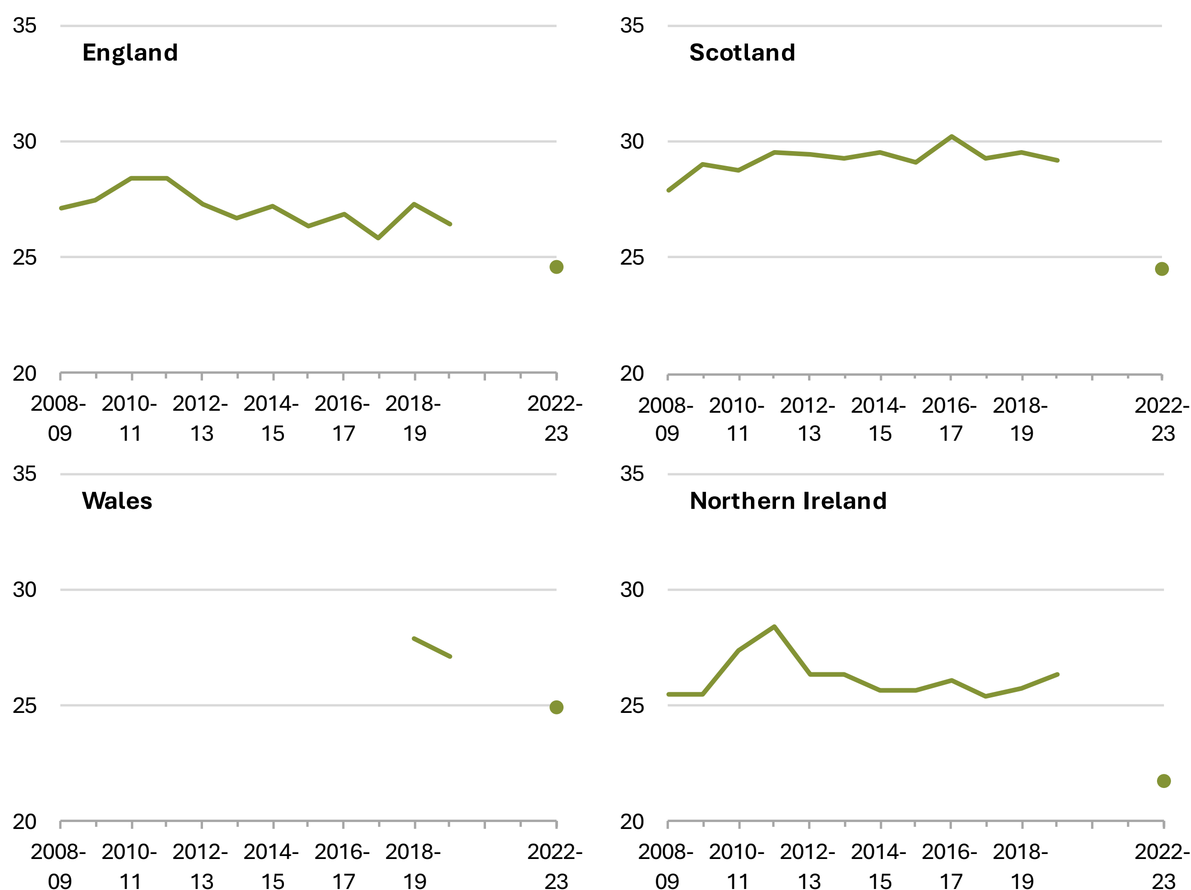
[45] NHS England, *Dentists' Working Patterns, Motivation and Morale – 2022/23.* https://digital.nhs.uk/data-and-information/publications/statistical/dental-working-hours/2022-23-working-patterns-motivation-and-morale

Ireland. Compared with 2019-20, the proportion of time spent on NHS/health service work had declined in each of the four countries: by 4 percentage points in England; by 5 percentage points in Wales; by 8 percentage points in Northern Ireland; and by 12 percentage points in Scotland.

5.23 The proportion of time spent on NHS work by associate dentists in 2022-23 was: 73.3 per cent in Wales; 73.0 per cent in England; 72.4 per cent in Scotland; and 64.7 per cent in Northern Ireland. Compared with 2019-20, the proportion of time spent on NHS/health service work had declined in each of the four countries: by 3 percentage points in England; by 4 percentage points in Wales; by 9 percentage points in Scotland; and by 13 percentage points in Northern Ireland.

5.24 From the estimates of total average hours worked and the percentage of time spent on NHS/health service work, we can derive estimates of the average weekly hours worked on NHS/health service work. The average weekly hours spent on NHS/health service work by principal dentists in 2022-23 were: 25.7 in Wales; 25.2 in England; 24.1 in Northern Ireland; and 24.0 in Scotland (see figure 5.3). Compared with 2019-20, the average number of hours spent on NHS/health service work had declined in England, Scotland and Northern Ireland but had increased in Wales.

Figure 5.4: Average weekly hours on NHS/health service work, associate dentists, 2008-09 to 2022-23



Source: NHS England, Dental Working Patterns Survey.

Note: This survey was not undertaken in 2020-21 or 2021-22.

5.25 The average weekly hours spent on NHS/health service work by associate dentists in 2022-23 were: 24.9 in Wales; 24.6 in England; 24.5 in Scotland; and 21.7 in Northern Ireland (see figure 5.4). Compared with 2019-20, the average number of hours worked on NHS/health service work declined in all four nations.

Long Term Workforce Plan

5.26 The Long Term Workforce Plan for England planned for training programmes for dentists to expand by 40 per cent by 2031-32. The number of dental training places was planned to increase from 809 in 2022 (and 2025) to 1,133 by 2031, with an initial expansion to 850 places in 2026 and 1,000 places by 2028-29. The total number of NHS dentists was projected to increase from 8,800 in 2021-22[46] to 19,000-20,000 by 2036.

5.27 The DHSC said it wished to undertake this expansion in a targeted way to improve provision in areas of the country where it was most needed. It said it would explore the creation of new dental schools in under-served parts of the country. The DHSC said that having more dentists was not the sole solution to the current workforce challenges in NHS dentistry. It noted that more than 35,000 dentists were registered with the General Dental Council (GDC) in England but only 24,151 of them delivered at least some NHS care in 2022-23. It said more dentists were needed to do more NHS work alongside, or instead of, their private work.

5.28 The DHSC launched a consultation in May 2024 on introducing a tie-in for graduate dentists.[47] These proposals would ensure that graduates spent at least some of their time delivering NHS care in the years following the completion of undergraduate training.

5.29 The British Dental Association (BDA) identified a number of shortcomings in the viability of the Long Term Workforce Plan. It said that no detail had been set out in the Plan, or elsewhere, as to how NHS England intended to increase dental school places, expand the estates of dental schools, increase the number of dental academics or expand the number of dental foundation training practices.

5.30 The BDA said that the predicted demand for 23,000 full-time equivalent NHS dentists/dental care professionals implied an additional 48 million units of dental activity (UDAs) being commissioned – about a 50 per cent increase – by 2038. The BDA estimated that this required an additional annual investment of £1.345 billion (at 2023 UDA values).

5.31 The BDA noted that the Plan intended for nearly two-thirds of the dentist workforce expansion (7,100 full-time equivalent) to come from dentists having a higher participation rate in the NHS than currently. The 40 per cent increase in the number of dental training places was anticipated to generate 500 to 900 full-time equivalent dentists. It said that there was no indication as to how this would be achieved.

5.32 The BDA also noted that the Plan would lead to an increased demand on the dental academic workforce to support the planned expansion of training places. It said that incentivising more dentists to join academia would be necessary to ensure there was sufficient capacity to support undergraduates studying dentistry.

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[46] This figure is significantly lower than the headcount number of dentists providing NHS services in England. We have been told that it was derived by extrapolating the total number of UDAs delivered in England in 2021-22 into a notional FTE figure, which therefore was artificially low given the restrictions on dental activity that were in place during that year.

[47] DHSC, *Proposal for a 'tie-in' to NHS dentistry for graduate dentists.* https://www.gov.uk/government/consultations/proposal-for-a-tie-in-to-nhs-dentistry-for-graduate-dentists/proposal-for-a-tie-in-to-nhs-dentistry-for-graduate-dentists

Access to dental services

5.33 Results from the 2023 GP Patient Survey for England indicated that 53 per cent of respondents had tried to get an NHS dental appointment in the last two years, up from 52 per cent in 2022, but down from 58 per cent in 2020. Of these, 77 per cent were successful, unchanged from the 2022 survey but down from 94 per cent pre-pandemic.

5.34 Evidence from the GDC on views and experiences of dentistry suggested that satisfaction with NHS dental care was declining (among those who were able to get it), and that there were increasing concerns about the ability to access NHS dental services, either because NHS services were unavailable at the time required or because of the cost of accessing NHS care.[48] An increasing percentage of the population were choosing to use private dentistry – some were happy to do so, but others were pushed in that direction because of an inability to access NHS services, while those without the necessary resources were more likely not to access dental care (private or NHS) at all. The GDC survey suggested that there was a public perception that people were not able to access NHS dental services and that people were less confident about the way that dental services were provided.

Dental Recovery Plan

5.35 The DHSC and NHS England jointly published *Faster, simpler and fairer: our plan to recover and reform NHS dentistry* on 7 February 2024.[49] It set out plans to expand access and increase the level of dental provision. Among the policies proposed were:

- Golden hello payments of £20,000 for dentists that moved to areas that were struggling to recover their activity levels.
- An additional payment of £15 or £50 for each new patient who had not been able to receive NHS dental care in the preceding two years.
- An increase to the minimum UDA rate.
- A commitment to future contract reform.
- Enabling practices to deliver beyond their contractual requirement.
- Ringfencing the NHS dentistry budget for 2024-25.
- Expanding dental undergraduate training places by 40 per cent (as set out in the Long Term Workforce Plan).
- A consultation on mandating NHS service for dentistry graduates.
- Making it easier for overseas dental professionals to work in the NHS.

5.36 The Plan said this would deliver more than 1.5 million additional NHS dentistry treatments or 2.5 million NHS dentistry appointments for patients across England.

5.37 The Plan proposed that a 'golden hello' incentive payment of £20,000 would be offered to up to 240 dentists in Integrated Care Board (ICB) areas that were struggling to recover their activity levels and would significantly benefit. Payments would be phased over three years, requiring a commitment from the dentist to stay in that area delivering NHS work for at least three years. Locations would be decided in the coming months, and the effectiveness of the scheme would be reviewed before considering whether to extend it in the future. The scheme was launched on 10 May 2024.

5.38 Under the Plan, dental practices would be offered an additional payment for each new patient requiring treatment. The payment level, of £15 or £50 depending on the treatment required,

[48] GDC, *Views and experiences of dentistry – 2022 survey of the UK public.* https://www.gdc-uk.org/about-us/what-we-do/research/our-research-library/detail/report/views-and-experiences-of-dentistry-2022-survey-of-the-uk-public
[49] DHSC, *Our plan to recover and reform NHS dentistry.* https://www.gov.uk/government/publications/our-plan-to-recover-and-reform-nhs-dentistry

would be in addition to the NHS funding a practice already received for this care and was to recognise the additional time that might be needed for practices to assess, stabilise and manage the oral health needs of patients who had not received NHS dental care for more than two years. The patient premium would be a time-limited scheme launching in March 2024 and ending in March 2025.

5.39 The Plan increased the minimum UDA rate, set at £23 in 2022, to £28; this would uplift the UDA rate for almost 1,000 contracts.

5.40 In oral evidence, the BDA told us that the fairly limited recommendations in the Dental Recovery Plan fell short of what was needed to address the crisis in dentistry. It was pointed out that funding for the Plan was less than the financial clawback recovered in 2022-23 and that recruiting dentists was an issue across the whole country so attracting them to specific areas would mean there was less provision elsewhere. The BDA also said that only 10 per cent of practices would be affected by the increase in the UDA value.

Recruitment and retention

5.41 NHS England said that current trends in the dental workforce were difficult to assess as available data did not detail whole or part-time working, which limited analysis of workforce capacity. It said it was aware that certain geographical shortfalls were limiting service provision, including in rural and coastal areas. To improve the available workforce data, NHS England had introduced a new biannual national dental workforce collection. This would provide data on: recruitment and retention of staff; vacancy rates; and delivery of NHS and private care.

5.42 The dental working patterns survey asked dentists if they often thought about leaving general dentistry. Among principal dentists, the proportion of responses agreeing in 2022-23 was: 63.6 per cent in England; 63.1 per cent in Scotland; 61.5 per cent in Wales; and 63.4 per cent in Northern Ireland. Compared with the 2019-20 survey, the results had worsened for England and Scotland but improved for Wales and Northern Ireland.

5.43 Among associate dentists, the proportion of those often thinking about leaving dentistry was: 60.7 per cent in England; 63.6 per cent in Scotland; 71.2 per cent in Wales; and 66.0 per cent in Northern Ireland. Compared with 2019-20, the results had worsened for all four nations.

5.44 The BDA's 2023 survey of GDPs from across the UK found that:

- 93 per cent of practice owners seeking to recruit an associate in 2022-23 had difficulty doing so. This was an increase from 90 per cent in the previous year and 70 per cent in 2018.
- 55 per cent of practice owners reporting vacancies had posts that had been empty for more than six months, increasing to 71 per cent for those with a high NHS commitment.

5.45 On retention, the BDA survey found that:

- 56 per cent of practice owners and 44 per cent of associates intended to leave NHS dentistry as soon as possible or in the next 12 months.
- 29 per cent of practice owners with a high NHS commitment indicated their intention to stay in their current role over the next five years, compared to 44 per cent without a high NHS commitment.
- 36 per cent of associates with a high NHS commitment indicated their intention to stay in their current role over the next five years, compared to 47 per cent without a high NHS commitment.

- 47 per cent of practice owners were intending to sell their practice over the next five years, with just 38 per cent intending to continue working in their current main role.

5.46 The DHSC said that around 30 per cent of all dentists on the GDC's register qualified outside of the UK and, in 2022, 46 per cent of new dentists joining the GDC register were trained overseas.

5.47 The Health and Social Care Select Committee published a report in July 2023 on NHS dentistry. It said the Government must urgently introduce incentives to attract and retain dentists to undertake NHS work.[50] These should include, but not be limited to, the reintroduction of NHS commitment payments, incentive payments for audit and peer review, and the introduction of late career retention payments.

5.48 The Welsh Government noted that recruitment and retention difficulties were being encountered in all health boards in Wales with particular issues in the more rural and remote areas. Recruitment and retention issues seemed to have been exacerbated by the pandemic and were having a significant impact on the provision of NHS dental services in some areas. Some health boards had been successful in awarding several new contracts or distributing funding to existing NHS contract holders for additional activity. The Welsh Government said this suggested there was appetite from new dentists wanting to become providing-performers and from existing practice owners to expand.

Earnings for providing-performer dentists

5.49 Earnings data for providing-performer and associate dentists comes from HMRC and the most up to date data available is for 2021-22. It combines earnings from private and NHS work. In 2020-21, average taxable income for providing-performer dentists grew strongly in Scotland (32 per cent annual growth), Northern Ireland (23 per cent) and England (17 per cent), but less strongly in Wales (1 per cent).

5.50 In 2021-22, average taxable incomes for providing-performer dentists in Wales, Northern Ireland and England were higher again than in 2020-21, by 21 per cent, 14 per cent and 2 per cent respectively. In Scotland, average taxable incomes for providing-performer dentists in 2021-22 were 8 per cent lower than in 2020-21 but remained 21 per cent higher than in 2019-20.

5.51 This meant that the nominal mean pre-tax incomes of providing-performer dentists in 2021-22 were higher than in 2019-20 (pre-COVID-19) in each nation. The increases in England, Scotland and Wales were between 20 and 22 per cent, while the increase in Northern Ireland was 40 per cent.

Table 5.1: Providing-performer dentists, pre-tax income, 2021-22

	England	Scotland	Wales	Northern Ireland
Mean (average)	£135,000	£125,100	£120,800	£138,800
Median	£106,100	£96,800	£112,500	£109,500
Lower quartile	£61,200	£66,500	£77,500	£75,800
Upper quartile	£169,800	£171,200	£160,000	£167,300

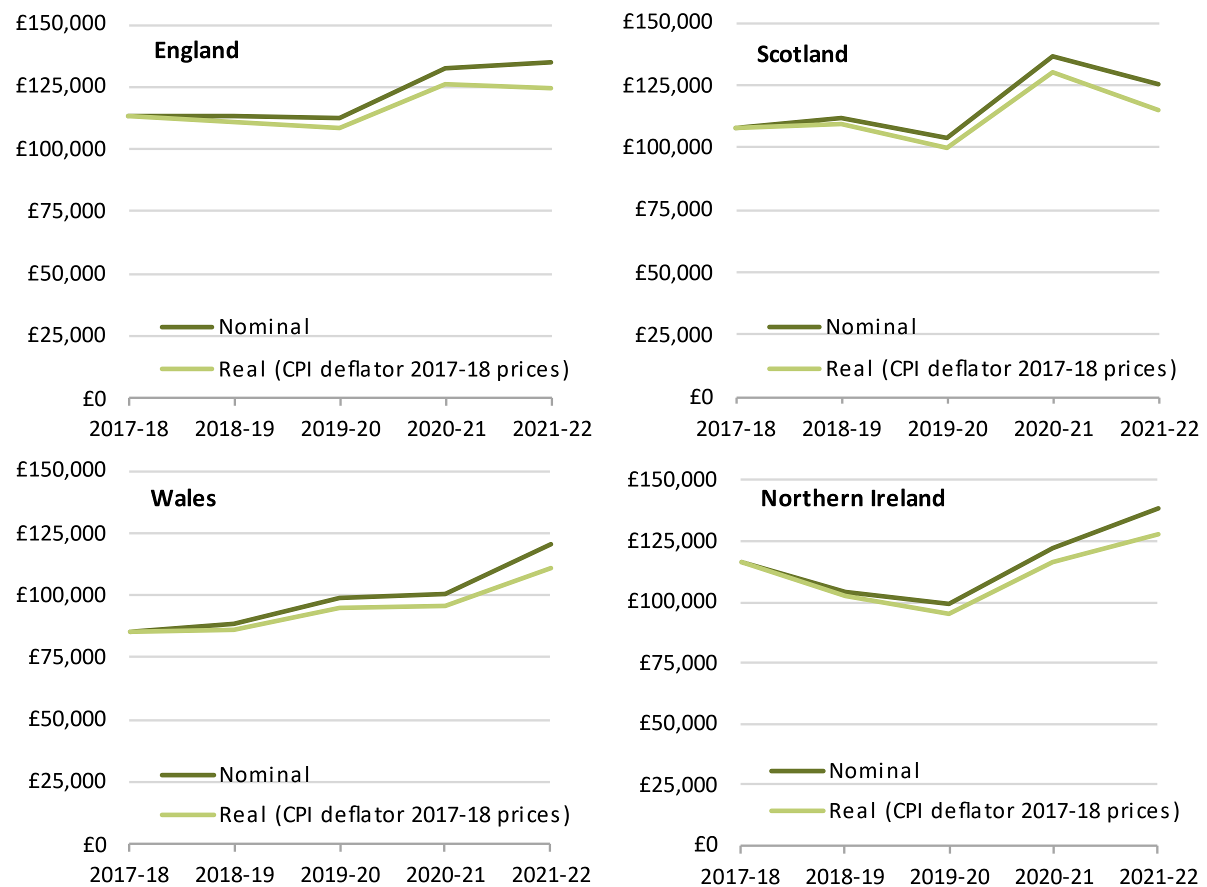
Source: NHS England.

[50] UK Parliament, *NHS Dentistry.* https://committees.parliament.uk/work/7140/nhs-dentistry/publications

5.52 In 2021-22, mean pre-tax incomes of providing-performer dentists were highest in Northern Ireland (£138,800) and England (£135,000), compared with Scotland (£125,100) and Wales (£120,800). Dentists in Wales, despite having the lowest mean and upper quartile pre-tax income, had the highest median and lower quartile pre-tax income, suggesting relatively few dentists had very high or very low pre-tax incomes in Wales.

5.53 Nominal pre-tax incomes of providing-performer dentists in 2020-21 and 2021-22 were at their highest levels since: at least 2017-18 in England and Wales; at least 2008-09 in Scotland; and at least 2007-08 in Northern Ireland (for Scotland and Northern Ireland, this is when the data series began). Adjusted by the Consumer Prices Index (CPI), average pre-tax incomes were at their highest levels since: at least 2017-18 in England and Wales; 2015-16 in Scotland; and 2010-11 in Northern Ireland.

Figure 5.5: Providing-performer dentists, average income before tax, nominal and CPI-adjusted, England, Scotland, Wales, Northern Ireland, 2017-18 to 2021-22



Source: OME calculations using data from NHS England and ONS.

Table 5.2: Changes to average pre-tax income for providing-performer dentists compared with DDRB recommendations, by nation, 2018-19 to 2021-22

	2018-19	2019-20	2020-21	2021-22	Increase over the period
DDRB recommendation	2.0%	2.5%	2.8%	3.0%	**11%**
England	-0.1%	-0.4%	17.4%	2.1%	**19%**
Scotland	4.3%	-7.6%	31.5%	-8.3%	**16%**
Wales	3.6%	11.9%	1.3%	20.8%	**42%**
Northern Ireland	-10.0%	-5.0%	23.0%	13.8%	**20%**

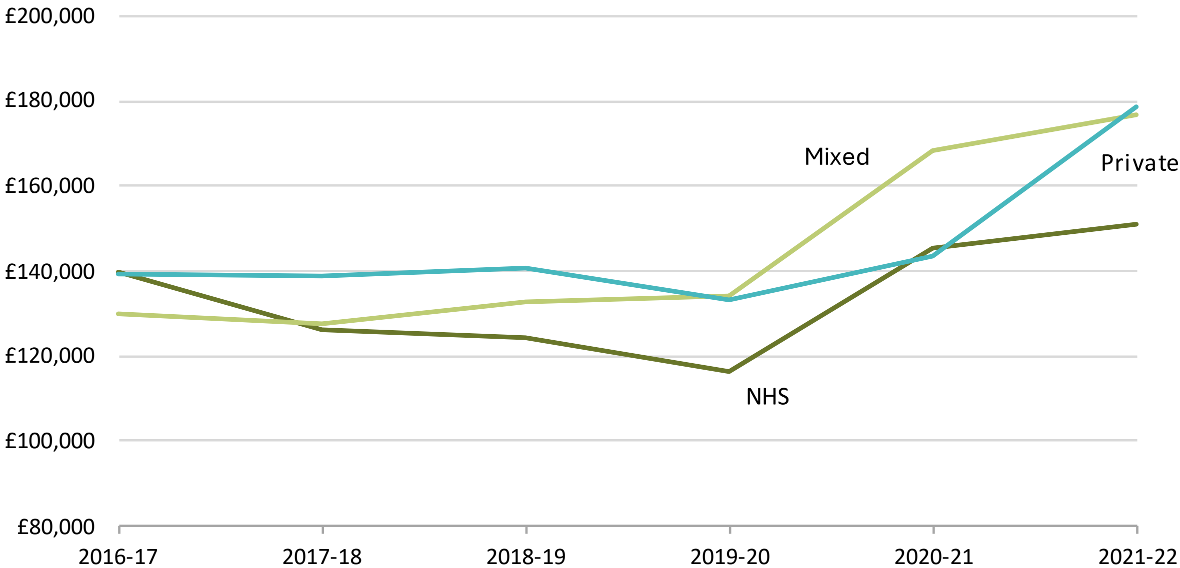
Note: Where the increase in average pre-tax income was below the DDRB recommendation the cell is shaded green.

5.54 Since 2018-19, increases in providing-performer dentists average taxable incomes have grown by more than the DDRB recommendation half of the time and by less than the DDRB recommendation half of the time. Over the period as a whole, the increase in average pre-tax incomes in each of the nations (between 16 per cent and 42 per cent) was greater than the value of the DDRB recommendations (11 per cent).

5.55 The BDA said that taxable income for practice owners was 2.6 per cent above 2008-09 levels in England, 7.1 per cent above in Northern Ireland, 5.4 per cent above in Scotland, and 1.3 per cent below in Wales. This meant that there had been significant real terms cuts to practice owners' take-home pay. The BDA said that the sharp increases in practice owners' earnings in 2020-21 and 2021-22 were in part a result of the financial arrangements in place during the pandemic and in part a result of the shift to private practice.

5.56 NHS England provided data from the National Association of Specialist Dental Accountants and Lawyers (NASDAL) for 2021-22 which indicated an increase in average net profit per principal from £145,498 in 2020-21 to £150,894 in 2021-22 for NHS practices, and an increase for the first time in a number of years in the average remuneration for an associate from £63,304 to £75,488.

Figure 5.6: Net profit per principal for the practice, 2016-17 to 2021-22



Source: NHS England, NASDAL.

Note: NHS practices are those with NHS earnings greater than or equal to 80 per cent of total earnings. Private practices are those with private earnings greater than or equal to 80 per cent of total earnings.

Earnings for associate dentists

5.57 In 2020-21, average taxable income (from NHS and private work) for associate dentists grew much less strongly than for providing-performer dentists. Average taxable incomes increased by between 1 per cent and 4 per cent in England, Scotland and Northern Ireland, but fell by 3 per cent in Wales. In 2021-22, average taxable incomes for associate dentists grew more strongly than in 2020-21 – by 11 per cent in England, 10 per cent in Wales, and 8 per cent in Scotland – but less strongly in Northern Ireland (2 per cent).

5.58 In 2021-22, mean pre-tax incomes of associate dentists in England, Scotland and Wales were in a narrow range, between £64,400 in Scotland and £66,300 in Wales. Mean pre-tax incomes in Northern Ireland were lower, at £60,700.

Table 5.3: Associate dentists, pre-tax income, 2021-22

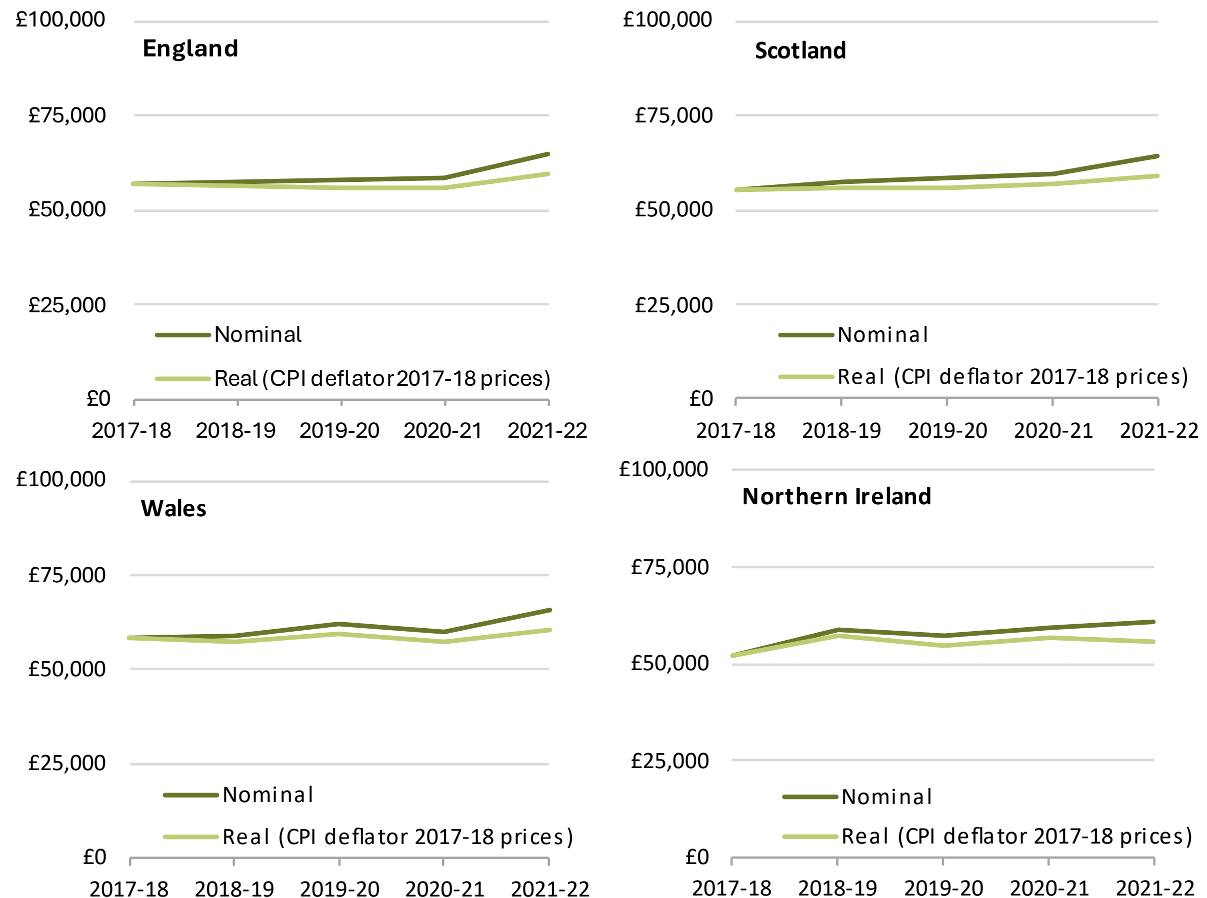
	England	Scotland	Wales	Northern Ireland
Mean (average)	£64,900	£64,400	£66,300	£60,700
Median	£59,000	£58,500	£60,600	£53,300
Lower quartile	£37,600	£43,100	£41,300	£37,800
Upper quartile	£82,600	£78,500	£84,000	£74,200

Source: NHS England.

5.59 Between 2019-20 and 2021-22, average pre-tax incomes for associate dentists grew by between 6 per cent (Northern Ireland) and 12 per cent (England). Mean nominal pre-tax incomes in 2021-22 were at their highest levels since: at least 2017-18 in England and Wales; 2008-09 in Scotland; and 2009-10 in Northern Ireland.

5.60 This means that in 2021-22, after adjusting for CPI inflation, average taxable incomes for associate dentists were at their highest level in Scotland since 2012-13, in England and Wales since at least 2017-18 (the earliest date for which consistent data is available), and in Northern Ireland since 2020-21.

Figure 5.7: Associate dentists, average income before tax, nominal and CPI-adjusted, England, Scotland, Wales, Northern Ireland, 2017-18 to 2021-22



Source: OME calculations using data from NHS England and ONS.

5.61 The BDA said that taxable incomes for associates remained below the 2008-09 level in cash terms in all four parts of the UK. It said that associates had seen increases in their incomes

since 2019-20, but by less than practice owners. The BDA said that this reflected pandemic income protections and the shift that associates had made to private dentistry. The BDA said that this was supported by data on the fees associates were paid per UDA in England, which had remained largely static over the past three years, while overall UDA delivery was down on pre-pandemic levels. Associates were earning similar amounts per UDA and were performing fewer UDAs. Therefore, the BDA concluded that the growth in associate earnings could not be attributed to a growth in income from NHS work.

5.62 Since 2018-19, increases in associate dentists average taxable incomes have grown by more than the DDRB recommendation just under half of the time and by less than the DDRB recommendation just over half of the time. Over the period as a whole, the increase in average pre-tax incomes in each of the countries (between 13 per cent and 16 per cent) was greater than the value of the DDRB recommendations (11 per cent).

Table 5.4: Changes to average pre-tax income for associate dentists compared with DDRB recommendations, by nation, 2018-19 to 2021-22

	2018-19	2019-20	2020-21	2021-22	Increase over the period
DDRB recommendation	2%	2.5%	2.8%	3%	**11%**
England	1.1%	0.9%	1.0%	10.6%	**14%**
Scotland	3.6%	1.6%	2.6%	7.7%	**16%**
Wales	0.9%	5.3%	-2.9%	9.8%	**13%**
Northern Ireland	12.2%	-2.6%	4.0%	2.0%	**16%**

Note: Where the increase in average pre-tax income was below the DDRB recommendation the cell is shaded green.

5.63 NHS England said that a high proportion of performer-only dentists worked as an associate within a practice on a self-employed basis. It said it had no contractual relationship with performer-only dentists; its contractual arrangement was with the contract holder, and therefore it was not involved in how their pay was determined. The income of performer-only dentists was determined by the arrangements they had agreed with the performing-provider, but they were typically paid a fixed sum per UDA delivered.

5.64 The DHSC said that it strongly recommended that providing-performer dentists applied the DDRB uplift to their associate dentists' salaries, but it was unable to enforce practices to do so. As practices were private businesses, it fell to them to set employee pay and conditions. NHS England was concerned that, where contractors did not pass on payment uplifts, this had a negative impact on workforce retention, contract delivery and the availability of patient care.

5.65 The BDA's survey reported that 86 per cent of associates in England and Wales did not have their NHS pay uplifted every year. Of those with no regular annual uplift, 34 per cent said that their NHS income was never uplifted, 13 per cent said it was last uplifted more than five years ago, 7 per cent within the last five years, 13 per cent within the last three years and 33 per cent within the last two years.

Views on pay

5.66 The dental working patterns survey asked whether dentists felt their pay was fair. Among principal dentists, the proportion of positive responses for 2022-23 was: 18.3 per cent in England; 10.4 per cent in Wales; 24.4 per cent in Scotland; and 16.1 per cent in Northern Ireland. Compared with the previous survey in 2019-20, the results had worsened for Wales, but improved for England, Scotland and Northern Ireland.

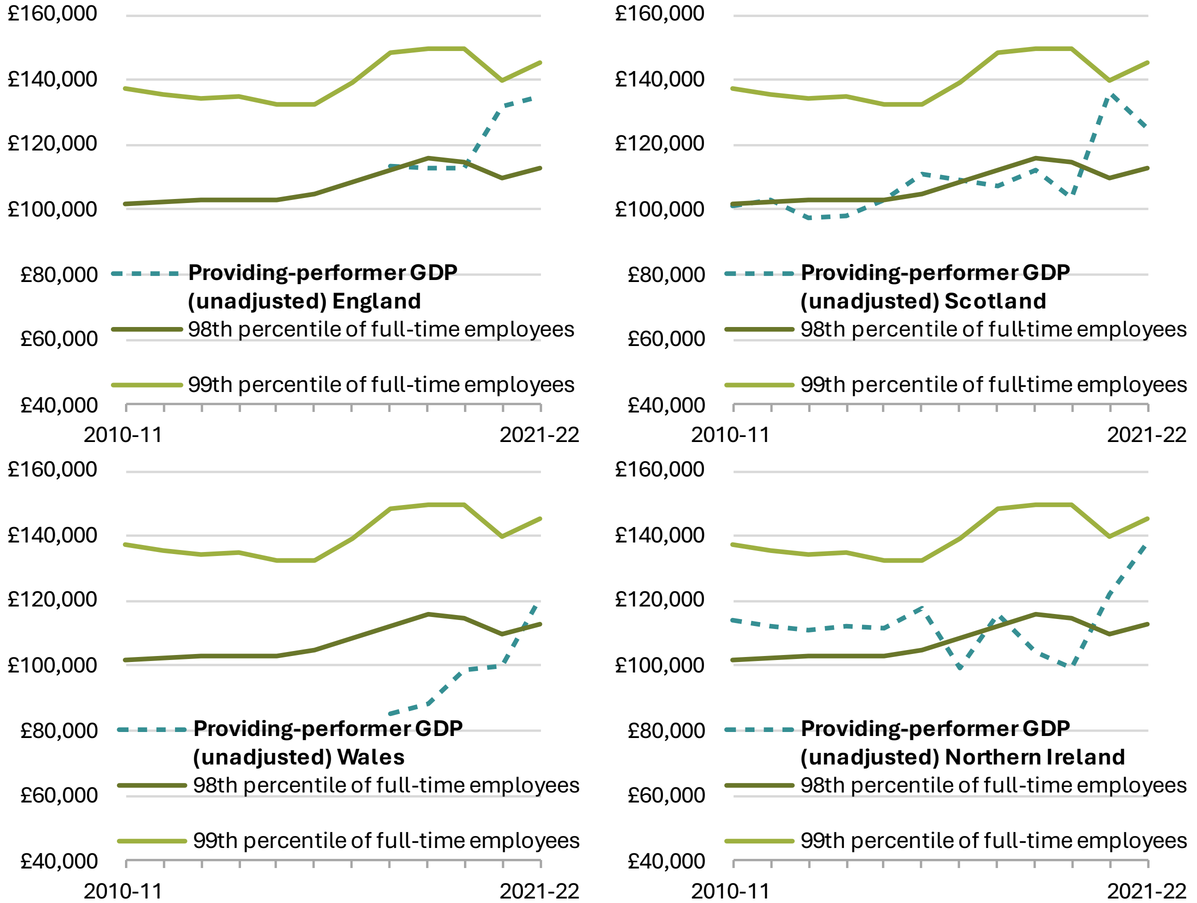
5.67 Among associate dentists, the proportion of positive responses was: 16.2 per cent in England; 15.6 per cent in Wales; 18.9 per cent in Scotland; and 15.2 per cent in Northern Ireland. Compared with the 2019-20 survey, the results had worsened for England, Wales and Scotland, but slightly improved for Northern Ireland.

5.68 The BDA survey found that 26 per cent of practice owners and 31 per cent of associates agreed or strongly agreed that they were fairly remunerated for their work, with 61 per cent of practice owners and 47 per cent of associates disagreeing or strongly disagreeing. Among practice owners with a high NHS commitment, 86 per cent disagreed or strongly disagreed that they were fairly remunerated for their work, compared to 46 per cent of those without a high NHS commitment. Among associates, 64 per cent with a high NHS commitment disagreed or strongly disagreed that they were fairly remunerated for their work, compared to 31 per cent of those without a high NHS commitment.

Pay comparisons

5.69 In both Scotland and Northern Ireland, providing-performer GDP earnings were broadly in line with the 98th percentile of all full-time employees between 2010-11 and 2019-20 but increased above this in 2020-21 and 2021-22. Data on GDP earnings for England and Wales is only available on a consistent basis from 2017-18. Providing-performer GDP earnings in England saw a similar pattern to Scotland since 2017-18, while providing-performer GDP earnings in Wales have increased from below to in line with the 98th percentile of all full-time employees since 2017-18. This does not take account of working hours.

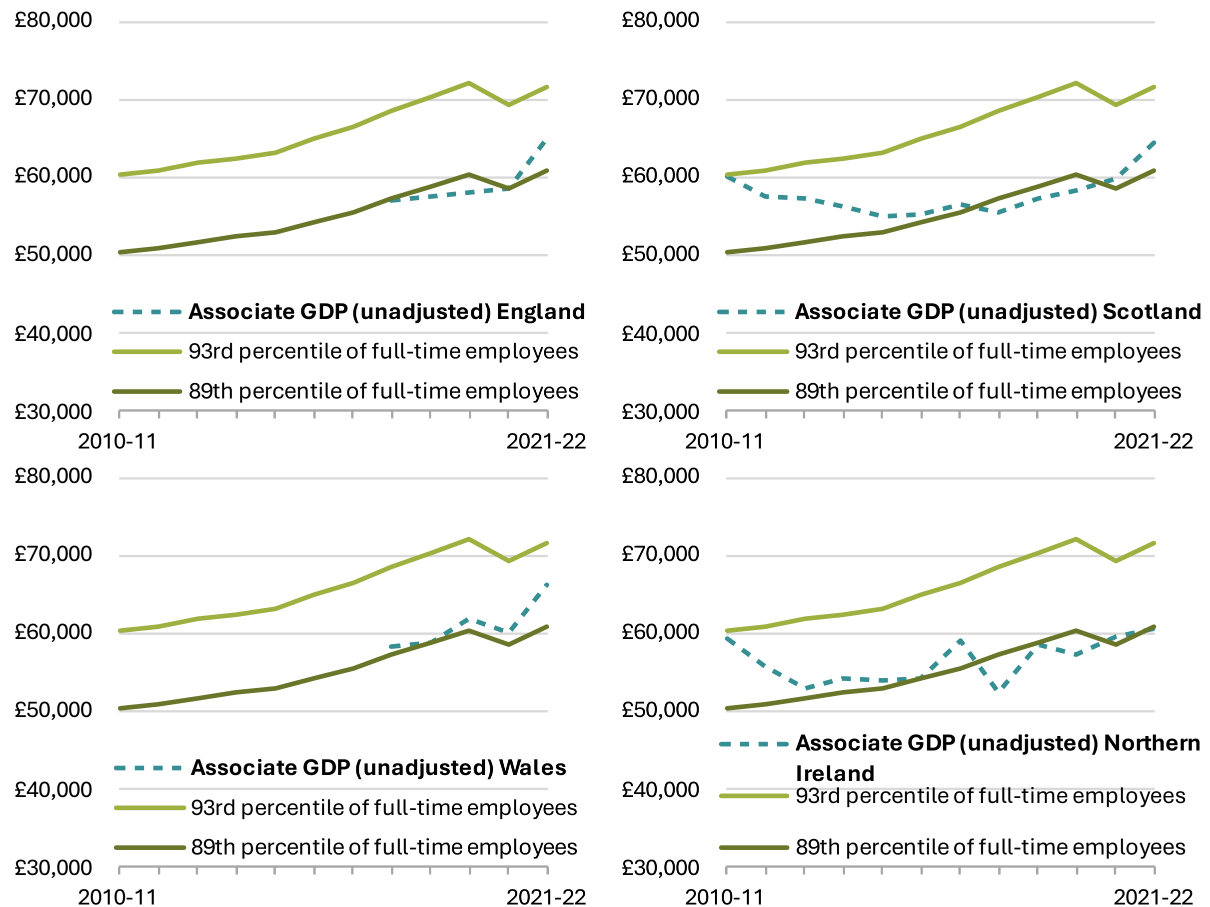
Figure 5.8: Average income before tax of providing-performer GDPs compared with the distribution of earnings of full-time UK employees, 2010-11 to 2021-22



Source: OME calculations using data from NHS England and ONS.
Note: Dental earnings are not adjusted for working hours.

5.70 Earnings for associate GDPs in Scotland and Northern Ireland fell back from the 93rd to the 89th percentile of all full-time earnings between 2010-11 and 2021-22. Associate GDP earnings in England and Wales are also around the 89th percentile, with a relative increase in 2021-22. Again, this does not take account of working hours.

Figure 5.9: Average income before tax of associate GDPs compared with the distribution of earnings of full-time UK employees, 2010-11 to 2021-22



Source: OME calculations using data from NHS England and ONS.

Note: Dental earnings are not adjusted for working hours.

Figure 5.10: Inter-quartile range of total earnings of providing-performer GDPs, England, compared with professional groups, matched by job size to market data, 2023

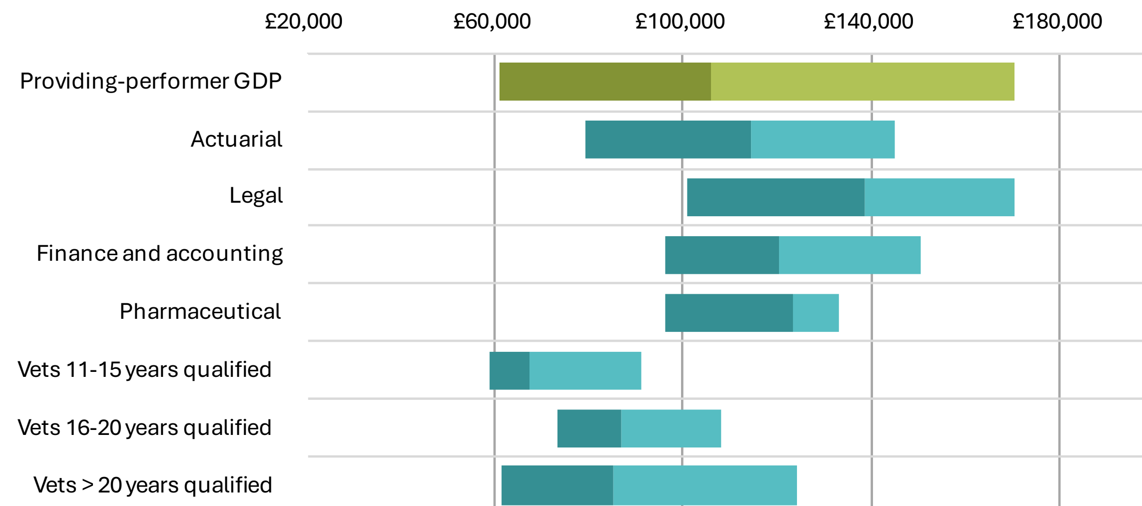
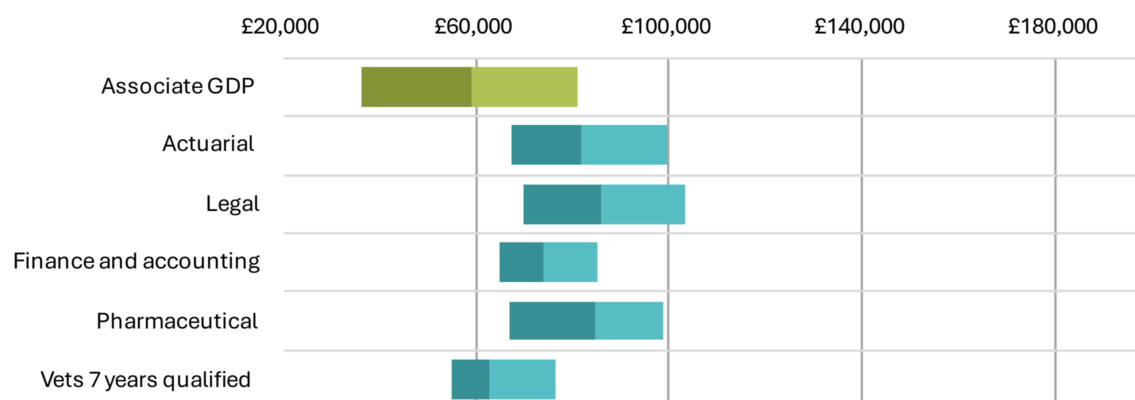


Figure 5.11: Inter-quartile range of total earnings of associate GDPs, England, compared with professional groups, matched by job size to market data, 2023



Source (for figures 5.10 and 5.11): OME analysis of data from Kornferry; Universities and Colleges Employers Association; The Society for Practising Veterinary Surgeons; NHS England; ONS.

Notes: Pay for comparator professions is on an FTE basis, whereas that for GDPs is on a headcount basis and is therefore lower than it would be on an FTE basis. GDP earnings are also from 2021-22, while comparator earnings are from 2023. Individual medical and dental roles are matched by job size to market data.

5.71 Median earnings for provider-performer GDPs were less than most comparators, with the exception of vets. Associate GDPs earned less than their full-time professional comparators, although GDP earnings are unadjusted for working hours.

GDP earnings by gender

5.72 In England and Scotland, average pre-tax incomes of female providing-performer dentists were lower than those of male providing-performers in 2021-22, by 19 per cent and 14 per cent respectively. In Wales, in 2021-22, average pre-tax incomes for female providing-performer dentists were 2 per cent higher than those for male providing-performers. This data does not adjust for working hours.

5.73 Average pre-tax incomes of female associate dentists in 2021-22 were lower than those of male associates: by 26 per cent in England; 24 per cent in Scotland, and 23 per cent in Wales. In each nation, the gap between male and female average incomes was little changed between 2019-20 and 2021-22.

Table 5.5: Providing-performer dentists income before tax, by gender and nation, 2017-18 to 2021-22

		2017-18	2018-19	2019-20	2020-21	2021-22
England	Male	£118,500	£119,200	£119,300	£137,000	£143,200
	Female	£99,300	£97,500	£96,100	£120,400	£115,800
	Difference	-16%	-18%	-19%	-12%	-19%
Scotland	Male	£115,000	£124,300	£110,300	£145,000	£132,200
	Female	£91,500	£90,500	£91,500	£122,000	£113,300
	Difference	-20%	-27%	-17%	-16%	-14%
Wales	Male	£77,200	£91,000	£99,600	£101,800	£120,000
	Female	£77,200	£81,500	£96,700	£95,700	£123,000
	Difference	0%	-10%	-3%	-6%	2%

Source: NHS England.

Notes: Does not adjust for working hours. Data not available for Northern Ireland.

Table 5.6: Associate dentists income before tax, by gender and nation, 2017-18 to 2021-22

		2017-18	2018-19	2019-20	2020-21	2021-22
England	Male	£67,500	£67,800	£69,100	£68,100	£76,900
	Female	£49,000	£50,100	£50,300	£52,100	£56,900
	Difference	-27%	-26%	-27%	-23%	-26%
Scotland	Male	£63,500	£66,400	£67,600	£68,000	£75,100
	Female	£49,400	£50,700	£52,000	£54,100	£56,800
	Difference	-22%	-24%	-23%	-20%	-24%
Wales	Male	£65,100	£64,200	£71,300	£69,300	£76,600
	Female	£52,000	£54,100	£54,900	£53,600	£59,200
	Difference	-20%	-16%	-23%	-23%	-23%

Source: NHS England.

Notes: Does not adjust for working hours. Data not available for Northern Ireland.

Expenses

5.74 Pre-tax income figures are derived from deducting expenses from gross earnings. For example, for providing-performer dentists in England, the 2021-22 estimate of pre-tax income (£135,000) results from gross earnings (£430,100) less expenses (£295,100). Average gross earnings and expenses vary between nations, being highest for contractors in England. Contractors in the other nations have similar average gross earnings, but contractors in Wales have higher average expenses than those in Scotland and Northern Ireland. Expenses account for 69 per cent of gross earnings in both England and Wales, 67 per cent in Scotland, and 64 per cent in Northern Ireland.

Table 5.7: Providing-performer dentists, gross earnings, expenses and pre-tax income, 2021-22

	England	Scotland	Wales	Northern Ireland
Gross earnings	£430,100	£375,400	£388,100	£384,200
Expenses	£295,100	£250,300	£267,400	£245,400
Income before tax (average)	£135,000	£125,100	£120,800	£138,800
Expenses as % of gross earnings	69%	67%	69%	64%

Source: NHS England.

5.75 On our visits, the issue of rising practice costs was consistently raised, in particular around energy bills and staff wages, as well as clinical and laboratory costs.

5.76 The BDA evidence said that expenses covered everything from clinical materials and laboratory fees to non-dentist staff costs, clinical waste disposal and mortgages or rent. It described these as the ‘costs of care’ and pointed out that fluctuations in these costs had a direct bearing on the remaining funding that was left as take-home pay for dentists.

5.77 The BDA used its survey of practice owners to ask for an indication of the amount different cost categories had increased. It inferred average increases of 17.7 per cent for staff costs, 18.0 per cent for laboratory and materials costs and 20.4 per cent for other costs.

5.78 The Association of Dental Groups said that the cost of delivering NHS dental care continued to increase over and above recent contract uplifts. It said members had seen increases in staffing costs of between 5 and 7 per cent, with a 9.7 per cent increase for some roles. Dental laboratory costs were estimated to have increased by 9-10 per cent and materials by 6 per

cent. It said that while some larger groups may have hedged energy costs, others reported increases of 16 per cent. It also noted an increase in the cost of borrowing.

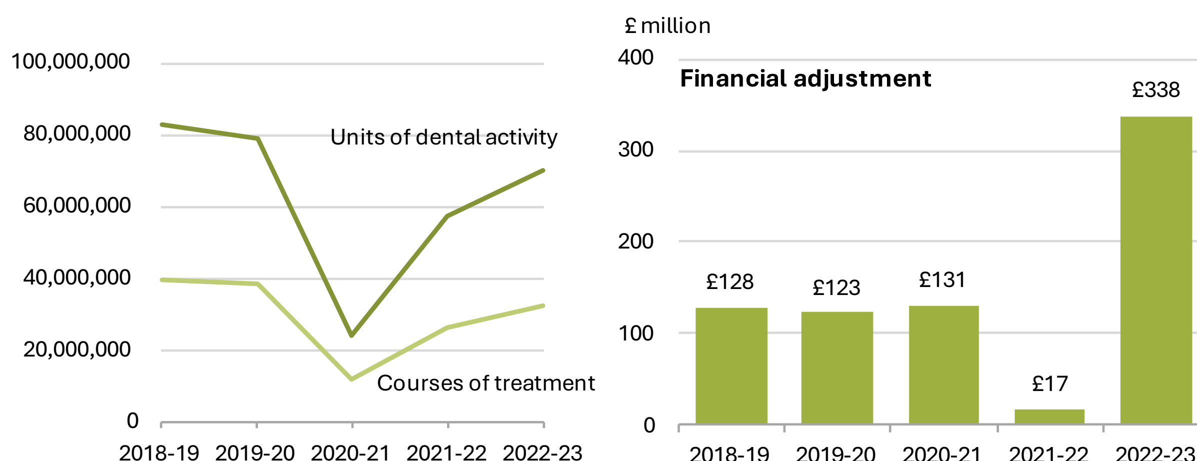
5.79 The BDA said that it was extremely frustrating that, despite the DDRB's clear view that practice operating cost uplifts should be agreed by negotiation and on the basis of reflecting increases experienced in the cost of care, none of the four governments approached the process in this way. It said that all four governments again indicated that affordability was the principal criterion in their decision-making.

Dental contracts in England

5.80 Funding for NHS dental practices comes from a combination of payments from NHS England and patient charges. From 1 April 2023, ICBs took on delegated responsibility for commissioning primary care dental services from NHS England. The DHSC said that total funding for primary care NHS dentistry in 2022-23, including community dental services and secondary care, was over £3.3 billion.

5.81 NHS primary care dentistry in England is delivered through contracts structured around UDAs – each treatment is allocated a number of UDAs in proportion to the complexity/amount of work required. Commissioners negotiate contracts with practices to deliver a certain number of UDAs each year. Where a contract holder has delivered less than 96 per cent of contract value, funding for the under-delivery is recovered in the following financial year. NHS England said this was used for other local NHS priorities. This performance adjustment (known as clawback) totalled £338 million in 2022-23.

Figure 5.12: Dental activity and performance adjustment, England, 2018-19 to 2022-23



Source: NHS England.

Note: The performance adjustment includes underperformance, payments where a contract has exceeded the contract value by up to 2 per cent and any other adjustment to contract values. This is on an accruals basis.

5.82 The BDA said it became clear there were significant problems facing practices in fully restoring their NHS activity to pre-pandemic levels throughout 2022-23 and that there would be very high levels of clawback. It said this was due to patients presenting with higher need, the extreme difficulties that practices faced in recruiting and retaining associates to perform NHS work, as well as challenges with other practice staff, notably dental nurses. The BDA said that, following the end of the financial year, NHS England agreed to lower the delivery threshold for the full year to 90 per cent. The BDA said this mitigated the levels of clawback, so that some practices no longer needed to repay funds, but there were still a significant number of practices that repaid substantial financial sums.

5.83 The DHSC said there was a 5.13 per cent uplift to dental contract values in 2023-24, backdated to 1 April 2023. It said that while pay elements in contracts were uplifted in line with the DDRB recommendation, expenses were uplifted in line with inflation calculated using the [forecast] GDP (gross domestic product) deflator from November 2022. The final uplift figure combined these based on the proportion of pay and expenses in the contract. The DHSC said it formally consults with the BDA on the uplift proposals each year before implementing them. The BDA said it was consulted, but the DHSC was unwilling to entertain serious negotiations.

Table 5.8: Increase in annual contract value, England, from 1 April 2023

Element	Weighting	Value	Source	Weighted value
Income	46.6%	6.00%	DDRB	2.80%
Staff costs	22.0%	6.00%	DDRB	1.32%
Laboratory costs	6.0%	3.23%	GDP deflator November 2022	0.19%
Materials	6.6%	3.23%	GDP deflator November 2022	0.21%
Other costs	18.8%	3.23%	GDP deflator November 2022	0.61%
Total				5.13%

Source: DHSC.

Note: GDP is gross domestic product.

5.84 The BDA said that the process for applying uplifts to dentists' contracts and salaries had been unacceptably and unnecessarily delayed. It said that implementation was further delayed for GDPs by the need to determine the practice operating costs element. The BDA said there was a real impact on morale from this ongoing disregard for the profession. It said that delayed uplifts also brought challenges to practices' financial sustainability and dentists' personal finances.

5.85 The Health and Social Care Select Committee report said that the DHSC and NHS England must urgently implement a fundamentally reformed dental contract, not only to address the crisis of access in the short-term, but to ensure a more sustainable, equitable and prevention-focused system for the future. It said this should be characterised by a move away from the current UDA system, in favour of a system with a weighted capitation element, which emphasised prevention and person-centred care. This should be based on the learnings from the Dental Contract Reform Programme and in full consultation with the dental profession.

5.86 The DHSC said it was 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. It said there were advantages and disadvantages to all payment models. It had previously tested a prototype system with a mix of capitation and treatment activity. The data on access after three years of this system showed a reduction in patients cared for to 91 per cent of the pre-prototype baselines. It said it must therefore proceed with care, and co-design any changes with the sector, to avoid reductions in access to care.

5.87 The BDA said that discussions about further contractual changes had taken place since September 2022. The BDA said it wished to move to a capitation-based contract. It said that NHS England had been unwilling to consider this and had insisted the focus was on changes that could be made within the existing contract, in particular around high needs patients and how working for the NHS could be made more attractive to dentists.

Dental contracts in Scotland

5.88 The Scottish Government said that major payment system reform for dental practitioners came into force on 1 November 2023. This had a blended model of payment, which included item of service, capitation, and a wide range of allowances. The BDA said that a bridging payment was made uplifting fees by a multiplier of 1.2 for three months from 1 October 2022 then 1.1 up to April 2023.

5.89 The payment reform was intended to sustain NHS dental services and provide equitable access. Reform was through the fee per item structure and the introduction of a single capitation payment for all registered patients. The Scottish Government said this was a major change to the levels of trust expected from dental contractors, through a move away from a prescriptive range of fees towards a modernised clinical approach and lower bureaucracy.

5.90 The new payment model reduces the number of care and treatment items from approximately 700 to 45, allowing improved clinical freedom and delivery of care based on patient need. Alongside this, a single capitation payment replaced the previous capitation and continuing care arrangements. The Scottish Government said it was important to note that payment reform was not contract reform because it did not have contractual arrangements with independent dental contractors. The payment reform was subject to discussion and negotiation with BDA Scotland.

5.91 The BDA said that the Scottish Government applied the DDRB's 6 per cent recommendation to gross item of service fees, capitation and continuing care payments. The BDA said that the Scottish Government did not discuss this with them.

Dental contracts in Wales

5.92 In 2022-23, nearly 1.4 million courses of treatment were recorded in Wales, a third (29.4 per cent) more than in 2021-22, but nearly 42 per cent lower than in the year prior to the pandemic (2019-20). Each dentist completed an average (mean) of 946 courses of treatment in 2022-23. This was 28.1 per cent higher than in 2021-22, but 42.7 per cent lower than 10 years ago. The Welsh Government said that, with the majority of practices now working under contract reform variation arrangements, it was difficult to compare activity on a like-for-like basis.

5.93 A new dental contract was introduced from April 2022 in Wales, which reduced the reliance on UDAs and focused on providing preventive dental care for a set number of patients for the annual contract value instead. Practices were required to see a given number of new NHS patients. For 2022-23, around 89 per cent of the total dental contract value commissioned in Wales was under the contract reform variation, dropping to 83 per cent in 2023-24.

5.94 The Welsh Government said that financial sanctions (clawback) were applied to 166 of the 391 contracts in place during 2022-23; 62 per cent of contracts that remained on the UDA contract were subject to sanctions compared to 37 per cent of contracts under reformed arrangements. The value of sanctions imposed was £8.7 million, around 7 per cent of the total net spend on General Dental Services (GDS) contracts in 2022-23. The Welsh Government said that funding returned as a result of financial sanctions could be used by health boards to re-invest in dental services.

5.95 The BDA said that approximately 80 per cent of practices in Wales took up the offer of the new variation of contract.[51] The BDA said it supported a preventative-based contract but had strong misgivings about the untested volumetrics and targets that comprised the contract variation offer for 2022-23. It noted a large increase in practices handing back or reducing the value of their NHS contracts in 2022-23 to the value of £8.25 million, compared to £0.68 million in 2021-22. The BDA said that the total of clawback and contract handing back totalled £16.6 million in 2022-23, 10.4 per cent of the GDS dental budget of £160 million.

5.96 The Welsh Government said that negotiations for a substantive dental contract started in September 2023 and were expected to continue to Spring 2024, with a new contract available from April 2025 provided negotiations were completed before June 2024. The way in which the annual uplift was negotiated and applied including the expenses element were included within the negotiation mandate.

5.97 The Welsh Government said that the DDRB recommendation of a 6 per cent pay uplift was unaffordable. A 5 per cent uplift to GDS contract values (to cover pay, staffing costs and expenses) was backdated to 1 April 2023 and implemented in January 2024, with links to quality improvement activity. The Welsh Government said that this was a significant change in the way in which the GDS annual uplift was awarded. It said that Ministers had been clear that pay awards for independent contractors were contingent on a wider package of reform and policy aims. It said this was the established process for the three other contracted professions (general practice, pharmacy and optometry).

Dental contracts in Northern Ireland

5.98 The Department of Health in Northern Ireland said that the number of dental practices had decreased by nine (-2.4 per cent) since 2020 and by 17 (-4 per cent) since 2014. The number of dental treatments carried out increased in 2022-23. The number of patients seen was up by 30 per cent compared to 2021-22. However, this was still 24 per cent lower than pre-pandemic figures. The Department said that GDS activity was plateauing at around 70-80 per cent of the pre-pandemic level, peaking at 84.2 per cent in January 2023. The impact for registered patients was longer waiting times and for unregistered patients it was a lack of access.

5.99 The current GDS arrangements in Northern Ireland were introduced in 1990 using a blended system of remuneration. Items of service payments account for approximately 60 per cent of GDP income; 20 per cent from capitation payments and the remaining 20 per cent from allowances, reimbursements, initiatives, and other payments. Since 2018-19, GDS contractual uplifts have been in line with the main DDRB recommendation.

5.100 The Department previously advised that there had been a desire to change the GDS contract to one more focused on prevention than treatment. Since the pandemic, the focus has been to rebuild General Dental Services so that the immediate oral health needs of the public were met and increasing activity as much as possible given the backlog in care.

5.101 In the absence of a Minister, and given the financial pressures the Department was facing, the ability to make significant changes had been limited. Officials were engaging with counterparts in Scotland (where a similar blended contract was in place), which announced

[51] The Welsh Government said last year that practices could opt into a variation of their contract that significantly reduced the reliance on the UDA as the principal measure of dental activity. Practices on the reformed contract were required to see a given number of new NHS patients, in order to improve access. The reformed contract had 25 per cent of activity allocated to existing metrics based on the UDA and 75 per cent of activity allocated to new metrics.

significant changes to the payment model from November 2023. Efforts were underway to model and cost this type of reform in the Northern Ireland context. The Minister confirmed a 6 per cent pay uplift for dentists for 2023-24 in March 2024.[52]

5.102 The BDA said that a chasm had emerged between the fees paid for health service dentistry and those paid for private work. It said that growing costs could not be recouped from static fees so dentists were necessarily focusing less on health service work. The BDA said that the actions and inactions of the Department of Health had disincentivised dentists from delivering health service dentistry and that without a vastly improved budget settlement/cash injection, the outlook for health service dentistry in Northern Ireland was critical.

Motivation, morale and wellbeing

5.103 The dental working patterns survey asked whether dentists felt good about their job. The proportion of positive responses from principal dentists for 2022-23 was: 44.3 per cent in England; 41.9 per cent in Scotland; 34.0 per cent in Wales; and 47.9 per cent in Northern Ireland. Compared with the 2019-20 survey (the last time the survey was conducted, and prior to COVID-19), the results had worsened for England, Wales and Scotland, but improved for Northern Ireland.

5.104 Among associate dentists, the proportion of positive responses was: 45.5 per cent in England; 38.3 per cent in Scotland; 42.8 per cent in Wales; and 41.4 per cent in Northern Ireland. Compared with 2019-20, the results had worsened for England, Wales and Scotland, but slightly improved for Northern Ireland.

5.105 The dental working patterns survey also asked dentists if their job gave them the chance to do challenging and interesting work. The proportion of positive responses from principal dentists for 2022-23 was: 53.9 per cent in England; 52.4 per cent in Scotland; 52.8 per cent in Wales; and 56.3 per cent in Northern Ireland. Compared with 2019-20, the results had worsened for Scotland and Northern Ireland, but improved for England and Wales.

5.106 Among associate dentists, the proportion of positive responses to this statement was: 50.4 per cent in England; 58.6 per cent in Scotland; 45.6 per cent in Wales; and 56.1 per cent in Northern Ireland. Compared with 2019-20, the results had worsened for Wales, Scotland and Northern Ireland but were little changed for England.

5.107 The dental working patterns survey asked dentists how they rated their morale. Among principal dentists, the proportion saying their morale was high or very high in 2022-23 was: 16.2 per cent in England; 9.4 per cent in Scotland; 13.1 per cent in Wales; and 16.1 per cent in Northern Ireland. Compared with 2019-20, the results had worsened for England, Wales and Scotland but improved for Northern Ireland. The most frequently cited cause of low morale among principal dentists was increasing expenses and/or declining income.

5.108 Among associate dentists, the percentage saying their morale was high or very high was: 18.1 per cent in England; 15.2 per cent in Scotland; 18.3 per cent in Wales; and 10.1 per cent in Northern Ireland. Compared with 2019-20, the results had worsened for all four nations. The most frequently cited cause of low morale among associate dentists was risk of litigation and the cost of indemnity fees.

[52] Department of Health, *Swann invests £9m in dental access.* https://www.health-ni.gov.uk/news/swann-invests-ps9m-dental-access

5.109 The BDA survey found that 60 per cent of practice owners reported low or very low morale, up from 39 per cent in 2018. 82 per cent of practice owners with a high NHS commitment reported low or very low morale, compared to 47 per cent of those without a high NHS commitment. Among associates, 49 per cent reported low or very low morale, up from 44 per cent in 2018. 61 per cent of associates with a high NHS commitment reported their morale as low or very low, compared to 37 per cent of those without a high NHS commitment.

5.110 In the BDA survey, 76 per cent of practice owners and 49 per cent of associates working in practices with a high NHS commitment reported that they were very or extremely stressed. The greatest causes of stress among practice owners were practice costs, and staffing, recruitment and retention issues.

5.111 The Welsh Government said it remained conscious of the concerns expressed by dentists about workload, pay, operational aspects of the contract, and perceived increases in administration all of which, combined with the current inflation, placed additional financial pressures on businesses. It said it recognised that providing-performer dentists in Wales had the lowest income and some of the lowest levels of motivation and morale in the UK but noted that, at the same time, associates had the highest incomes and were among the most motivated in the UK.

Dental trainers

5.112 NHS England said that some regions had found it difficult to recruit educational supervisors and training practices for the 2022 and 2023 cohorts, with the number leaving dental foundation training exceeding the recruitment of trainers, especially in rural and coastal areas. Reasons given for leaving included the workload of training, and payment for the service component of training not having been increased since 2013 despite inflation. NHS England said that the latter was a disincentive for practices to become or carry on as a training practice and required urgent review from the relevant government bodies.

Community and Public Dental Services

5.113 The CDS in England, Wales and Northern Ireland and the PDS in Scotland provide general dental care to people who cannot be treated through practice-based GDPs. This includes those with particular dental needs, including vulnerable groups. CDS/PDS dentists are salaried and are usually managed as NHS trust employees, with their own nationally agreed pay, terms and conditions. Where applicable, CDS/PDS dentists may also have their pay and conditions aligned to other employed medical and dental staff such as consultants, depending on their post, grade or seniority.

5.114 NHS England said it had about 70 contracts that provided community dental services across 296 geographical locations; most of these were held with foundation, community and mental health trusts and the remainder with community interest companies (CICs). Those employed by NHS trusts were remunerated based on nationally agreed pay rates; those employed in CICs might be subject to different rates of pay and wider terms and conditions. CICs tended to reference the NHS bands for salaried dentists in setting their pay scales and needed to comply with the employment protections and payments laid out in the Statement of Financial Entitlements, but their pay scales would also reflect the individual contract value.

Workforce

5.115 We have minimal workforce data from any of the nations on the CDS or PDS. NHS England said this was being addressed through the new biannual dental workforce collection.

5.116 The BDA said there were falling workforce numbers and rising demand across all nations. It noted a number of community dentists carrying out roles as a specialist but appointed to the lowest grades.

5.117 In a discussion paper on the future of the CDS in England, the BDA said CDS dentists were experiencing significant increases in demand. The key causes included an ageing population and a dramatic increase in those with long-term chronic conditions. Other causes included a wider decline in overall NHS dental spend, the impact of the access crisis and spillover of demand from general dental services, and the impact of short-term approaches being adopted in the commissioning of CDS services.

Recruitment and retention

5.118 We do not have comprehensive data on recruitment or retention for the CDS or PDS in any of the nations.

5.119 Just under a quarter of trusts in the NHS Providers pay survey employed community dentists. Of these, 27 per cent said that the starting salary was creating recruitment and retention issues, 27 per cent said that it was not, and 45 per cent did not know.

5.120 NHS Employers said that several employers had faced difficulties when trying to recruit to band A salaried dentists, with adverts active for long periods without any applicants. Some employers had looked at band A positions and had developed those roles into band B to aid the attractiveness of the role to generate interest and applications. Additional funding and local incentives were often required when advertising but competing with private practices was difficult. One NHS employer described how band A dentists often left to go into dental core training posts. Due to competitive salaries in private practice, salaried dentists often left when these opportunities arose.

5.121 In its discussion paper, the BDA said that frequent re-tendering caused disruption with some services only attracting small amounts of funding for short-term projects which only allowed fixed-term contracts for staff and no continuity or retention of good clinicians. It also said that coastal and rural areas struggled to attract the dental workforce which caused additional challenges to service provision.

5.122 The Association of Dental Groups said that there had been a noticeable drop in the number of applicants applying for CDS roles in recent years, in particular for dentists and therapists, especially in more rural areas. CDS providers were having to accommodate more flexibility into roles, potentially adding costs both in the recruitment processes and in ongoing salary and related costs.

5.123 The Department of Health in Northern Ireland said there were anecdotal reports that applications for CDS posts had increased compared to previous years. It said that, since the introduction of the new CDS contract in Northern Ireland in 2019, the starting salary for a dental officer was very competitive to young associates, along with the other benefits of being employed, such as annual leave, sick pay and a training allowance. The ability to negotiate part-time working hours was also a significant benefit, as well as no requirement for on-call or weekend cover. However, a number of trusts in Northern Ireland noted that recruitment within the CDS had become increasingly challenging with the process itself taking a significant period of time. This resulted in prolonged periods of unfilled posts which had a detrimental impact on patient care, productivity and staff morale. It was noted that differences in pay and conditions between the nations of the UK had grown wider and that CDS posts in Northern Ireland needed to have parity with the rest of the UK both to attract new staff and to

encourage retention of existing staff by enhancing career progression, increasing the number of senior posts, training pathways and specialist grades.

Pay

5.124 The pay structure for CDS dentists in England was introduced from April 2008 and consists of three pay bands covering: dentists, senior dentists; and specialist/managerial dentists. Each pay band has six pay points and the dentist needs to demonstrate the competencies for the post to move through the band. The other nations have a similar structure, although there are two senior pay bands in Northern Ireland.

5.125 We do not have data on actual earnings of those in the CDS or PDS for any of the nations. The pay band of £47,653 to £71,749 in England (for 2023-24) compares to average associate dentist earnings of £64,900 in England (for 2021-22) and an inter-quartile range of £37,600 to £82,600. The latter is two years earlier and will include part-time working.

5.126 In the NHS staff survey for England, 35 per cent of salaried primary care dentists said they were satisfied with their pay, a decrease of 4 percentage points from 2022 and 17 percentage points since 2020. This compared to 32 per cent of all medical and dental staff in 2023.

5.127 The BDA reported that 80 per cent of community dentists in England were dissatisfied with their pay, compared to 50 per cent in 2021. The BDA said that many dentists could not consider the CDS as a career option after core training because the pay in comparison to other parts of dentistry was poor.

Motivation and morale

5.128 The NHS staff survey for England showed significant declines in the engagement and job satisfaction scores for salaried primary care dentists in 2023, compared to small increases for the medical and dental workforce as a whole. For example, 56.4 per cent of salaried primary care dentists said they were enthusiastic about their job in 2023, compared to 67.2 per cent in 2022. The positive response for all medical and dental staff increased from 65.0 per cent in 2022 to 66.9 per cent in 2023.

5.129 The BDA survey highlighted particular problems in the CDS/PDS:

- In England, of a lack of staff, increasing workload, and poor leadership/management culture.
- In Scotland, of poor job satisfaction, low morale, and increased workload and stress.
- In Wales, of a lack of staff which was creating capacity issues, poor working conditions, and a lack of career structure and development.
- In Northern Ireland, of workload pressures, pay (in particular the lack of a 2023 uplift), and staffing levels.

Wellbeing and workload

5.130 The proportion of salaried primary care dentists reporting in the NHS staff survey that they were able to meet all the conflicting demands on their time at work was unchanged at 34.1 per cent in 2023 and was at a similar level to all medical and dental staff (34.4 per cent). Just under half, 46.8 per cent, of salaried primary care dentists reported that they achieved a good balance between work and home life in 2023, down from 50.7 per cent in 2022 and compared to 42.0 per cent for all medical and dental staff.

5.131 NHS Employers said that burnout was a key theme in how employers described their salaried dentists. One employer reported that they had put waiting list initiatives in place to try to

tackle the backlog, but after a year it was paused due to the pool of staff working additional hours reporting exhaustion.

5.132 The BDA reported from members in the CDS and PDS that they had reached breaking point after more than a decade of ever-increasing workloads and severe shortages of community dentists caused by below-inflation pay awards. The BDA said that the language being used by community dentists had now shifted further with many directly expressing anger, depression, withdrawal and hopelessness regarding the situation.

5.133 The BDA reported that CDS/PDS dentists often felt the stress associated with long waiting lists and frustration by those not able to access services such as using hospital theatres. The BDA said that increased workforce pressures from the inability to adequately plan ahead and provide patient care, while working through ever growing patient waiting lists, was causing intolerable strain.

5.134 The Department of Health in Northern Ireland said that CDS staff were reporting an increase in workload challenges including waiting list pressures and the management of increasingly complex patients with a lack of efficient referral pathways and access to consultant-led services. A number of trusts In Northern Ireland noted that challenges with the GDS contract had resulted in reduced availability of NHS dentistry and led to increasing pressures on the CDS. A substantial increase in referrals from GDS had had a knock-on effect and put additional strain on staff with no corresponding increase in manpower.

Our comments

Workforce

5.135 There are fewer dentists providing NHS services in England, Scotland and Wales than before the pandemic. More significantly, there has been a reduction in NHS working hours across all nations with dentists moving to private work. This means the UK has not returned to pre-COVID-19 levels of NHS dental activity with, for example, the number of patients seen in England in the last 12 months at around 86 per cent of pre-pandemic levels. Access to NHS dentistry continues to be poor and public satisfaction is declining.

5.136 The overall reduction in access to NHS dentistry is widely recognised and is of high public concern but we have not yet seen government policies in place sufficient to address it. This under-provision of NHS dentistry is having a knock-on effect on the Community Dental Services and on secondary care. We observe that the significant amount of funding being clawed back from dental contracts in England following under-performance is being used for other NHS priorities, rather than being invested back into the dental system.

5.137 There does not appear to be an overall problem with attracting people into dentistry as a profession: there was an increase in applications to study undergraduate dentistry and there are plans to increase dental training places from 2026. However, there is broader evidence that younger dentists do not want to work in the NHS but instead are training for a career spent predominantly in private practice which uses all the skills they learned at dental school; for example, practices with higher NHS commitments are finding it harder to recruit associate dentists. The UK government is trying to address this by proposals to ensure that graduate dentists spend at least some of their time delivering NHS care in the years following the completion of training.

5.138 We are concerned to see evidence of worsening motivation and morale among NHS dentists across most nations. A low propotion of both contractor and associate responses to the dental

working hours survey felt pay was fair, although this has not changed significantly since 2019. However, a BDA survey found that views on the fairness of pay were significantly worse among practices with a higher proportion of NHS work.

5.139 It is clear to us that the current contractual arrangements are not enabling NHS dentistry to be sustained or to grow, partly because recently qualified dentists are increasingly choosing to work outside the NHS. We have repeatedly highlighted this as an area of concern and no successful attempt has been made to address the contractual framework. Despite an understanding of these issues, policies to address them have been piecemeal. We strongly recommend that governments embark on a programme of modernisation and contractual reform, starting from the position of what they want the provision of NHS dentistry to be.

Earnings

5.140 There has been strong growth in GDP earnings in the latest two years of data (for 2020-21 and 2021-22) which are available to us. Given the decreasing amount of NHS work performed, this increase is likely due to private work. We note that GDP earnings have kept pace with, or increased, relative to all employees in recent years, although they are slightly behind their market comparators. We note the broad range of earnings across GDPs which may reflect the variation in business models.

5.141 The level of GDP earnings is fairly similar across nations. However, there is significant variation in earnings growth both year-to-year and between nations, and earnings growth has been above our recommendations in recent years. This may be due to contractual differences, varying levels of COVID-19 support, or changes in the balance of NHS and private work. Given the NHS and private work are not separated out in the HMRC data, it is difficult for us to understand the earnings dentists are receiving for the NHS part of their work, and how this is changing.

5.142 Dentists have made clear to us that they have seen a significant increase in costs since 2021-22, which has not been met by contractual uplifts for their NHS work. The impact of the particularly high inflation of recent years will not yet be reflected in the earnings data available to us. Combined with a lack of visibility over the balance between NHS and private work and its relative profitability, this makes trying to make a single appropriate pay uplift recommendation especially challenging.

Community and Public Dental Services

5.143 We are especially concerned about the issues of rising workloads, falling staff numbers and worsening morale in the Community and Public Dental Services. Despite our request last year, we received a disappointing lack of evidence on workforce trends, recruitment and retention. This is an important service delivering care to an increasing population of vulnerable patients and the lack of evidence makes it hard for us to make appropriate pay recommendations. We would like to explore the workforce issues for this important service in more detail next year.

Data concerns

5.144 We welcome the recently published dental working patterns survey and hope that it continues to be an annual publication. However, the data on recruitment and retention of GDPs is relatively weak. NHS England has recognised this and has said this is being addressed. We would like to receive better data next year on joiners and leavers from the dental workforce and evidence on job vacancies, in addition to the concerns around earnings data outlined above.

Chapter 6 Looking forward

6.1 I this final chapter we look ahead to some of the challenges facing our remit group, as well as some of the key developments that are likely to be important to our consideration of recruitment, retention, motivation and morale in the coming years. We also discuss some of the things we wish to see covered in the parties' evidence submissions for next year's report.

DDRB reform

6.2 Changes to the way we operate were made as part of the agreement between the UK government and consultants in England. The changes are effective for our next round and fall into five areas:
- The process for appointing DDRB members.
- Terms of reference.
- Remit letters.
- The timetable for the pay round.
- The data submitted in evidence.

6.3 The Government said it was committed to ensuring that the pay setting process and the DDRB operated effectively and independently to maintain the confidence of the relevant professions and stakeholders. It said that it recognised that all parties' input to the pay-setting process – from the point at which remit letters are prepared onwards – should be made in this spirit, and in support of a shared commitment to use the process to maintain positive industrial relations. We note that as part of this reform the Government has also agreed to make changes to the DDRB appointments process including greater involvement from the trade unions.

6.4 It is disappointing that there was not a broader discussion across all parties of the changes agreed to the DDRB process, in particular the devolved nations. We are a UK-wide body and need to respond to the requirements of all four nations. The Scottish Government in particular said the time was right for a four-countries review of the process to work collectively to address the concerns of stakeholders and bring back faith in the DDRB from the profession. We were also disappointed that we were not consulted on the changes in the terms of reference or other changes to the DDRB process.

6.5 We are aware that a lack of confidence in the terms of reference for the DDRB has been raised by some parties, so it is a positive step that the new terms of reference have been agreed by the unions, alongside the UK government.

6.6 The revised terms of reference are set out in box 6.1. Specific additional factors to be considered in making our recommendations are:
- The need to attract, recruit, retain and motivate doctors and dentists, including consideration of local and regional labour market factors, in view of their contribution to the health of the nation.
- Developments in doctors' and dentists' earnings in the context of long-term trends in the wider labour market, alongside comparator professions, including relevant international comparators.

6.7 Following the publication of this report, we will undertake the preparatory work required to put us in a position to work to these new terms of reference from the start of the 2025-26 pay round. We would like to hear all parties' views of the significance of the changes to our terms of reference and how they might operate in future. It will be important to consider these

before we commence our next round, so we will be looking to consult with parties later this year.

Box 6.1: Our revised terms of reference for the 2025-26 pay round

The Review Body on Doctors' and Dentists' Remuneration was appointed in its current form in July 1971. Its terms of reference were introduced in 1998, and amended in 2003, 2007 and 2024 and are reproduced below.

The Review Body on Doctors' and Dentists' Remuneration is independent. Its role is to make recommendations to the Prime Minister, the Secretary of State for Health and Social Care, the First Minister and the Cabinet Secretary for NHS Recovery, Health and Social Care of the Scottish Government, the First Minister and the Minister for Health and Social Services of the Welsh Government and the First Minister, Deputy First Minister and Minister of Health of the Northern Ireland Executive on the remuneration of doctors and dentists taking any part in the National Health Service.

In reaching its recommendations, the Review Body is to have regard to the following considerations, evaluating the weight of each independently, in parallel and non-contingently:

- The need to attract, recruit, retain and motivate doctors and dentists, including consideration of local and regional labour market factors, in view of their contribution to the health of the nation.
- Developments in doctors' and dentists' earnings in the context of long-term trends in the wider labour market, alongside comparator professions, including relevant international comparators.
- Economic and other evidence submitted by the Government, and the funds available to the Government Health Departments.
- Economic and other evidence submitted by staff and professional representatives, and others.
- Wider macroeconomic factors.
- The overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.
- The legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief, and disability.

The Review Body may also be asked to consider other specific issues, where agreed by relevant unions and the Government.

These Terms of Reference are intended to give all parties, including the remit groups, confidence that the Review Body's recommendations have been independently, properly and fairly determined.

Reports and recommendations should be submitted jointly to the Prime Minister, the Secretary of State for Health and Social Care, the First Minister and the Cabinet Secretary for NHS Recovery, Health and Social Care of the Scottish Government, the First Minister and the Minister for Health and Social Services of the Welsh Government, and the First Minister, Deputy First Minister and Minister of Health of the Northern Ireland Executive.

Source: DHSC, Offer for the consultant workforce in England, March 2024.

6.8 It was also set out in the consultants' agreement that remit letters from the UK government will not include information about inflation and wider economic performance, which will instead be addressed through government evidence. We note this approach was taken by the UK government for the current pay round.

6.9 While remit letters signal the formal start of the round and confirm that the governments are requesting a recommendation and providing evidence, our process and decision making are driven by our terms of reference, based on the evidence provided by all parties, and not necessarily constrained by the remit letters.

Timing of the round

6.10 The ongoing late implementation of pay uplifts, and the negative financial impact for individuals and employers, was discussed in chapter 1. It is frustrating that, despite a recognition from all parties of the damaging impact of late payment, this year's round has lagged even further behind last year. We understand that industrial disputes have not helped with this. Our Chair wrote to the Prime Minister in February to raise our concerns about delays to government evidence and the subsequent damage to the pay setting process.

6.11 The consultants' agreement said that the parties would agree a timetable which would see awards announced earlier than in recent years and which the Government would use its best endeavours to meet. As part of this, the Government agreed that it would look to implement the outcome of each year's DDRB process as soon as practically possible, with the aim of the pay award being known at the start of the financial year from the 2025-26 pay round.

6.12 We fully endorse this proposal and would expect parties to consult and agree on a timetable as soon as possible that will enable our recommendations to be submitted, agreed and implemented as close to the start of the financial year and the 1 April effective date as possible. This is likely to require remit letters by September 2024 at the latest and the submission of written evidence in the autumn. This means a heightened commitment from all parties will be necessary to deliver what is agreed would be a significant improvement and would enable our remit group to receive their 2025-26 pay award on time. Committing to an earlier timetable in future will reinforce the need for evidence from all parties to be received timeously.

Participation in our process

6.13 Our consideration of written evidence, and the opportunity to hold oral evidence with all parties, are vital parts of our process and enable us to make balanced and informed recommendations. It was particularly regrettable this year that we did not receive written evidence on doctors and dentists in training from the British Medical Association in any of the nations. We do not believe it is in the best interests of our remit group members for their views not to be fully represented in the process that is setting their pay. We hope that all parties will submit comprehensive written evidence and play a full part in the pay-setting process next year.

Our approach to pay comparability

6.14 As set out in chapters 3, 4 and 5, we currently examine trends in pay for doctors and dentists in three main ways. We consider how earnings have evolved relative to the pay distribution across the UK economy; how real terms pay has changed over time; and how pay compares to comparator professions. Our pay comparability methodology for the latter was last reviewed

by the Institute for Employment Studies in 2017.[53] We will consider whether this methodology needs to be updated for future rounds.

6.15 Our terms of reference for 2025-26 ask us to consider local and regional labour market factors and international comparators. We will consider how best to achieve this as part of our preparations for next year's pay round.

Workforce planning

6.16 The publication of the Long Term Workforce Plan for England was an important and positive step forward and we welcome it. We make a number of observations:

- We expect to see detailed action plans, specific to individual workforces, as well as the plan for ongoing monitoring, in future years.
- There is a need for substantial commitment to the NHS workforce in the next Spending Review if the Plan is to be delivered.
- There needs to be much more detailed planning around the demand for medical specialties, and how this matches to the current ambitions of doctors in training.
- The Plan predicts a decreasing reliance on internationally qualified doctors. Given this is in contrast to the increasing dependence on internationally qualified doctors in recent years, we expect to see details set out on how this will be achieved.
- Many parties have suggested that the productivity targets required by the Plan are unrealistic. Productivity gains typically require members of the workforce to deliver more, which will require both technological improvement and capital investment to deliver. It is important to set out how structural changes to the workforce and the delivery of care might best deliver these productivity improvements.
- Significant concerns have been raised by many parties that the trainers and training infrastructure is currently insufficient to deliver the significant expansion to training places set out in the Plan. We would expect to see a far greater focus on whether appropriate reward and incentives are in place for experienced members of the medical and dental professions to deliver this training.
- There was no discussion of pay levels in the Plan and no party has indicated to us how the pay system might support this planned substantial expansion to the medical and dental workforces. The medical and dental professions will need to remain attractive to prospective applicants and appropriate incentives will need to be in place to direct doctors and dentists in training to the specialties and localities where they are needed.
- Concerns have not yet been raised about whether the expansion in medical and dental places will lead to a reduction in the quality of trainees, as currently these places are heavily oversubscribed. The expansion of medical and dental school places, and the new ways of delivering these qualifications, should provide opportunities to increase the diversity of the workforce. In particular, we would like to see opportunities taken to increase the socio-economic diversity of medical and dental trainees.
- The medical and dental labour markets across the four nations are interdependent, and we would like a greater understanding of how the Long Term Workforce Plan in England affects the other nations and how workforce planning can be complementary across the UK.

6.17 We would expect updates on workforce plans from all nations in evidence next year.

[53] Institute of Employment Studies, *Review of DDRB Pay Comparability Methodology 2017.* https://www.gov.uk/government/publications/review-of-ddrb-pay-comparability-methodology-2017

Divergence across nations

6.18 Our remit covers all four nations of the UK and we receive separate evidence on each. The labour market for medical and dental staff is both a UK-wide and an international one. When making our recommendations, however, we are cognisant of differences between the nations, in the economy, the labour market, health services and government policies. We are sensitive to flows of medical and dental staff between nations, and any differences between pay and other terms, and wish to avoid an unnecessary internal market.

6.19 In future we will continue to consider the differential positions on affordability, recruitment and retention, motivation and morale across the nations each year to see if a differential approach is required. Unwarranted pay differentials across nations are likely to create inefficient competition for specialists, and a sense of unfairness as individuals are paid differently for doing the same job. We would be keen to hear from parties about the relative importance of maintaining UK-wide reward structures versus the need to recognise and respond to the particular objectives in the health services of the four nations. We would also like evidence on how diverging contract and reward structures affect recruitment and retention between different parts of the UK.

Time out of training and locally employed doctors

6.20 Doctors are increasingly likely to take time out of training, in particular between the foundation stage and core training, and for an increasing length of time. Many of these doctors are staying with the NHS working as locally employed doctors, often locums or clinical fellows. We are also seeing increasing levels of dissatisfaction with working lives and conditions among these doctors.

6.21 The Long Term Workforce Plan recognised that locally employed doctors were a huge asset to the NHS. The Plan said there was a commitment to review medical career pathways and identify ways to better support postgraduate career progression for locally employed doctors, including routes to progress their careers into high demand specialties. However, NHS Employers noted that many locally employed doctors left within the first 12 months of their contract, often to enter postgraduate training. This created a constant cycle of recruitment and induction which generated a large administrative and financial burden for employers.

6.22 Three-quarters of doctors stepped out of training after completing the foundation stage in 2022. While many are doing this for personal reasons, and some because they need a break from the training environment, we are concerned that increasing numbers of doctors are taking time out of training because they have not secured a training place. At the same time, increasing proportions of the less popular training specialties, in general practice and psychiatry, are being filled by international medical graduates.

6.23 We would like to better understand whether the increasing number of locally employed doctors represents a positive development. While this group provide a flexible resource for trusts and health boards, a break from training for doctors and a chance to find the training place they desire, the growing numbers may reflect a mismatch between the demand for and supply of speciality training places, a restriction to the supply of consultants and specialist doctors and create unnecessary churn in the workforce.

6.24 A first step towards this would be to better identify locally employed doctors, and doctors taking time out of training, in the workforce data. We support the joint work proposed in the recent offer to SAS doctors to better understand the make-up of the locally employed workforce.

SAS contracts

6.25 The issues with the new (2021) SAS contracts in England, Wales and Northern Ireland are well understood: some of the pay points on the open 2021 contract are lower than on the closed 2008 contract; and the top 2008 specialty doctor pay point is above the bottom 2021 specialist pay point. Along with differences in the scope of plain time, these are disincentivising doctors to move from the old to the new contracts.

6.26 The recent agreement with SAS doctors in England makes progress to address the pay structure issues. We hope that the issues can be similarly addressed in Wales and Northern Ireland. We would hope to see increasing numbers of doctors move to the new contracts and would therefore expect to see figures on this in all nations for our next round.

Consultant reward schemes

6.27 We have not made a recommendation again this year on clinical excellence awards, clinical impact awards, commitment awards, distinction awards or discretionary points. There are a number of reasons for this: the schemes are in transition in some nations; we were explicitly asked not to make a recommendation for some schemes, such as distinction awards and discretionary points in Scotland; and we did not receive enough evidence on the operation of the clinical impact awards scheme in England and Wales to draw conclusions.

6.28 For our next round, it would be useful to have clear direction from Scotland, Wales and Northern Ireland on approaches to discretionary pay in future. For clinical impact awards, we would like to see evidence on their effectiveness and equality outcomes, including the impact on patient care and productivity, with a view to making a recommendation on this scheme next year.

Reporting on equalities

6.29 We received a disappointing lack of evidence on the gender pay gap in secondary care this year. Given the very positive developments in this area recently, with the Mend the Gap report and the recent consultant pay restructuring, we would like to receive more evidence on gender pay gaps across the secondary care workforce next year. We would also like to be updated on progress on ethnicity pay gap reporting, which was not addressed in evidence this year.

6.30 We would like to receive evidence on the socio-economic background of the medical and dental workforces, and how the expansion of training places will be used as an opportunity to increase social diversity.

General medical practitioners

6.31 We would like to receive stronger evidence on the recruitment and retention of general medical practitioners (GPs), such as data on job vacancies. We have been given anecdotal evidence of falling GP vacancies and it is important to understand the reasons behind this. It would also be valuable to have a greater understanding of GPs' decisions around working hours, and how this relates to pay. We have seen falling numbers of GP partners in recent years, despite rising earnings, and we would like to understand the risks this poses to the overall general practice model.

Earnings and expenses

6.32 For both GPs and general dental practitioners (GDPs), one issue we have particularly encountered this year is that the lag in the provision of earnings data prevents us from

understanding recent trends. This has been a significant issue at a time of high inflation. COVID-19 payments also prevent us from seeing the underlying trend in incomes. Some GPs and GDPs have told us they face rising costs and falling incomes, to a level at which their NHS practice is endangered, but we do not have robust data on this. We would like to explore if it is possible to have an earlier indication of GP and GDP earnings, possibly through Integrated Care Board data collection.

6.33 We have been concerned for some years that the process by which expenses uplifts are determined for GPs and dentists is not functioning effectively. This has become especially stark during the recent period of rapidly rising costs. We would like governments to explore a mechanism that ensures contract uplifts are sufficient both to ensure that our pay recommendations are delivered and to ensure that funding is sufficient to meet average cost increases over the medium term. We will also be looking closely at the earnings and expenses data for 2022-23, due to be published in the summer of 2024, to see how GP and dental incomes have changed.

General dental practitioners

6.34 We welcome the recently published dental working patterns survey and hope this continues to be an annual publication. This confirms the falling amount of NHS work by dentists and the relative increase in private work. While the under-delivery of NHS dentistry across all four nations is a well-recognised concern, a critical step in resolving this is broader contract reform. We would, however, like to better understand how our recommendations can contribute to incentivising NHS dentistry.

6.35 The data on recruitment and retention of GDPs is relatively weak. NHS England has recognised this and has said it is being addressed. We would like to receive better data next year on joiners and leavers from the dental workforce and evidence on job vacancies. Furthermore, as NHS and private work is not separated out in HMRC earnings data it is very difficult for us to understand the earnings dentists are receiving for the NHS part of their work, and how it is changing, and to make appropriate recommendations to incentivise NHS work.

Community and Public Dental Services

6.36 We have once again received a disappointing lack of evidence on the Community and Public Dental Services. This is an important service delivering care to an increasing population of vulnerable patients and the lack of evidence makes it hard to us to make appropriate pay recommendations. We would like to receive data on the number of dental employees, their grades and earnings, data on leavers and joiners, vacancies, working hours, activity and waiting lists. We hope that the forthcoming national dental workforce collection will address these issues for England, and we would also like to receive better evidence in this area from the other nations. In particular, we would like a review of whether the current reward system supports service delivery and career progression. It has been suggested to us that the starting salary is too low to support recruitment, for example, and we would like to see evidence on this.

Pensions

6.37 The last year has seen significant changes to pension taxation, making the regime considerably more generous for higher earners, and reforms to enable greater flexibility around retirement. We have been told by parties previously that pension taxation and the structure of the pension scheme were discouraging additional work and incentivising earlier retirement. The recent changes should incentivise senior doctors and dentists to continue working rather than taking full retirement. It has been too soon this year to see any clear

impact in the data, and we hope this will be closely monitored in the near future. We have heard on our visits that the pension taxation regime had stopped consultants from taking on additional programmed activities; we would like to see data on how this trend has changed over time.

6.38 We note the small falls in pension scheme membership. We might expect membership to grow among the consultant workforce following the pension taxation changes that make it more valuable to stay in the scheme. The fall in pension scheme membership among those in core training in England is starker, at 11 percentage points over five years and 14 percentage points over 10 years. While the DHSC has reported that this is related to the increase in international recruits, the BMA have pointed to the cost of living and the high level of employee pension contributions. We think it is important this is explored further.

6.39 The rollout of the McCloud remedy is creating a degree of uncertainty over pension values, in particular around pension taxation. It would be helpful to understand how this is affecting individuals and their retirement decisions.

Fees, grants and additional payments

6.40 Doctors and dentists can claim a range of fees, grants and additional payments for specific work and activities. These include payments such as dispensing fees and GP appraiser fees. We have not made recommendations on these as we have not received adequate evidence on their value, scope, cost or purpose. We would expect the four nations to regularly review the purpose and level of all fees, grants and additional payments to ensure that they are set at the appropriate level to ensure that they achieve their objectives, and that doctors and dentists are suitably attracted to performing these roles.

Future data and evidence requirements

6.41 In addition to the areas covered above, there are a number of specific areas where we would welcome data and evidence from the parties. This is in addition to what we normally receive.

Table 6.1: Further data and evidence requirements

Area	Data and evidence requests
Context	• Updates on the progress of the Gender Pay Gap Review Implementation Panel. • Ethnicity pay gaps across all medical and dental workforces. • Socio-economic background of medical and dental workforces.
Secondary care workforces	• Vacancy data across the main workforce groups in each nation. • Staff survey results in Scotland, Wales and Northern Ireland that identify doctors and dentists separately. • Specific recruitment and retention challenges associated with land borders and contractual differences between different parts of the UK, and between Northern Ireland and the Republic of Ireland. • Flows of medical and dental staff to and from other countries. • Spend on temporary medical and dental staff as a proportion of the overall paybill. • Data on how doctors progress through the stages of training. • Evaluations of the financial initiatives in place to incentivise working in particular areas or specialties, including flexible pay premia in England, TERS in England, Scotland and Wales, and Foundation Priority Programmes in England. • Actions to improve the trainee experience. • Uptake of the new SAS contracts across all nations, and actions being taken to ensure that the benefits of contract reform are realised. • The number of specialist posts created. • Average working hours for the main workforce groups. • The average number of programmed activities and supporting professional activities worked by consultants over time. • Equalities and outcomes data for consultant reward schemes. • The number of doctors on local contracts and their terms and conditions. • The impact of changes to the pension regime on the retention of senior doctors and dentists.
Primary care workforces	• Leavers and joiners, turnover and vacancies in the GP and GDP workforces. • Average retirement ages for GPs and GDPs. • Pay awards for salaried GPs. • Whether the salaried GP pay range is set appropriately. • Number of GPs and GP appointments in the private sector. • Number of dental employees, grades, working hours and earnings in CDS/PDS. • Leavers and joiners, turnover and vacancies in the CDS/PDS.

Appendix A Remit letters

Department
of Health &
Social Care

From the Rt Hon Victoria Atkins MP
Secretary of State for Health and Social Care

39 Victoria Street
London
SW1H 0EU

020 7210 4850

21 December 2023

Dear Mr Pilgrim,

I would firstly like to offer my thanks for the Review Body for Doctors' and Dentists' Remuneration's work over the past year on the 2023-2024 report. The Government appreciates the independent, expert advice and valuable contribution that the DDRB makes.

I write to you now to formally commence the 2024-2025 pay round. I am asking you to provide recommendations in line with your terms of reference and would welcome your report by May 2024.

As you will be aware, the Government has recently been involved in talks with various medical groups. In the case of consultants, this has resulted in an offer around pay scale reform that has been put to members. This offer does not affect the pay award consultants received this financial year and should not interfere with your recommendations for 2024-25. In the case of ongoing talks, these should also not impact on your recommendations.

With that in mind, we invite you to make recommendations on an annual pay award for all doctors and dentists, including contractor General Medical Practitioners.

For Specialty Doctors and Associate Specialists (SAS), you will be aware of the multi-year pay and contract reform deal agreed with the British Medical Association (BMA) in 2021. SAS doctors on the 2021 contract are no longer in a multi-year pay deal so I invite you to make recommendations for all SAS doctors.

Independent contractor General Medical Practitioners are no longer subject to a five-year pay agreement between NHS England and Improvement and the BMA. We invite you to make recommendations on uplifts for General Medical Practitioner contractors.

As always, whilst your remit covers the whole of the United Kingdom, it is for each administration to make its own decisions on its approach to this year's pay round and to communicate this to you directly.

I would like to thank you again for your and the Review Body's invaluable contribution to the pay round and look forward to receiving your report for 2024-2025 in due course.

Yours ever,

RT HON VICTORIA ATKINS MP

From the Permanent Secretary
and HSC Chief Executive

Christopher Pilgrim
Chair of the Review Body for
Doctors' and Dentists' Remuneration
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2-6 Salisbury Square
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Our ref: SSUB-0015-2024

Date: 10 January 2024

Dear Mr Pilgrim

DDRB 2024/25 PAY ROUND

I am writing to formally commence the 2024/25 pay round for doctors and dentists in Northern Ireland. I wish to begin by thanking the Review Body for Doctors' and Dentists' Remuneration (DDRB) for its invaluable work on the 2023/24 pay round.
The Department of Health welcomed the recommendations and observations from the Report.

I previously wrote to you in August this year to advise of the ongoing challenging outlook for our financial position, and to confirm that it would remain my intention to recommend acceptance of the recommendations contained in the 51st Report, should an Executive be restored and sufficient funding secured. As the Executive is yet to reform the position remains unchanged. We are also mindful of further proposals resulting from negotiations between the UK Government and the BMA.

It is recognised that this is not the position we would want to be in: appropriate reward and recognition for our staff is clearly an important part of demonstrating that we value the work that they undertake. I continue to look at what we can do in the current situation.

I do, however, want to emphasise that the work of the Doctors' and Dentists' Pay Review Body in providing recommendations will be of great value to the Department. That will become most evident in the event of any prospective resolution and the return of our political institutions.

Working for a Healthier People

I would therefore welcome your pay recommendations for doctors and dentists working in health and social care in Northern Ireland. The Department will, of course, keep you updated in regard to any progress made in respect of 2023/24 awards.

Yours sincerely

PETER MAY

Working for a Healthier People

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Mr Christopher Pilgrim
Chair
Review Body on Doctors' and Dentists' Remuneration

30 January 2024

Dear Christopher,

I would like to thank you for the DDRBs hard work and independent observations in the 2023-24 round which have been invaluable.

I am now writing to formally commence the 2024-25 pay round for Medical and Dental staff in Wales.

In order to support your work, I will provide written evidence to the Pay Review Body and I also plan to attend the oral evidence session when arranged.

I would like to take this opportunity to say I truly value the hard work and commitment of all our dedicated healthcare workers in Wales and recognised the pressures on our workforce.

Therefore, I would like to receive your advice and recommendations as soon as possible to ensure that payment of any award to our dedicated NHS workforce is not unduly delayed past April 2024.

I would like to thank you again for your and the DDRBs invaluable observations, and I look forward to receiving your advice and recommendations.

Yours sincerely,

M. E. Morgan.

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

Cabinet Secretary for NHS Recovery Health and Social Care
Rùnaire a' Chaibineit airson Ath-shlànachadh NHS, Slàinte agus Cùram Sòisealta
Neil Gray MSP

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Mr Christopher Pilgrim (Chair)
Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
3rd floor, Windsor House
42-50 Victoria Street
London SW1H 0TL

5 March 2024

Dear Christopher,

I am writing to formally set out our remit for the Doctors' and Dentists' Review Body (DDRB) for 2024-25.

The Scottish Government has always valued the opinions and analysis offered by the DDRB and its independent review of the economic, social, and budgetary pressures facing both the NHS Medical workforce, and the 4 UK governments.

You will be aware that the Scottish draft budget was announced in the Scottish Parliament on the 19 December 2023, and that Cabinet took the decision to delay setting public sector pay metrics until after the UK Government budget, which we now know will take place on 6 March 2024. You may wish to consider this in your deliberations.

In Scotland, we agreed a separate pay deal with Junior Doctors, and that deal has elements including a commitment to develop a pay bargaining system for Junior Doctors in Scotland, as well as a commitment to enter discussions to reform the Junior Doctors Contract. We remain committed to this agreement and will not be seeking recommendation for Junior Doctors.

You will wish to note that the BMA Scottish Consultants Committee and Scottish Speciality and Specialist Committee have informed us that both committees will not participate in the DDRB process this year, and wish to see DDRB reformed. BMA Scotland General Practitioners and BDA Scotland, however, remain within the DDRB process.

isters, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

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Whilst I fully recognise the position of the BMA Scottish Consultants Committee and Scottish Speciality and Specialist Committee in terms of their participation, I have taken the decision to submit a remit to the DDRB which is seeking recommendations for all Medical and Dental Craft Groups, with the exception of Junior Doctors. I will consider the DDRB recommendations as part of any decision I make on pay uplifts for NHS Scotland.

Accordingly, and in conclusion, the Scottish Government will provide a written evidence document, and we would be pleased to hear the DDRB views regarding a recommendation for one year only (2024-25). This will be for all medical and dental staff in NHS Scotland with the exception of Junior Doctors.

Copies of this letter will be sent to the Secretary of State for Health and Social Care, the respective Ministers in the devolved governments as well as representatives of the Staff Side and NHS Employers.

Yours sincerely,

NEIL GRAY

isters, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

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Appendix B Detailed recommendations on remuneration

Recommendations on remuneration in England from 1 April 2024

Doctors and dentists in training (2016 contract)	2023 £	2024 £
Foundation doctors – year 1	32,398	35,342
Foundation doctors – year 2	37,303	40,541
Core/run-through training – years 1-2	43,923	47,558
Core/run-through/higher training – years 3-5	55,329	59,649
Core/run-through/higher training – years 6 +	63,152	67,941
Flexible pay premia (2016 contract)		
General practice	9,693	10,275
Psychiatry core training	3,941	4,177
Psychiatry higher training (3 year)	3,941	4,177
Psychiatry higher training (4 year)	2,956	3,133
Academia	4,729	5,013
Histopathology	4,729	5,013
Emergency medicine/oral & maxillofacial surgery:		
3 years	7,881	8,354
4 years	5,911	6,266
5 years	4,729	5,013
6 years	3,941	4,177
7 years	3,378	3,581
8 years	2,956	3,133
Dental foundation training	38,742	41,067

	2023 £	2024 already agreed £	2024[1] £
Specialty doctor (2021 contract)	52,530	55,825	59,175
	60,519	64,315	68,174
	67,465	71,696	75,998
	74,675	79,359	84,121
	82,400	90,000	95,400
Specialist (2021 contract)	83,945	91,500	96,990
	89,610	95,079	100,784
	95,275	101,089	107,154

[1] DDRB recommendation for 2024-25.

	2023	2024 already agreed	2024[2]
	£	£	£
Specialty doctor (2008 contract)	46,958	48,358	51,259
	50,973	52,373	55,515
	56,193	57,593	61,049
	58,991	60,391	64,014
	63,022	64,422	68,287
	67,037	68,437	72,543
	71,142	72,542	76,895
	75,249	76,649	81,248
	79,356	80,756	85,601
	83,461	84,861	89,953
	87,568	88,968	94,306
Associate specialist (2008 contract)	65,837	67,237	71,271
	71,130	72,530	76,882
	76,421	77,821	82,490
	83,409	84,809	89,898
	89,465	90,865	96,317
	91,978	93,378	98,981
	95,257	96,657	102,456
	98,536	99,936	105,932
	101,814	103,214	109,407
	105,093	106,493	112,883
	108,375	109,775	116,362
Staff grade practitioner (1997 contract)	43,504	44,904	47,598
	46,958	48,358	51,259
	50,411	51,811	54,920
	53,865	55,265	58,581
	57,319	58,719	62,242
	61,385	62,785	66,552
	64,225	65,625	69,563
	67,678	69,078	73,223
	71,131	72,531	76,883
	74,585	75,985	80,544
	78,038	79,438	84,204
	81,493	82,893	87,867

[2] DDRB recommendation for 2024-25.

	April 2023	March 2024	April 2024
	£	£	£
Consultant (2003 contract)	93,666	99,532	105,504
	96,599		
	99,532		
	102,465	105,390	111,713
	105,390	108,390	114,893
	112,356	118,884	126,017
	119,323		
	126,281	131,964	139,882

	2023	2024
National clinical impact awards	£	£
Level 1	20,000	20,000
Level 2	30,000	30,000
Level 3	40,000	40,000
Salaried general medical practitioner range		
Minimum	68,975	73,114
Maximum	104,085	110,330
Salaried primary care dental staff (2008 contract)		
Band A: Salaried dentist	47,653	50,512
	52,947	56,124
	60,889	64,542
	64,860	68,752
	68,831	72,961
	71,479	75,768
Band B: Salaried dentist[3]	74,126	78,574
	76,773	81,379
	80,744	85,589
	82,730	87,694
	84,715	89,798
	86,701	91,903
Band C: Salaried dentist[4,5]	88,686	94,007
	91,334	96,814
	93,981	99,620
	96,628	102,426
	99,276	105,233
	101,923	108,038

[3] The first salary point of band B is also the extended competency point at the top of band A.
[4] The first salary point of band C is also the extended competency point at the top of band B.
[5] The first three points on the band C range represent those available to assistant clinical directors.

London weighting	2023 £	2024 £
Resident staff	602	602
Non-resident staff	2,162	2,162

Recommendations on remuneration in Scotland from 1 April 2024[6]

	2023 £	2024[7] £
Foundation house officer 1	31,082	
	33,024	
	34,964	
Foundation house officer 2	38,553	
	41,075	
	43,597	
Specialty registrar (full)	40,995	
	43,504	
	47,007	
	49,126	
	51,680	
	54,235	
	56,793	
	59,348	
	61,903	
	64,461	
Dental core training[7]	45,532	
Dental senior house officer/senior house officer	38,553	
	41,075	
	43,597	
	46,117	
	46,638	
	51,158	
	53,679	

[6] DDRB is not making recommendations for doctors and dentists in training in Scotland for 2024.
[7] On completion of core training, employees move to the nearest point on or above their existing salary on the dental senior house officer scale.

	2023	2024
	£	£
Specialty doctor (2022 contract)	58,198	61,690
	69,427	73,593
	73,678	78,099
	82,184	87,115
	90,688	96,129
Specialty doctor (2008 contract)	47,905	50,779
	52,001	55,121
	57,325	60,765
	60,179	63,790
	64,291	68,148
	68,387	72,490
	72,574	76,928
	76,764	81,370
	80,953	85,810
	85,141	90,249
	89,329	94,689
Specialist (2022 contract)	88,118	93,405
	94,065	99,709
	100,011	106,012
Associate specialist (2008 contract)	67,163	71,193
	72,562	76,916
	77,959	82,637
	85,088	90,193
	91,265	96,741
	93,829	99,459
	97,174	103,004
	99,513	105,484
	102,762	108,928
	106,009	112,370
	109,259	115,815

	2023	2024
	£	**£**
Staff grade practitioner (1997 contract)	44,381	47,044
	47,905	50,779
	51,426	54,512
	54,949	58,246
	58,472	61,980
	62,620	66,377
	65,518	69,449
	69,040	73,182
	72,563	76,917
	76,086	80,651
	79,610	84,387
	83,133	88,121
Consultant (2004 contract)	96,963	102,781
	99,011	104,952
	101,957	108,074
	104,906	111,200
	107,846	114,317
	114,846	121,737
	121,846	129,157
	128,841	136,571
Salaried general medical practitioner range		
Minimum	69,993	74,193
Maximum	104,469	110,737

Salaried primary care dental staff (2008 contract)	2023 £	2024 £
Band A: Dental officer	49,089	52,034
	54,545	57,818
	62,726	66,490
	66,815	70,824
	70,906	75,160
	73,633	78,051
Band B: Senior dental officer	76,360	80,942
	79,086	83,831
	83,178	88,169
	85,223	90,336
	87,269	92,505
	89,314	94,673
Band C: Assistant clinical director	91,359	96,841
	94,086	99,731
	96,812	102,621
Band C: Specialist dental officer	91,359	96,841
	94,086	99,731
	96,812	102,621
	98,565	104,479
Band C: Clinical director/chief administrative dental officer	91,359	96,841
	94,086	99,731
	96,812	102,621
	98,565	104,479
	101,212	107,285
	103,860	110,092

Recommendations on remuneration in Wales from 1 April 2024[8]

	2023 £	2024 £
Foundation house officer 1 (2015 contract)	28,471	31,179
	30,249	33,064
	32,028	34,950
Foundation house officer 2 (2015 contract)	35,315	38,434
	37,625	40,883
	39,933	43,329
Specialty registrar (full)	37,737	41,001
	40,044	43,447
	43,270	46,866
	45,222	48,935
	47,571	51,425
	49,925	53,921
	52,277	56,414
	54,630	58,908
	56,981	61,400
	59,336	63,896
Dental foundation training	38,292	41,590
Dental core training	35,488	38,617
	37,810	41,079
	40,129	43,537
	42,451	45,998
	44,770	48,456
	47,092	50,918
	49,412	53,377
Specialty doctor (2021 contract)	52,542	55,695
	60,532	64,164
	67,480	71,529
	74,691	79,172
	82,418	87,363
Specialist (2021 contract)	83,963	89,001
	89,630	95,008
	95,296	101,014

[8] Recommendations do not take into account additional offers made to medical and dental staff in Wales in June 2024.

	2023	2024
Specialty doctor (2008 contract)	**£**	**£**
	47,447	50,294
	51,502	54,592
	56,778	60,185
	59,603	63,179
	63,674	67,494
	67,732	71,796
	71,878	76,191
	76,028	80,590
	80,178	84,989
	84,326	89,386
	88,475	93,784
Associate specialist (2008 contract)	66,520	70,511
	71,867	76,179
	77,212	81,845
	84,271	89,327
	90,392	95,816
	92,928	98,504
	96,242	102,017
	99,556	105,529
	102,867	109,039
	106,182	112,553
	109,497	116,067
Staff grade practitioner (1997 contract)	43,958	46,595
	47,447	50,294
	50,936	53,992
	54,423	57,688
	57,914	61,389
	61,400	65,084
	64,892	68,786
	68,380	72,483
	71,869	76,181
	75,358	79,879
	78,845	83,576
	82,335	87,275
Consultant (2003 contract)	91,722	97,225
	94,644	100,323
	99,529	105,501
	105,201	111,513
	111,682	118,383
	115,377	122,300
	119,079	126,224

	2023	2024
National clinical impact awards	**£**	**£**
Level 0	10,000	10,000
Level 1	20,000	20,000
Level 2	30,000	30,000
Level 3	40,000	40,000
Commitment awards[9]	3,334	3,334
	6,668	6,668
	10,002	10,002
	13,336	13,336
	16,670	16,670
	20,004	20,004
	23,338	23,338
	26,672	26,672
Salaried general medical practitioner range		
Minimum	71,061	75,325
Maximum	107,229	113,663
Salaried primary care dental staff (2008 contract)		
Band A: Salaried dentist	47,914	50,789
	53,240	56,434
	61,224	64,897
	65,216	69,129
	69,209	73,362
	71,871	76,183
Band B: Salaried dentist[10]	74,531	79,003
	77,193	81,825
	81,158	86,027
	83,181	88,172
	85,179	90,290
	87,175	92,406
Band C: Salaried dentist[11,12]	89,174	94,524
	91,833	97,343
	94,494	100,164
	97,157	102,986
	99,818	105,807
	102,479	108,628

[9] Awarded every three years once the basic scale maximum is reached.
[10] The first salary point of Band B is also the extended competency point at the top of Band A.
[11] The first salary point of Band C is also the extended competency point at the top of Band B.
[12] The first three points on the Band C range represent those available to assistant clinical directors.

Recommendations on remuneration in Northern Ireland from 1 April 2024

	2023	2024
	£	£
Foundation house officer 1	29,566	32,340
	31,334	34,214
	33,099	36,085
Foundation house officer 2	36,371	39,553
	38,666	41,986
	40,964	44,422
Specialty registrar (full)	38,780	42,107
	41,078	44,543
	44,283	47,940
	46,224	49,997
	48,563	52,477
	50,903	54,957
	53,243	57,438
	55,582	59,917
	57,921	62,396
	60,261	64,877
Specialty doctor (2021 contract)	52,350	55,491
	60,519	64,150
	67,645	71,704
	74,675	79,156
	82,400	87,344
	67,365	71,407
Specialist (2021 contract)	83,945	88,982
	89,610	94,987
	95,275	100,992
Specialty doctor (2008 contract)	47,186	50,017
	51,223	54,296
	56,467	59,855
	59,278	62,835
	63,329	67,129
	67,365	71,407
	71,489	75,778
	75,616	80,153
	79,741	84,525
	83,868	88,900
	87,994	93,274

	2023	2024
	£	£
Associate specialist (2008 contract)	66,158	70,127
	71,477	75,766
	76,793	81,401
	83,815	88,844
	89,899	95,293
	92,425	97,971
	95,721	101,464
	99,015	104,956
	102,310	108,449
	105,603	111,939
	108,903	115,437
Staff grade practitioner (1997 contract)	43,717	46,340
	47,185	50,016
	50,656	53,695
	54,128	57,376
	57,598	61,054
	61,684	65,385
	64,538	68,410
	68,007	72,087
	71,478	75,767
	74,948	79,445
	78,418	83,123
	81,891	86,804
Consultant (2004 contract)	94,127	99,775
	97,076	102,901
	100,024	106,025
	102,970	109,148
	105,908	112,262
	112,912	119,687
	119,912	127,107
	126,907	134,521
Salaried general medical practitioner range		
Minimum	69,974	74,172
Maximum	105,592	111,928

Salaried primary care dental staff	2023 £	2024 £
Band 1: Salaried dentist	43,738	46,362
	47,276	50,113
	50,813	53,862
	54,353	57,614
	57,891	61,364
	61,427	65,113
	64,968	68,866
	68,506	72,616
Band 2: Senior salaried dentist	62,500	66,250
	67,447	71,494
	72,392	76,736
	77,337	81,977
	82,284	87,221
	83,376	88,379
	84,464	89,532
Band 3: Assistant clinical director salaried dentist	83,051	88,034
	84,336	89,396
	85,619	90,756
	86,907	92,121
	88,190	93,481
	89,476	94,845
Band 4: Clinical director salaried dentist	83,051	88,034
	84,336	89,396
	85,619	90,756
	86,907	92,121
	88,190	93,481
	89,476	94,845
	90,762	96,208
	92,070	97,594
	93,356	98,957
	94,640	100,318

Appendix C The number of doctors and dentists in the NHS/HSC in the UK[1]

England[2]	2022		2023		Percentage change 2022-2023	
	Full-time equivalent	Headcount	Full-time equivalent	Headcount	Full-time equivalent	Headcount
Hospital and Community Health Services medical staff						
Consultants	54,312	58,332	56,255	60,706	3.6%	4.1%
Associate specialists	2,103	2,360	2,394	2,688	13.8%	13.9%
Specialty doctors	8,372	9,475	8,896	10,015	6.3%	5.7%
Staff grades	334	373	349	382	4.5%	2.4%
Specialty registrar	33,681	35,299	34,129	35,795	1.3%	1.4%
Core training	19,092	19,493	21,624	22,151	13.3%	13.6%
Foundation doctor year 2	6,370	6,427	6,913	6,974	8.5%	8.5%
Foundation doctor year 1	7,164	7,190	7,625	7,661	6.4%	6.6%
Hospital practitioners/clinical assistants	626	1,733	636	1,778	1.6%	2.6%
Other staff	815	1,305	833	1,301	2.2%	-0.3%
Total	**132,869**	**141,579**	**139,656**	**148,994**	**5.1%**	**5.2%**
General medical practitioners[3]	**36,017**	**44,550**	**36,657**	**45,638**	**1.8%**	**2.4%**
GP partners	16,587	19,361	16,217	18,939	-2.2%	-2.2%
GPs in training	9,311	9,448	9,831	10,065	5.6%	6.5%
GP retainers	254	621	276	665	8.6%	7.1%
Salaried GPs	9,864	15,477	10,333	16,369	4.8%	5.8%
General dental practitioners[4]		**24,272**		**24,151**		**-0.5%**
Providing performers		4,752		4,604		-3.1%
Associates		19,485		19,512		0.1%
Unknown		35		35		0.0%
Total general practitioners		**68,822**		**69,789**		**1.4%**
Total – NHS doctors and dentists		**210,401**		**218,783**		**4.0%**

[1] An employee can work in more than one organisation, location, specialty or grade and their headcount is presented under each group but counted once in the headcount total.
[2] Data as 31 December of each year unless otherwise indicated.
[3] Data excludes locums.
[4] This is the number of dental performers who have any NHS activity recorded against them via FP17 claim forms in 2021-22 and 2022-23.

Scotland[5]	2022		2023		Percentage change 2022-2023	
	Full-time equivalent	Headcount	Full-time equivalent	Headcount	Full-time equivalent	Headcount
Hospital and Community Health Services medical staff						
Consultants	6,040	6,604	6,137	6,755	1.6%	2.3%
Staff and associate specialist grades	1,214	1,546	1,240	1,554	2.2%	0.5%
Doctors in training	6,560	6,855	6,737	7,101	2.7%	3.6%
Other staff	1,510	2,199	1,608	2,371	6.5%	7.8%
Total	**15,324**	**17,047**	**15,723**	**17,590**	**2.6%**	**3.2%**
General medical practitioners	**3,494**	**4,514**	**3,478**	**4,474**	**-0.5%**	**-0.9%**
Performers (partners)	2,656	3,255	2,624	3,196	-1.2%	-1.8%
Performer (salaried)	818	1,221	828	1,249	1.3%	2.3%
Retainers[6]	27	61	26	51	-2.6%	-16.4%
General dental practitioners (non-hospital)[7]		**3,155**		**3,134**		**-0.7%**
General Dental Service		2,790		2,800		0.4%
Public Dental Service		365		334		-8.5%
Total general practitioners		**7,669**		**7,608**		
Total – NHS doctors and dentists		**24,716**		**25,198**		**2.0%**

[5] Data as 31 December of each year unless stated otherwise indicated.
[6] GP retainers are practitioners who provide service sessions in general practice. The practitioner undertakes the sessions as an assistant employed by the practice. A GP retainer is allowed to work a maximum of four sessions of approximately half a day per week.
[7] Data at 30 September each year. Includes salaried, community and public dental service dentists.

Wales[8]	2022		2023		Percentage change 2022-2023	
	Full-time equivalent	Headcount	Full-time equivalent	Headcount	Full-time equivalent	Headcount
Hospital and Community Health Services medical staff[9]						
Consultants	2,904	3,137	2,974	3,248	2.4%	3.5%
Associate specialists	145	165	137	156	-5.8%	-5.5%
Specialty doctors	778	880	836	939	7.5%	6.7%
Staff grades	3	3	2	2	-33.3%	-33.3%
Specialist registrars	2,845	3,033	2,978	3,189	4.7%	5.1%
Foundation house officers 2	641	662	695	716	8.4%	8.2%
Foundation house officers 1	525	556	547	578	4.2%	4.0%
Other staff	61	171	64	165	5.8%	-3.5%
Total	**7,901**	**8,607**	**8,233**	**8,993**	**4.2%**	**4.5%**
General medical practitioners	**1,871**	**2,470**	**1,841**	**2,523**	**-1.6%**	**2.1%**
GP partners	1,107	1,424	1,030	1,371	-6.9%	-3.7%
GP salaried	342	558	392	662	14.5%	18.6%
General practice specialty registrars	411	461	409	463	-0.6%	0.4%
GP retainers	11	27	11	27	-4.5%	0.0%
General dental practitioners[10]		**1,420**		**1,434**		**1.0%**
General Dental Services only		1,114		1,144		2.7%
Personal Dental Services only		74		70		-5.4%
Trust-led Dental Services contracts		48		52		8.3%
Mixed		184		168		-8.7%
Total general practitioners		**3,890**		**3,957**		**1.7%**
Total – NHS doctors and dentists		**12,497**		**12,950**		**3.6%**

[8] Data as 30 September of each year.
[9] Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic practitioners.
[10] Data at 31 March of each year.

Northern Ireland[11]	2022		2023		Percentage change 2022-2023	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services medical staff[12,13]						
Consultants	1,929	2,062	1,972	2,107	2.2%	2.2%
Associate specialists/specialty doctors/staff grade	553	638	564	644	2.0%	0.9%
Specialty/specialist registrars	1,542	1,620	1,522	1,605	-1.3%	-0.9%
Foundation doctors	521	526	534	539	2.5%	2.5%
Other[14]	223	369	200	343	-10.2%	-7.0%
Total	**4,767**	**5,215**	**4,791**	**5,212**	**0.5%**	**-0.1%**
General medical practitioners		**1,419**		**1,448**		**2.0%**
GP principals		1,180		1,175		-0.4%
GP salaried		225		261		16.0%
GP retainers		14		12		-14.3%
General dental practitioners		**1,146**		**1,163**		**1.5%**
Total general practitioners		**2,565**		**2,611**		**1.8%**
Total – NHS doctors and dentists		**7,780**		**7,823**		**0.6%**

[11] As at 31 March unless otherwise specified.
[12] Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic practitioners.
[13] As at March that year.
[14] Due to changes in the definition of staff groups, the ‘other’ category is not consistent across year groups and should not be compared with previous years.

Appendix D Previous DDRB recommendations and the governments' responses

The main DDRB recommendations since 1990 for the general pay uplift are shown below, together with the latest RPI and CPI inflation figures available at the time of finalising the report and the governments' responses to the recommendations as a whole.

Report year	Main uplift	RPI %[1]	CPI %[2]	Government response
1990	9.5%	7.3	5.5	Not accepted. Rejected increases at top of consultants' scale and in the size of the A+ distinction award; staged implementation
1991	9.5% to 11%	10.9	7.8	Accepted, but staged implementation
1992	5.5% to 8.5%	3.7	7.1	Accepted
1993		3.6	2.6	No report following Government's decision to impose a 1.5% pay limit on the public sector
1994	3%	1.4	2.3	Accepted
1995	2.5% to 3%	2.4	1.8	Accepted
1996	3.8% to 6.8%	3.2	2.8	Accepted, but staged implementation
1997	3.7% to 4.1%	2.7	2.6	Accepted, but staged implementation
1998	4.2% to 5.2%	3.7	1.9	Accepted, but staged implementation
1999	3.5%	3.1	1.4	Accepted
2000	3.3%	1.2	1.2	Accepted
2001	3.9%	3.1	1.1	Accepted, but Government suspended the operation of the balancing mechanism (which recovers GPs 'debt')
2002	3.6% to 4.6%	0.9	0.8	Accepted
2003	3.225%	2.6*	1.5	Accepted
2004	2.5% to 2.9%	2.5	1.3	Accepted
2005	3.0% to 3.4%	3.4**	1.5	Accepted
2006	2.2% to 3.0%	2.2**	2.1	Accepted, although consultants' pay award of 2.2 per cent was staged – 1.0 per cent paid from 1 April 2006 and the remaining 1.2 per cent paid from 1 November 2006
2007	£1,000 on all pay points***	3.9	2.7	Accepted, although Scottish Executive did not implement one of the smaller recommendations relating to the pot of money for distinction awards to cover newly eligible senior academic GPs. England and Wales chose to stage awards in excess of 1.5 per cent – 1.5 per cent from 1 April 2007, the balance from 1 November 2007
2008	2.2% to 3.4%	4.3	2.1	Accepted
2009	1.5%	3.0****	4.1	Accepted
2010	0% to 1.5%	0.3	1.9	Mostly accepted: DDRB recommended: 0% for consultants and independent contractor GPs and GDPs; 1% for registrars, SAS grades, salaried GPs and salaried dentists; and 1.5% for FHOs. England and Northern Ireland both restricted the FHO recommendation to 1%

[1] At November in the previous year unless otherwise indicated, series CZBH
[2] At November in the previous year unless otherwise indicated, series D7G7

Report year	Main uplift	RPI %[1]	CPI %[2]	Government response
2011	No recommendation due to public sector pay freeze	4.7	3.3	
2012	No recommendation due to public sector pay freeze	5.2	4.8	
2013	1%	3	2.7	Accepted
2014	1%	2.6 (Q4 figure)	2.1 Q4	Accepted in Scotland Partially accepted in England and Wales: no uplift to incremental points. 1% non-consolidated to staff at the top of pay scales Northern Ireland – no uplift to incremental points. 1% non-consolidated to staff at the top of pay scales
2015	1%	1.9 Q4	0.9 Q4	Recommendation only applied to independent contractor GPs and GDPs in the UK and for salaried hospital staff in Scotland Accepted
2016	1%	1.0 Q4	0.1 Q4	Accepted
2017	1%	2.2 Q4	1.2 Q4	Accepted with the exception of uplifts to CEAs, discretionary points and distinction awards in Scotland and Northern Ireland
2018	2%	3.7 Q1	2.7 Q1	Staged and abated in England. Accepted in Wales and Northern Ireland. Accepted in Scotland, except for staff earning at least £80,000 who received £1,600
2019	2.5%	2.5 Q1	1.9 Q1	Accepted with the exception of uplifts to CEAs, discretionary points and distinction awards. Additional 1% for SAS not implemented anywhere
2020	2.8%	2.6 Q1	1.7 Q1	Accepted
2021	3%	1.4 Q1	0.6 Q1	Accepted
2022	4.5%	8.4 Q1	6.2 Q1	Accepted with the exception of SAS doctors and dentists at the top of the 2008 specialty doctor pay scale in Wales, where a 4.5% non-consolidated payment was made instead Subsequent to implementing most of the recommendations, the Welsh Government also implemented an additional 1.5% consolidated uplift and made a 1.5% non-consolidated payment to HCHS doctors and dentists and uplifted the salaried GP pay range by 1.5%

Report year	Main uplift	RPI %[1]	CPI %[2]	Government response
2023	6% (6%+£1,250 consolidated uplift for doctors and dentists in training) (3% above the uplift in the SAS 2021 contract multi-year deal in England, Wales, and Northern Ireland)	13.6 Q1	10.2 Q1	Accepted in England. Partially accepted in Scotland except for doctors and dentists in training who were awarded 12.4%. Not accepted in Wales where a 5% increase was implemented except for SAS on the 2021 contract who received a 1.5% uplift above that in the multi-year deal. Accepted in Northern Ireland.
2024	6% (6%+£1,000 consolidated uplift for doctors and dentists in training in England, Wales and Northern Ireland)	4.6 Q1	3.5 Q1	

* Due to the late running of the round, DDRB was also able to take account of the March figures for RPI (3.1 per cent).

** Due to a later round, November to February, DDRB was also taken into account the December RPI figure.

*** £650 on the pay points for doctors and dentists in training. The average banding multiplier for juniors meant that this would also deliver approximately £1,000.

**** DDRB also took into account the December RPI figure (0.9 per cent).

Appendix E The data historically used in our formulae-based decisions for independent contractor GPs and GDPs

1. This appendix gives the latest data that would have populated the formulae for both general medical practitioners (GPs) and general dental practitioners (GDPs), had we used the previous formulae-based approach.

2. While we are not making formula-based recommendations for independent contractor GPs and GDPs, we set out below the data that would have populated the formulae as they existed in 2015. Given our ongoing concerns with the reliability of the formula, we do not consider it appropriate to adjust the weightings of the coefficients in the formula. When we last considered this issue, the coefficients and their weightings for dentists were based on data that covered all dentists, regardless of the time devoted to NHS work: as noted in our 2012 report, average earnings and expenses for dentists reporting a high NHS share were similar to the total dental population. If we were using the formula this year, then we would wish to examine whether that case remained sound. The parties may wish to consider this point as part of their discussion of expenses and the uplift.

Table E.1: Data historically used in our formulae-based decisions for independent contractor GPs and GDPs

Coefficient	Value
Income (contractor GPs, salaried GPs across the UK) *DDRB recommendation*	6.0%
Staff costs (GPs) *Annual Survey of Hours and Earnings (ASHE) 2023 (general medical practice activities)*	4.4%
Other costs (GPs) *Retail Prices Index excluding mortgage interest payments (RPIX) for Q4 2022*	4.3%
Income (GDPs) *DDRB recommendation*	6.0%
Staff costs (GDPs) England, Scotland, Wales, Northern Ireland *ASHE 2023 (dental practice activities)*	12.2%
Laboratory costs (GDPs) England, Scotland, Wales, Northern Ireland *RPIX for Q4 2023*	4.3%
Materials (GDPs) England, Scotland, Wales, Northern Ireland *RPIX for Q4 2023*	4.3%
Other costs (GDPs) England, Wales, Northern Ireland *Retail Prices Index (RPI) for Q4 2023*	5.5%
Other costs (GDPs) Scotland *RPIX for Q4 2023*	4.3%

Sources: Annual Survey of Hours and Earnings (Table 16.5a, all, median), Consumer Price Inflation (CDKQ, CZBH).

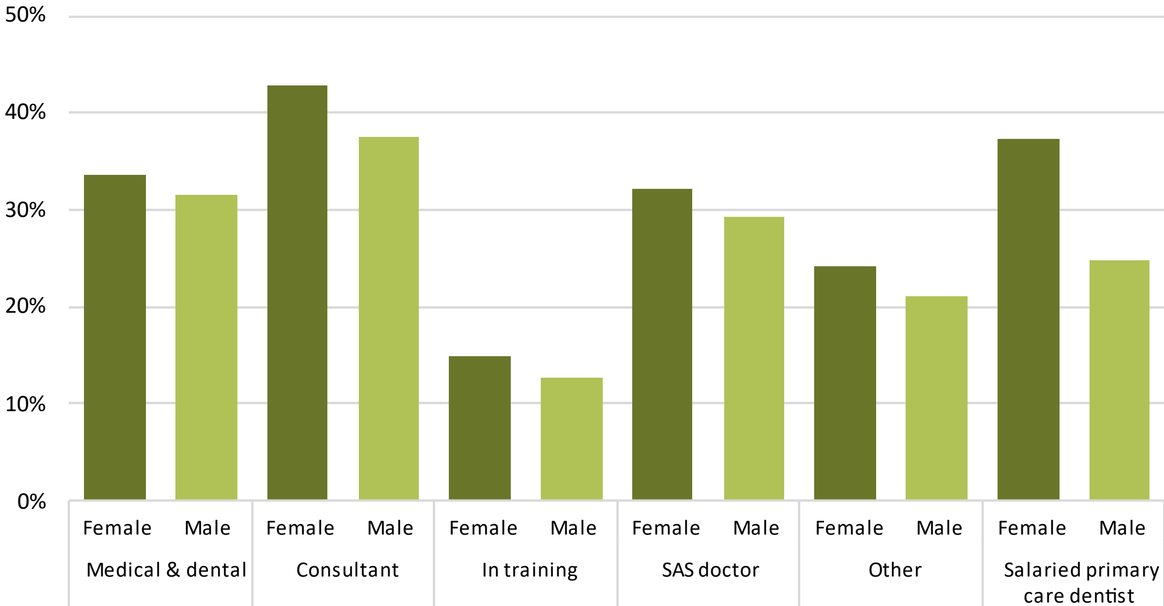
Appendix F NHS staff survey, gender and ethnicity data

1. This appendix looks at NHS staff survey data from 2023 for England, broken down by gender and ethnicity.

Hospital and Community Health Services

2. Figure F1 shows satisfaction with pay broken down by staff group and gender in 2023 across all Hospital and Community Health Services (HCHS) medical and dental staff. When looking across all medical and dental staff, there was a 2 percentage point difference between female and male staff: 34 per cent of female staff and 32 per cent of male staff expressed satisfaction with pay. Female consultants, doctors and dentists in training, SAS doctors, primary care dental staff and 'other' medical and dental staff were all more likely than their male counterparts to express satisfaction with pay.

Figure F.1: HCHS medical and dental staff satisfied or very satisfied with their pay, by grade and gender, England, 2023



Source: NHS Staff Survey.

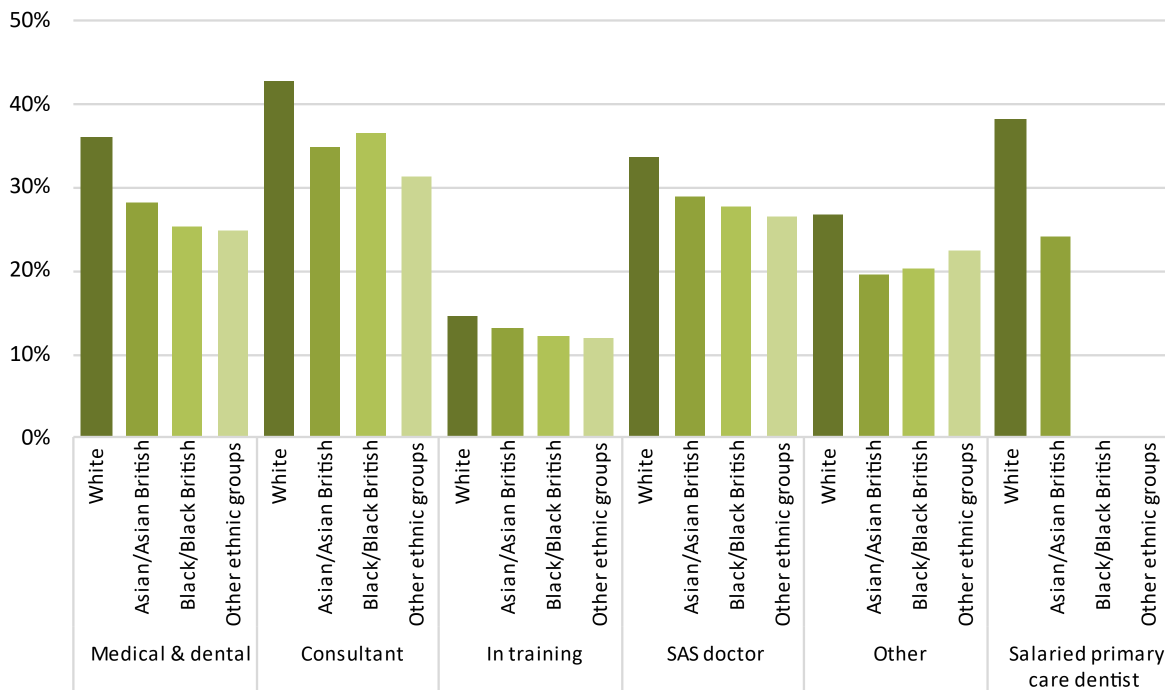
Note: Percentage of staff saying they were 'very satisfied' or 'satisfied' with their pay.

3. Figure F2 shows satisfaction with pay broken down by staff group and ethnic group in 2023.[1] When looking across all medical and dental staff, 36 per cent of White staff expressed satisfaction with their pay, compared with 28 per cent of Asian/Asian British staff, 25 per cent of Black/Black British staff and 25 per cent of staff from other ethnic groups.

[1] In this appendix, the data for Asian/Asian British is a weighted average of the data for Asian/Asian British – Indian, Asian/Asian British – Pakistani, Asian/Asian British – Bangladeshi, Asian/Asian British – Chinese, Asian/Asian British – any other Asian background.
The data for Black/Black British is a weighted average of the data for Black/Black British – African, Black/Black British – Caribbean, Black/Black British – any other Black/African/Caribbean background.
The data for other ethnic groups is a weighted average of the data for mixed/multiple ethnic background: White and Black Caribbean; White and Black African; White and Asian; any other mixed/multiple ethnic background and other ethnic group: Arab; any other ethnic background.

- White consultants (43 per cent) were more likely to express satisfaction with their pay than Black/Black British consultants (36 per cent), Asian/Asian British consultants (35 per cent) and consultants from other ethnic groups (31 per cent).
- White doctors and dentists in training (15 per cent) were more likely to express satisfaction with their pay than Asian/Asian British doctors and dentists in training (13 per cent), Black/Black British doctors and dentists in training (12 per cent) and doctors and dentists in training from other ethnic groups (12 per cent).
- White SAS doctors and dentists (34 per cent) were more likely to express satisfaction with their pay than Asian/Asian British SAS doctors and dentists (29 per cent), Black/Black British SAS doctors and dentists (28 per cent) and SAS doctors and dentists from other ethnic groups (26 per cent).
- White salaried primary care dentists (38 per cent) were more likely to express satisfaction with their pay than Asian/Asian British salaried primary care dentists (24 per cent). Data was not available for Black/Black British salaried primary care dentists and salaried primary care dentists from other ethnic groups.
- White ‘other’ staff (27 per cent) were more likely to express satisfaction with their pay than ‘other’ staff from other ethnic groups (22 per cent), Black/Black British ‘other’ staff (20 per cent) and Asian/Asian British ‘other’ staff (20 per cent).

Figure F.2: HCHS medical and dental staff satisfied or very satisfied with their pay, by grade and ethnic group, England, 2023



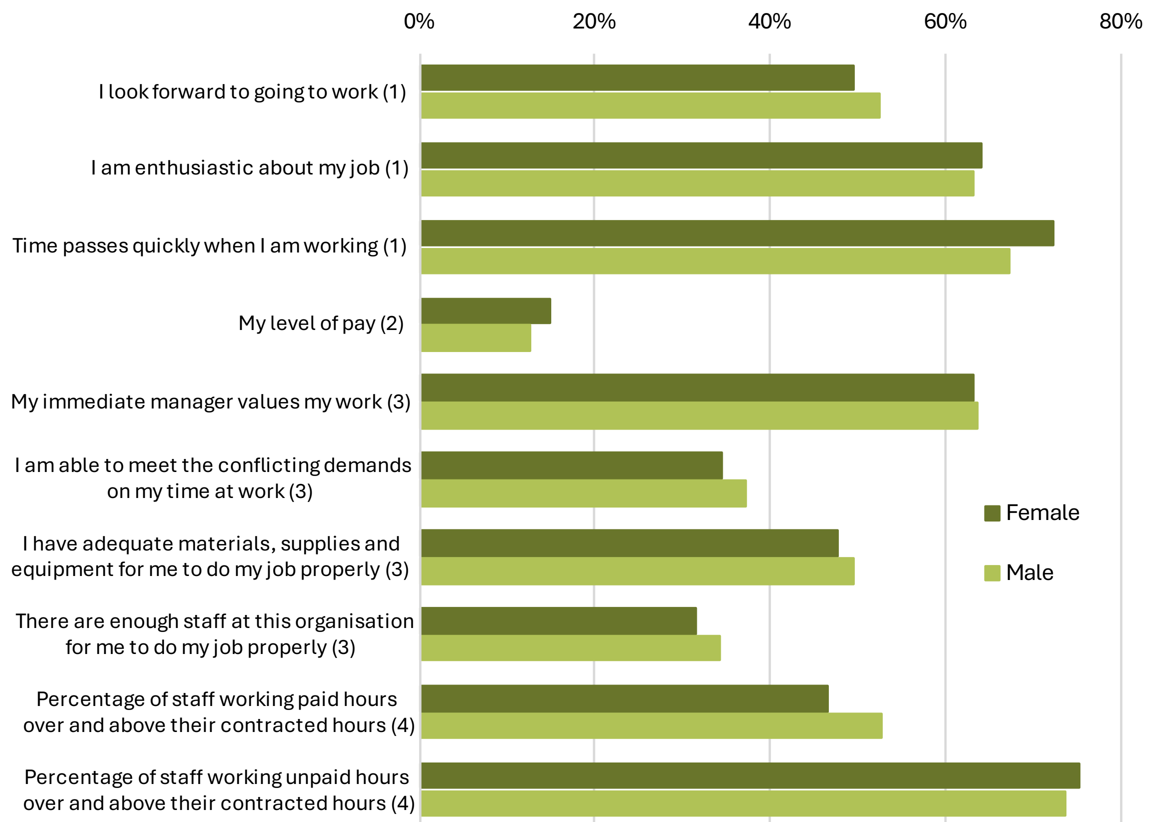
Source: OME calculations, using data from the NHS Staff Survey.

Notes: Percentage of staff saying they were ‘very satisfied’ or ‘satisfied’ with their pay. The sample was too small to generate data for salaried primary care dentists: Black/Black British and other ethnic groups.

Doctors and dentists in training

4. In 2023, female doctors and dentists in training were more satisfied with their pay than their male colleagues (see figure F3). However, compared with female colleagues, male doctors and dentists in training were more likely to say that they looked forward to going to work, were able to meet the conflicting demands on their time, and had adequate materials and enough staff to do their job. Male doctors and dentists in training were more likely to work paid hours over and above their contracted hours, and less likely to work extra unpaid hours.

Figure F.3: HCHS doctors and dentists in training, satisfaction with aspects of the job and work pressures by gender, England, 2023

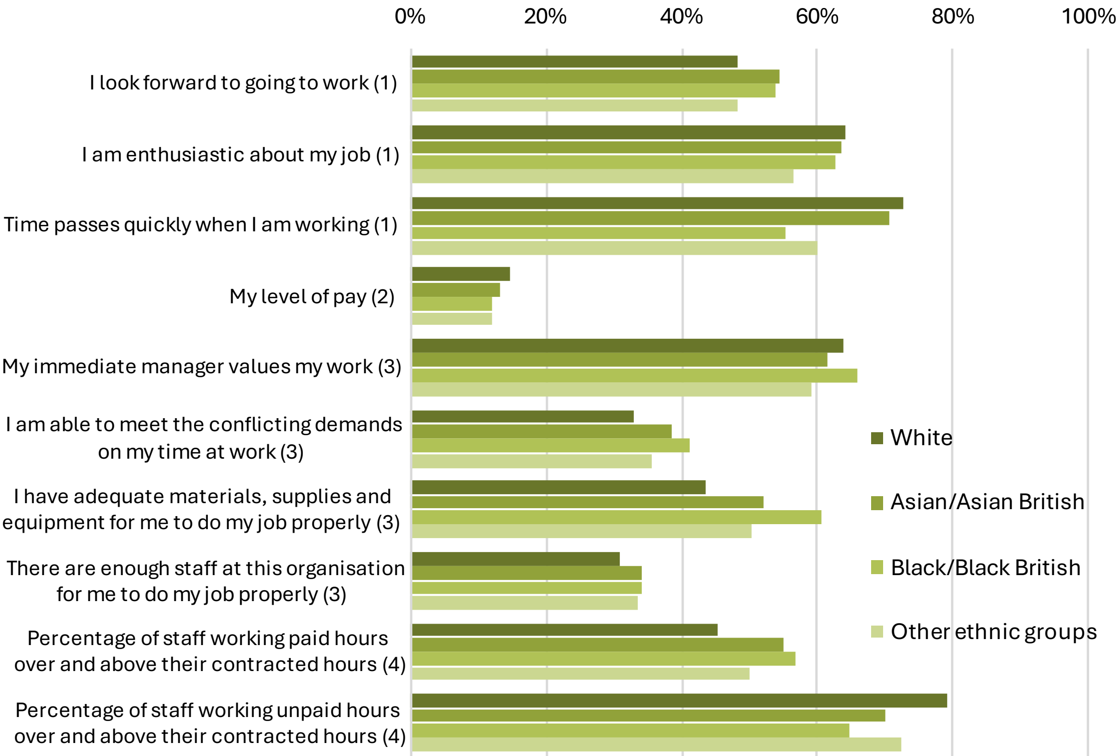


Source: NHS Staff Survey, England, 2023.

Note: (1) Staff responding 'often' or 'always'; (2) Staff responding 'satisfied' or 'very satisfied'; (3) Staff responding 'agree' or 'strongly agree'; (4) Staff indicating one or more additional hours.

5. Figure F4 shows satisfaction with aspects of the job and work pressures by ethnic group among doctors and dentists in training. Asian/Asian British and Black/Black British doctors and dentists in training were more likely to say that: they looked forward to going to work; were able to meet the conflicting demands on their time; had adequate materials and equipment to do their job properly; and that there were enough staff at their organisation to do their job properly than White doctors and dentists in training and those from other ethnic groups. White doctors and dentists in training were less likely to say that they worked paid hours in addition to their contracted hours than colleagues from other ethnic groups, while White doctors and dentists in training were more likely to say that they worked unpaid hours in addition to their contracted hours.

Figure F.4: HCHS doctors and dentists in training, satisfaction with aspects of the job and work pressures by ethnic group, England, 2023



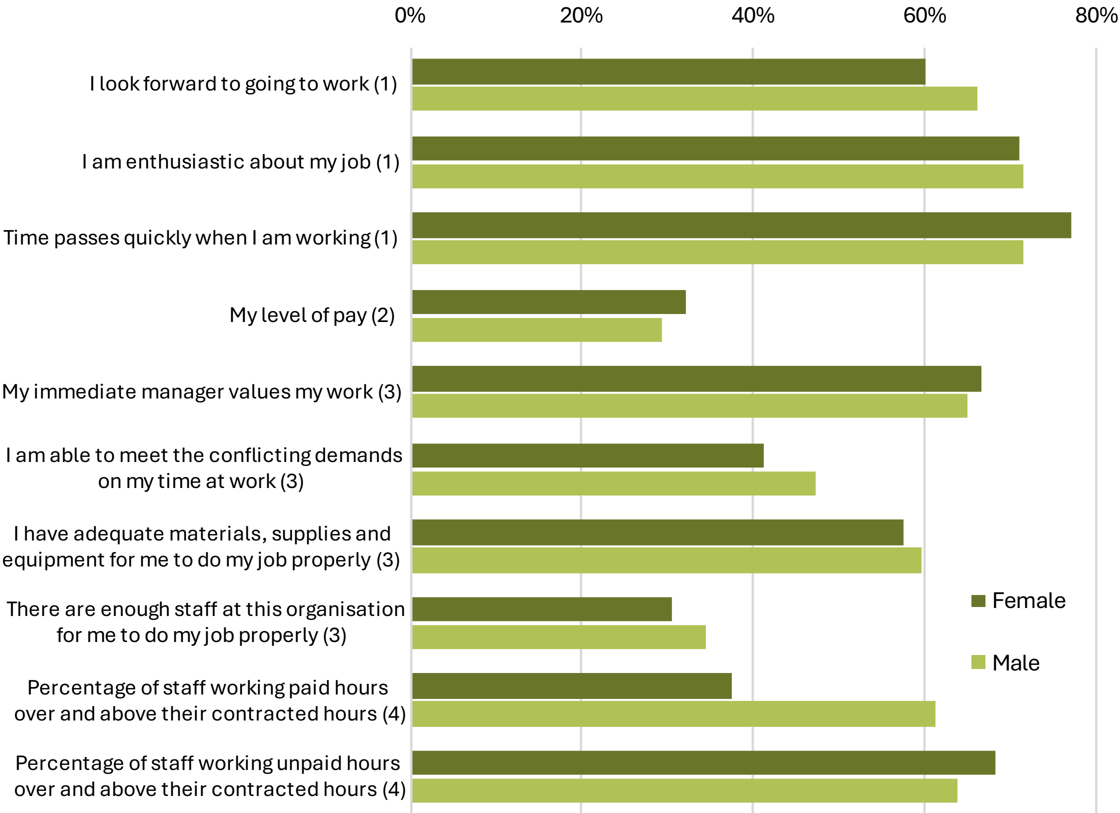
Source: NHS Staff Survey, England, 2023.

Note: (1) Staff responding ‘often’ or ‘always’; (2) Staff responding ‘satisfied’ or ‘very satisfied’; (3) Staff responding ‘agree’ or ‘strongly agree’; (4) Staff indicating one or more additional hours.

SAS doctors and dentists

6. In 2023, female SAS doctors and dentists were more satisfied with their pay than their male colleagues (see figure F5). However, compared with female colleagues, male SAS doctors and dentists were more likely to say that they looked forward to going to work, were able to meet the conflicting demands on their time, and had adequate materials and enough staff to do their job. Male SAS doctors and dentists were more likely to work paid hours over and above their contracted hours, and less likely to work extra unpaid hours.

Figure F.5: HCHS SAS doctors and dentists, satisfaction with aspects of the job and work pressures by gender, England, 2023

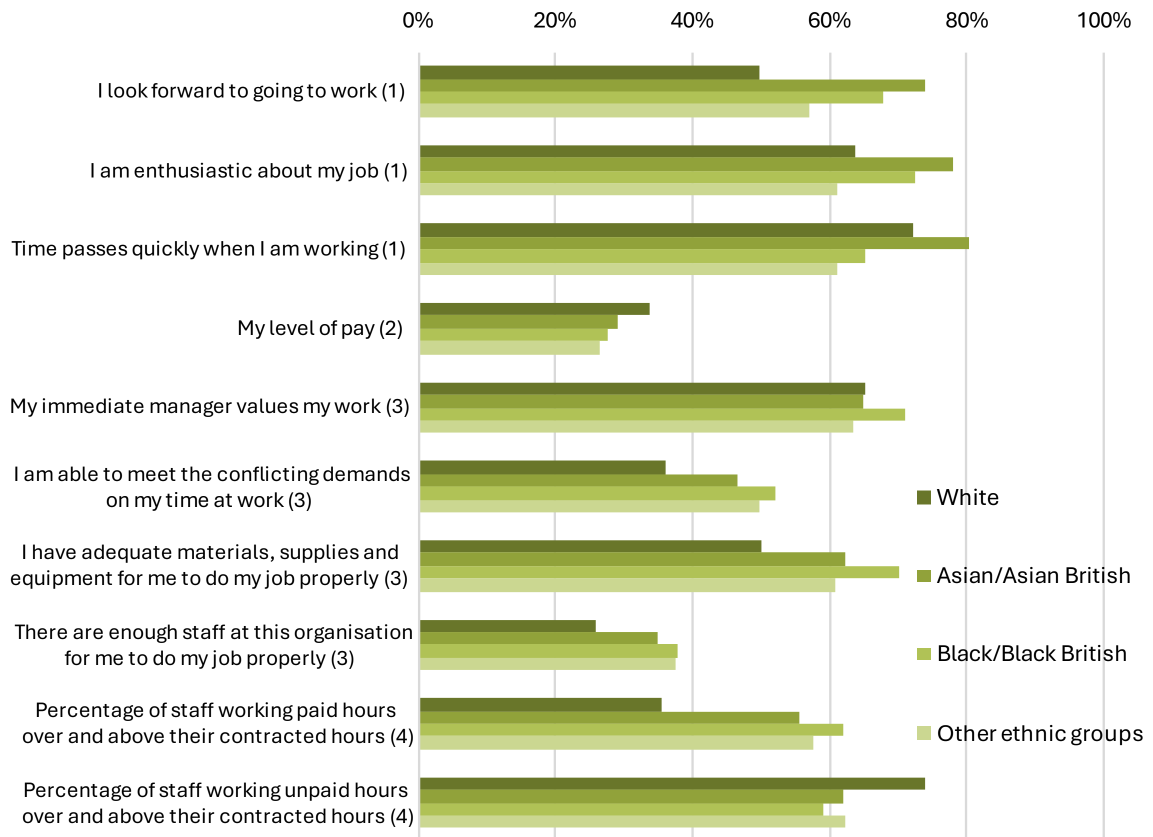


Source: NHS Staff Survey, England, 2023.

Note: (1) Staff responding ‘often’ or ‘always’; (2) Staff responding ‘satisfied’ or ‘very satisfied’; (3) Staff responding ‘agree’ or ‘strongly agree’; (4) Staff indicating one or more additional hours.

7. Figure F6 shows satisfaction with aspects of the job and work pressures by ethnic group among SAS doctors and dentists. Asian/Asian British SAS doctors, compared with those from other ethnic groups, were more likely to say that: they looked forward to going to work; were enthusiastic about their job; and that time passed quickly when they were working. Black/Black British SAS doctors, compared with those from other ethnic groups, were more likely to say that: their immediate line manager valued their work; they were able to meet conflicting demands on their time at work; they had adequate materials and equipment to do their job properly; there were enough staff at their organisation to do their job properly. White SAS doctors, compared with those from other ethnic groups, were the least likely to work extra paid hours but the most likely to work extra unpaid hours.

Figure F.6: HCHS SAS doctors and dentists, satisfaction with aspects of the job and work pressures by ethnic group, England, 2023



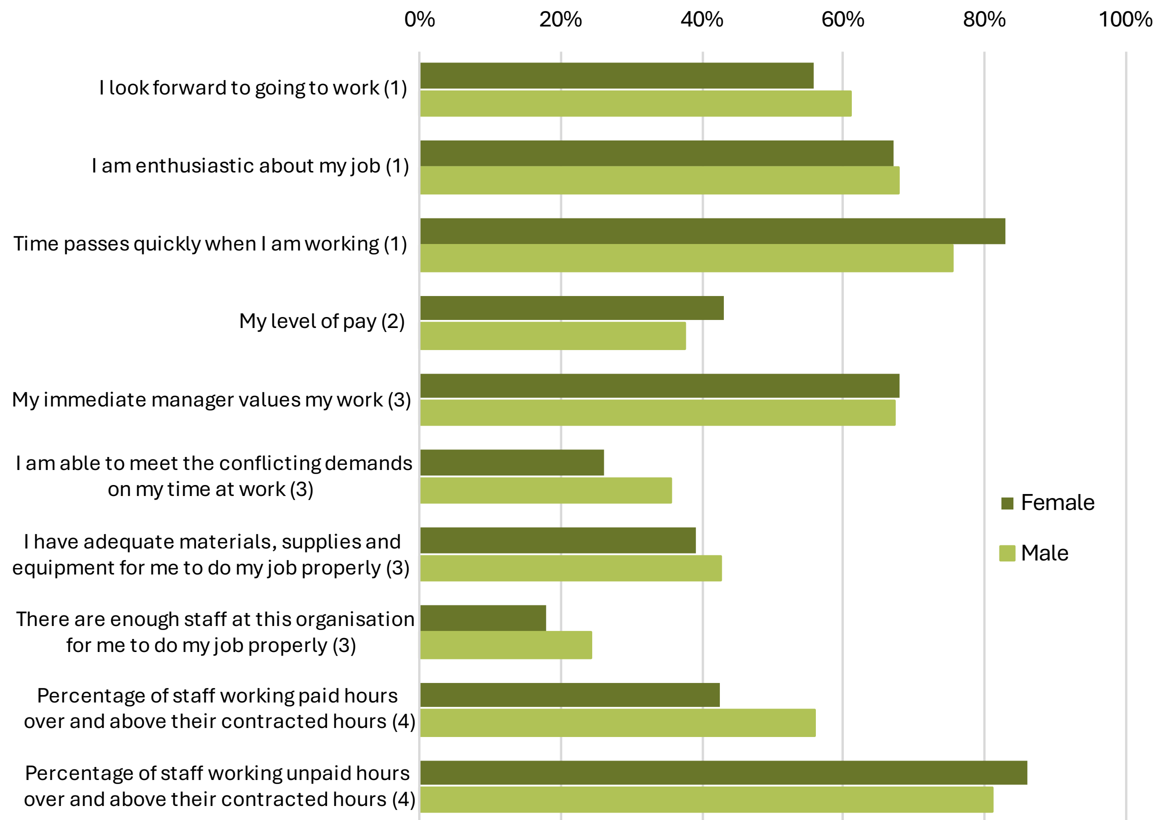
Source: NHS Staff Survey, England, 2023.

Note: (1) Staff responding 'often' or 'always'; (2) Staff responding 'satisfied' or 'very satisfied'; (3) Staff responding 'agree' or 'strongly agree'; (4) Staff indicating one or more additional hours.

Consultants

8. In 2023, female consultants were more satisfied with their pay than their male colleagues (see figure F7). However, compared with female colleagues, male consultants were more likely to say that they looked forward to going to work, were able to meet the conflicting demands on their time, and had adequate materials and enough staff to do their job. Male consultants were more likely to work paid hours over and above their contracted hours, and less likely to work extra unpaid hours.

Figure F.7: HCHS consultants, satisfaction with aspects of the job and work pressures by gender, England, 2023

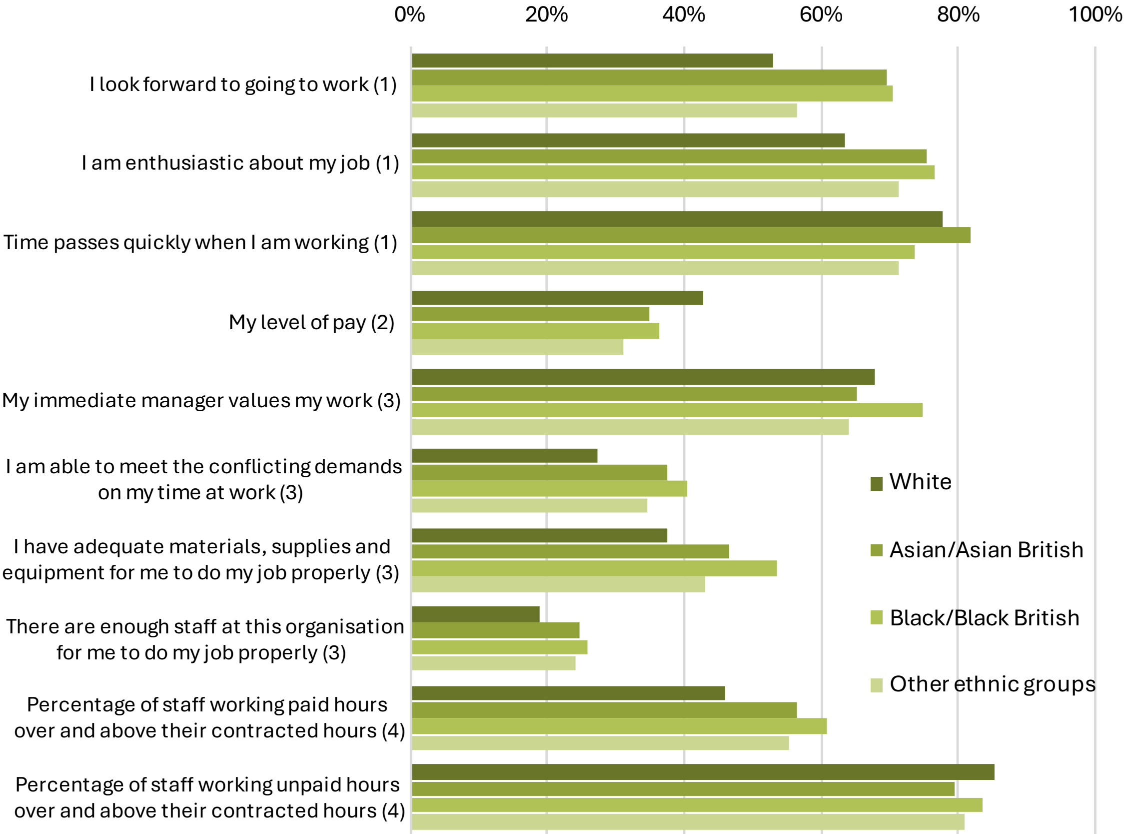


Source: NHS Staff Survey, England, 2023.

Note: (1) Staff responding 'often' or 'always'; (2) Staff responding 'satisfied' or 'very satisfied'; (3) Staff responding 'agree' or 'strongly agree'; (4) Staff indicating one or more additional hours.

9. Figure F8 shows satisfaction with aspects of the job and work pressures by ethnic group among consultants. Asian/Asian British and Black/Black British consultants, compared with those from other ethnic groups, were more likely to say that they: looked forward to going to work; were enthusiastic about their job; they were able to meet conflicting demands on their time at work; they had adequate materials and equipment to do their job properly; there were enough staff at their organisation to do their job properly. White consultants, compared with those from other ethnic groups, were the least likely to work extra paid hours but the most likely to work extra unpaid hours.

Figure F.8: HCHS consultants, satisfaction with aspects of the job and work pressures by ethnic group, England, 2023



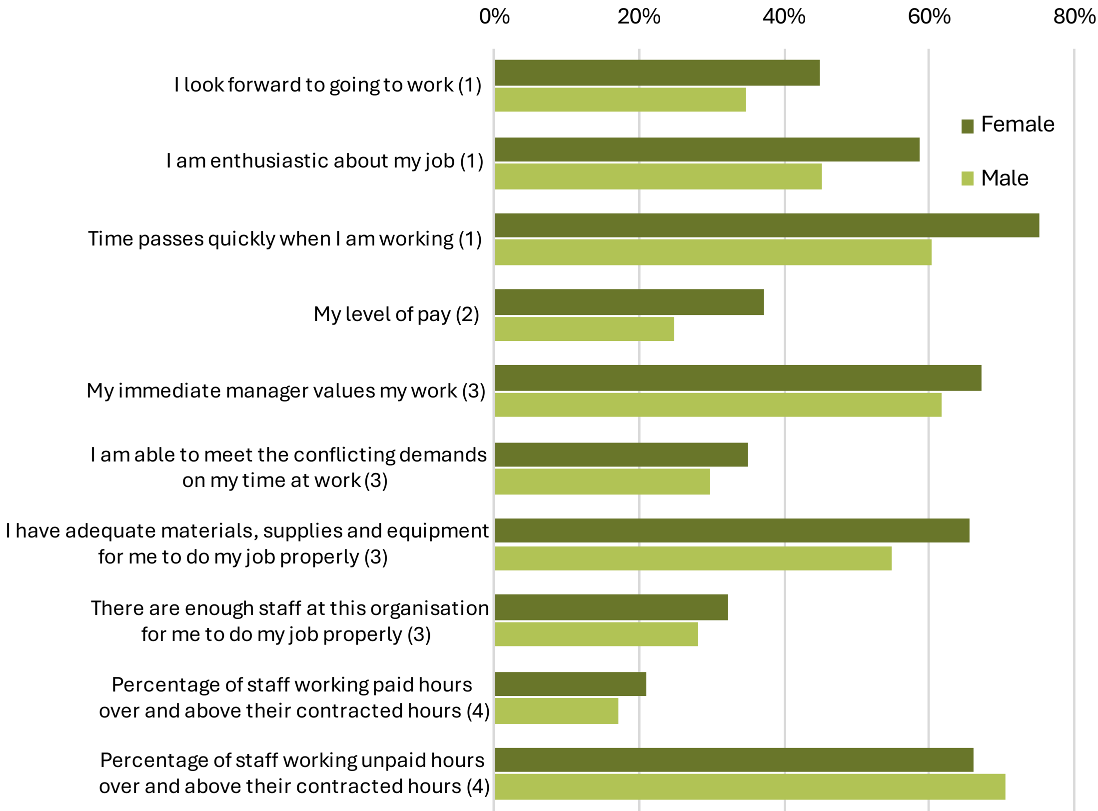
Source: NHS Staff Survey, England, 2023.

Note: (1) Staff responding 'often' or 'always'; (2) Staff responding 'satisfied' or 'very satisfied'; (3) Staff responding 'agree' or 'strongly agree'; (4) Staff indicating one or more additional hours.

Salaried primary care dental staff

10. In 2023, female salaried primary care dental staff were more satisfied with their pay than their male colleagues (see figure F9). Compared with male colleagues, female salaried primary care dental staff were more likely to say that: they looked forward to going to work; were enthusiastic about their job; that their line manager valued their work; they were able to meet the conflicting demands on their time; and had adequate materials and enough staff to do their job properly. Female salaried primary care dental staff were more likely to work paid hours over and above their contracted hours, and less likely to work extra unpaid hours, than their male colleagues.

Figure F.9: HCHS, salaried primary care dental staff, satisfaction with aspects of the job and work pressures by gender, England, 2023

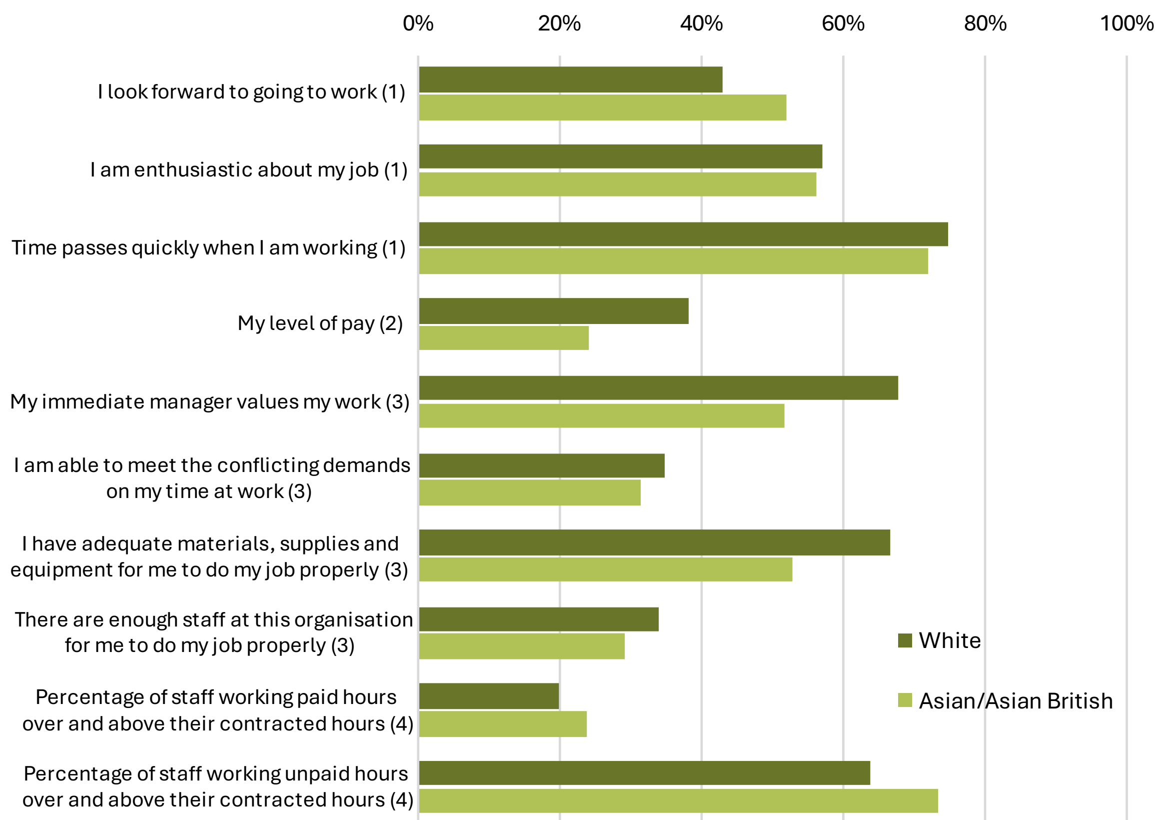


Source: NHS Staff Survey, England, 2023.

Note: (1) Staff responding 'often' or 'always'; (2) Staff responding 'satisfied' or 'very satisfied'; (3) Staff responding 'agree' or 'strongly agree'; (4) Staff indicating one or more additional hours.

11. Figure F10 shows satisfaction with aspects of the job and work pressures by ethnic group for salaried primary care dental staff. The sample was too small to generate data for Black/Black British salaried primary care dentists and those from other ethnic groups. Asian/Asian British salaried primary care dentists were more likely than their White colleagues to say that they looked forward to going to work, but were less likely to say that: their line manager valued their work; they were able to meet the conflicting demands on their time at work; they had adequate materials and equipment to do their job properly; or there were enough staff at their organisation for them to do their job properly. Asian/Asian British salaried primary care dentists were more likely to do both paid and unpaid additional hours than their white colleagues.

Figure F.10: HCHS doctors and dentists, salaried primary care dental staff, satisfaction with aspects of the job and work pressures by ethnic group, England, 2023



Source: NHS Staff Survey, England, 2023.

Note: (1) Staff responding ‘often’ or ‘always’; (2) Staff responding ‘satisfied’ or ‘very satisfied’; (3) Staff responding ‘agree’ or ‘strongly agree’; (4) Staff indicating one or more additional hours.

Appendix G Glossary and abbreviations

ACCIA	Advisory Committee on Clinical Impact Awards
ASHE	Annual Survey of Hours and Earnings
BDA	British Dental Association
BMA	British Medical Association
CDS	Community Dental Services
CEA	Clinical excellence award
CIA	Clinical impact award
CIC	Community Interest Company
CPI	Consumer prices index
CPIH	Consumer prices index including owner occupiers' housing costs
COVID/COVID-19	Coronavirus disease 2019
CT	Core training, years 1-3
DDRB	Review Body on Doctors' and Dentists' Remuneration
DHSC	Department of Health and Social Care
EEA	European Economic Area
EU	European Union
F1-2	Foundation, years 1-2
FHO	Foundation house officer (doctors in the foundation years)
FTE	Full-time equivalent
GDC	General Dental Council
GDP	General Dental Practitioner
GDS	General Dental Services
GMC	General Medical Council
GMS	General Medical Services
GP	General Medical Practitioner
GPC	General Practitioners Committee
HCHS	Hospital and Community Health Services
HCSA	Hospital Consultants and Specialists Association
HEIW	Health Education and Improvement Wales
HMRC	His Majesty's Revenue and Customs
HM Treasury	His Majesty's Treasury
HSC	Health and Social Care
ICB	Integrated Care Board
IDR	Incomes Data Research
IfG	Institute for Government
IFS	Institute for Fiscal Studies
IMG	International medical graduate

LED	Locally employed doctor
LEO	Longitudinal Education Outcomes
LRD	Labour Research Department
MDT	Multi-disciplinary team
NASDAL	National Association of Specialist Dental Accountants and Lawyers
NHS	National Health Service
OBR	Office for Budget Responsibility
OECD	Organisation for Economic Co-operation and Development
OME	Office of Manpower Economics
ONS	Office for National Statistics
PAYE	Pay as you earn
PDS	Public Dental Service
PMQ	Primary medical qualification
RDEL	Revenue Departmental Expenditure Limits
RPI	Retail prices index
SAS	Specialty, associate specialist and specialist
ST1-9	Specialist training, years 1-9
TERS	Targeted Enhanced Recruitment Scheme
UCAS	Universities and Colleges Admissions Service
UDA	Unit of dental activity
UK	United Kingdom

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