Department of Health & Social Care

The Department of Health and Social Care's written evidence to the Review Body on Doctors' and Dentists' Remuneration for the pay round 2025 to 2026

Published 10 December 2024

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1. NHS strategy and introduction

This chapter sets out the wider context for the department's evidence for the 2024 to 2025 pay round and provides an overview of this year's written evidence to the Review Body on Doctors' and Dentists' Remuneration (DDRB).

This follows the 2023 to 2024 pay round in which the government asked for recommendations for all doctors and dentists covered by its remit. The government accepted the recommendations in full. This year, the government is again inviting the DDRB to make pay recommendations for all doctors and dentists within the remit group.

The government is immensely grateful for the critical role all NHS staff play in our health service and the high quality, compassionate care they deliver. The Secretary of State for Health and Social Care has been clear he wants to reset relations with NHS staff and is determined to work with them to rebuild the health service and fix the foundations.

Data approach

This year, to avoid unnecessary duplication of evidence, we have taken a more collaborative approach with NHS England (NHSE) on our analytical evidence. This means that, in places, rather than including data ourselves, we will reference data that has been provided by NHSE in their data pack. We will provide our own policy narrative to accompany this in this document and reference clearly where NHSE data pack figures, or publicly available data sources, are being referenced. Any feedback on this approach would be appreciated.

The NHS workforce

The new government has set out 5 missions for this parliament, one of which is to 'Build an NHS fit for the future'. An essential component to achieve this mission is an appropriately resourced NHS, with a skilled and diverse workforce which is effectively distributed across care settings and the country. The total reward package that accompanies working for the NHS is pivotal in attracting and retaining such a workforce, and this evidence looks to provide the context, data, and policy detail that will enable the DDRB to make informed recommendations.

The 10 Year Health Plan will be the foundation for building an NHS fit for the future setting out how the government will shift the NHS from analogue to digital, hospital to community and treatment to prevention. In turn, it will set departmental priorities and NHS workforce planning. To inform the development of the 10 Year Health Plan, Lord Darzi was recently commissioned to carry out an investigation into the state of the national health service in

England. His report was published in September 2024 and found that an increasing workforce in the NHS has not translated into productivity gains and that better workforce planning, alongside training and support, was required to improve this. Chapter 3 details the work being undertaken in workforce planning, as well as programmes relating to training, education, and international recruitment.

Primary care is foundational to the NHS, providing the first point of contact for the majority of people seeking care, and it will be central to the delivery of the 10 Year Health Plan. Recruitment and retention of GPs and dentists is therefore a priority and chapter 4 of our evidence focuses on the data relating to these workforces and their demographics.

Chapter 5 of our evidence considers earnings and expenses. Data suggests that pay awards over recent years have broadly achieved parity with comparators in the wider economy. As well as considering historic earnings data, we would also anticipate the DDRB to consider forecasts for earnings and pay settlements.

2023 to 2024 was saw a series of deals with different remit groups of the DDRB and SAS, consultant, and resident doctors have now all agreed deals with the government. Chapter 6 considers the impact of these deals, and any remaining workforce specific issues and reward schemes.

Chapter 7 of our evidence for the last pay round highlighted a number of changes which were likely to have a positive impact on the reward package of staff, such as the continuation of retire and return easements, and new retirement flexibilities for late career staff. The positive impact of these changes will have been felt recently and are explored in this chapter. In addition, Government Actuary Department (GAD) analysis has shown a continuation in the trend on the total wider reward package increasing year on year.

We look forward to receiving your report in 2025.

2. NHS finances

This chapter describes the financial context within which NHS pay awards will need to be met. Findings from the Treasury spending audit earlier this year revealed £22 billion of unfunded pressure inherited from the previous government, leading to the Chancellor taking difficult decisions to find £5.5 billion of savings across Department budgets for financial year 2025 to 2026.

The Autumn Budget 2024 means NHS England RDEL budgets will rise to £182.8 billion in 2024 to 2025 and £192 billion in 2025 to 2026. Investment alone won't be enough to tackle the problems facing the NHS - it must go hand in hand with fundamental reform. In the short term, patient care pathways will be reformed to ensure patients are seen in settings which can deliver better patient experience for lower cost, enhancing patient choice and embedding best practice right across the country.

Economic context

As outlined in the terms of reference, the Pay Review Bodies should take account of the broader economic context, settlement data are the most comparable data to PRB decisions as they are a direct measure of consolidated pay awards, and so are not affected by broader labour market factors such as changes to working hours or workforce composition. Settlement data are tracking downwards and expected to fall further as we enter the period of the pay award according to survey data, this is in line with OBR's forecast earnings growth for 2025 to 2026 of 3% in the short term before reducing to around 2% in 2026 to 2027.

The rate of UK economic growth since the global financial crisis (GFC) of 2008 has been substantially lower than in previous decades. Annual real productivity growth (GDP per hour worked) fell by around 1.5 percentage points, from an average of 2.1% in the decade prior to the GFC, to 0.6% between 2010 and 2019. Higher productivity enables higher wages and living standards. Only sustained productivity growth over the medium-term can deliver sustainable long-run economic growth and real-terms wage rises.

The government is committed to delivering a decade of national renewal. Through the growth mission, the government is restoring stability, increasing investment, and reforming the economy to drive up prosperity and living standards across the UK.

Funding growth

Table 1: mandate Funding for NHS England

	NHSE Revenue Departmental Expenditure Limits (RDEL) excluding ringfence (RF) (cash) £ billion	NHSE Capital Departmental Expenditure Limits (CDEL) excluding ringfence (RF) (cash) £ billion
2019 to 2020	121.334	0.260
2020 to 2021	147.132	0.365
2021 to 2022	147.973	0.337
2022 to 2023	155.228	0.330
2023 to 2024	171.036	0.439
2024 to 2025	176.916	0.431

Source: 2024 to 2025 financial directions to NHS England

Table 1 above shows the closing mandates for NHSE up to 2023 to 2024, the opening mandate in 2024 to 2025. The 2023 to 2024 and 2024 to 2025 RDEL figures have been adjusted for education and training budgets. The figures are adjusted annually to account for reallocation of resource, additional funding, and changes of responsibility between government bodies. The application of IFRS16 has revised the funding amounts from 2019 to 2020 onwards. Figures exclude depreciation, annually managed expenditure (AME) and the technical accounting budget, namely capital grants or Private Finance Initiative.

The 2024 to 2025 totals will be updated in April 2025 closing the financial directions which will reflect the changes made at Autumn Budget 2024, including increased funding which contributes to the cost of the pay awards announced in the July 2024 statement.

Financial position

The NHS' (commissioners and providers in aggregate) final spend position shows a significant deficit of £1.3 billion (as set out in the table below), which is a marked deterioration on the year before. Final audited spend in the 2023 to 2024 financial year will be laid before Parliament and is available in NHS England's published Annual Report and Accounts.

The fiscal and economic environment has pushed the NHS into a challenging financial position. The 2024 to 2025 pay uplifts were awarded in the final year of the Spending Review 2021, which was published at a time of lower inflation and no strike action. Consequently, recent pay awards and pension costs have resulted in significant pressures on planned 2024 to 2025 budgets.

The Autumn Budget 2024 means NHS England RDEL budgets will rise to £182.8 billion in 2024 to 2025 and £192 billion in 2025 to 2026.

Table 2 shows the breakdown of funding provided to NHS providers since the 2017 to 2018 financial year, including preliminary outturn data for 2023 to 2024.

Table 2: NHS providers RDEL breakdown

NHS Providers RDEL Breakdown (£m)	**2017 to 2018**	**2018 to 2019**	**2019 to 2020**	**2020 to 2021**	**2021 to 2022**	**2022 to 2023**	**2023 to 2024**
Gross deficit	2,433	2,755	1,560	158	126	1,001	1,606
Gross surplus	-1,337	-1,889	-567	-363	-442	-299	-305
Reporting adjustment	-105	-39	-323	-450	-240	-252	12
NHS providers SRP (Sector Reported Performance)	991	827	670	-655	-556	450	1,312
Plus additional RDEL adjustment	47	-1	338	-77	-39	528	69
Net NHS providers RDEL NRF	1,038	826	1,008	-732	-595	978	1,382

Share of resources going to pay

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

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

Year	**NHSE RDEL (£ billion)**	**NHS Provider Permanent and Bank Staff Spend (£ billion)**	**% of spend on staff**	**Increase in total spend**	**Increase in provider permanent and bank staff spend**
2019 to 2020	121.334	58.447	48.17%	Not applicable	Not applicable
2020 to 2021	141.104	65.264	46.25%	16.29%	11.66%
2021 to 2022	146.719	68.865	46.94%	3.98%	5.52%
2022 to 2023	152.553	73.942	48.47%	3.98%	7.37%
2023 to 2024	165.926	81.699	49.24%	8.77%	10.49%

Notes:

- 2020 to 2021: NHSE RDEL figure represents the net outturn of the NHS Group, as the NHS Group was underspent by £6.0 billion with respect to its funding
- 2021 to 2022: NHSE RDEL figure represents the net outturn of the NHS Group, as the NHS Group was underspent by £1.3b billion with respect to its funding
- 2022 to 2023: excludes non-recurrent funding for a non-consolidated pay award (£2.675 billion excluded from NHSE RDEL figure, £2.490 billion excluded from NHS Provider permanent and bank staff spend figure)
- 2023 to 2024: excludes Health Education England (HEE) funding from NHSE RDEL figure (note corresponding figure in table 1 is inclusive of HEE funding)
- 2024 to 2025: the 2024 to 2025 pay award is expected to increase the proportion of resources going on pay
- figures in the table are correct to the specified level of significance. Percentage increases may not match increases calculated from budget or spend figures as given in the table due to rounding

The DDRB recommended a 6% pay increase for salaried GP practice staff, consultants, SAS and high-street and salaried dentists. Resident doctors received an average of 8.2% increase in pay from DDRB plus additionally accepted on average a further 4.05% backdated to 2023 to 2024.

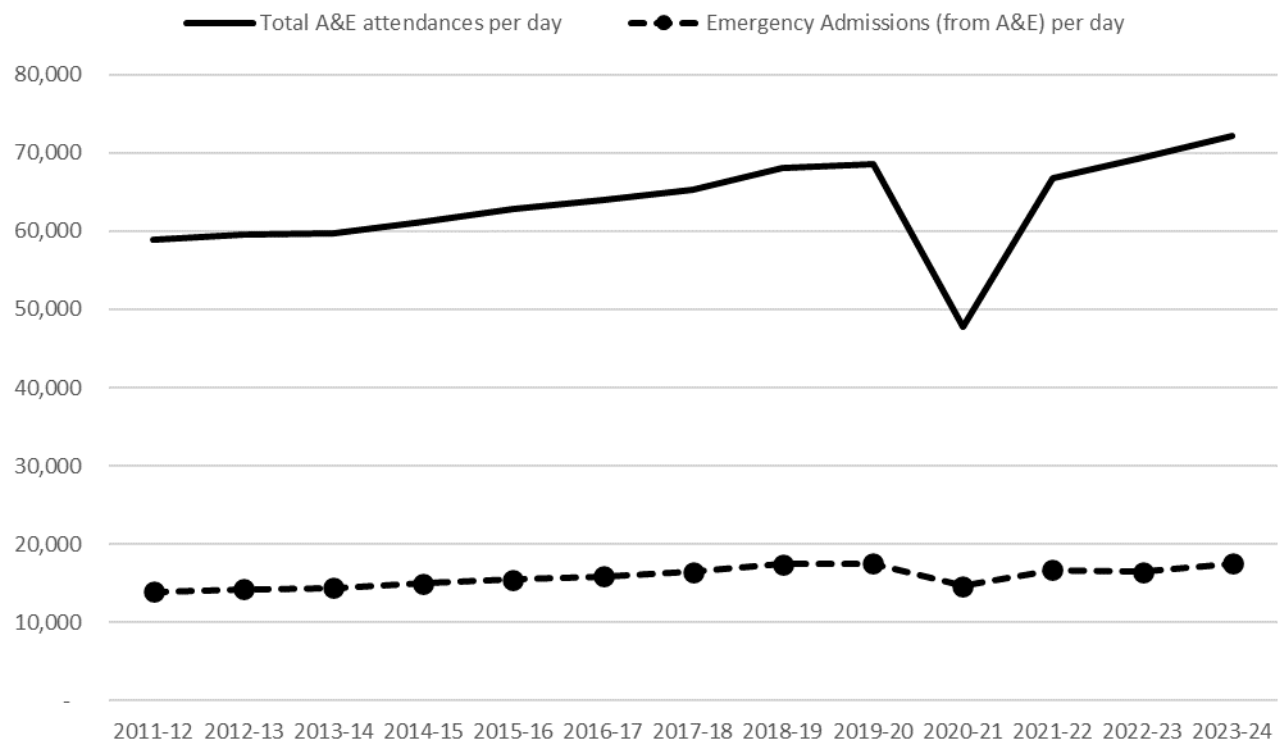
In 2024 to 2025, the pay awards were above the government's affordability envelope. As a result, this created an unfunded pressure addressed as part of the July 2024 spending audit. The government took a range of difficult decisions to manage the pressures identified in the audit, including targeting winter fuel payments, and on health specifically, cancelling Social Care charging reform and reviewing the New Hospitals Programme. On pay, all departments needed to find savings to absorb at least £3.2 billion of the overall pay pressure. DHSC Group undertook a reprioritisation exercise to identify the funding necessary (together with additional HMT funding), With budgets confirmed at the Autumn Budget 2024.

Demand pressures

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

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

Figure 1: total and emergency admissions per calendar day



Source: A&E attendances and Emergency Admission Statistics

Figure 2.1 shows the total attendances and emergency admissions to NHS England per calendar day between 2011 to 2012 and 2023 to 2024.

In 2019 to 2020, there were an average of 68,540 A&E attendances and 17,551 emergency admissions per day. In 2023 to 2024, there were 72,113 A&E attendances and 17,563 emergency admissions per day. This equates to a 5% increase in A&E attendances, while emergency admissions remained relatively stable between 2019 to 2020 and 2023 to 2024.

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

Year	RTT estimated clock starts per working day	RTT total completed pathways and unreported removals per working day	Waiting list
2011 to 2012	59,771	59,897	2,443,952
2012 to 2013	63,085	62,150	2,677,497
2013 to 2014	66,281	64,806	3,052,280
2014 to 2015	69,473	68,853	3,209,293
2015 to 2016	73,252	71,403	3,675,298
2016 to 2017	77,956	77,085	3,897,530
2017 to 2018	79,764	78,945	4,102,999
2018 to 2019	82,231	81,272	4,345,467
2019 to 2020	79,712	79,552	4,386,297
2020 to 2021	55,824	53,595	4,950,297
2021 to 2022	74,916	69,322	6,365,772
2022 to 2023	79,511	75,665	7,331,186
2023 to 2024	82,163	81,332	7,538,830

Source: NHSE consultant led referral to treatment statistics.

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

Elective recovery has been an ongoing focus for the NHS since the pandemic and the size of the challenge remains significant. The waiting list currently stands at 7.6 million (as of July 2024). This is slightly down from 7.7 million in July 2023, but up from 4.5 million in July 2019 before the pandemic.

The NHS Constitution sets out that 92% of patients should wait no longer than 18 weeks from Referral to Treatment (RTT). As of July 2024, the start of the current parliament, only 58.8% of waits are within the 18-week standard. Almost 50,900 patients had been waiting more than 65 weeks and over 290,000 patients had been waiting more than 52 weeks for elective treatment in July 2024. The government will support the NHS to make progress towards the commitment that patients should expect to wait no longer than 18 weeks from referral to treatment.

There has been significant additional funding for elective recovery to address the backlog from the COVID-19 pandemic, via the Elective Recovery Fund (ERF) (£8 billion from 2022

to 2025) and capital funding to increase diagnostic and theatre capacity (£2.3 billion for diagnostics and £1.38 billion for theatre capacity). We have observed an increase in elective activity: per working day activity (completed pathways, including Specialist Advice and Guidance) in August 2024 was above pre-pandemic levels at 112.9% compared to August 2019. However, activity levels are still lower than originally planned; the 2022 Elective Recovery Plan envisaged they would be 30% higher by 2024 to 2025. This has been due to slower productivity recovery, in part due to industrial action. NHS analysis estimates that the waiting list could have fallen by an extra 430,000 from December 2022 to March 2024 without strikes.

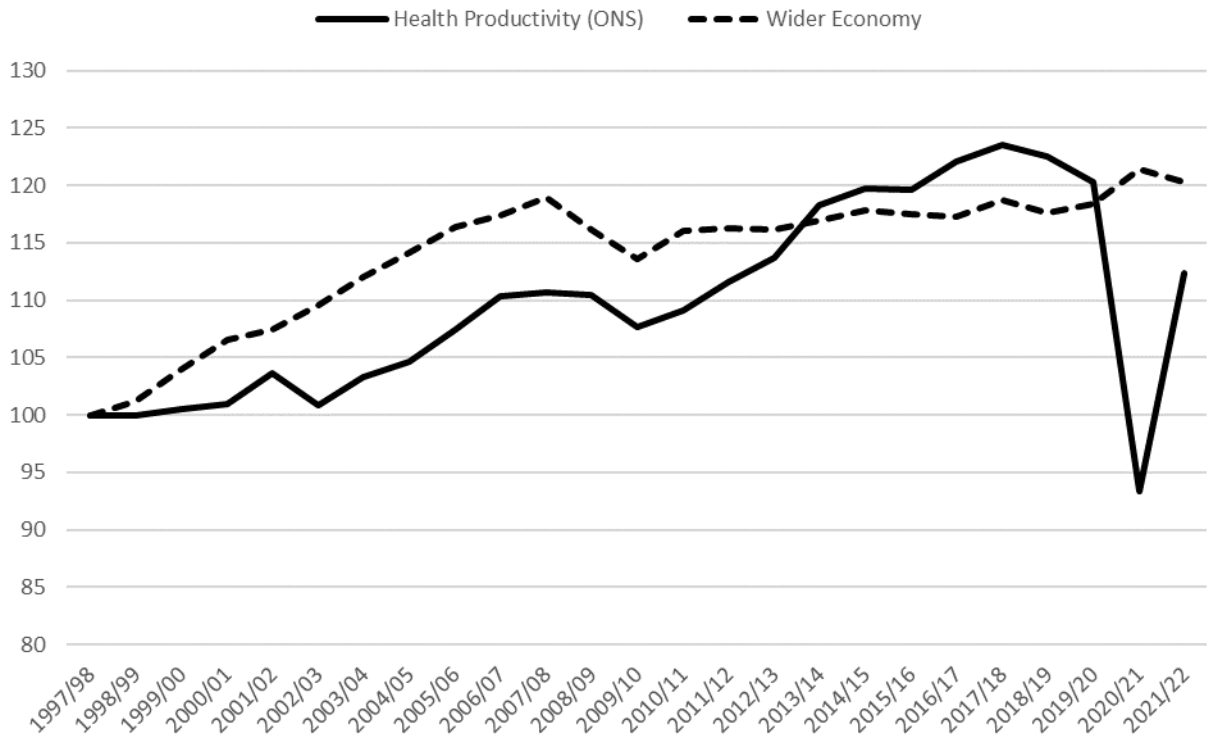
Demand recovered more slowly than expected following the large decrease in referrals seen during the pandemic. Average growth in the years leading up to the pandemic (between October 2016 and February 2020) was 2.1%, although, outside of the pandemic, annual growth ranged from -3.1% to 6.4%. Demand returned to pre-pandemic levels in January 2023, and rebounded at a rate of 6.1% across 2022 to 2023. The rate of demand growth across the last year has fallen; year-to-date demand growth is currently -1.1%. However, we expect demand growth to return to the long-term trend seen before the pandemic of between 2% to 3%.

Calculating productivity in the NHS

Health productivity is hard to measure due to problems with capturing health outcomes in existing data. Despite these challenges York University and the Office for National Statistics (ONS) publish recognised measures of health productivity. England healthcare productivity increased on average by 0.8% per annum from 1995 to 1996 until 2019 to 2020 - a similar rate to the UK wider economy. Health productivity was lower prior to the 2008 financial crash but higher from the 2008 financial crash to the COVID-19 pandemic in 2020.

Figure 2 shows health productivity compared to wider productivity between 1997 to 1998 and 2021 to 2022.

Figure 2: ONS England Health vs Wider Economy Multi Factor Productivity (index 1997 to 1998 is 100)



Source: ONS England Health Productivity and ONS UK Multi-Factor Productivity

The chart above shows when indexed to 1997 to 1998 health productivity was below wider economy productivity until 2013 to 2014. After 2013 to 2014 health is higher than wider economy productivity until 2020 to 2021. In 2020 to 2021, health productivity dropped by much more than the wider economy productivity. Health productivity recovered in 2021 to 2022 but is still below both the wider economy and health's pre-pandemic level.

ONS figures showed a 22.4% reduction in NHS productivity in 2020 to 2021. This was the result of increasing inputs (for example, staff) to cover the risk of surges in COVID-19 patients and reductions in the number of outputs (for example, operations) due to infection controls and limiting elective treatments. It is important to note that infection controls and lockdowns implemented throughout the COVID-19 pandemic delivered health benefits (for example, fewer COVID-19 cases) not captured in our usual measures of productivity.

ONS reported a significant bounce back in 2021 to 2022 to 6.6% below the 2019 to 2020 level, but some of this recovery is due to the inclusion of Test and Trace and COVID-19 vaccinations. A more modest recovery of 12.5% below the 2019 to 2020 level was reported by York Centre for Health Economics University who publish a similar England wide measure that excluded Test and Trace and most COVID-19 vaccinations.

These formal estimates are only published to 2021 to 2022, but ONS publish a total public sector productivity measure to shorter time scales, of which the health sector comprises 40%. The latest publication (January to March 2024) showed public sector productivity is recovering but is still 6.4% below its pre-pandemic equivalent. Suggesting that many of the problems with recovering productivity to its pre-pandemic level remain.

Table 5: productivity levels versus 2019 to 2020 for different measurements

The latest is defined as January to March 2024 versus January to March 2020.

	ONS Health specific measure	York Centre for Health Economics England wide health measure	ONS total public sector
2020 to 2021	-22.4%	-23.0%	-16.1%
2021 to 2022	-6.6%	-13.3%	-5.4%
Latest	Not applicable	Not applicable	-6.4%

Sources: ONS health productivity, York University Centre of Health Economics: Productivity of the English NHS, and ONS Quarterly Public Sector Productivity

While public sector productivity remains at below pre-pandemic levels, the NHS continues to face evolving challenges. The backlog for elective care persists due to the long-term effects of managing COVID-19, including delays in discharge, longer non-elective length of stay (constraining elective capacity), high staff sickness and vacancies, and the continued reliance on agency staff. Additionally, industrial action by nurses, resident doctors, and consultants in 2023 to 2024 has resulted in lost opportunities for elective treatment and associated productivity declines. Nevertheless, despite these challenges, acute sector productivity grew by 2% in 2023 to 2024, and this positive trend has continued with an additional 2% growth in the first quarter of 2024 to 2025 compared to the same quarter the previous year.

Productivity and efficiency in the NHS

The autumn budget announcement in October 2024 included a commitment that DHSC (including NHS) would deliver 2% productivity growth in 2025 to 2026, driven by significant technology and digital infrastructure investments. This includes over £2 billion investment to advance NHS technology, which will free up staff time, ensure all Trusts have Electronic Patient Records, improve cyber security and enhance patient access through the NHS App.

Increasing NHS productivity and efficiency remain essential to meet the growing demand for health services to support enduring improvements in performance and ensure financial sustainability.

In recent years, funding and workforce levels within the NHS have gradually increased. However, though there has been progress since the COVID pandemic, this has not yet translated into corresponding improvements in productivity. The 2% productivity growth aims to address this gap, to ensure that increased resources translate into measurable improvements in efficiency and service delivery for patients.

To realise this productivity growth, sustained reform is essential for achieving operational excellence. This includes reducing administrative burdens through technological advancements and infrastructure upgrades, delivering care in efficient settings, and prioritising preventive care to reduce costly admissions. Upskilling and retention strategies are also crucial for leveraging a broader range of skilled professionals, ensuring that the NHS workforce can meet growing demands while supporting sustainable productivity improvements.

Lord Darzi's recommendations, on which the 10 Year Health Plan will be based on, emphasise that the NHS needs smarter and broader investment rather than simply more funding. This includes focusing on system reform to drive productivity improvements, leveraging technology, and investing in workforce development. The report stressed that any financial increase, including pay should be tied to productivity gains and wider systemic improvements. The Carter Review (2016) showed that operational changes could realise substantial savings (£3.57 billion by 2020), highlighting the potential for reform-driven productivity improvements. Following the budget announcement for spending review phase 1 in October 2024, it is clear that future pay decisions should be considered alongside these broader reforms to ensure sustainable investment that enhances both workforce well-being and service delivery.

Steps are also being taken to control spending on temporary staffing, such as expanding staff banks, increasing compliance with agency price caps, and reducing the use of off-framework agency staff. The 2024 to 2025 Planning Guidance challenged systems to improve workforce productivity and reduce agency spend below 3.2% of the total paybill across 2024 to 2025 and end use of all off-framework agencies Off-framework spend now makes up less than 1% of agency spend. Together, this will help shape the NHS workforce. Ensuring the right skills mix, in the right place, could optimise productivity and better meet patient needs now and in the future.

Achieving this productivity improvement also requires a combination of delivery of the same care in lower cost settings for example, moving treatment from theatres into outpatient settings, moving hospital admissions to hospital at home, delivering large-scale skills mix opportunities by expanding the workforce with a diverse range of professional

roles, as well as upskilling and retaining our staff, and reducing the administrative burden on clinicians through technological advancement, such as artificial intelligence (AI) and robotic process automation.

The NHS workforce will need to take full advantage of innovations as set out in the Topol Review, Data Saves Lives Strategy and A Plan for Digital Health and Social Care. The widespread safe, effective, and ethical adoption of digital and technological innovations will be one of the most important ways of delivering the government's productivity ambitions.

As part of delivering the 2% productivity target, NHS England is also looking into other areas that can help drive efficiency, deliver better value for money and meet growing demands, while managing costs. Some of these areas include:

1. Operational and clinical excellence: improve patient flow, reduce discharge delays, adopt best practices to minimise clinical variation, and deliver care in the right place at the right time through new models of care.

2. Health rather than illness: focus on increasing healthy life years through prevention and screening, and shift care upstream to primary, community, and mental health services.

3. Reducing waste: achieve efficiencies in medicines, enhance commercial processes, and improve corporate services by exploring large-scale automation.

Additionally, NHS England has committed to reporting on productivity metrics at national, ICB, and trust levels starting in the second half of 2024 to 2025, reflecting a more data-driven approach to identify inefficiencies and areas for improvement.

General practice finances

In March 2024, the 5-year framework for GP contract reform to implement The NHS Long Term Plan, which was agreed between NHSE and the BMA's General Practitioners Committee (GPC) in 2019, came to an end. Due to uncertainty around future funding settlements, a decision was taken to use the 2024 to 2025 GP contract as a stepping stone year. The department and NHS England will be in a position to consider setting a longer-term contract framework for general practice following phase 2 of the multi-year spending review, culminating in spring 2025.

In 2024 to 2025, following the DDRB's recommendation, the GP contract was uplifted to provide a 6% uplift for all salaried General Practice Staff (this includes GPs, nurses and admin). GP contractors were also included in this uplift for the first time since 2019. For 2025 to 2026, the department will continue to seek recommendations for salaried and contractor GPs.

Arrangements for the GP contract for 2025 to 2026 are subject to consultation with the BMA’s GPC, which will commence in autumn 2024. The final arrangements will be published in spring, with new contractual arrangements beginning on 1 April 2025.

Investment in general practice

Data on investment in general practice is published by NHS England. Our evidence for 2024 to 2025 included this data from the 2017 up to 2022, there was however no more recent data published at the time of writing our evidence for 2025 to 2026.

As mentioned in chapter 3 of our evidence, in August 2024 ringfenced funding of £82 million was announced to allow primary pare networks (PCNs) to recruit more than 1,000 newly qualified salaried GPs through the Additional Roles Reimbursement Scheme (ARRS). This was a short-term emergency measure to address issues of unemployment among newly qualified GPs.

Detail on how the Autumn Budget 2024 will impact on general practice finances was yet to be fully established at the time of writing our evidence. Specific allocations within the settlement available for health and social care will be subject to department wide budget setting processes.

Dental finances

NHS dentistry in England is funded by a combination of payments from NHS England and patient charges. Dental funding for 2024 to 2025, before applying DDRB's recommendation, is over £3.8 billion (dependent on patient income). From April 2024, dental patient charges in England increased by 4%. The dentistry recovery plan was published in February 2024, with the previous government backing the plan with £200 million. NHS England has issued guidance on the ringfencing of dental budgets in 2024 to 2025.

NHS primary care dentistry is delivered through contracts structured around Units of Dental Activity (UDAs). From April 2024, the government set a new minimum UDA value of £28. Where a contract holder has delivered less than 96% of contract value by the end of the financial year, funding for the contract under-delivery is recovered by the NHS in the following financial year.

In 2024 to 2025, following the DDRB’s recommendation, the government has proposed that NHS primary care dentistry contract values be uplifted by 4.64%, net of pay (6%) and expenses (1.68%) elements. For dentists in employed NHS roles, including those in Community Dental Services, salary and pay scales were uplifted by 6%. For 2025 to 2026,

the department will continue to seek recommendations for general dental practitioners and salaried dentists.

Detail on how the Autumn Budget 2024 will impact on dental finances was yet to be fully established at the time of writing our evidence. Specific allocations within the settlement available for health and social care will be subject to department wide budget setting processes. Phase 2 of the spending review, which will conclude in late spring 2025, will also provide a longer term picture of dental finances for future years.

Affordability

Previously in this chapter we have set out the economic and financial landscape for 2025 to 2026 which builds on the challenging position following 2024 to 2025.

Resetting the governments approach to affordability

This government will take a different approach to affordability evidence, as part of resetting the relationship with staff and staff representatives, and rebuilding confidence in the PRB process. In recent years, the government's affordability number had lost credibility, and the DDRB's recommendations were consistently above affordability. From now onwards, government will set out a credible figure both to the PRB, and to the NHS to allow integrated care boards to plan ahead of the PRB recommendations to support robust system financial planning.

In doing so, the government will need to factor in the fiscal and economic context, as well as a realistic estimate of the eventual uplift. This should end the period where the government's affordability number is seen as a floor for the PRB recommendations. This approach should mean that in some years recommendations may be below the level of affordability, and sometimes slightly above, depending on other factors the PRBs consider. However, if recommendations are above the level DHSC has budgeted for, the department will need to carefully consider them. Accepting recommendations above what is budgeted for would mean stark trade-offs against activity and wider budgets or consideration to whether productivity improvements can unlock further funding.

Affordability for 2025 to 2026

The Department of Health and Social Care (DHSC) has set aside 2.8% for pay for both NHSPRB and DDRB remit groups. DHSC view this as a reasonable amount to have set aside based on the macroeconomic data and forecasts and taking into account the fiscal and labour market context.

In 2024 to 2025, the government made a number of difficult decisions at the July statement to manage unfunded pressures including pay awards. On health, this included cancelling social care charging reform and reviewing the New Hospitals Programme. For 2025 to 2026, the Chancellor set out at Autumn Budget 2024 how the government has taken further difficult decisions across tax, spending and welfare through the budget and phase 1 of the spending review in order to repair the public finances, including through driving efficiencies and reducing wasteful spending, reforming its approach to welfare, and increasing the rate of employer NICs to fund public services. Departmental settlements for 2025 26 will need to fund the next round of public sector pay awards.

This government has announced its ambition to build an NHS fit for the future and will set out its vision for this via a new 10 Year Health Plan for the NHS. This included announcing funding to support the delivery of an extra 2 million operations, scans and appointments a year to reduce waiting lists across England. The government is carefully balancing delivery of services for patients and ensuring staff are paid fairly and have supportive working conditions that enables delivery of the best patient care.

The NHS workforce is the backbone of service delivery with pay the largest component of NHS costs (as set out in the share of resources going to pay chapter above). Therefore, upwards pressures on pay recommendations do have a significant material impact in managing overall DHSC Group Budgets.

3. Workforce planning, education and training

Chapter summary

This chapter sets out the actions that the government and NHSE are taking to ensure that the NHS workforce is able to meet growing and changing patient demand and is able to adapt as the NHS shifts from analogue to digital, hospital to community and treatment to prevention.

It recognises that the NHS is the largest employer in Europe and plays a significant role in supporting local communities. The chapter starts with an assessment of the medical workforce in Hospital and Community Services (HCHS). It sets out how workforce planning and expansions will, over time, drive growth in our economy.

This chapter also covers the work that the DHSC and NHSE are taking forward to make the NHS the best place to work. This includes information on ensuring strong and accountable leadership and progress on work to make the NHS People Promise a reality for all NHS staff and improve retention.

There is also a detailed section on education and training, to further support a long-term ambition to increase the domestic supply of staff and reduce reliance on international recruitment. The chapter includes information on changes to the Additional Roles Reimbursement Scheme (ARRS), expansion of medical school places and the steps being taken to rebuild dentistry.

Medical workforce Health and Community Health Services (HCHS)

This section describes and discusses the trends in the medical workforce and covers significant issues with regards to patterns of recruitment, retention and motivation.

It does not seek to replicate the data that is already regularly published into the public domain, a summary of these sources and relevant links can be found at the end of this section. Statistics presented here present a point in time prior to the agreement of the 2024 to 2025 pay award.

This section should also be read in close conjunction with the evidence submitted by NHSE where some topics are covered in more depth.

By June 2024, there were over 150,000 medical staff, the equivalent of over 140,000 full time equivalents (FTE). The financial year 2023 to 2024 saw a 5.2% increase in the number of FTE medical staff. This is well above the average annual rate of circa 2% since financial year ending 2011. It is also slightly above the change in non-medical staffing over the same period (5.0%). The early signs are that the medical workforce has continued to grow at a similar rate to 2023 to 2024 in the financial year 2024 to 2025 so far.

Rates of medical staff leaving active employment in the NHS are lower than pre-pandemic levels, with 5.0% of consultants leaving active service in the year to June 2024 along with 8.0% of specialist, associate specialist and speciality (SAS) grade doctors. This compares with 5.5% and 9.0% respectively in the year to June 2019. Published leaver rates reflect leavers from active service in NHS trusts, so include some staff going on maternity leave or career breaks, as well as people leaving to work in GP settings or elsewhere in the health and care sector. Planned movements to general practice settings in particular make interpretation of movement data for resident doctors difficult.

It is important for registered professions, such as doctors, to place this level of leavers in the context of analysis from wider datasets which suggest that annual leaver numbers from the medical profession are low[1]. Leaver rates from the General Medical Council (GMC) register, the marker of people giving up the profession completely, are around 4% a year which includes those retiring and have not changed significantly in recent years. NHS staff survey results suggest around 80% of those considering leaving their current job intend to stay in the NHS, with around 13% leaving the NHS for employment outside the NHS and 8% considering leaving due to retirement or a career break. Over the past 3 years the rate of vacancies for medical staff have remained stable, with increasing staffing numbers being matched by increased planned workforce.

Although there are lower levels of staff leaving the NHS, there are continued signs that the workforce is feeling stretched. Doctors and dentists are reporting higher levels of stress than pre-pandemic. The latest NHS Staff Survey scores indicates that levels of morale amongst doctors and dentists remain low. We further note that reported increased intentions from doctors to look at employment opportunities outside of the UK show no signs of crystalising into significant additional outward flows of staff at this point in time[2]. We however remain alert to this risk and continue to monitor for any significant change in behaviour. More information is provided on measures to address issues impacting the retention of staff in the 'Retention' section later in this chapter.

[1] Is staff retention an issue in the public sector? - Office for National Statistics (ons.gov.uk)
[2] Migrating Doctors Research (gmc-uk.org)

Workforce planning

While the number of training places on offer has increased and there are more staff in the workforce than ever before, it is clear from the Lord Darzi report that this has not translated to increased productivity and the workforce remains under significant pressure. This is in part due to patients not flowing efficiently through hospitals and outdated infrastructure such as analogue technology hindering the workforce's ability to deliver care.

The NHS is in a state of disrepair, and significant reform is needed to ensure that patients receive the appropriate care and the workforce is supported. Expansion alone will not solve the issues facing the health system. New models of care are needed to transform services for patients, allowing greater choice and options, integration of services and an increased focus on prevention and providing more services within the community. We know that the demand on the NHS and wider social care system will continue to grow, impacted by the changes in the way services are provided, population growth in the coming years, and demographic changes including more patients with more complex multimorbidities meaning an ageing population with different and more complex health needs. This is why it is essential that we have an effective workforce strategy in place to ensure we have the right mix and number of staff, with the rights skills and experience, in the right places to deliver safe, high-quality care that patients expect from the NHS.

Following on from Lord Darzi's report, we are now engaging extensively to develop the 10 Year Health Plan for the NHS which will set out how we will shift the NHS from analogue to digital, hospital to community and treatment to prevention. The workforce plan will need to align to these priorities, ensuring the supply is sufficient to meet the demand and the workforce is able to provide the level of service needed to get our NHS back on track and we have the staff practising in the places patients need them.

However, the NHS is more than just a service provider. It is the largest employer in Europe and is therefore able to play a significant role in supporting local communities. The government recognises the importance of aligning expansion to local NHS workforce needs, with an emphasis on priority geographical areas, including remote, rural and coastal areas. This is why, going forward, we will allocate a greater proportion of the new medical school places in under-doctored areas, to address inequalities in access to healthcare. Doctors are more likely to settle and practise in the areas they train, therefore medical school expansion into remote, rural and coastal areas increases the experience in medical degrees and helps to better address the health needs of these areas. The government is also anxious to ensure that in future a much wider section of society is able to benefit from the opportunities of medical training and a career in the NHS

The department will work with the university sector and colleagues across government to ensure that we train the doctors, nurses and healthcare professionals that we need and maximise the contribution that our great research institutions make to the country. The

NHS and universities can work to become anchor institutions across all our local areas, not just to drive employment opportunities through training for a career in the NHS and social care but where we collectively work to drive growth in our economy.

Medical workforce planning across the UK

In response to last year's written evidence, the DDRB commented that the medical and dental labour markets across the 4 nations are interdependent, and wanted a greater understanding of how workforce planning in England affects the other nations and how it can be complementary across the UK.

Previous workforce planning, including NHSE's Long Term Workforce Plan (LTWP), covered England only, because health is a devolved matter. NHS workforce planning is therefore devolved in Scotland, Northern Ireland and Wales, but there is a high level of cooperation and collaboration between the 4 nations, and any future workforce planning, while continuing to be devolved will reflect this.

The UK Foundation Programme Office (UKFPO) manages the national application process for the UK Foundation Programme, issues guidance on foundation training and promotes the consistent delivery of the Foundation Programme across the UK. It is funded by and is accountable to the 4 UK health departments. Funding is historical and based on the Barnett formula: 83% England, 9% Scotland, 5% Wales, 3% NI. Governance for this is via the UK Medical Education Reference Group.

The UKFPO does not determine programme numbers across the UK. Each nation determines the number of programmes they will make available and in recent years, despite significant oversubscription, the 4 nations have increased post numbers, to ensure all eligible applicants have been allocated to a programme.

Medical education and reform

Under the previous government, 205 and 350 additional medical school places were allocated for the 2024 to 2025 and 2025 to 2026 academic years respectively. This brings the total number of government funded medical school places for the 2025 to 2026 academic year to approximately 7,800[3]. An update on the 2026/27 intake will be provided in due course. The department is committed to ensuring that the NHS has the workforce it needs, as well as maximising the NHS's role as an anchor institution that provides jobs to local people and helps local economies grow and thrive. It will ensure that there are more doctors training and practising in the NHS, in particular, in the parts of the country that

[3] Office for Students Health education funding: Medical and dental maximum fundable limits

need them most. It will widen participation in medicine, so that the medical workforce better reflect the population it serves. It will help ensure that we are training doctors equipped to work in specialities that face the biggest staff shortages.

A crucial step will be to increase the number of government funded places at medical schools. As we do so we will be considering the geographical distribution of those places to ensure there is greater equity across the country. In addition, we remain committed to increasing opportunities for students from socially and economically disadvantaged backgrounds to study medicine.

This government is committed to reform that is designed to deliver what patients and the NHS needs and that provides an attractive offer and experience to those considering a career in medicine and those studying medicine - it has to work for everyone involved, including universities. We have inherited an NHS that is broken, but not beaten. The expansion of medical school places for 2026 is just the start. Fundamental, long-term reform will be at the heart of our work to rebuild the NHS workforce. For example, the workforce implications of moving from analogue to digital will be a powerful driver of change over the next decade.

As agreed in the deal between the government and the BMA Resident Doctors Committee; as part of the work to develop a 10 Year Health Plan, DHSC will lead work in partnership with the BMA Resident Doctor Committee, NHSE, devolved administrations, the Medical Royal Colleges, the GMC and employers to reform the current system of training and rotational placements.

International recruitment

As the training expansions to increase the domestic supply of NHS staff come to fruition, our reliance on internationally educated staff will significantly reduce. However, internationally educated staff from overseas will remain an important part of the workforce. We value the skills, expertise and care that the NHS's internationally educated staff bring to work every day. In the UK in 2022, 63% of doctors taking up or returning to a licence to practice on the GMC register had a non-UK Primary Medical Qualification. The latest information on the number and proportion of doctors joining the UK workforce with a non-UK qualification is available in the reports and data tables on the GMC state of medical education and practice in the UK website.

International recruitment must be done ethically. Health and care professionals are globally mobile and migration provides opportunities and challenges for the individual, home country and receiving country.

We ensure high ethical standards in international recruitment practices through the Code of Practice for International Recruitment of Health and Social Care. The Code prohibits active recruitment from red list countries identified by the WHO as having significant health workforce challenges. We conduct regular checks of UK recruiters, through NHS Employers, to ensure no active recruitment is taking place in these countries. However, the Code is mindful of an individuals' right to migrate and where individuals in red list countries want to come to the UK to work, they have every right to apply to a health and social care employer for a job independently and of their own accord (referred to as 'direct applications') and can expect equitable and fair treatment during the process.

The DHSC publishes international candidate guidance to ensure prospective candidates are well informed before they seek a health or care job in the UK. It includes information on how to avoid scams, being aware of exploitation and what to do about it and other practical information that those seeking work in the UK need to know about. We continue to work with stakeholders to ensure the guidance is disseminated widely and reaches potential international candidates before they have taken the decision to move to the UK.

Health and Care Worker visa data for doctors shows significant growth in visa grants for doctors between 2021 and 2022, rising from 5,829 in 2021 to 8,578 visas in 2022 with a marginal increase in 2023 to 8,910 visas granted. Latest published data indicates a slight decline in visas granted in the first quarter of 2024. There were 1,648 visas granted to doctors between January and March 2024 - 20% fewer than in the same quarter in 2023.

The number of Health and Care Worker visas granted to dentists is much smaller than those granted to doctors (with 356 awarded to dentists in 2023). Unlike with doctors, the number of grants has not declined in the first quarter of 2024 (with 90 visas granted to dentists in quarter one of 2024 compared to 78 in quarter one of 2023).

Health and Care Worker visa data by nationality indicates where doctors are coming from. The number of visas granted to doctors by top 10 nationalities in the first quarter of 2021 to 2024 is shown in the table. This shows visa grants for doctors peaking or remaining static across the majority of nationalities in the first quarter of 2023 compared to 2022 before dropping in the first quarter of 2024. Information on the outflow of doctors to other countries is not available.

Table 6: health and care worker visas granted to doctors between January and March in each of 2021 to 2024 by top 10 2024 nationalities

	2021	2022	2023	2024
India	224	299	523	441
Pakistan	198	154	335	281
Egypt	177	173	173	156
Nigeria	143	329	226	150
Sri Lanka	49	72	132	71
Sudan	71	83	54	53
Bangladesh	55	27	90	42
Australia	15	29	30	42
Greece	7	27	30	38
Jordan	17	30	46	36
Total visas (all nationalities)	1,183	1,544	2,052	1,648

While the recent reduction in visa grants for doctors coincides with a number of changes to the visa rules announced by the previous administration in December 2023, NHS staff are broadly unaffected by the changes. This is because health and care occupations remain exempt from the skilled worker salary threshold increases and instead must meet the national pay scale for their role or the new minimum threshold of £23,200 (whichever is higher). The fall in visa grants is therefore more likely attributable to wider factors including changes in demand for international staff.

NHS temporary staffing

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

Measures were introduced in 2016 to curb NHS agency spending. These included price caps, the mandatory use of approved frameworks for procurement, and the requirement for all systems to stay within the specified annual expenditure ceilings for agency staff.

The measures, which are regularly monitored for compliance and effectiveness, aim to reduce cost and give greater assurance of quality. Metrics used to monitor performance on agency usage are included in the NHS Oversight Framework, which reinforce the rules with which NHS trusts and FTs should comply.

Trusts are encouraged to develop and improve their strategy, procurement, and commercial negotiation in their approach to temporary staffing. NHSE supports NHS trusts to reduce off-framework supply and to develop staff banks, increasing transparency and collaborative arrangements.

Agency spend was £2.96 billion in financial year 2021 to 2022 and £3.46 billion in financial year 2022 to 2023. Following a period of agency spend growth, there is more recently some evidence that the measures to reduce agency spend are having an effect, with year to date spend in Q3 of 2023 to 2024 at £2.34 billion compared with £2.56 billion in Q3 of the previous year.

Price cap compliance for all staff groups has remained constant at 60% since 2018 until 2022 to 2023 when it dropped to 55%. However, for the medical and dental staff group, compliance was typically around 14.95% in 2022 to 2023 to 2023 to 2024. The national shortages of medics in certain specialities (such as orthopaedics, geriatrics, cardiothoracic oncology and radiology) may contribute to poor compliance rates amongst this group. This causes greater variability in hourly rates between on and off-framework spending.

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

NHS Planning Guidance stated that agency spend should account for 3.7% of the NHS pay bill in 2023 to 2024. NHS Planning Guidance for 2024 to 2025 states that the system should further reduce agency spending across the NHS to 3.2% of the total pay bill. The Planning Guidance also states that NHS trusts should have ended the use of off-framework agencies by the end of July 2024.

There are some signs that agency spend is further decreasing in 2024 to 2025. However, the government intends to go further. In ‘Fixing the Foundations - Public Spending Audit 2024/25’, the government committed to working with NHSE to review how to rapidly reduce the costs of temporary staffing.

Leadership

Strong and accountable leadership plays an important role in driving NHS performance and fostering a positive, compassionate culture in the NHS, which is why we have committed to introducing professional standards and regulation for managers. This will be supported by a wider programme of work that is being implemented by NHS England to improve NHS leadership development more widely including for clinical leaders, and will be complemented by the establishment of a College of Executive and Clinical Leadership.

NHSE’s Management and Leadership Development Programme is delivering an ambitious 3 year plan to increase professional accountability and boost public confidence in NHS leaders and managers, which will increase their sense of pride in their profession. This supports the ambitions of the LTWP to invest in the development of clinical and non-clinical managers and leaders.

NHSE's 3 year plan responds to the 'Leadership for a Collaborative and Inclusive Future' review (published 2022) led by Sir Gordon Messenger, which focuses on the best ways to strengthen leadership and management across health and adult social care. The review made 7 recommendations to improve leadership and culture through developing training, career development and talent management, and through embedding inclusive cultures and behaviours within health and care. NHSE is taking forward implementation of all 7 accepted recommendations from this review. On 13 November 2024, the Secretary of State for Health and Social Care announced that Sir Gordon Messenger has been asked to support the department to build on his original recommendations to develop and attract the leadership talent needed to deliver the 10 Year Health Plan.

To respond to the challenge of ensuring leaders have the right skills and capabilities, the Secretary of State announced that the creation of a new national college of NHS leadership - a professional body dedicated to raising standards of management leadership and across the NHS. This college will support ongoing development, set clear expectations, and promote best practice. It will bring together clinical and non-clinical managers, creating a network of accredited leaders with the skills and knowledge to lead the reforms laid out in the 10 Year Health Plan. Through this college, we will strengthen and develop our current leaders and build a future pipeline of top talent.

At the same time, NHS league tables will be introduced. Providers to be placed into a league table to review NHS performance across the entire country. This will be made public and regularly updated to ensure leaders, policy makers and patients know which improvements need to be prioritised. High-performing providers will be given greater freedom over funding and flexibility. There is little incentive across the system to run budget surpluses as providers cannot benefit from it. These reforms will reward top-performing providers and give them more capital and greater control over where to invest it in modernising their buildings, equipment and technology.

Persistently failing managers will be replaced and turnaround teams of expert leaders will be deployed to help providers which are running big deficits or poor services for patients, offering them urgent, effective support so they can improve their service. In the context of our strategy for senior leaders, it is also imperative that pay for senior leaders fairly reflects the complexities of their roles while also being used as an incentive to improve performance and patient care.

Retention

Making the NHS an attractive employer with an engaged workforce is an important priority and this underpins efforts to improve both recruitment and retention. The NHS LTWP recognises this and has a focus on improving workplace culture and creating a more supportive and inclusive environment for staff to work in. Lord Darzi's report emphasises the challenges of staff not feeling engaged and the impact this is having on patient experience, care quality and patient safety. He also noted the impact this is having on discretionary effort across the workforce.

Staff retention is a complex issue that ultimately depends on the personal choices and decisions of people working across the NHS. Many factors can influence this including but not limited to: career progression; pay and reward; access to learning and development; culture and leadership; relationships with managers and colleagues; pressures in the workplace; and opportunities to work flexibly.

NHSE is leading a range of work programmes to improve retention through its retention programme and with specific emphasis on the NHS People Promise. They will set out in their evidence the progress that is being made in this area, including the learnings from the People Promise Exemplar programme, the importance of promoting flexible working opportunities, the benefits of investing in good occupational health and staff wellbeing initiatives, and work to tackle discrimination, bullying and abuse against staff through the NHS Ethnicity, Diversity and Inclusion (EDI) improvement plan and other initiatives. They will also cover the findings of the NHS Staff Survey that was published in March 2024 which showed broadly positive results.

Action on retention needs sustained commitment and leadership and more consistent roll-out across NHS organisations to reap the full benefits at organisational level and make a genuine difference to how staff feel about working in the NHS. Through the 10 Year Health Plan for the NHS, we will look at how we can build on the NHS LTWP and the NHS retention programme to ensure staff feel well supported.

Gender and ethnicity pay gaps

NHSE are responsible for ethnicity, diversity and inclusion through Workforce Race Equality Standard WRES and the NHS EDI Improvement Plan. The latter sets out a series of High Impact Actions, one which specifically asks NHS organisations to 'eradicate' their pay gaps in relation to gender, ethnicity and disability. Lack of ethnicity pay gap reporting was highlighted as an area of concern in the DDRB response and this is an issue that is being addressed by NHSE. There has been no data collection this year, but NHSE will be including an outline in their evidence ongoing work around sharing good practice and work that will be commencing later this year. The gender and ethnicity pay gaps are explored

further in chapter 5 with reference to the data, and chapter 6 with reference to consultants and GPs.

General practitioners

The government has committed to reforming general practice. This will include training thousands more GPs, guaranteeing face-to-face appointments, and delivering a modern booking system to end the 8am rush. The government is also committed to bringing back the family doctor by incentivising GPs to see the same patient.

The Delivery Plan for Recovering Access to Primary Care, published in 2023, sets out how we aim to address significant challenges facing the sector by streamlining patient access to care and advice. Delivery of the plan is ongoing, and we recognise an important factor in improving access to primary care is to increase the GP workforce.

We continue to recognise the importance of expanding GP training places, and the development of a 10 Year Health Plan will grow the numbers of available training places to support long term workforce sustainability. Data on the numbers and fill rates of GP training places can be found in chapter 4 of our evidence.

Efforts have also been made to widen the range of clinical staff working in general practice. As part of changes to the GP contract for 2024 to 2025, the flexibilities made to the Performers List regulation brought in during the Covid-19 pandemic were made permanent. This enables practices to continue to engage a variety of medical professionals to operate as part of the primary care team.

The department is continuing to work with NHSE to boost the recruitment of GPs and address the reasons why doctors leave the profession. Earlier in the year, a decision was made by NHSE to stop central funding for the GP fellowship scheme and Supporting Mentors scheme. The department and NHSE are continuing to work together to identify potential solutions to improving GP retention.

The additional roles reimbursement scheme (ARRS)

The ARRS has led to considerable diversification of the GP workforce and has been crucial in delivering additional appointments. The ARRS has enabled primary care networks (PCNs) to recruit a diverse range of professionals into primary care. Between March 2019 and June 2024, 37,000 additional primary care professionals have been recruited into general practice. The scheme has allowed patients to be seen by a wider range of professionals and access the care they need while freeing up capacity for GPs to focus on the work that only GPs can do.

A number of changes have been made to the Additional Roles Reimbursement for 2024. As part of changes to the GP contract, enhanced nurses were added to the scheme as a reimbursable role. In addition to this, caps on the numbers of advanced practitioners PCNs can recruit through the scheme have also been removed as well as caps on other direct patient care roles. There is also increased flexibility around funding for mental health practitioners employed through the scheme.

In August 2024, ring fenced funding of £82 million was announced, allowing PCNs to recruit GPs through the scheme. This is a measure to respond to feedback from the profession and to help solve the immediate issue of GP unemployment. This is an issue which partly results from more GPs qualifying after an increase in training places. We are working with NHSE to identify a longer-term solution.

Dentists

The government is determined to rebuild NHS dentistry, but it will take time and there are no quick fixes. Strengthening the workforce is integral to our ambitions.

The government has committed to tackling the immediate crisis in NHS dentistry with more urgent dental appointments and recruiting new dentists to areas that need them most. To rebuild dentistry in the long term, the government has committed to reforming the dental contract, with a shift to focus on prevention and the retention of NHS dentists.

We acknowledge that there are areas of the country that are experiencing recruitment and retention issues, and we are taking steps to address the workforce challenges across the country. The government is also exploring how we can better support the whole dental team to work in NHS dentistry. A consultation for a tie-in to NHS dentistry for graduate dentists closed on 18 July 2024 and we are considering the responses. The government position on this proposal will be set out in due course.

We are currently reviewing the previous government’s dentistry recovery plan and what elements of that can be taken forward effectively and within NHS budgets.

4. Data on recruitment, retention and motivation in the general practice and dental workforces

Introduction

This chapter covers available data on recruitment, retention and motivation in the general practice and dental workforces. This includes breakdowns of role types, participation rates, training places and retirement.

General practice workforce data

The department recognises the need for growth of the general practice workforce. Workload continues to be a primary factor in low morale and retention of the workforce. Trends in workforce data can provide useful insight.

Data on the general practice workforce is published by NHS England. These workforce numbers are subject to fluctuations over the year, due to training and recruitment cycles. They are typically highest in September as a new cohort of GP trainees begin their training, and gradually decline throughout the year. Comparisons of workforce data should take this into account and take a year-to-year view.

Tables 7 and 8 present a summary of doctors by role type working in general practice by full time equivalent (FTE) and headcount since 2019. As of September 2024, there were a total of 38,420 FTE doctors working in general practice in England.

Table 7: doctors in general practice in England, FTE, by role, September 2019 to September 2024

Practitioner type	September 2019	September 2020	September 2021	September 2022	September 2023	September 2024
All doctors in general practice	34,729	35,393	36,495	37,026	37,419	38,420
GP partners	18,462	17,641	17,059	16,750	16,342	15,897
Salaried GPs	8,496	9,133	9,752	9,865	10,065	11,179
GPs in training grade	6,547	7,454	8,576	9,470	10,116	10,455
GP retainers	186	228	254	252	272	287
GP regular locums	1,037	937	854	689	623	602

Source: NHS England, General Practice Workforce, 30 September 2024, October 2024, table 1a. Data includes estimates for practices that did not provide fully valid staff records.

Table 8: doctors in general practice in England, headcount, by role, September 2019 to September 2024

Practitioner type	September 2019	September 2020	September 2021	September 2022	September 2023	September 2024
All doctors in general practice	43,442	44,617	45,980	46,283	46,842	48,758
GP partners	21,100	20,363	19,876	19,537	19,073	18,640
Salaried GPs	13,109	14,257	15,267	15,433	15,914	17,834
GPs in training grade	6,686	7,558	8,664	9,628	10,353	10,823
GP retainers	485	576	640	618	655	688
GP regular locums	2,532	2,297	2,117	1,668	1,457	1,403

Source: NHS England, General Practice Workforce, 30 September 2024, October 2024, table 1b. Data includes estimates for practices that did not provide fully valid staff records.

Recent data suggests that the GP workforce is growing. Overall, the general practice workforce data shows the number of doctors in general practice grew by 3,692 FTE from September 2019 to September 2024, an increase of 11%. While the number of training

places is driving some of this growth, we are also starting to see consistent growth in the fully qualified workforce. However, the number of FTE GP contractors has continued to decline from September 2023 to September 2024. More information on the declining numbers of GP contractors can be found in chapter 6 of our evidence.

Demographics

The demographic makeup of the GP workforce is similar to previous years. As of September 2024, there were more female doctors in general practice than males with a headcount of 28,125 and 20,450 FTE for females with a headcount of 20,292 and 17,721 FTE for males. However, more males continue to work as GP partners (57% of all GP partners or 9,065 FTE) and regular locums. GP trainees made up 27% of the workforce, broadly similar to September 2023.

Age and gender distribution also varies with role. Salaried GPs and doctors in training make up a higher proportion of the younger workforce, female doctors make up a higher proportion of GPs under 45, and there is a higher proportion of male GPs in older age bands. Differences in working patterns (see tables 10 and 11 on participation rates) between male and female workers are likely to impact workforce trends in FTE by role.

Part time working and participation rates

Participation rates are used to measure the extent of part-time working in the general practice workforce. They are defined as the ratio of full-time equivalents to headcount. Participation rates as of September 2024 are shown by role and gender in table 10 and by age and gender in table 11. A full-time working week is considered to be 37.5 hours.

Participation rates are lower for female GPs in each role and age band. Contractor GPs and GPs in training have the highest participation rates regardless of gender; regular locums and retainers have the lowest. GPs in training grade appear to have higher participation rates as a trainee’s full-time contract is 40 hours compared to the standard full time salaried/contractor GP contract which is 37.5 hours. Overall, participation rates are similar to last year, and table 9 shows how this changed year on year.

Table 9: doctors in general practice, participation rates, by role, September 2019 to September 2024 (%)

Staff group	**September 2019**	**September 2020**	**September 2021**	**September 2022**	**September 2023**	**September 2024**
All doctors in general practice	80	79	79	80	80	79
GP partners	87	87	86	86	86	85
Salaried GPs	65	64	64	64	63	63
GPs in training grade	98	99	99	98	98	97
GP retainers	38	40	40	41	41	42
GP regular locums	41	41	40	41	43	43

Source: NHS England, General Practice Workforce, 30 September 2024, October 2024, tables 1a and 1b. Data includes estimates for practices that did not provide fully valid staff records.

Table 10: participation rates of doctors in general practice by gender and job role, September 2024 (%)

Practitioner type	**Male**	**Female**	**All (including unknown)**
All doctors in general practice	87	73	71
GP partners	92	77	84
Salaried GPs	68	60	60
GPs in Training Grade	101	93	98
GP retainers	48	40	42
GP regular locums	45	40	43

Source: NHS England, General Practice Workforce, 30 September 2024, October 2024, tables 1a and 1b. Data includes estimates for practices that did not provide fully valid staff records.

Table 11: participation rates of doctors in general practice by age and gender, September 2024 (%)

Age band	Male	Female	All (including unknown)
All	87	73	79
Under 30	104	101	102
30 to 34	89	80	84
35 to 39	83	69	74
40 to 44	84	67	73
45 to 49	89	67	76
50 to 54	89	70	78
55 to 59	89	71	80
60 to 64	83	69	77
65 and over	77	69	75
Unknown	72	60	69

Source: NHS England, General Practice Workforce, 30 September 2024, October 2024, tables 2a and 2b. Data includes estimates for practices that did not provide fully valid staff records.

GP locums

The number of regular locums as of September 2024 was 602 FTE (1,403 headcount). This was 21 FTE fewer regular locums than September 2023. There were an additional 209 FTE (1,183 headcount) ad hoc locums working in general practice during June 2024, based on provisional data. 297 ad hoc locums worked in another general practice role during the reporting period, for example as a salaried or contractor GP at another practice.

Many locum GPs work for practices on a longer-term regular basis. For example, locums may provide maternity cover or provide regular weekly or monthly sessions. Ad hoc locums are those who work on a less regularised basis, covering sessions at short notice.

As part of methodological changes implemented in the June 2021 publication to facilitate the move to monthly practice workforce reporting, ad hoc locum GP figures were removed from the main publication and included in an annex. Figures for ad hoc locums are collected and calculated differently to the rest of the general practice workforce.

Other primary care staff

Steps have been taken to diversify the general practice workforce. Since 2019, there have been an additional 37,802 FTE additional primary care professionals recruited into general

practice. This covers a range of roles including pharmacists, physiotherapists and dieticians.

In September 2021, to complement the existing general practice and primary care networks (PCNs) level workforce data. NHS England introduced experimental quarterly statistics on the entirety of the primary care workforce. As of June 2024, this publication showed that there were 37,802 more direct patient care staff. This includes 5,618 direct patient care staff which have been recruited directly by practices since March 2019.

Table 12: all staff working in general practice (excluding PCNs), FTE, September 2019 to September 2024

Staff group	**September 2019**	**September 2020**	**September 2021**	**September 2022**	**September 2023**	**September 2024**
All staff	131,370	133,663	138,372	143,126	146,033	148,853
All staff excluding doctors	96,641	98,270	101,877	106,099	108,614	110,432
Doctors	34,729	35,393	36,495	37,026	37,419	38,420
Nurses	16,530	16,635	16,510	16,779	16,903	16,916
Other direct patient care staff	12,154	13,148	14,519	15,754	16,601	17,274
Admin/non-clinical	67,108	68,474	70,245	73,006	74,721	76,174

Source: NHS England, General Practice Workforce, 30 September 2024, October 2024, table 1a. Data includes estimates for practices that did not provide fully valid staff records. Does not include staff employed by primary care networks.

Table 13: direct Patient Care Staff employed in GP practices and primary care networks, September 2021 to June 2024

Staff group	September 2021	September 2022	September 2023	June 2024
Other direct patient care staff	24,351	32,492	45,899	48,763

Note: September 2024 data was not yet available at the time of preparing the evidence.

Table 14: all staff working in general practice (excluding PCNs), headcount, June 2019 to June 2024

Staff group	September 2019	September 2020	September 2021	September 2022	September 2023	September 2024
All staff	180,924	183,234	188,476	192,011	194,449	197,683
All staff excluding doctors	137,506	138,654	142,565	145,800	147,682	149,014
Doctors	43,442	44,617	45,980	46,283	46,842	48,758
Nurses	23,773	23,807	23,554	23,490	23,284	23,121
Other direct patient care staff	17,874	18,994	20,712	21,840	22,560	23,115
Admin/non-clinical	96,181	96,190	98,690	100,958	102,322	103,282

Source: NHS England, General Practice Workforce, 30 September 2024, October 2024, table 1b. Data includes estimates for practices that did not provide fully valid staff records.

GP recruitment

The government is committed to growing the general practitioner workforce and has committed to training thousands more GPs. Increasing GP training places will increase capacity and appointments in practices and ease workload. Trainee GPs are able to provide safe direct patient care while being supervised.

Table 15: General Practice Specialty training places available

GP Specialty Training Places	2018	2019	2020	2021	2022	2023	2024
Places available	3,250	3,250	3,750	4,000	4,000	TBA	TBA
Acceptances	3,473	3,540	3,793	4,001	4,032	TBA	TBA
Fill rate	107%	109%	101%	100%	101%	TBA	TBA

There are currently 4,000 GP training places available a year, up from 2,761 in 2016. In 2022, 4,032 trainees accepted a place on GP training - up from 2,671 in 2014.

Data on recruitment fill rates for showed 3,427 trainees accepted a place on GP training in Recruitment Rounds 1 and 2 in England in 2023, a fill rate of 99.83% for 3,433 places.

Source: NHS England: 2023 Recruitment England Fill Rates - Round 1 and Round 2

There continue to be schemes available to attract more doctors into GP specialty training including the Targeted Enhanced Recruitment Scheme (TERS). TERS is a national incentive scheme that funds a £20,000 salary supplement to attract trainees to work in areas of the country where training places have been unfilled for a number of years. Since 2016, the scheme has widened its criteria to include under-doctored and deprived areas. 800 places were available in 2022 and 782 places were available in 2023. The final number of TERS places available in 2024 to 2025 in England was not available information at the time of writing our evidence. Future funding for the scheme also had not been confirmed at the time of writing our evidence.

GP retention

As mentioned earlier in this chapter, data suggests we are starting to see consistent growth in the number of fully qualified GPs. The government has committed to increasing the number of GPs, and this commitment includes doing more to address GP retention and addressing reasons GPs are leaving the profession. We recognise it is vital for roles to be satisfying, rewarding and sustainable so that our experienced GPs continue to contribute throughout their career.

Between September 2023 and September 2024, 2,628 headcount fully qualified GPs (7.3%) left general practice, while 4,158 GPs joined. This rate was highest among GPs aged under 30 (24.2%) and GPs aged 65 to 69, though both of these age groups make up only a small proportion of fully qualified GPs. By gender, leavers rates were higher among male GPs (7.5%) than female GPs (7.1%). In terms of raw headcount, the highest number of leavers in this period was in the 35 to 39 age group.

This data is based on GPs who joined or left the workforce between the beginning of September 2023 and end of September 2024. It does not include GPs in training grade and does not capture migration between practices. Data quality issues mean that in some cases, a GP recorded as a leaver in these figures may have left one practice and joined another practice with poor data completion. In instances such as this, a GP will be incorrectly recorded as a leaver due to the identifying information no longer being present in the dataset. Conversely, a GP could appear in the practice cohort as a joiner but may have joined from a practice with poor data completion rather than being a new addition to the GP workforce.

Data on GP vacancies

Until September 2019, NHS England published high-level figures on staff absence and vacancies. However, the completeness and coverage of the data were very low, and in March 2020 this analysis was suspended. NHS England are not currently collecting information on staff absence or practice-level vacancies within the general practice workforce

As mentioned in chapter 3, changes to the ARRS made in August 2024 will enable over 1,000 newly qualified GPs to be recruited. This change is intended to address urgent issues around GP unemployment and patient access, following reports of significant number of newly qualified GPs currently looking for employment. This ARRS change is an emergency measure for 2024 to 2025, and the government is working to identify longer term solutions to address recruitment and ensure opportunities for newly qualified GPs.

Voluntary early retirement

There are 2 NHS Pension Schemes, the 1995/2008 Scheme (which closed in 2015) and the newer 2015 Scheme. According to analysis of NHS Pension Scheme membership, of the GPs taking their 1995 Section pension on an age or voluntary early retirement (VER) basis, the proportion doing so on a VER basis increased from 21.5% in 2008 to a peak of 52.7% of 2017.

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

Chapter 7 of our evidence includes data from 2008 to 2024 of the total numbers of GPs claiming 1995 Scheme pension benefits each year, as well as the numbers of staff in these groups who claim their pension benefits earlier than their normal pension age.

Average GP retirement ages

Data is not held on overall age of retirement for GPs as there are 2 types of retirement - voluntary early retirement (explained above) and age retirements.

The normal pension age is the age that you can retire from NHS employment and have your pension paid without reduction or enhancement. The 1995 section has a normal pension age of 60, and the 2008 section has a normal pension age of 60. Age retirements

are taken at or after pension age, while voluntary early retirements are taken before reaching pension age. Members of the 1995 section can take early retirement from age 50 or 55 depending on active membership periods, and for the 2008 section the minimum age is 55.

In October 2023 partial retirement was introduced for NHS pension scheme members aged 55 and over in an effort to retain more doctors. This means that members of the NHSPS age 55 or older can take between 20% and 100% of all their pension benefits in one or 2 drawdown payments, without having to leave their current job. As of September 2024, 76 GPs have taken partial retirement.

GP workload and morale

Surveys of the GP workforce across the life course of their careers provide insight into morale and decisions around their careers.

The GP Worklife survey is commissioned by DHSC and carried out by a team based at the University of Manchester, on behalf of the National Institute for Health Research's (NIHR) Policy Research Unit in Health and Social Care Systems and Commissioning. The survey provides valuable insight into issues including morale, workload and satisfaction among general practitioners and these insights were used to inform last year's evidence to the DDRB from DHSC. While a new survey is currently being carried out, there has been no new survey completed and reported on since last year's evidence.

A survey carried out in May 2024 by the Royal College of General Practitioners (RCGP) found that, when asked what would help keep them in the profession, 66% of GPs cited a reduction in administrative workload with 56% saying a reduction in clinical workload. The GMC's national training survey in 2024 sought to measure risk of burnout among trainees and trainers across specialties using the Copenhagen Burnout Inventory (CBI) tool. 21% of trainees in general practice were found to be at high risk of burnout, the same figure as in their 2023 survey. Among trainers in general practice, 15% were found to be at high risk of burnout, also the same figure as in their 2023 survey. Across all the specialties assessed, only emergency medicine and ophthalmology showed a higher rate of burnout risk among trainers than general practice. In October 2024 the Secretary of State for Health and Social Care announced a 'red tape challenge' to cut down on bureaucracy between general practice and secondary care and free up more time for GPs to see patients. The challenge will be led by NHSE and a review group of doctors across primary and secondary care will report back to the department and NHSE in the new year.

In addition to tackling the causes of stress and burnout among GPs, there are wellbeing and mental health support options available to the workforce, such as the Practitioner

Health scheme. NHSE are currently undertaking a review of mental health support for the NHS workforce.

Dental workforce data

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

Data on NHS dentistry is published by NHS England. NHS England published findings from its new dental workforce data collection for the first time as 'Management Information' on 14 November 2024. The publication indicates that 10,539 FTE general dentists are delivering dental services for the NHS. Nationally, the vacancy rate for NHS general dentists is 21%, with 2,749 FTE vacancies. The region with the highest NHS vacancy rates for general dentist posts is the South West, with a vacancy rate of 29%; London has the lowest NHS vacancy rates at 15%. This data can be found at this link: dental workforce data.

The 2023 to 2024 NHS dental statistics show a positive trend in the recovery of NHS dentistry following the pandemic. 18.4 million adults were seen by an NHS dentist in the 24 months up to 30 June 2024, an increase of 320,000 (1.8%) when compared to the previous year, and 6.7 million children were seen by an NHS dentist in the 12 months up to 30 June 2024, an increase of 360,000 (5.7%) when compared to the previous year.

Furthermore, 34.1 million courses of treatment (CoT) were delivered in 2023 to 2024, an increase of 4.3% compared to the previous year. 48.6% of courses of treatment were delivered to non-paying adults and children in 2023 to 2024 compared to 47.5% for 2022 to 2023.

24,193 dentists performed NHS activity (any amount over 1 unit of dental activity) during 2023 to 2024. This was an increase of 42 on the previous year though 483 fewer than the number who performed NHS work in 2019 to 2020. Of the total for 2023 to 2024, a majority (81.5%) were associate dentists.

Table 16: number of dentists with NHS activity by dentist type, 2019 to 2020 and 2023 to 2024

Dentist type	2019 to 2020	2023 to 2024	% of total (2019 to 2020)	% of total (2023 to 2024)
Providing performer	4,850	4,458	19.7 %	18.4 %
Associate (performer)	19,786	19,714	80.2 %	81.4 %
Unknown	40	21	0.2 %	0.1 %
Total	24,676	24,193	100%	100%

NHS BSA, Dental Statistics 2023/24, Workforce Overview, table 1b.

Table 17: number of dentists with NHS activity by dentist type, 2019/20 to 2023/24

Dentist type	2019/20	2020/21	2021/22	2022/23	2023/24
Providing performer	4,850	4,684	4,752	4,604	4,458
Associate (performer)	19,786	19,024	19,485	19,512	19,714
Unknown	40	25	28	35	21
Total	24,676	23,733	24,265	24,151	24,193

Sources: NHS BSA, Dental Statistics 2023/24, Workforce Overview, table 1b.

Demographics

As of 2023 to 2024, there were more female dentists performing NHS dental activity than males, with a headcount of 13,172 females (54.4%) compared to 11,021 males (45.6%). By comparison, in 2019 to 2020 there were still more female dentists performing NHS dental activity than males, though by a smaller proportion (51.3% female to 48.7% male).

In 2023 to 2024, the age group with the highest proportion of female dentists was the under 35 band (61.1%). The age group with the highest proportion of male dentists was the 55 or over band (67.1%).

Table 18: number of dentists with NHS activity by gender, 2019 to 2020 to 2023 to 2024

Dentist gender	2019/20	2020/21	2021/22	2022/23	2023/24
Female	12,654	12,301	12,775	12,931	13,172
Male	12,022	11,432	11,490	11,220	11,021
Total	24,676	23,733	24,265	24,151	24,193

NHS BSA, Dental Statistics 2023/24, Workforce Overview, table 1c.

Table 19: percentage of dentists with NHS activity by gender across age groups, 2023 to 2024

Age band	Female	Male
Under 35	61.1%	38.9%
35 to 44	59.2%	40.8%
45 to 54	51.6%	48.4%
55 or over	32.9%	67.1%
All	54.4%	45.6%

Source: NHS BSA, Dental Statistics 2023/24, Workforce Overview, table 1c.

Overseas-trained dentists

Overseas-trained dentists remain an important part of the NHS workforce. As of December 2023, 30.3% of the 45,204 dentists registered with the General Dental Council (GDC) in the UK qualified outside of the UK. Of those that qualified outside of the UK, the largest individual group was dentists with a European Economic Area qualification (headcount of 8,142, 18% of the total), followed by those dentists that qualified through the GDC's Overseas Registration Exam (headcount of 3,988, 8.8% of the total).

Table 20: dentists on the GDC register as of 31 December 2023 by region of qualification

Region of qualification	Amount	% of total
UK qualified	31,471	69.7%
EEA qualified	8,142	18%
ORE - UK Statutory Examination	3,988	8.8%
Rest of the world qualified	1,603	3.5%
Total	45,204	100%

5. Earnings and expenses

Introduction and core messages

This chapter contains information on average earnings and expenses for doctors and dentists working across hospital, general practice, and dental settings as well as information on growth over the past year and comparisons with the wider economy.

The core messages we will outline include:

- Doctors and dentists benefit from a system of national pay structures that covers the full length of the training cycle from the end of university through to consultant level with pay increasing at each stage on this journey.

- In 2023 to 2024 pay increases were consistent with the outcome of the DDRB round Since then there have been further agreements with the consultant, SAS and resident workforces which set a higher baseline for the forthcoming pay decision.

- For 2024 to 2025 the government accepted the recommendations of DDRB and have increased pay scales by 6% with pay scales for resident doctors increasing by an additional £1,000. This means that earnings growth (at least 6%) is expected to be favourable when compared to the wider economy (OBR forecast of 4.5%)

- As well as considering outturn earnings growth the PRB will also want to take account of forecasts for earnings and pay settlements to ensure that pay recommendations take into consideration both past events and future forecasts. OBR forecasts, published alongside the autumn budget, forecast wider economy earnings growth of 3.0% in 2025 to 2026 which is similar to indications of forecast pay settlements for 2025.

Average pay and earnings in 2023 to 2024

NHS England publishes information on average pay and earnings for staff working in the HCHS in England. This data does not include any outside earnings including bank, agency or independent work.

All figures in this section are provided on a 'gross' basis which is the total before the impact of tax, national insurance or other deductions which determine 'take-home' pay and is the data that we use for pay analysis as well as being the policy challenge for the department and DDRB.

Average pay and earnings in the HCHS sector

There are different ways to measure average pay and earnings in the HCHS in England with choices capturing the difference between basic pay and total earnings.

In this section we predominately use:

- total earnings per person - this is the average level of earnings across the group and includes all pay elements: basic pay, additional activity and clinical impact awards

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

Table 21 presents earnings data for staff working in the hospital and community health sector in the 12 months to March 2024 and includes a comparison with the prior year.

Table 21: average pay and earnings by medical grade for staff working in NHS trusts and core organisation - 12 months to March 2024 and comparison with previous year

Medical Grade	Average FTE (count)	Basic pay per FTE (£)	Earnings per person (£)	Growth in basic pay per FTE (%)	Growth in earnings per person (%)
All grades	**137,637**	**£77,147**	**£93,417**	**5.0%**	**6.1%**
Consultant	55,751	£111,596	£136,682	5.8%	7.4%
Associate specialist	2,329	£98,346	£108,095	3.9%	5.5%
Specialty doctor	8,775	£74,781	£81,852	4.8%	7.5%
Staff grade	347	£62,866	£76,755	3.8%	7.8%
Specialty registrar	33,877	£51,995	£66,577	5.9%	5.1%
Core training	20,782	£45,377	£58,671	4.7%	4.4%
Foundation year 2	6,787	£34,960	£45,354	3.7%	4.2%
Foundation year 1	7,547	£29,974	£37,814	2.5%	2.0%
HPs and CAs	618	£127,245	£46,963	2.9%	2.3%
Other and local grades	823	£102,468	£66,697	3.4%	10.1%

Source - NHS England earnings statistics

Note - average FTE is based on average FTE in NHS Trusts and core organisations between April 2023 and March 2024.

Some of the significant messages from these data are:

- for staff working in NHS trusts and core organisations in the 12 months to March 2024 average basic pay per FTE ranged from around £29,900 for doctors in foundation year 1 to around £111,600 for consultants (note the figure for hospital practitioners

(HPs) and clinical assistants (CAs) was higher at around £127,200 but most of these staff work on a sessional basis) while average earnings per person ranged from around £37,800 for foundation year 1 doctors to around £136,800 for the consultant workforce

- for resident doctors the average growth in observed pay was less than the value of the pay award which may reflect the impact of pay deductions for staff taking part in industrial action. This is also one reason why average basic pay per FTE for these doctors may be below pay scale values

- the growth in pay for SAS doctors was also a little below the average value of the pay award which may follow workforce expansion and an influx of new staff who are more likely to be toward the bottom of pay ranges

- there are a small number of doctors remaining on 'staff grade' contracts - as this is a closed contract any changes in pay and earnings are impacted by those who are still working including if leavers are predominately at the top of the pay scale

Because earnings statistics are subject to fluctuations caused by changes in the size and shape of the workforce or outside events impacting staff activity, we believe that changes to pay values through either the annual pay settlement, or negotiated agreements, provide a good indication as to the increase in average pay over a period.

The impact of pay agreements and the 2024 to 2025 pay decision.

Published earnings statistics will not yet include the full impact from recent pay agreements or the outcome of the 2024 to 2025 pay round.

For consultants:

- the agreement with consultants in April 2024 agreed structural reform to the consultant contract with a reduction in the number of pay points and a reduction in the minimum length of time required to reach the top of the pay scale. Increases to pay points ranged from 0% to 12.8%. It also removed the right to Local Clinical Excellence Awards from 1 April 2024

- from 1 April 2024 pay scales increased by 6.0% following the government's acceptance of DDRB recommendations and there was no change to the value of remaining clinical impact awards

For SAS doctors:

- the agreement with SAS doctors in June 2024 agreed structural reform to improve incentives for doctors working under the 2021 SAS contracts. The pay points for these contracts were uplifted by between 6.1% and 9.22%. A £1,400 consolidated increase was made to staff remaining under pre-2021 conditions

- from 1 April 2024 pay scales increased by 6.0%, on both 2021 and pre-2021 contracts, following the government's acceptance of DDRB recommendations

  For resident doctors:

- the agreement with resident doctors will increase the value of pay in 2023 to 2024 by between 3.71% and 5.05% with the higher increase being for those on nodal point 3 to support recruitment and retention at an important stage of training

- from 1 April 2024 pay scales increased by 6.0% plus an additional £1,000 consolidated increase following the government's acceptance of DDRB recommendations. On average this is expected to increase average pay for resident doctors by around 8.2%

Full pay scales are published by NHS Employers and are available at NHS Employers pay circulars.

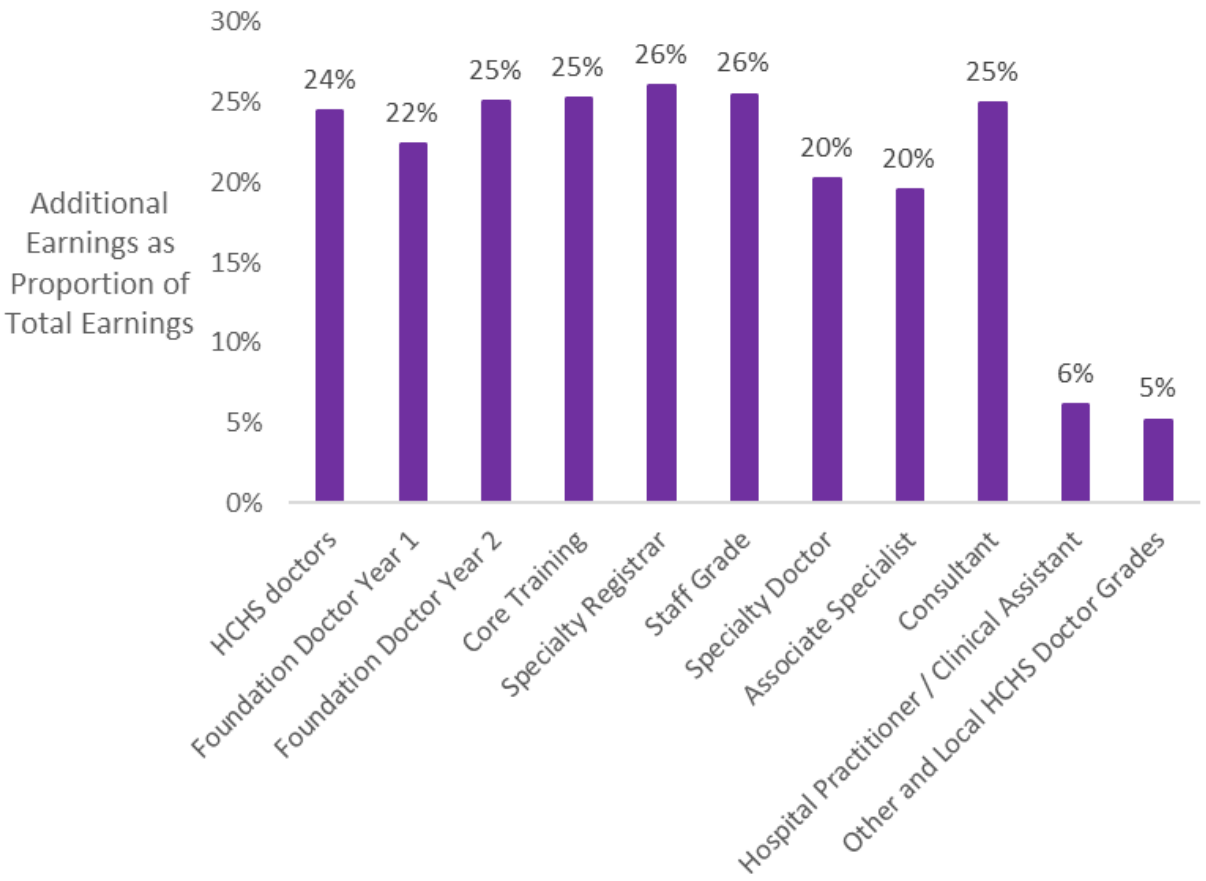
There are other non-pay elements of the deals that are explored in chapter 6 on remit groups.

Additional earnings

The national medical contracts contain provisions by which staff can increase their earnings if they work additional hours / undertake additional programmed activities beyond the standard job plan, work during unsocial hours or for consultants, being in receipt of either Local Clinical Excellence Awards or National Clinical Impact Awards.

Figure 3 shows the contribution of additional earnings to total pay in the 12 months to March 2024 and is split by medical career grade. Overall, around a quarter of total earnings are not from basic pay which is generally unchanged from the 12 months to March 2023.

Figure 3: additional earnings (non-basic pay) as proportion of total earnings by medical career grade - 12 months to March 2024



Source - [NHS England Earnings Statistics, NHS Trusts and Core Organisations, 12 months to March 2024, table 1]

This is a chart showing average non-basic pay as a proportion of average total earnings in the 12 months to March 2024 and is split by medical career grade. It shows that non-basic pay contributes between 5% and 26% of total earnings with all grades except for 'hospital practitioners' and 'other doctors' being in the range of 20% to 26%

Earnings distribution

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

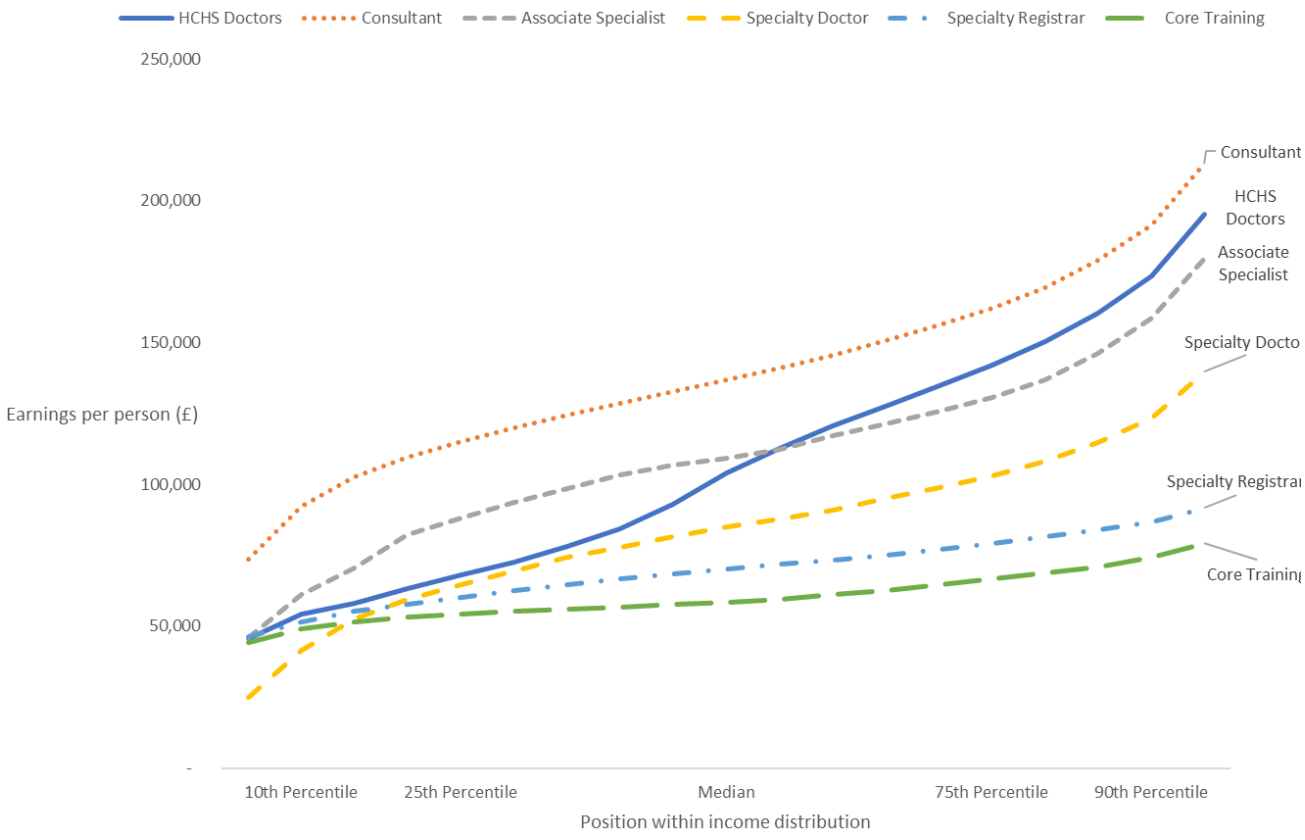
Figure 4 is based on data on the income distribution for medical staff provided by NHS England. To ensure that this analysis is not impacted by people leaving or switching grades, these data only include staff who were employed in the same career grade throughout the period April 2023 to March 2024 which is why it does not include F1 and F2

doctors as they would usually be expected to progress to the next stage within a 12-month period.

Consultants have the highest earnings at all points in the earnings distribution and had median earnings of over £135,000 in the 12 months to March 2024 while the median across all grades was just over £103,000. Median earnings for those in the resident grades of core training and specialty registrar were around £58,000 and £70,000 respectively.

The income distribution is shown to be somewhat shallower for those in resident grades which may reflect the fact that those at the top of the consultant income distribution may benefit from things like national Clinical Impact Awards.

Figure 4: chart of income distribution for HCHS doctors in the 12 months to March 2024 split by medical grade



Source - NHS England earnings statistics - 12 months to March 2024

This is a chart showing the income distribution for different medical career grades in the 12 months to March 2024. It shows that earnings were higher for consultants than for other medical grades across the income distribution followed by SAS doctors and then resident doctors. The income distribution is 'shallower' for those in the resident grades and steeper for consultant doctors where there is a bigger difference between lower and higher earning consultants.

Pay growth drivers

The average earnings for the whole HCHS medical workforce can change for many reasons. Some relate to changes in the composition of the workforce, while some relate more specifically to pay rates. Table 22 shows a breakdown of average earnings growth for HCHS medical staff over recent years into its component drivers, where:

- Average earnings growth = Headline pay award + Earnings drift

- Earnings drift = Basic pay drift + Additional earnings drift impact + Grade mix effect

Changes to pay rates due to the annual pay award or negotiated pay deals will have an impact on average earnings. This is captured in the 'headline pay award', which measures the change in total earnings per FTE that would be expected due to the pay award (including negotiated pay deals, where applicable), other things being equal.

In practice, average earnings usually grow at a different rate, for example because of changes in the make-up of the workforce. This is captured in 'earnings drift', the difference between total earnings per FTE growth and the headline pay award.

The reasons for earnings drift can be broadly separated into grade mix effects, basic pay effects, and additional earnings effects:

- changes in the distribution of staff between higher and lower earning grades (for example, a lower proportion of consultants and higher proportion of resident doctor grades) will affect average earnings. This is captured in the 'grade mix effect', which is based on the HCHS medical staff groups presented in NHS England published data (and used in table 21 above)

- the basic pay component of average earnings can change due to shifts in the distribution of staff across pay points. This is captured in 'basic pay drift', and is measured based on changes within each grade to exclude grade mix effects (avoiding double-counting)

- the additional earnings component of average earnings can change due to increases or decreases in the use of payments for additional activity, shift working, medical awards, and other non-basic pay earnings (for example, an increase in hours worked as additional activity). This is captured in 'additional earnings drift impact', which more specifically measures the extent to which average additional earnings grow at a different rate to average basic pay. (Many elements of additional earnings are directly linked to basic pay, such as additional activity payments, and so would be expected to grow at the same rate as basic pay, other things being equal)

Pay growth estimates are based on data on workforce earnings and size published by NHS England. Drift estimates, the difference between pay growth and the pay award, are based on changes to pay values from pay circulars weighted by pay point workforce size estimates based on NHS England workforce data. The analysis is for NHS trusts and core organisations and NHS support organisations and central bodies combined (so figures for average basic pay and earnings growth may differ slightly from figures based on NHS trusts and core organisations in table 22). Growth in earnings per FTE may also differ from growth in earnings per person due to changes in average FTE per person.

Table 22: breakdown of average earnings growth for HCHS medical staff between 2018 to 2019 and 2023 to 2024

Pay growth element	**2018 to 2019**	**2019 to 2020**	**2020 to 2021**	**2021 to 2022**	**2022 to 2023**	**2023 to 2024**
Basic pay per FTE growth	2.3%	3.3%	2.1%	3.0%	3.6%	5.1%
Additional earnings per FTE growth	-2.4%	-2.9%	3.5%	2.8%	2.5%	9.8%
Total earnings per FTE growth	1.1%	1.8%	2.5%	2.9%	3.3%	6.2%
Components of total earnings per FTE growth	-	-	-	-	-	-
(a) Headline pay awards	1.0%	3.4%	2.7%	2.7%	3.7%	6.6%
(b) Total earnings drift	0.0%	-1.6%	-0.3%	0.2%	-0.4%	-0.5%
Components of (b) Total earnings drift	-	-	-	-	-	-
(b1) Basic pay drift (excluding grade mix effect)	1.2%	0.3%	0.1%	0.2%	0.0%	-1.3%
(b2) Additional earnings drift impact (excluding grade mix effect)	-1.3%	-1.7%	0.4%	0.0%	-0.1%	1.3%
(b3) Grade mix effect	0.2%	-0.2%	-0.8%	-0.1%	-0.4%	-0.5%

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

The impact of headline pay awards on average earnings for doctors in 2023 to 2024 compared to 2022 to 2023 was 6.6%, which reflects the combined effect of:

- 5.7% impact for consultants (average of 6% increase to basic pay scales and no change in the value of clinical excellence awards (CEAs), discretionary points and distinction awards)

- 8.8% impact for resident doctors (average impact of 6% plus £1,250 increase to basic pay scales)

- 5.7% impact for SAS doctors (average impact across all SAS doctors, reflecting 6% increase to basic pay scales for pre-2021 contracts, and average impact of uplifts varying by pay point for 2021 contracts under the multi-year agreement plus an additional 3% uplift)

Average total earnings grew by less in 2023 to 2024 than the pay awards impact (6.2% vs 6.6%), implying negative earnings drift. Earnings drift reflects the combined effect of:

- a negative ‘basic pay drift’ (excluding grade mix effects) of -1.3% in 2023 to 2024. This is largely due to average basic pay for resident doctors increasing by less than their headline pay award, which is consistent with the impact of pay deductions for staff taking part in industrial action

- a positive ‘additional earnings drift impact’ of 1.3%, which indicates an increase in the overall use of additional earnings payments in 2023 to 2024. This mainly reflects an increase in the use of additional activity payments and 'local' payments for consultants, consistent with payments for activity to cover for staff taking part in industrial action (partly offset by a continuing decrease in the use of banding supplements as resident doctors remaining on the pre-2016 contract move out of the resident doctor workforce)

- a negative ‘grade mix effect’ of -0.5%, reflecting a shift in the workforce towards lower earning medical grades. Consultant, SAS doctor and resident doctor FTEs have all grown over recent years, but the resident doctor workforce has grown more quickly than other parts of the workforce since 2019 to 2020, which reflects recent expansion of doctor training posts, increased training post fill rates, and international recruitment to resident doctor grades. In 2023 to 2024, SAS doctor FTEs grew by more than resident doctors, but the share of total medical FTEs increased for both groups and decreased for consultants

Average pay and earnings for general practitioners

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

The data contains information on salaried GPs and contractor GPs, working under General Medical Services (GMS) and Personal Medical Services (PMS) contracts, but the data does not include GPs who work solely as locums. As the data is collected via self-assessment tax return, it will exclude GPs who do not need to complete a self-assessment tax return. As the data is provided at headcount level, it is not possible to split the data between those who work privately and those who undertake NHS work or to distinguish

between full and part-time workers. Due to concerns around validity, NHS England no longer publishes experimental data on GP earnings estimates by FTE or working hours.

Table 23 sets out the average percentage increase in annual earnings for salaried and contractor GPs over recent years, against the uplift recommended by DDRB and agreed by government in the corresponding year. As highlighted in previous years' evidence, there does not appear to be a link between agreed government uplifts to pay and changes in average earnings for GPs. As independent contractors, it is for GP partners to determine pay uplifts in pay for themselves and their employees.

Contractor GPs were stood down from the remit of DDRB for the duration of the 5-year framework contract from 2019 to 20 to 2023 to 24. Salaried GPs were stood down for one year in 2019 to 2020 with a 2% uplift agreed through contract negotiation.

Table 23: average percentage increase in annual earnings for salaried and partner GPs and the recommended and agreed uplifts for the same year (%)

Year	**DDRB recommendation**	**Government response**	**Average % earnings increase for salaried GPs**	**Average % earnings increase for GP partners**
2015 to 2016	1.0	1.0	-1.4	1.1
2016 to 2017	1.0	1.0	1.3	4.5
2017 to 2018	1.0	1.0	3.2	3.5
2018 to 2019	4.0	2.0	3.8	3.4
2019 to 2020	Not applicable	2.0 (agreed via 2019 to 2020 contract for salaried GPs)	5.0	3.8
2020 to 2021	2.8 (salaried GPs only)	2.8 (salaried GPs only)	2.0	16.6
2021 to 2022	3.0 (salaried GPs only)	3.0 (salaried GPs only)	4.8	8.0
2022 to 2023	4.5 (salaried GPs only)	4.5	1.8	-8.6

Source: NHS England, GP Earnings and Expenses, 2022 to 2023 August 2024, tables 1a and 7a.

Contractor GP earnings

GP contractors are responsible for meeting the requirements set out in the contract for their practice and they take an income after practice expenses. There is therefore a trade

off between contractor GP earnings, uplifts to salaried GP pay and other pressures on practice finances. In England, the average pre-tax income for a contractor GP working in either a GMS or PMS contract was £140,200 in 2022 to 2023, a statistically significant decrease of 8.6% compared to 2021 to 2022. The data above represents headcount figures only, therefore it is not possible to isolate how changes in working hours have impacted earnings.

In 2022 to 2023, median pre-tax income for GP contractors in GMS and PMS practices was £128,700. At the 25th percentile, pre-tax income was £98,000 and at the 75th percentile it was £167,400.

The participation rate for contractor GPs (based on contracted hours of work) in June 2024 was 85%, a decrease of one percentage point compared to June 2023. This may not reflect actual working hours, particularly ad hoc hours.

While there has been a decrease in 2022 to 2023, earnings and expenses have still increased compared to 2019 to 2020 where the average pre-tax income for a GP contractor on a GMS or PMS contract was £121,800.

Table 24 represents average earnings for GP contractors in both GMS and PMS practices. The GMS contract is the national standard GP contract. Expenses are split into categories including office and general business, premises, employee, car and travel, interest, net capital allowance and other (for example, cost of drugs for dispensing GPs).

Table 24: average earnings for GP contractors in both GMS and PMS practices between 2013 to 2014 and 2022 to 2023

	Report population (count)	Estimated gross earnings, cash term (£)	Total expenses, cash terms (£)	Income before tax, cash terms (£)	Estimated gross earnings, real terms	Total expenses, real terms (£)	Income before tax, real terms(£)
2013 to 2014	25,700	290,900	189,000	101,900	359,400	233,500	125,900
2014 to 2015	25,500	302,600	198,800	103,800	369,300	242,700	126,700
2015 to 2016	18,300	315,600	210,800	104,900	382,500	255,400	127,100
2016 to 2017	19,850	338,300	228,700	109,600	400,900	271,000	129,900
2017 to 2018	20,350	357,300	243,900	113,400	416,800	284,500	132,300
2018 to 2019	20,300	380,900	263,600	117,300	435,200	301,200	134,000
2019 to 2020	19,250	402,600	280,800	121,800	449,400	313,500	135,900
2020 to 2021	18,600	438,700	296,700	142,000	464,400	314,100	150,300
2021 to 2022	18,350	482,400	329,000	153,400	514,900	351,200	163,700
2022 to 2023	18,350	495,400	355,200	140,200	495,400	355,200	140,200

Source: NHS England, GP Earnings and Expenses, 2022 to 2023 August 2024, tables

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

Salaried GPs' earnings

Salaried GPs should be on a salary no less favourable than the minimum pay range in the model terms and conditions set out by NHS Employers and the model salaried GP contract. In responding to DDRB’s recommendations, the government adjusts the

minimum and maximum pay threshold accordingly, but it is up to practices to determine pay uplifts for their staff.

The average pre-tax income for a salaried GP in England working under either a GMS contract or PMS (GPMS) contract was £69,200 in 2022 to 2023, a statistically significant increase of 1.8% compared to £68,000 in 2021 to 2022. This compares to an average increase of 4.8% in 2021 to 2022 compared to 2020 to 2021.

In 2022 to 2023, median pre-tax income for salaried GPs in GMS and PMS practices was £64,200. At the 25th percentile, pre-tax income was £48,000 and at the 75th percentile pre-tax income was £84,400.

The UK income distribution figures from 2021 to 2022 show that salaried GPs were in the 93rd percentile group (£69,200 to £74,000 for that year). The participation rate for salaried GPs in September 2022 was 59%, although this may not accurately reflect working hours.

Table 25: earnings and expenses for salaried GPs in England, GMS and PMS, all practice types, 2013 to 2014 to 2022 to 2023

	Count	Employment (£)	Self Employment (£)	Total (£)	Total expenses, cash terms (£)	Total income before tax, cash terms (£)	Total gross earnings, real terms (£)	Total income before tax, real terms (£)
2013 to 2014	8,000	48,200	15,800	64,100	9,200	54,900	79,100	67,800
2014 to 2015	8,750	50,800	14,700	65,500	8,700	56,700	79,900	69,300
2015 to 2016	7,250	51,500	12,300	63,900	7,900	55,900	77,400	67,800
2016 to 2017	8,550	51,700	13,700	65,300	8,700	56,600	77,400	67,100
2017 to 2018	9,400	52,400	15,800	68,200	9,800	58,400	79,600	68,200
2018 to 2019	10,500	53,700	16,400	70,100	9,400	60,600	80,100	69,300
2019 to 2020	11,000	55,300	16,300	71,600	8,000	63,600	79,900	71,000
2020 to 2021	11,950	57,200	15,300	72,200	7,400	64,900	76,500	68,700
2021 to 2022	12,900	58,500	18,400	76,900	8,900	68,000	82,100	72,600
2022 to 2023	13,450	59,600	20,100	79,700	10,500	69,200	79,700	69,200

Source: NHS England, GP Earnings and Expenses Estimates, 2022 to 2023, August 2024, tables 7a and 7b. The conversion to real terms has been carried out using gross domestic product (GDP) deflators as at July 2024 available from HM Treasury.

Average pay and earnings for general dental practitioners

Data on earnings and expenses is available for self-employed primary care dentists who have completed some NHS work during the financial year, however figures relate to both

NHS and private income. Private earnings are determined by the amount of demand from individual patients, which may be in addition to NHS care.

According to NHS data published 25 July 2024, there was a 2.7% decrease in taxable income of self-employed dentists in England in 2022 to 2023. On average, expenses increased and gross earnings fell in England between 2021 to 2022 and 2022 to 2023. On average, providing-performer dentists that spent more than 75% of their time performing NHS work earned the highest taxable income (£139,200). By comparison, the highest taxable income among associate dentists was for those spending less than 25% of their time performing NHS work (£85,600).

The government has proposed a 4.64% uplift to contract values (net of pay and expenses) to dentists in 2024 to 2025, backdated to 1 April 2024. While each year we strongly recommend that providing-performer dentists apply this uplift to their associate dentists' salaries, DHSC is unable to enforce practices to do so. As practices are private businesses, it falls to them to set employee pay and conditions.

Table 26: gross income, expenses and taxable income for all self-employed primary care dentists from 2017 to 2018 to 2022 to 2023

	Average gross earnings (£)	Average expenses (£)	Average taxable income (£)	Expenses ratio (%)
2017 to 2018	£146,700	£78,100	£68,500	53.3%
2018 to 2019	£147,100	£78,500	£68,600	53.4%
2019 to 2020	£144,700	£76,100	£68,600	52.6%
2020 to 2021	£141,400	£68,900	£72,500	48.7%
2021 to 2022	£156,100	£78,200	£77,900	50.1%
2022 to 2023	£155,200	£79,300	£75,800	51.1%

Source: Dental Earnings and Expenses, 2022/23 - NHS England

In England, the earnings of a self-employed primary care dentist vary depending on whether they are a providing-performer dentist or an associate dentist. Providing-performer dentists hold an NHS contract, commissioned by the ICB to provide a given number of units of dental activity or units of orthodontic activity. Associate dentists work as performers under the contract; they deliver NHS dental services under a contract held by their providing-performer but do not themselves hold a contract with the NHS. Generally, providing-performers tend to earn more (higher gross earnings and taxable income). In 2022 to 2023, providing-performer dentists had an average taxable income of £128,800, a 4.6% decrease from £135,000 in 2021 to 2022. Associate dentists also saw their average taxable income decrease, by a smaller amount of 0.9% to £64,300 in 2022 to 2023 compared to £64,900 in 2021 to 2022.

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

Table 27: taxable income, in cash and real terms, for providing-performer dentists in England, from 2017 to 2018 to 2022 to 2023

	Average taxable income (£)	GDP (£)	CPI (£)	RPI (£)	RPIX (£)
2017 to 2018	£113,200	£132,000	£135,400	£144,600	£144,600
2018 to 2019	£113,100	£129,300	£132,500	£140,200	£140,300
2019 to 2020	£112,600	£125,700	£129,700	£136,100	£136,100
2020 to 2021	£132,200	£139,900	£151,300	£157,800	£157,600
2021 to 2022	£135,000	£144,100	£148,500	£152,400	£152,000
2022 to 2023	£128,800	£128,800	£128,800	£128,800	£128,800

Table 28: taxable income, in cash and real terms, for associate dentists in England, from 2017 to 2018 to 2022 to 2023

	Average taxable income (£)	GDP (£)	CPI (£)	RPI (£)	RPIX (£)
2017 to 2018	£57,000	£66,500	£68,200	£72,800	£72,900
2018 to 2019	£57,600	£65,800	£67,500	£71,400	£71,400
2019 to 2020	£58,100	£64,900	£67,000	£70,300	£70,300
2020 to 2021	£58,700	£62,100	£67,200	£70,100	£70,000
2021 to 2022	£64,900	£69,300	£71,400	£73,300	£73,000
2022 to 2023	£64,300	£64,300	£64,300	£64,300	£64,300

Source for tables 27 and 28: Dental Earnings and Expenses, 2022/23 - NHS England.

Data and information for Salaried Dental Staff (including terms and conditions for Salaried Primary Care Dental Staff; training supplement for Band A Salaried Primary Care Dentists; and pay scales for Dental Educators), and on the hospital dental trainees ('Dentists in training') (2016 contract) basic salary and allowances, are to be found in the NHS Employers Pay and Conditions Circular (M&D) 5/2024 R.

Medical pay structures and career trajectories

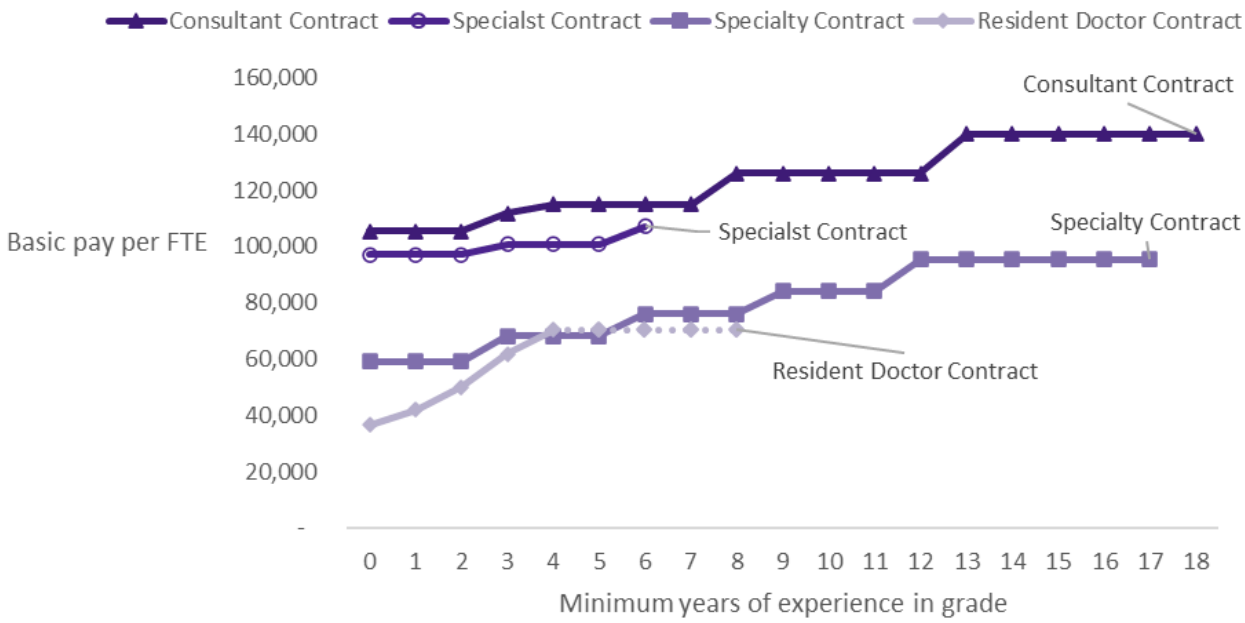
Medical staff benefit from clearly defined routes of career advancement from leaving university to being 'doctors in training' and eventually to long term careers as consultants, SAS doctors or GPs. In 2024 to 2025, basic pay for medical staff on national contracts ranges from £36,616 for Foundation Year 1 through to £139,882 for the most experienced consultants. Staff who complete additional work, work unsocial hours, or who are recognised through Clinical Impact Awards, receive additional payments as set out in their respective medical contracts.

These additional payments, alongside basic pay, can enable medical staff to significantly increase their incomes and give them some autonomy and flexibility in their individual earnings potential. As discussed in chapter 5 in additional earnings data, as of March 2024, around a quarter of earnings were not from basic pay. Some medical staff may also supplement their income through private and other work, but this is not something for which there is publicly available data.

The medical pay structure is based around factors including career grade, stage of training and level of experience. After graduating from medical school, resident doctors will enter a training pathway that includes the 2-year foundation programme followed by specialty or core training. The pay system for those in training includes a series of 5 ‘nodal points’ with different pay for the different stages of training offering higher pay for more advanced trainees. Since 2020, the most senior resident doctors, in ST6 and above, have benefited from a fifth nodal point recognising their skills and service contribution. Upon completion of specialty training most doctors will seek a role as either a consultant, join the SAS workforce or become a GP.

Figure 5 shows the current system of national pay contracts for medical staff in 2024 to 2025 and the minimum number of years of experience required to reach each pay point - note that in most cases to pass through progression points doctors must demonstrate competence against set criteria as well as have a given length of service.

Figure 5: Pay values on national contracts for hospital doctors in 2024 to 2025



Source - Uses pay scales for 2024 to 2025 extracted from [NHS Employers pay circular - 2024 (5) R]

This is a chart of basic pay scale values on the 4 main national contracts (2016 resident doctors, 2021 specialty doctor, 2021 specialist doctor and 2003 consultant contract) and is based on pay scales in 2024 to 2025 after the implementation of recent pay agreements and DDRB recommendations.

Table 29 highlights the extent of pay progression in the 4 main national contracts for hospital doctors and the total pay progression that is possible between entry into the foundation programme and the top of the consultant pay scale. For example, resident doctors basic pay almost doubles between nodal point 1 (FY1) and nodal point 5 (which takes at least 7 years) and basic pay can nearly quadruple over the full career path from FY1 through to the top of the consultant pay scale which requires at least 14 years of experience as a consultant.

Table 29a: minimum and maximum basic pay values by medical contract in the year 2024 to 2025

Career grade	Payscale minimum (£)	Payscale maximum (£)	In-grade progression (£)
Resident	36,616	70,425	92%
Specialty (2021 contract)	59,175	95,400	61%
Specialist (2021 contract)	96,990	107,155	10%
Consultant	105,504	139,882	33%

Source - NHS Employers pay circulars

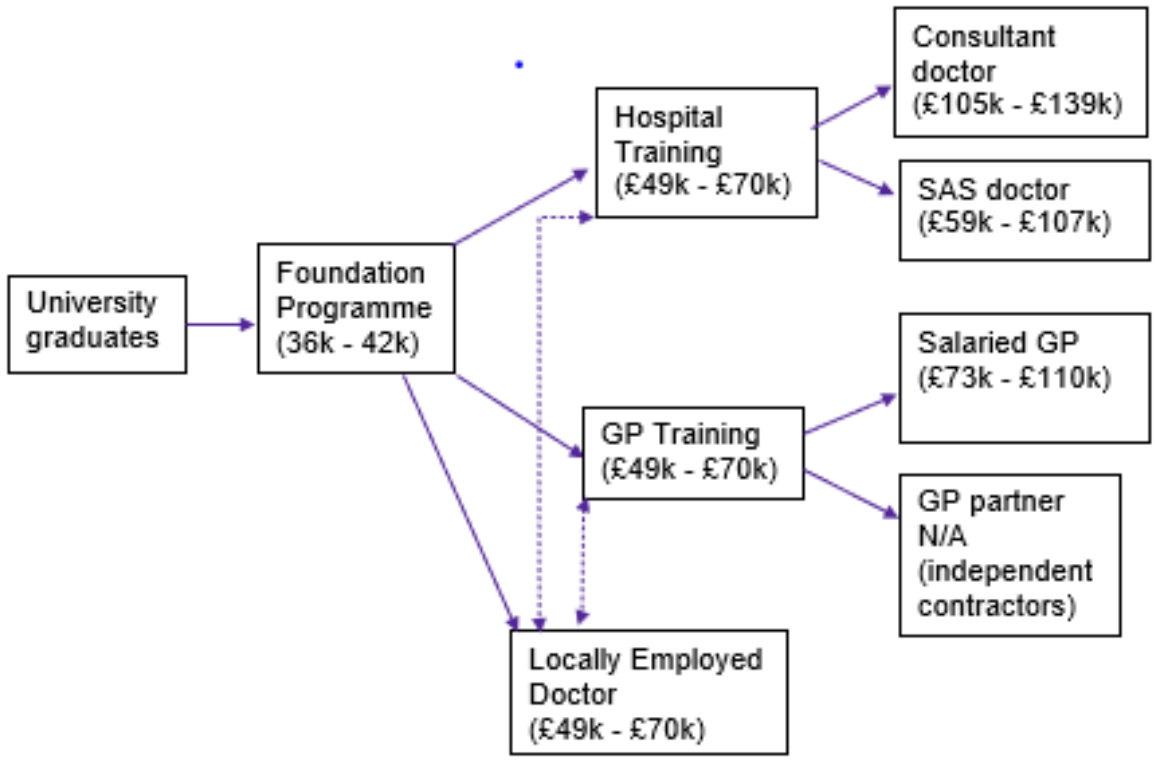
Table 29b: F1 consultant minimum and maximum basic pay values by medical contract in the year 2024 to 2025

Pay route	Payscale minimum (£)	Payscale maximum (£)	In-grade progression (£)
F1 - consultant max	36,616	139,882	282%

Source - NHS Employers pay circulars

Typical career pathways in HCHS sector

Figure 6: possible pathways for medical graduates with 2024 to 2025 base salary ranges at different stages (not including additional earnings)



Source - NHS Employers pay circulars

This is a figure showing hypothetical career trajectories and includes pay scales from 2024 to 2025. It shows some of the ways which staff may progress through university, into the foundation programme, specialty training and then into career grade roles as either GPs or consultants.

Career journeys and pay disparities

Career movements between 2014 and 2024

Using data records extracted from the Electronic Staff Record (ESR) we can observe how individuals move around the HCHS system over time. Table 30 considers staff who were employed in the HCHS sector in March 2014 and shows any change in career grade between 2014 and 2024. This highlights the extent to which staff who are newer to the profession have a reasonable expectation of progression to more senior roles.

The data shows:

- around two thirds of those working as consultants in 2014 were still working as consultants 10 years later. While most of the remainder appear to no longer be working in the HCHS sector this likely reflects the age profile of the consultant workforce and include those leaving the workforce following retirement

- around 40% of those who were working at resident level in 2014 were either consultants (37%) or SAS (3%) doctors after 10 years. While just under half were not working in the secondary care sector this is consistent with the numbers who would usually be expected to move into general practice. As shown in table 31 this movement into a career post is likely to have brought a substantial pay increase

Table 30: movement of doctors working in hospital and community health sector between March 2014 and March 2024, by career grade

	Resident in 2024 (%)	SAS in 2024 (%)	Consultant in 2024 (%)	Other grades in 2024 (%)	Not present in HCHS in 2024 (%)	Rounded count (in 2014)
Resident in 2014	13%	3%	37%	0%	46%	50,000
SAS in 2014	1%	37%	16%	0%	46%	10,000
Consultant in 2014	0%	0%	66%	0%	34%	42,200
Other grades in 2014	0%	2%	1%	27%	70%	2,800

Source - DHSC analysis of electronic staff record.

Longitudinal pay in HCHS Sector

ESR data can also be used to analyse pay and earnings for individual members of staff through time. This provides insight into how employees experience the pay system and goes beyond looking at headline averages which can be impacted by other factors including workforce growth or changes to grade mix.

Table 31 presents data on the change in average basic pay per FTE for around 60,000 medical staff who were employed in the HCHS sector in both March 2014 and March 2024 and is split according to the individual's grade in March 2024.

The median increase in basic pay per FTE was over 49% (4.1% per annum) while 25% of the workforce experienced an annual increase of over 9.5% pa, which will generally be associated with promotion to more senior grades. For example, the upper quartile figure for consultants (154% over the full period which is equivalent to 9.8% per annum) is likely to include the impact of promotion to the consultant grade as well as any progression within that role on top of headline pay awards. A similar analysis for the past year indicates average increases which were consistent with the outcome of the 2023 to 2024 pay round.

Table 31: change in basic pay per FTE for HCHS staff employed in both March 2014 and March 2024

	Count	25th Percentile - one quarter saw increases of less than	Median - one half saw increases of at least.	75th percentile - one quarter saw increases of at least
Consultant	47,700	39.9	44.8	154.6
Associate specialist	2,000	34.5	43.7	61.4
Specialty doctor	3,400	39.4	58.3	101.6
Staff grade	100	26.3	26.3	26.3
Specialty registrar	5,900	73.7	101.1	144.4
Core training	900	65.3	97.1	124.9
All medical staff	60,800	39.9	49.3	147.3

Source - DHSC Analysis of Electronic Staff Record data warehouse.

Notes - Estimates of pay increases will not include the impact of pay agreements for medical workforce or the impact of the 2024 to 2025 pay decision.

Because this analysis is based on data from the ESR it does not cover individuals who may have moved to roles in other parts of the healthcare system, including general practice, and does not include any earnings beyond an individual's substantive contract in the HCHS sector. Later in this chapter we cover data from the Longitudinal Education Outcomes (LEO) dataset which aims to provide information on outcomes for all university graduates across different subjects and can be used to compare medical graduates against those from other courses.

Development and progression for locally employed doctors (LEDs)

The DDRB has invited evidence around career progression for locally employed doctors who, as outlined in (remit group chapter) are predominately working at resident level.

While we are not able to do long term tracking of this cohort due to difficulties in accurately identifying locally employed doctors on closed contracts as prior to the introduction of the new resident doctor contract from 2016 the same coding system was used for both LEDs and those on structured training pathways. We can look at the experience of individuals who are recorded as LEDs on ESR on terms mirroring the 2016 resident doctor contract.

Table 32 provides some evidence that people may use LED roles as 'bridging' points to other parts of either the training or career grade structure based on around 11,800 LEDs identified as working in 2023.

Based on this sample of locally employed doctors:

- of the 5,000 LEDs working at a level equivalent to nodal point 3 in 2023 around 30% were in a training post one year later
- of the 1,400 LEDs working as LEDs at a level equivalent to nodal point 5 around 20% were working at consultant level one year later

For those working as LEDs in both periods we also see some movement between nodal points especially for those working at a level equivalent to foundation level in NP1 or 2. As with other tracking analysis the number not working in HCHS organisations will include those who have moved to posts in general practice.

Table 32: movement of locally employed doctors between 2023 and 2024 by nodal point and contract

Columns represent the nodal point of the locally employed doctor in 2023 and rows represent the contract individual is working at in 2024

Grade and level	MT01 (F1 level)	MT02 (F2)	MT03 (ST1-2)	MT04 (ST3-5	MT05 (ST6+)	MT01 - 05 (all levels)
Count	240	980	5,100	4,100	1,400	11,800
Locally employed doctor (LED)	62%	66%	50%	51%	43%	51%
Of which LED - Same Point	7%	17%	43%	45%	43%	41%
O/W LED - Higher Point	55%	49%	7%	6%	0%	10%
Other National Contracts	16%	15%	31%	29%	34%	29%
O/W RD in Training	16%	14%	30%	19%	11%	22%
O/W SAS	0%	0%	2%	6%	4%	3%
O/W Consultant	0%	0%	0%	4%	18%	4%
Other Contracts	7%	3%	2%	3%	3%	3%
Closed 2002 RD Contract	7%	3%	2%	3%	3%	3%
Others	0%	0%	0%	0%	0%	0%
Not in HCHS Organisation	15%	16%	17%	17%	21%	16%

Source - DHSC analysis of Electronic Staff Record

Pay disparities - gender and ethnicity pay gaps

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

Independent review into gender pay gaps in medicine

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

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

Data analysis - gender and ethnicity pay gaps in hospital sector.

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

The gender or ethnicity pay gap is typically measures by comparing average pay for different demographic groups either across the whole workforce or a segment of it. For staff working in HCHS organisations some information is published (link) as part of NHS earnings statistics.

While the system of national pay contracts should limit the extent to which pay gaps develop they can occur based on how staff are distributed across grades and pay scales:

- career grade mix - a gap will develop if men or white staff are more likely to be in more senior career grades compared to women or ethnic minority staff

- point mix - a gap will develop if male and white staff are more likely to be further up established pay scales than women or ethnic minority staff

- Across the entire medical workforce pay gaps are predominately driven by differences in the proportion of staff in different career grades (for example, a higher proportion of white men being consultants) while differences within specific grades are caused by differences in how staff are distributed across the pay scale (for example, having more staff at the top of the scale)

- table 33 presents the latest data on the gender and ethnicity pay gap as of May 2024 based on basic pay per FTE. Gender and ethnicity are shown separately to isolate the impact of either factor

Table 33: estimated gender and ethnicity pay gaps by medical career grade as of May 2024 based on average basic pay per FTE

Staff group	Comparison of white women to white men (GPG - white)	Comparison of minority women to minority men (GPG - minority)	Comparison of white women to minority women (EPG - women)	Comparison of white men to minority men (EPG - women)
HCHS doctors	-11.5%	-14.8%	-18.6%	-15.5%
Consultants	-2.6%	-2.9%	-2.6%	-2.3%
SAS doctors	-0.4%	-5.5%	-6.7%	-1.7%
Resident doctors	-2.1%	-4.0%	-3.2%	-1.4%

Source - NHS England Earnings Statistics, June 2024

Because pay gaps are fundamentally related to the distribution of staff across the workforce it is rare for there to be major changes over a short period of time as this would usually require a major rebalancing of the workforce which is unlikely given the structures of medical contracts including the time taken to become consultants or move through those pay structures.

The reforms to the consultant pay contract, ratified in June 2024, included a reduction in the number of separate pay points (from 8 to 5) and a reduction in the amount of time taken to reach the top of the pay scale (from 19 to 14 years) In the medium term it is expected that this should help to reduce the gender pay gap in medicine as a higher proportion of staff will be at the top of the pay scale and the differential between the bottom and top of the scale is reduced.

Data analysis - gender and ethnicity pay gaps in GP sector

Mean earnings, expenses and income by age group and gender for contractor and salaried GPs are set out in tables 34 and 35. As in previous years, the data shows that for salaried and contractor GPs, men earn more on average than women GPs in each age category.

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

Table 34: average GP partner earnings and expenses in England by age and gender, GMS and PMS, all practice types, 2022 to 2023

Age	Gender	Report population	Average total gross earnings (£)	Average total expense (£)	Average total income before tax (£)	Average total income Comparison of women to men (£)
Under 40	Women	1,250	417,000	302,600	114,400	-23%
Under 40	Men	1,300	492,200	343,600	148,600	Not applicable
40 to 49	Women	3,800	451,700	326,200	125,500	-20%
40 to 49	Men	3,600	560,000	403,600	156,400	Not applicable
50 to 59	Women	2,950	462,900	335,900	127,100	-20%
50 to 59	Men	3,350	556,200	398,100	158,200	Not applicable
Over 60	Women	600	430,900	300,700	130,200	-8%
Over 60	Men	1,500	470,800	329,300	141,400	Not applicable

Source: NHS England, GP Earnings and Expenses, 2022 to 2023 August 2024

Note - Comparison of women to men is based on average total income before tax

Table 35: average salaried GP earnings and expenses in England by age and gender, GMS and PMS, all practice types, 2022 to 2023

Age	Gender	Report population	Average total gross earnings (£)	Average total expenses (£)	Average total income before tax (£)	Average total income Comparison of women to men (£)
Under 40	Women	4,750	70,900	8,700	62,200	-25%
Under 40	Men	1,750	101,500	18,900	82,600	Not applicable
40 to 49	Women	3,250	75,600	10,300	65,300	-27%
40 to 49	Men	950	104,500	15,500	89,000	Not applicable
50 to 59	Women	1,450	71,300	4,700	66,600	-24%
50 to 59	Men	600	97,500	10,000	87,500	Not applicable
Over 60	Women	300	58,300	2,800	55,500	-21%
Over 60	Men	400	82,500	11,800	70,700	Not applicable

Source: NHS England, GP Earnings and Expenses, 2022 to 2023, August 2024

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

Labour market overview and comparative analysis

Because developments in the wider labour market will influence what an appropriate pay strategy might be to support recruitment, retention and motivation we expect the PRBs to take account of underlying labour market conditions and how they are expected to change over the course of this pay review period.

labour market indicators show:

- in 2025 to 2026 the Office for Budget Responsibility forecast earnings growth of 3.0% with the growth in earnings continuing to reduce over the course of the year from around 4.8% in the first quarter of 2025 to around 2.0% by the first quarter of 2026. This is materially lower than forecasted growth for 2024 to 2025 of 4.5%

- available data on pay settlements, the measure most closely aligned with PRB recommendations, also show a moderation in settlements with the median reducing from the current figure of 4% in the 3 months to October 2024 to around 3.0% in 2025

- data indicates that the position of NHS staff within the broader labour market has been broadly stable over recent pay rounds with staff groups remaining in around the same location of the UK income distribution

- there is evidence of differences in growth rates across the earnings distribution with higher growth rates for those with lower earnings which may follow substantial increases to the National Living Wage in April 2024

Earnings forecasts for 2025 to 2026

When making recommendations for 2025 to 2026 we believe it is important to be aware of what is forecast to happen to earnings and pay settlements over the period covered by this pay round. We believe this is particularly the case this year when the government has brought forward the timing of the pay cycle meaning that current data may be less reflective of the prevailing conditions for this pay round.

While earnings growth is currently high by historical standards it has moderated in recent months and this is expected to continue over 2025 to 2026. Average earnings growth is

forecast to be materially lower over 2025 to 2026 than 2024 to 2025, at 3.0% according to the OBR's forecast with a reduction over the course of the year around 4.3% in the first quarter of the financial year to under 2% by the end.

Survey evidence also points to an easing in wage growth, with Brightmine's survey showing that settlements are expected to average 3% in 2025 which is down from the current value of 4% and data from the Bank of England decision maker panel also forecasting wage growth of around 4% over the 12 months from October 2024

General economy comparisons

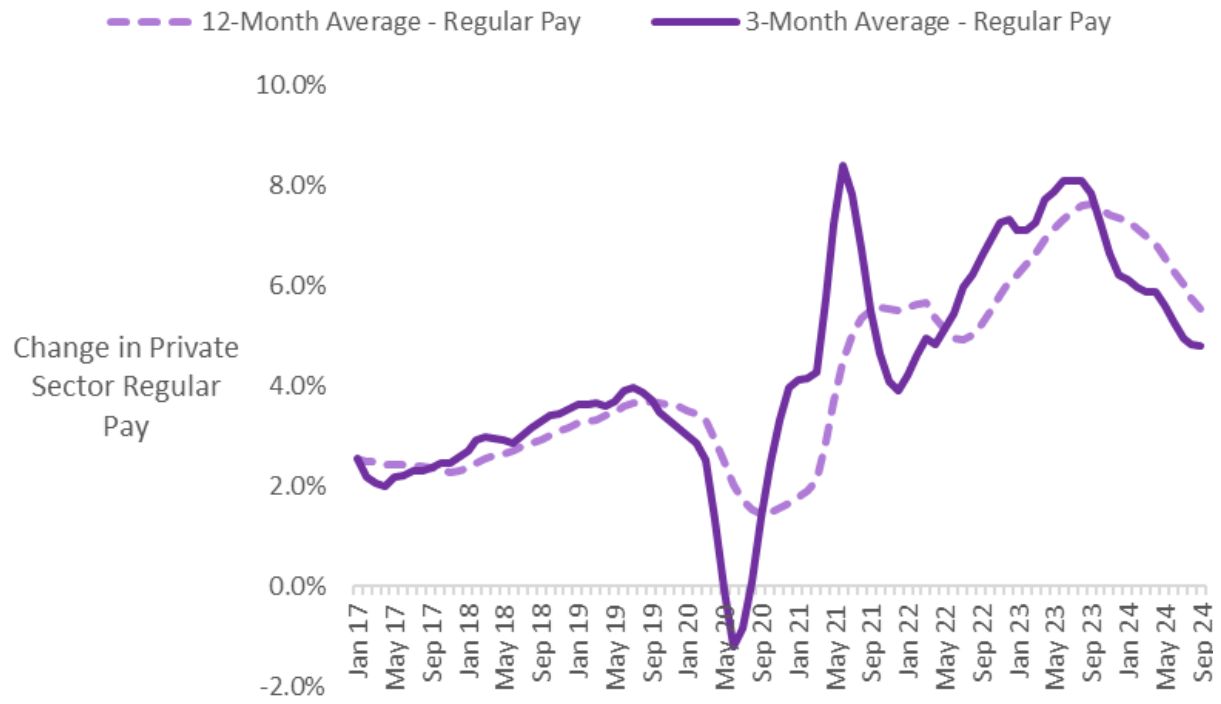
Previous growth in earnings

We also appreciate that the Pay Review Body will want to take account of recent earnings growth in the wider economy and how that has impacted the relative position of NHS staff in the labour market.

ONS publishes data on average weekly earnings which is the lead measure on earnings growth per employee and is based on data from the monthly wages and salaries survey. Changes in average weekly earnings cover more than just pay settlements and include the impact of changes in averages working hours of alterations to workforce composition.

As shown in figure 7 the pace of earnings growth has moderated in after reaching peaks in autumn 2023 and this is expected to continue with OBR forecasting earnings growth of 4.5% across 2024 to 2025.

Figure 7: increase in average weekly earnings in the private sector, 3-month and annual growth rates between July 2017 and September 2024, £ per month, 3 month moving average



Source: Office for National Statistics, average weekly earnings

This is a chart showing the increase in average weekly earnings in the private sector between July 2017 and September 2024 on both a 3-month and annual average basis. It shows that the increase in earnings, using the 3-month average, is just under 5% as of September 2024 but has reduced from around 8% during 2023.

Because data on pay growth is broader than the impact of pay awards alone, we are also interested in data on pay settlements which most closely resemble the decision facing PRBs and don't include the impacts of changes to workforce composition or pay drift. Current estimates of average pay settlement may point to recorded pay settlements being lower than headline wage growth. The most recent pay survey from Brightmine, formerly known as XPertHR shows a median basic pay award in the 3 months to the end of September 2024 of 4%. Information from the Bank of England Decision Maker Panel estimated year ahead wage growth of 4.1% in October 2024, which was unchanged from the previous reporting period.

Earnings growth across the earnings distribution

In addition to a general understanding of earnings growth we can assess how earnings growth is changing across the income distribution. If different parts of the earnings distribution are growing at different rates then it may impact our optimal pay strategy.

The Office for National Statistics publishes information on growth at different sections of the income distribution based on 'real-time' information from Pay as You Earn data.

Median growth between July and September 2024 was just under 6% while earnings growth was higher for lower earners following large increases to the National Living Wage. Toward the upper end of the earnings distribution, where we expect to find the majority of doctors and dentists the growth in earnings appears to have been lower and has fallen more quickly than at other points of the distribution. The increase in earnings growth in the period to September may reflect the latest round of public sector pay decisions including back-pay.

Table 36: estimated growth in earnings by income distribution percentile - 3-month moving average to September 2024 compared to 3-month average to September 2023

	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile	95th percentile	99th percentile
Sept 2024	5.5%	8.2%	5.4%	3.2%	2.5%	2.5%	3.4%

Source - Office for National Statistics, real time information

Note current data, for September 2024, is impacted by non-consolidated payments made to civil Servants and NHS staff in summer 2023.

High income professions and earnings percentile analysis

Earnings percentile analysis

One way to assess any change in the competitiveness of medical pay is to consider how the average earnings of different grades compare with the UK income distribution and how they may have changed through time. We believe it is best to focus on long term trends rather that year-to-year movement which can be influenced by variations in the ASHE sample or extraordinary events such as the COVID pandemic which impacted earnings throughout the economy.

As shown in table 36, there have been only very small changes in the relative ranking of the different medical grades over time - HCHS doctors are consistently in the top 5% of the UK earnings distribution with consultants consistently in the top 2% of earners. Average earnings for resident doctors are also above the UK average pay with only those in foundation training not in the upper quartile of the earnings distribution. The slight reduction for those in resident doctor grades likely reflects the impact of industrial action on average earnings.

Table 37: estimated income percentile for NHS career grades based on average earnings per person in the NHS mapped against ASHE

12 months ending in March 2024

Grade	2018	2019	2020	2021 (SOC 10)	2021 (SOC 20)	2022	2023	2024
HCHS doctors	96	96	96	96	96	96	96	96
Consultant	98	98	98	98	98	98	98	98
Associate specialist	97	97	97	97	97	97	97	97
Specialty doctor	93	93	93	94	94	95	94	94
Staff grade	92	92	93	94	94	94	93	93
Specialty registrar	91	91	91	92	92	92	91	90
Core training	87	87	86	89	89	88	86	85
Foundation Year 2	79	79	77	80	80	77	75	73
Foundation Year 1	70	70	67	69	69	67	64	62

Source: NHS England Earnings Statistics (table 2a), Annual Survey of Hours and Earnings (table 1.7a), Gross Annual Earnings for 90th to 99th Percentile.

Note - A figure of 98 indicates that average earnings are above the 98th percentile but lower than the 99th percentile.

Based on a comparison of NHS average earnings per person with gross total pay from Annual Survey of Hours and Earnings. Note - this may differ slightly from previous Office 104 of Manpower Economics (OME) analysis as this is based on average earnings per person rather than FTE salaries.

Annual survey of hours and earnings

The previous section provides an indication of the position of medical staff within the overall income distribution. Data from the annual survey of hours and earnings (ASHE) can be used to indicate how the growth in earnings for medical staff compares to specific occupations which may be similar based on the level of qualifications or experience required.

When interpreting ASHE data, and what it says about growth in earnings for the medical workforce, it should be placed into context against other data sources and known increases to pay scales. For example, the decrease in median earnings for medical practitioners since 2018 that we see in ASHE data is not consistent with NHS England earnings data which shows increases to earnings that have been consistent with known increases to pay scales.

Potential factors that contribute to this discrepancy may include an unrepresentative ASHE sample composition, for example, one that contains a large proportion of resident doctors,

or a small sample size compared to the entire population and it is known that since the pandemic the Labour Force Survey, which the ASHE is drawn from, has suffered from lower response rates. It is also important to recognise that ASHE includes medical practitioners from the NHS with private healthcare industry, hence it is not entirely representative of NHS earnings.

The medical practitioner group, which includes both specialists and generalists, remain among the highest earning professions. Median earnings for the whole group are in the top 15 of over 350 professions, unchanged from 2023, and median earnings for the 'specialist' group of over £70,000 are below only 6 professions including airline pilots, chief executives, senior managers, and directors.

Since the introduction of more detailed 'standard occupation codes' from 2021 it is possible to separate 'specialist' and 'generalist' medical practitioners. Specialist medical practitioners make up around 75% of the combined group and as shown in table 37 - they have significantly higher annual earnings than generalists. Once again, the lack of growth for specialist medical practitioners is not consistent with other data sources.

Table 38: median annual earnings per person (£)

Description	2021	2022	2023	2024
All medical practitioners	56,122	54,572	59,151	61,534
Change	Not applicable	-3%	8%	4%
Of which generalist medical practitioners	48,959	41,159	41,202	45,506
Change	Not applicable	-16%	0%	10%
Of which specialist medical practitioners	66,763	63,861	70,536	70,192
Change	Not applicable	-4%	10%	0%

Source - Annual survey of hours and earnings 2024 - table 14.7a

Longitudinal Education Outcomes

Data from the Longitudinal Education Outcomes (LEO) dataset can be used to monitor employment and earnings outcomes for graduates and postgraduates from English higher education providers one, 3, 5 and 10 years after graduation based on information provided by the Department for Education, the Department for Work and Pensions and HMRC. The data can be used to analyse the performance of healthcare graduates against those from other courses using either average earnings (though this measures earnings only and does not elements of wider reward, or differences in the balance between headline pay and wider reward which is particularly relevant to healthcare staff in the NHS) or employment prospects.

Table 39 compares median earnings for medicine and dentistry graduates to median earnings for graduates from other subjects one, 3, 5 and 10 years after graduation. Earnings after one year of graduation are just over 76% higher than average (excluding medicine and dentistry), and after 10 years of graduation, are just over 70% higher than the average. It shows that median earnings of those with medicine and dentistry degrees are the highest throughout the first 5 years after graduation.

After 10 years economics graduates had slightly higher median earnings compared to medical graduates however this represents data for the cohort of students who graduated in 2010 to 2011, which coincides with when there were lower pay increases linked to public sector pay policy and does not include the impact of recent higher pay awards or pay agreements which will feed into this data in future years.

Table 39: median earnings for medicine and dentistry graduates 1, 3, 5 and 10 years after graduation with comparison to other subjects based on earnings in fiscal year 2021 to 2022

Median earnings for first degree students	1 year after graduation (graduated 2019 to 2020)	3 years after graduation (graduated 2017 to 2018)	5 years after graduation (graduated 2015 to 2016)	10 years after graduation (graduated 2010 to 2011)
Medicine and dentistry	£39,100	£48,900	£52,600	£59,100
Medicine and dentistry rank (35 subjects)	1	1	1	2
Subject average (excluding medicine and dentistry)	£22,200	£26,800	£30,100	£34,700

Source: Longitudinal education outcomes (LEO) (Department for Education). Data includes graduates not working in NHS too, however the vast majority (94%) after 5 years work in the health sector.

LEO also includes information on employment which further highlights the value of medical and dental degrees. Those with medicine and dentistry degrees are most likely to be in sustained employment or training 5 years after graduating. Although the proportion of individuals in sustained employment or training remains high in all stages after graduation, it is worth noting that this figure falls as the years since graduation increase. This is seen across all degrees and will include the impact of things like family commitments. This is shown in table 40. One note is that Celtic studies had the highest ranking 3 and 10 years after graduation but their sample size is much smaller, at 30 respondents or less.

LEO also publishes information on which industry graduates are working in. One year after graduation, over 97% of first-degree medicine and dentistry graduates surveyed worked in

human health and social work activities. 3 years after graduation, over 95% remained in the same industry. 5 years after graduation, over 94% remained in the same industry.

Table 40: proportion of medicine and dentistry first degree graduates in sustained employment, training, or both after 1, 3, 5 and 10 years with comparison to other subjects in 2021 to 22 fiscal year

Proportion in sustained employment, further study, or both % (first degree only)	1 year after graduation (graduated 2019 to 2020)	3 years after graduation (graduated 2017 to 2018)	5 years after graduation (graduated 2015 to 2016)	10 years after graduation (graduated 2010 to 2011)
Medicine and dentistry	96.6%	93.8%	92.9%	88.8%
Medicine and dentistry rank (35 subjects)	1	5	1	3
Average (all subjects excluding medicine and dentistry)	87.6%	88.1%	87.7%	84.9%

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

Local, regional and international labour markets

Following the pay agreement with the consultant workforce the terms of reference of the DDRB has changed to include:

- 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

- at the outset it is important to recognise that pay is only one factor that can influence staff when they are deciding where to live and work. Other influential factors will include the distribution of medical schools, training places for their chosen specialties as well as wider lifestyle factors

Local and regional labour markets

Medical staff covered by the DDRB are employed via a series of national pay contracts which, except for a small allowance for those working in London, are the same across England with the same set of pay scales being used across the country.

While specific evidence is limited, we acknowledge there may be cases where organisations may struggle to recruit specific types of staff using national terms and conditions. In these cases the pay system includes a series of flexibilities including the use of Recruitment and Retention premia to help alleviate such issues. Our understanding is that these flexibilities are very rarely used with earnings data published by NHS England suggesting that fewer than 0.5% of the medical workforce were in receipt of a payment marked as a RRP in 2023 to 2024.

For the General Practice workforce a similar scheme (The Targeted Enhanced Recruitment Scheme) is an initiative that offers a one off payment of £20,000 to GP Specialty Trainees committed to working in a select number of training locations in England that either have a past history of under-recruitment or are in under-doctored or deprived areas. There is evidence that these schemes have helped to attract people to these areas and many doctors choose to stay in those locations after the completion of training.

International comparisons

As part of its updated terms of reference for the 2025 to 2026 pay round the DDRB has been invited to consider relevant international comparisons

The Organisation for Economic Co-Operation and Development (OECD) compiles some information on the remuneration of medical staff as part of its annual Health at a Glance reports including estimates of how wages for specialists and general practitioners compare to the national average wage for that country based on national accounts data. In the 2023 report this shows that most countries, including the UK, have salaries substantially above this measure of average pay although the extent of this differential does differ between countries.

Comparisons of this sort can give insight and useful labour market context for the DDRB to consider. However, it is difficult to make appropriate comparisons between countries due to differences in things like the types of employment status of staff (for example, self-employed versus salaried), differences in workforce definitions, qualifications or differences in the total reward package. In addition, living standards in different countries will be affected by a range of wider factors, as will people's ability to move easily between countries.

In the context of a lack of quality data outside of that shared above, we believe that any international comparisons must be treated with caution, given the need to recognise the complexities of such comparisons including the contexts of different countries, economies and health systems which are not captured in a comparison of pay values.

6. Remit groups

This chapter provides further detailed information on each of the groups within the DDRB's remit. This includes information relating to pay arrangements, issues specific to particular groups and deals to end industrial disputes.

The chapter also responds to some of the requests for information the DDRB made in their last report.

Consultants

NHS consultants are senior doctors that have completed full medical training in a specialised area of medicine and are listed on the GMC’s specialist register. Since the year 2019 to 2020, consultant FTE in NHS trusts and core organisations has grown by 14%, from an average of 48,837 in 2019 to 2020 to an average of 55,751 in the year 2023 to 2024.

Following negotiations between the government and the BMA Consultants Committee and the HCSA executive committee in February 2024, union members voted to accept an offer made to them, ending their strike action in England. The details of this deal have been set out in previous chapters.

The consultants’ deal

The government agreed a deal with trade unions representing NHS consultants to end their strike action in England. The deal included a number of reforms, aimed at improving equalities and better rewarding performance.

The deal amended the consultant pay structure by reducing the number of pay points and the time it takes to reach the top, effective from 1 March 2024. The number of pay points reduced from 8 to 5, with the time to reach the top of the pay scale reduced from 19 years to 14 years.

As women are more likely to have interrupted careers, reducing the length of the pay scale will enable a higher proportion of female consultants to amass the experience required to reach the top of the pay scale quicker and thus help to reduce the size of the gender pay gap. The review conducted by Prof Dame Jane Dacre, Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England, in 2020, concluded that reducing the number of scale points would compress the population in each grade making it easier for women to 'catch up' and narrow the gender pay gap. Report can be found at: Mend the Gap: the Independent Review into Gender Pay Gaps in Medicine in England.

The deal also introduced a new pay progression process, whereby criteria will be used to authorise progression through pay points. This will ensure that there is a clearer link between pay progression and evidence of skills, competencies and experience and will support progression and role development. When it is time for the consultant to move to a new pay point, the clinical manager has to authorise that progression once they were satisfied certain criteria have been met. This new process brings consultants more in line with other NHS staff.

In addition, the deal included a contractual right to enhanced shared parental leave, bringing it in line with other staff and increasing equalities across staff groups.

This deal also set out the detail of work to reform the process for the appointment of members to the DDRB, and further revising the panel's terms of reference. Parties agreed that these changes would take effect for the 2025 to 2026 pay year. These are currently being implemented.

As noted above, to enable these reforms, it was agreed that Local Clinical Excellence Awards (LCEAs) would end going forward and the funding be redeployed into pay scale reform. This took effect from 1 April 2024. Any multi-year non-consolidated awards issued since April 2018 have not been impacted.

Consolidated LCEAs awarded prior to reform in 2018 will be retained and these awards shall remain pensionable and consolidated. The value of these awards will be frozen and therefore the department will not be seeking recommendations on an uplift to these awards.

Prior to the deal, pre-2018 LCEAs were subject to a process of review whereby, to maintain their award, a consultant would demonstrate continued achievement at regular intervals. As part of the deal, the review process for these awards will be removed.

As noted in the DDRB evidence last year, new arrangements for LCEAs were introduced in 2022 which allowed employers to develop awards schemes at the local level to meet their local priorities and needs. However, progress on this had been relatively slow by employers: employers found it difficult to move away from the COVID-19 provision whereby LCEA funding was distributed equally among eligible consultants, it was time consuming for employers and there was no mechanism to monitor effectiveness and equalities of the awards. TUs also reported that the schemes had been unpopular amongst members.

In the context of a limited envelope available for reform, it was agreed that redeploying LCEA funding into basic pay would support the shared ambitions of significantly reforming the pay scale.

In its report, the DDRB has asked for equalities data of existing consultant reward schemes. DHSC do not hold that information in relation to the consolidated LCEAs that remain in pay and have no current plans to gather such data.

The government is currently finalising implementation of the deal.

Contract reform

The core contract for consultants had not been updated for 20 years prior to the consultants' deal. As noted above, the deal made a number of contractual reforms, such as reforming the pay scale, introducing enhanced shared parental leave and introducing new pay progression arrangements. As part of implementing the consultants' deal, the contract has been updated to reflect these changes.

Trade unions and the government are currently in discussions to update schedule 30 to reflect the end of LCEAs.

Despite this, there remain elements of the contract that are out of date and out of step with the rest of the NHS workforce and it remains our ambition to modernise terms and conditions.

Consultant job plans

In their last report, the DDRB asked the department to supply information on the average number of programmed activities and supporting professional activities worked by consultants over time.

The department does not hold information on how, on average, consultant job plans are broken down into Programmed Activities and Supporting Professional Activities (SPA). Information on job plans is held at local level.

ACCIA only collects data from a small proportion of the consultant population (around 2% annually) and relies on self-reporting of Programmed Activities worked, so the information they have available is not representative of the consultant workforce.

Schedule 3 of the 2003 consultant contract includes details of how the consultants' job plan should be agreed with the clinical manager, and that all job plans should be reviewed annually. Under the consultants' deal, one of the criteria for pay progression is participating satisfactorily in the job planning process. This should help to ensure commitment from both employers and consultants to regular job planning reviews.

National clinical impact awards

Following public consultation in March 2021, the reformed National Clinical Impact Awards (NCIA) scheme was launched in 2022 with the first new awards granted for 5 years from 1 April 2022. Crucial to the reforms were the recommendations made by the DDRB in 2012 and wider evidence including the Gender Pay Gap in Medicine Review.

One of the main aims of the reform was to broaden access. ACCIA has since increased the number of awards available to up to 600 awards per year, which has only been made possible by setting the award values to their current level and making the payments non-consolidated and non-pensionable.

Consequently, the success rate for applications increased from 29.3% in the 2021 award round to 46.6% in the 2022 and 45.8% in 2023 awards round.

More than ever, we are recognizing and rewarding clinicians who have significantly contributed to the NHS through enhanced patient care and increased productivity. The reforms have shifted the scheme's focus to acknowledge those who have made a substantial impact on the NHS at a national level, rather than merely considering the status or activity input of a clinician. Examples include system reports on how the NHS can function more efficiently, with recommendations that have been endorsed and implemented nationwide. Clinicians have delivered research that has fundamentally changed national and international guidelines, introduced new therapies and treatment pathways, and positively impacted patients globally. They have also served as role models and mentors for other clinicians, providing training for emerging researchers and fellows. Additionally, they have delivered innovative local work that has demonstrated increased productivity and better patient outcomes, which has subsequently been adopted across the country.

Our award holders are leaders and innovators from various specialties and are spread across the country, with the highest success rate being achieved by West Midlands (49.1%) in 2022 and Cheshire and Mersey (48.9%) in 2023. Awards are granted to applicants from major teaching hospitals, medical schools, smaller trusts in under doctored areas, and increasingly consultants employed by organisations such as charities who deliver contracted out NHS services.

Moreover, changes to the scheme rules regarding pensions, implemented at the same time as the introduction of flexible retirement into the NHS Pension Scheme, have enabled senior experienced clinicians who would have lost their awards to continue to deliver in the NHS while accessing their pension benefits. As a result of these changes, around 10.4% of the total award holders, who would have otherwise lost their award, remain in the scheme and continue making an impact on the health service. For consultants to benefit from this change, they must continue to meet the minimum eligibility criteria of having 3

clinically relevant programmed activities. Consequently, all have maintained commitments with the NHS, where they might not have done so had they lost their awards.

Furthermore, removing the pro-rating of less than full time (LTFT) applicants has been crucial to our retention strategy. This approach acknowledges the valuable contributions of LTFT clinicians, who often balance demanding professional roles with personal commitments. It recognises and incentivises a diverse and flexible workforce. LTFT consultants make up 19% of clinicians awarded an NCIA since 2022, including a number of younger consultants with no prior national award, some of whom have received the highest level of national award on their first application to the scheme.

ACCIA runs a yearly feedback exercise for applicants following the application window closure. In 2024, of those who responded, 97% of applicants highlighted that they would feel validated and recognised if they received an NCIA for their hard work and commitment to the NHS. Consultant responses demonstrate that they continue to value the scheme in its purpose of recognising and rewarding those who go above and beyond their contractual duties and demonstrate significant impact at a national and international level.

Equalities data

ACCIA publishes annual reports providing detailed summaries of the equalities data collected from applicants. The database used to manage the pre-reform national Clinical Excellence Award scheme only collected age, sex, and ethnic background information from applicants, but a new online application portal introduced alongside the reformed scheme in 2022 collects information on all 9 protected characteristics set out in the Equality Act 2010.

The most recent published annual report is that for the 2022 award round, with the 2023 annual report due to be published autumn 2024. All diversity data are self-reported by applicants and there is an option to not declare for every option.

In the 2019 round, 113 applications were received from applicants aged between 36 and 45, compared to 236 applications from those aged 35 to 44 in the 2022 round. The increased application volume from younger consultants translated into an increased number of awards granted, with 33 awards granted to the respective age category in 2019 and 76 in 2022.

In terms of sex and ethnic background, applications from female consultants have increased from 26.3% of the total in 2019 to 33.3% of the total in 2022, and the proportion of applications from white background consultants has fallen from 67.4% in 2019 to 61.1% in 2022. There remain disparities in the success rates between applicants of different sexes and ethnic background, and ACCIA is aware that there remains work to do to

ensure that applications received, and awards granted reasonably reflects the consultant population.

Specialty doctors, associate specialists and specialists

This group comprises of doctors employed on 2 open contracts - specialty doctor (2021) and specialist - and on a variety of closed contracts including specialty doctor (2008), associate specialist, staff grade and senior clinical medical officers.

A multi-year agreement applied to SAS doctors for the years 2021 to 2022 to 2023 to 2024. The pay uplifts agreed as part of the deal applied only to the open contracts. During that period, doctors on closed contracts had their pay uplifted annually in line with the government's response to recommendations made by the DDRB.

The DDRB's 52nd report was the first time that recommendations were made for the whole of the SAS workforce following the conclusion of the multi-year agreement. The government accepted the DDRB's recommendation to uplift pay for SAS doctors on all contracts by 6%.

Prior to the DDRB's last report, the government had made a pay and reform offer to the BMA to bring an end to the industrial dispute with SAS doctors. The offer provided uplifts to pay points on the 2021 contracts aimed at reducing unintended divergence between pays scales and a £1400 consolidated uplift to pay scales on all pre-2021 contracts. In a referendum of BMA members, this offer was accepted in June 2024 by 79% of SAS doctors who voted. The uplifts associated with the offer were backdated to 1 April 2024.

Impact on SAS pay scales

In our previous evidence to the DDRB we have set out how the pay scales of the 2008 and 2021 specialty doctors contract diverged during the course of the multi-year agreement.

The combined effect of recent pay uplifts agreed through the DDRB process and the pay element of the deal agreed with the BMA has made some positive change in this respect. The below table sets out a comparison of the 2 pay scales:

Table 41: comparison of the pay scales for the 2021 specialty doctor contract and the 2008 specialty doctor contract

Minimum years of experience/step pay point	**2021 Specialty Doctor contract (with effect from 1 April 2024)**	**2008 Specialty Doctor contract (with effect from 1 April 2024)**	**£ gap (2008 to 2021)**
0	59,175	51,260	7,915
1	59,175	55,516	3,659
2	59,175	61,049	-1,874
3	68,174	64,014	4,160
4	68,174	68,287	-113
5	68,174	72,543	-4,369
6	75,998	72,543	3,455
7	75,998	76,895	-897
8	75,998	76,895	-897
9	84,121	81,248	2,873
10	84,121	81,248	2,873
11	84,121	85,601	-1,480
12	95,400	85,601	9,799
13	95,400	85,601	9,799
14	95,400	89,953	5,447
15	95,400	89,953	5,447
16	95,400	89,953	5,447
17	95,400	94,306	1,094

Source: Pay and Conditions Circular (M&D) 5/2024 R

This table show that there are now 6 pay step points on the 2008 contract where pay is higher than the 2021 contract. For most of the other pay step points, pay is notably higher on the 2021 contract.

The latest figures to July 2024 show that 58% of specialty doctors are now on the new 2021 contract, an increase from 49% to July 2023. However, only 16% of doctors on the 2021 specialty doctor contract have transferred from the 2008 contract. It is too soon to understand the impact of the changes in pay agreed as part of the SAS deal, however, the intention of our targeted action to reduce the differentiation between the 2 pay scales is that it will stimulate further transfer of specialty doctors to the new contract.

We recognise that there are likely to be reasons beyond pay which discourage specialty doctors from transferring to the new contract, for example lack of understanding of the benefits or inefficiencies in the transfer process. The SAS Deal Implementation Group, consisting of representatives from DHSC, NHS England, NHS Employers and the BMA, has therefore also been looking at where improvements can be made to the transfer process.

Specialist grade

The specialist grade was introduced as part of the multi-year agreement in 2021. The intention behind opening the grade was to provide career progression opportunities for skilled and experienced SAS doctors. Specialist posts are created by employers where there is a service need for expert clinical decision makers in a specialised area. The posts are filled through fair and open recruitment.

The previous issue whereby the top of the 2008 specialty doctor pay scale was higher than the starting point of the specialist pay scale has now been resolved. There is now a pay increase of over £2,500 on promotion to the specialist grade from the top of the 2008 specialty doctor contract and almost £1,600 from the top of the 2021 specialty doctor contract.

Since the new grade was introduced, the number of specialist posts has been steadily increasing. A total of just over 1,300 specialist posts have been created since April 2021. Over the 24 months to July 2024, approximately 36 specialist roles were created on average each month.

While overall the number of 'senior SAS' (specialist and associate specialist) roles continues to grow, we recognise concerns raised by the BMA that specialist roles are being created at a slower rate than had been anticipated.

Just under 45% of specialist posts are filled by doctors who were on one of the 2 specialty doctor contracts the month before they transferred. Around 10% have moved from the Associate Specialist grade.

Given that the specialist post was created as a means to offer career progression for specialty doctors, we would have anticipated that a larger proportion of the roles would have been filled by this group.

Supporting the career development and progression of SAS doctors

Concerns around opportunities for career support and development have consistently been raised by SAS doctors over a number of years. As mentioned above, this was the impetus for introducing the specialist grade in 2021.

As these concerns are ongoing, the deal agreed with the BMA in 2024 contained a number of measures specifically aimed at supporting career progression.

The SAS Deal Implementation Group has been working collaboratively to refresh advice and guidance in this respect. The group is also undertaking actions aimed at exploring national levers available to encourage and establish specialist roles. This will include

guidance to employers which sets out more clearly the expectations around vacancy filling and making sure that when specialty doctors are acting up to specialist roles this is properly recognised.

In addition, the department is leading on commissioning a piece of research to understand why more specialist roles are not being created. It's currently expected that this work will conclude by the end of March 2025 and the SAS Deal Implementation Group will then consider how any recommendations can be taken forward.

Career progression for SAS doctors is not only about accessing the specialist role. In recognition of this the SAS deal also committed to promoting job planning to ensure that SAS doctors have access to appropriate opportunities to support their development. The deal also committed to a piece of joint work between the stakeholders with the objective of helping SAS doctors who would like to progress through the Portfolio Pathway.

While it may take some time to see tangible outcomes from these measures, in terms of more opportunities for progression, the intention of the deal was to make clear to all SAS doctors that there is a clear and joint commitment at a national level to supporting their career ambitions.

Resident doctors

In 2023, the BMA voted to moved away from use of the term 'junior doctor' and, in 2024 selected the term 'resident doctor' as a replacement. This term officially came into use in September 2024. The contract for resident doctors in England continues to be named Terms and Conditions of Service for NHS Doctors and Dentists in Training (2016).

In July 2024, the government announced that an offer had been agreed with the BMA Junior Doctor Committee (now known as the Resident Doctor Committee) which sought to end the industrial dispute which had been ongoing since 2022.

The BMA announced in September 2024 that members had voted to accept the offer, with 66% of doctors voting in favour, on a turnout of 69%. The offer was also accepted by members of the British Dental Association (BDA) (87% voted to accept on a turnout of 56%) and the HCSA (69.3% accepted, on a turnout of 48.7%). This brings an end to the long-running national industrial dispute with all resident doctors and means the government can work together with them to progress its mission of fixing the health service for patients.

In line with the deal agreed with the BMA, the government asks the DDRB to consider, as part of its pay recommendations, the overall reward package and career progression for

resident doctors to ensure that medicine is an attractive and rewarding career choice to deliver our consultants and GPs of the future.

Impact of the deal on pay

The deal for resident doctors included an average 4.05% investment into 2023 to 2024 pay scales effective from 1 April 2023, with a payment to reflect backpay. This was on top of the uplift they had already received for 2023 to 2024 from the DDRB. Resident doctors also received the uplift of 6% plus £1000 recommended by the DDRB effective from 1 April 2024.

The negotiating parties opted to target a greater proportion of the 2023 to 2024 investment at Nodal Point 3, as this is where they identified the greatest recruitment and retention risk. As the DDRB uplift for 2024 to 2025 included a flat cash element, this resulted in a greater percentage uplift to doctors at the start of the pay scale. The table below sets out the resulting combined uplifts:

Table 42: impact of the deal for resident doctors and the DDRB uplift for 2024 to 2025 on the 2016 contract pay scale

Training stage	**2023 to 2024 pay scale value (post 2023 to 2024 DDRB uplift)**	**2024 to 2025 pay scale value (post deal and 2024 to 2025 DDRB uplift)**	**Total % increase**
Foundation Year 1	£32,398	£36,616	13.0
Foundation Year 2	£37,303	£42,008	12.6
ST Year 1 to 2 / CT Year 1 to 2	£43,923	£49,909	13.6
ST Year 3 to 5 / CT Year 3	£55,329	£61,825	11.7
ST Year 6+	£63,152	£70,425	11.5

Source: Pay and Conditions Circular (M&D) 5/2024 R

Targeting different percentage uplifts at different stages of training has marginally altered the shape of the pay scale. However, movement through training continues to attract meaningful increases in pay at each stage.

In addition to basic pay, resident doctors may receive payments for additional activity and unsocial hours, worth on average around 29% of basic pay for Foundation Year 1 doctors and around 33% of basic pay for Foundation Year 2 doctors. This is expected to result in average total earnings of £42,600 and £51,000 for Foundation Year 1 and Foundation Year 2 doctors respectively in the year 2024 to 2025.

Flexible pay premia

As part of the deal for resident doctors, it was agreed that the terms and conditions of service will be amended so that the DDRB aligns the recommended uplift to the Flexible Pay Premia each year with their pay recommendation. This change to the contract will be agreed over the coming months with the relevant parties. The DDRB is, therefore, asked to take this into consideration when making recommendations for 2025 to 2026.

Measures aimed at improving the experiences of resident doctors

The deal agreed with the BMA also contained a number of measures which seek to address concerns that resident doctors have raised in relation to their experiences of work.

DHSC and NHS England will work in partnership with other stakeholders, including the BMA, to reform the current system of rotational placements. The work will seek to review the training model in relation to the number and frequency of rotations, responding to resident doctor concerns about the personal disruption and administrative/logistical burden rotations currently cause.

Separately, NHS England will be undertaking a review of training numbers, to address bottlenecks and the planned expansion of medical school places. NHS England will provide more information relating to this and the plans for reform of rotational placements in their evidence.

A joint piece of work will also take place to review the current provisions applicable to exception reporting - the mechanism to ensure doctors are compensated for work performed and agreed educational opportunities are upheld. A set of principles have already been agreed and these will be translated into revised arrangements to be included in the terms and conditions of service. The overarching aim of these reforms will be to minimise the time-consuming nature of the process and empower resident doctors to engage with the process as professionals. Development of the new arrangements is being jointly led by the BMA and NHS Employers.

Separately from the deal, and earlier this year in April 2024, NHS England sent out a letter to the system setting out a range of measures to improve the working lives of doctors in training. Broadly, this sets out measures to: increase choice and flexibility through better rota management and deployment; reduce duplicative inductions and pay errors through streamlining and improving HR support; and create a sense of value and belonging for doctors. Progress in these areas should have a perceptible benefit to resident doctors and remove some of the current day to day frustrations they face.

Locally employed doctors

As we have set out in previous evidence, centrally held information on locally employed doctors is limited. It is difficult to gain a completely accurate picture of the numbers of locally employed doctors due to the different ESR codes utilised by employers for these staff. However, table 43 below uses an analysis of ESR data to set out the proportions of doctors in various contractual arrangements in the years 2021 to 2022 and 2023 to 2024.

Table 43: estimated HCHS medical workforce split by grade and contract status. average for 2021 to 2022 and 2023 to 2024

Contract	2021 to 2022 Estimated FTE	2021 to 2022 Estimated Share	2023 to 2024 Estimated FTE	2023 to 2024 Estimated Share
Consultant (open contracts)	52,463	42%	55,723	41%
SAS - specialist contract (open contracts)	84	0%	900	1%
SAS - specialty contract (open contracts)	1,007	1%	4,684	3%
Resident doctor - 2016 contract (open contracts)	42,830	34%	47,613	35%
Resident dentist - 2016 contract (open contracts)	260	0%	302	0%
Closed grades	21,438	17%	15,233	11%
Trust grades (LEDs)	7,790	6%	12,308	9%
Other	123	0%	127	0%

Source - DHSC Analysis of Electronic Staff Record

The table above shows that on average in 2021 to 2022, only 6% of the medical workforce were employed on 'trust grades' and could be alternatively described as locally employed doctors (LEDs). However, by 2023 to 2024 this had risen to 9%, demonstrating the increase in locally employed doctors over recent years.

It is our understanding that the majority of locally employed doctors are employed on terms and conditions which mirror national contracts and national pay scales. We believe that these posts are likely to be occupied by doctors who have stepped out of formal training,

many of whom will return to training when the time is right. This arrangement allows flexibility for doctors to continue to provide service to the NHS and build their experience while taking a pause from training. This of course also benefits employers who can maintain retention of experience doctors which ultimately benefits patients.

The increase in locally employed doctors would become concerning in a certain set of circumstances: either if significant numbers of doctors were feeling 'forced' into taking time out of training due to a lack of suitable opportunities, or if doctors on local contracts were being treated unfavourably compared to those on national contracts. We are keen to do more to understand the picture on the ground, for example through the work looking into training bottlenecks.

As part of the deal agreed for SAS doctors in England, DHSC, NHS England and NHS Employers committed to undertaking a joint piece of work with the BMA to determine how LEDs can be better supported to progress in their careers. This work includes a number of strands, including gathering more reliable data to understand the make-up of the LED workforce, the types of roles LEDs are undertaking, the reasons why employers use local terms and conditions and how they differ from national terms and conditions.

Building on this data, the SAS Implementation Group will collectively develop a process by which LEDs in roles comparable to SAS doctors for more than 2 years can be offered employment on a national SAS contract. The process would also cover how LEDs who do not fulfil these criteria but have been on a fixed term contract for more than 24 months can be offered a permanent contract. We would anticipate that this will reduce the number of doctors who are employed on local contracts long-term. The aim behind this work will be to ensure that local contracts are not being used as a long-term solution if it not in the best interests of or not the choice of the doctor concerned.

General medical practitioners

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

Implementation of the multi-year deal for contractor GPs

In March 2024, the 5 year framework for general practice which was agreed between NHSE and the British Medical Association (BMA) came to an end. Funding for the core contract and GP contractor pay was agreed and fixed for the 5 year period at the outset of this 5 year deal.

Insight on effects of industrial dispute with the General Practitioners Committee England (GPCE)

Following the 2024 to 2025 GP contract being implemented without agreement, the BMA held a non-statutory ballot for GP partners and contractors in England. This closed on 29 July 2024 with 67% of eligible members voting, of which 98.3% of members voted yes to collective action. The GPCE called for action to start on 1 August 2024. GPCE have set out options for 'work to rule' action which GP practices can choose to take. NHS England published guidance for commissioners, trusts and general practices, and information for patients on how collective action can be managed.

Since the BMA balloted, the government has accepted and implemented the independent pay review body recommendation of a 6% uplift in GP pay and has committed to hiring an extra 1,000 GPs. As the action is non-statutory, GPs are not required to tell their commissioners if they are taking part in action or which actions they are taking, it is therefore challenging to ascertain the level of collective action taking place.

Numbers completing training and becoming general medical practitioners (GMPs)

As part of their general practice workforce statistics series, NHS England analyses data tracking GPs in training into fully qualified general practice roles. Data from September 2018 onwards is available and is updated quarterly. There are a number of limitations to the data available which are set out alongside the data published. Due to the limitations set out, we have not drawn insights from the data in this evidence.

Source: Tracking GPs in training into fully qualified general practice roles, published July 2024 by NHS England.

Tackling GP partnership decline and numbers taking on contractor roles:

There has been a decline over time in the number of GP partners and a rise in salaried GPs as a proportion of the workforce. Table 44 displays the general trend over time of falling GP partner numbers and rising numbers of salaried GPs as a proportion of the workforce.

Table 44: doctors in general practice in England, FTE, by role, September 2019 to September 2024 (%)

Practitioner type	**September 2019**	**September 2020**	**September 2021**	**September 2022**	**September 2023**	**September 2024**
All doctors in general practice	100	100	100	100	100	100
GP partners	53	50	47	45	44	41
Salaried GPs	24	26	27	27	27	29
GPs in training grade	19	21	23	26	27	27
GP retainers	1	1	1	1	1	1
GP regular locums	3	3	2	2	2	2

Source: NHS England, General Practice Workforce, 30 September 2024, October 2024, table 1a. Data includes estimates for practices that did not provide fully valid staff records.

NHSE's submission will include further detail on uptake of GP contractor roles.

Reasons for GPs not wanting to take on a contractor role or moving back to a salaried role from a contractor role can vary and include concerns about workload and work/life balance, the personal financial risk involved or a lack of interest in aspects of the work, such as managing income and expenditure. Past reports from the GP Worklife survey explore levels of satisfaction with different elements of the workload for partner and salaried GPs. The survey also tracks the proportion of GPs' time spent on different tasks such as administration and external meetings vs direct patient care.

Research commissioned by the government and published in 2022 explored the gendered barriers to partnership roles and is informing our work to address the gender gap in the partner vs salaried workforce in addition to the gender pay gap in general practice.

In 2020, NHS England launched the New to Partnership Payment Scheme to encourage GPs to take on partnership roles. The scheme ran from July 2020 to June 2023 and was open to GPs and other health professionals who took on partnership roles in general practice for the first time between 1 April 2020 and 31 March 2023. It offered successful applicants a one-off payment of £20,000 (for an FTE role, pro-rata for part-time), a further 20% contribution towards tax and National Insurance payments, plus a £3,000 training grant. While the scheme successfully recruited 2,939 GPs into partnership roles, the overall decline in GP partners is a continuing issue.

We were asked for information on average retirement ages among GPs. This is covered in chapter 4 in our evidence around recruitment, retention and morale.

Evaluations of the financial initiatives in place to incentivise working areas or specialties

There are schemes currently in place to incentivise training in particular areas that struggle with recruitment:

Targeted Enhanced Recruitment Scheme

Under the Targeted Enhanced Recruitment Scheme (TERS), NHS England offer a £20,000 salary supplement to attract GP trainees to work in areas of the country where GP training places have been unfilled for a number of years. The locations included in the scheme are decided annually by the GP National Recruitment Office (GPNRO). Information on the number of places in the scheme is in chapter 4 of our evidence.

The fill rates of places on the TERS scheme have been consistently high overall, showing successful recruitment to the areas identified by the scheme. NHSE England provided some evaluation of the scheme in their evidence to the DDRB for 2024 to 2025, which noted:

“Caution is exercised in the evaluation of TERS results, as longitudinal tracking is required to ascertain if TERS trainees remain in an area post qualification and this is still a relatively new scheme.”

Foundation priority programmes

Foundation Priority Programmes (FPP) have been developed to support specific areas of the UK that have historically found it difficult to attract and retain doctors in training through the foundation and specialty recruitment processes. Evaluation of foundation priority programmes will be covered in NHSE’s evidence.

Locally employed doctors

The DDRB has asked for further information on locally employed doctors. We are not aware of any locally employed doctors working within general practice in England. However, as covered in previous chapters, changes have been made to the Performers List regulation to enable practices to continue to engage a variety of medical professionals to operate as part of the primary care team.

Doctors taking time out of training

We have also been asked for information on doctors taking time out of training. There are a number of reasons doctors may take time out of GP specialty training, but we do not hold insights into any trends or risks around this.

General dental practitioners

This government's ambition is to make sure that everyone who needs dental treatment can access a dentist. The government has committed to tackling the immediate crisis in NHS dentistry with more urgent dental appointments and recruiting new dentists to areas that need them most. To rebuild dentistry in the long term, the government has committed to reforming the dental contract, with a shift to focus on prevention and the retention of NHS dentists.

We are currently reviewing the previous government's dentistry recovery plan and what elements of that can be taken forward effectively and within NHS budgets.

Dental payment models

To rebuild dentistry in the long term, we will reform the dental contract, with a shift to focus on prevention and the retention of NHS dentists. There are no perfect payment models and careful consideration needs to be given to any potential changes to the complex dental system so that we deliver genuine improvements for patients and the profession.

Commissioning

The DDRB requested information on the bidding process in place in England and Wales, how this may affect remuneration, and identification of any checks and balances in place to ensure that bidders for dental contracts do not undermine their viability by bidding below a sustainable level. From 1 April 2023, the responsibility for commissioning primary care dentistry to meet the needs of the local population has been delegated by NHS England to all integrated care boards (ICBs) across England. This included the transfer of all funding, Units of Dental Activity (UDAs) and the management responsibility for National Health Service dentistry. ICBs are responsible for having local processes in place to involve patient groups, and for undertaking oral health needs assessments, to identify areas of need and determine the priorities for investment.

NHS primary care dentistry is delivered through contracts structured around UDAs - each treatment is allocated a number of UDAs in proportion to the complexity/amount of work required. There are currently 4 UDA bands (with band 2 split into 3 sub-bands from November 2022). Commissioners negotiate contracts with practices to deliver a certain

number of UDAs each year. Contract holders are awarded funding at the start of the financial year based on the contracted number of UDAs. Where a contract holder has delivered less than 96% of contract value by the end of the financial year, funding for the contract under-delivery is recovered by the NHS in the following financial year.

Differential UDA rates allow providers to use differing pay rates to reflect the local market rates. From April 2024, the government set a new minimum UDA value of £28 to support practices with historically low UDA rates. ICBs can also influence the UDA rate locally, which may help to support local interventions.

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

Dental patient charges

From April 2024, dental patient charges in England increased by 4%. This means that a dental charge payable for a band 1 course of treatment rose by £1.00, from £25.80 to £26.80. For a band 2 course of treatment, there was an increase of £2.80 from £70.70 to £73.50. A band 3 course of treatment increased by £12.30 from £306.80 to £319.10. There are a range of exemptions to NHS dental patient charges for those who need the most financial support. Support is also available through the NHS Low Income Scheme for those patients who are not eligible for exemption or full remission. 48.6% of courses of treatment were delivered to non-paying adults and children in 2023 to 2024.

New patient premium

The previous government’s dentistry recovery plan announced the New Patient Premium initiative. The initiative launched in March 2024 to run for one year. Participating NHS dental practices were offered additional payments of up to £50 per new patient treated.

Golden hellos

The previous government’s dentistry recovery plan announced a recruitment incentive scheme through which a 'golden hello' cash incentive of £20,000 is being offered to up to 240 dentists to deliver NHS to work in those areas that need them most for 3 years. The payment is in line with similar existing incentive offers such as the GP Targeted Enhanced Recruitment Scheme (TERS).

The scheme is expected to deliver 284,000 more treatments per year. NHS England has issued guidance to practices wishing to express an interest in the scheme and ICBs have started to advertise posts through the Golden Hello scheme.

Working hours

The Dentists' Working Patterns, Motivation and Morale survey published on 24 April 2024 provides headline information on working patterns, motivation, and morale for self-employed primary care dentists in England for 2022 to 2023.

The average percentage of time spent on NHS work by all dentists in England was 70.2% in 2022 to 2023. This is lower than the 2019 to 2020 figure of 73.0%. The figure in 2022 to 2023 for providing-performer dentists was 61.2%, and the figure for associate dentists was 73.0%. Furthermore, the average number of hours worked in dentistry in England in 2022 to 2023 was 35.3. This is lower than 2019 to 2020 when the figure was 36.6 hours and is lower than all other UK nations.

Community dental services

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

CDS are available in a variety of places to ensure everyone can have access to dental care. These include hospitals, specialists' health centres and mobile clinics, as well as home visits or visits in nursing and care homes. ICSs are responsible for identifying areas of local need and determining the priorities for investment.

An NHS clinically led Getting It Right First Time (GIRFT) report about CDS is due to be published shortly. The report will draw on survey responses from all CDS providers, highlighting the challenges faced across the country, and will make recommendations for improvements.

Further information and data on CDS will be provided by NHSE.

Dental therapy and hygiene

Dental care in England could not function without the vital contribution of its dental care professionals, including dental therapists, hygienists and nurses.

The use of skill mix is not a new concept in general dental practice, especially within private practice. It is also extremely common in other healthcare settings and is the dominant model within general medical practice. NHS England's January 2023 guidance clarified that dental therapists and dental hygienists can open and close NHS courses of treatment and provide further direct access to NHS care, where that care is within the

GDC Scope of Practice, provided that they are qualified, competent, and indemnified to do so.

Amendments to the Human Medicines Regulations 2012 took effect on 26 June 2024, to enable suitably trained and supported dental hygienists and dental therapists to supply and administer specified medicines (such as certain local anaesthetics and fluoride varnish) without requiring a Patient Group Direction or a Patient Specific Direction from a dentist. NHS England has issued guidance for contractors, which includes information about training for those wishing to work under the exemptions. The guidance can be accessed here: NHS England » Supply and administration of medicines by dental hygienists and dental therapists.

Expenses

The government has proposed an overall uplift of 4.64% to NHS primary care dental contract values for 2024 to 2025 (6% for pay elements and 1.68% for non-pay (expenses) elements), following the 52nd report of DDRB. For clarity, we do not apply the DDRB recommendation on pay to the expenses uplift element of the contract. Expenses (costs) are uplifted in line with inflation at the same time each year.

Our position is that there is a strong rationale for using GDP deflators for calculating expenses, to ensure increases to contract payments are affordable and equitable within the overall settlement, and as this is the measure more typically used across the NHS, including in general practice and ophthalmology. Furthermore, GDP deflators provide an estimate of whole economy price rises rather than the sub-set which forms CPI.

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

Table 45: increase in Annual Contract Value to allow for a 6% uplift on pay and staff costs, and GDP deflator (1.68% as of the Autumn Statement 2023) on expenses from 1 April 2024

Element	Weighting	Index	Source value	Weighted value
Income	46.60%	6.00%	DDRB	2.80%
Staff costs	22.00%	6.00%	DDRB	1.32%
Laboratory costs	6.00%	1.68%	GDP autumn 2023	0.10%
Materials	6.60%	1.68%	GDP autumn 2023	0.11%
Other costs	18.80%	1.68%	GDP autumn 2023	0.32%
Total	100.00%	Not applicable	Not applicable	4.64%

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

7. Total reward

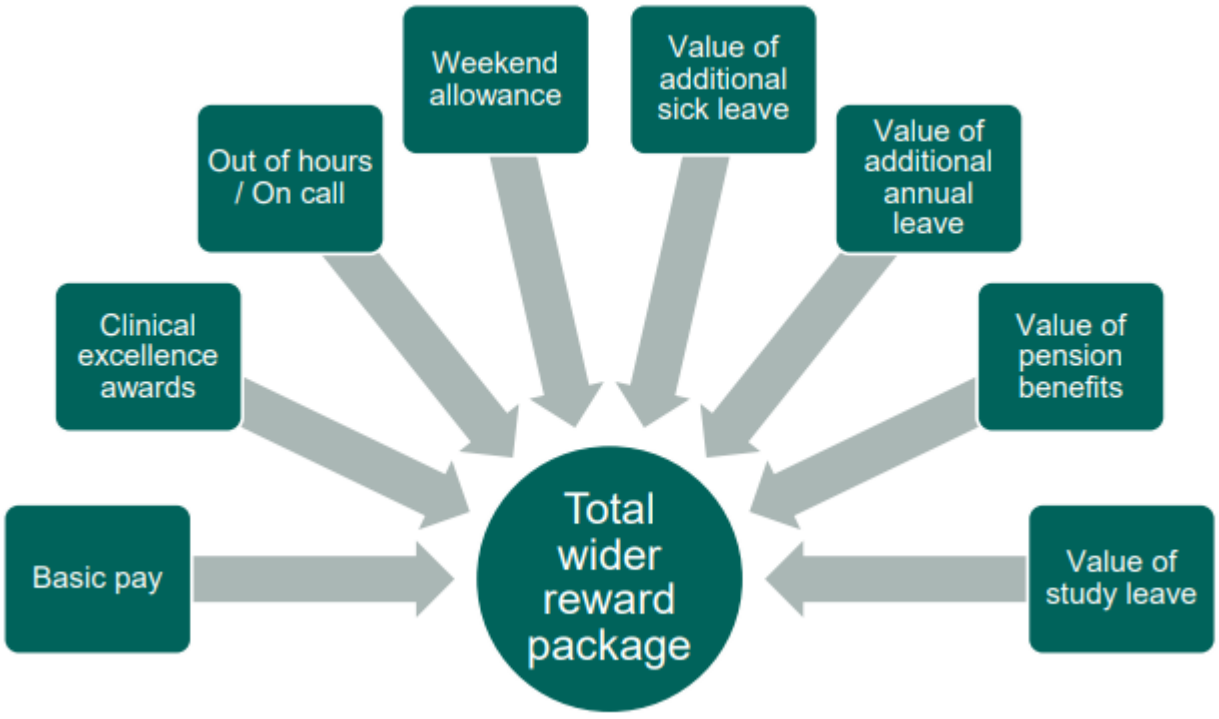
Introduction to total reward

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

The total reward package in the NHS includes a generous holiday allowance, which increases each year on top of public holidays, sickness absence arrangements of up to 12 months of payment, access to a defined benefit pension scheme with an employer contribution rate of 23.7%, enhanced parental leave, and support for learning, development, and career progression. These benefits are above the statutory minimum and exceed those offered in other sectors. Comparisons with the wider labour market should not just be limited to pay but include the full reward package.

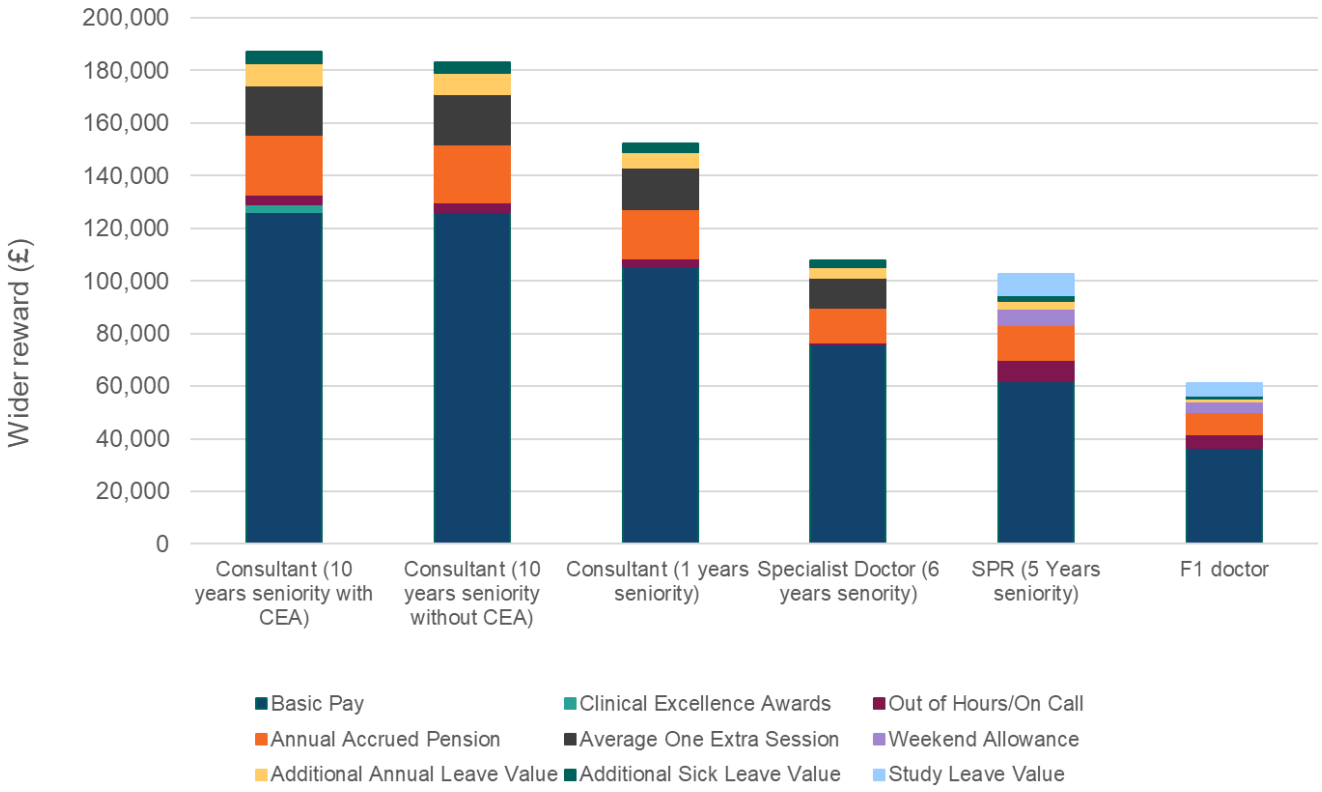
Measuring the value of the package

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



The figure above shows the different elements that make up wider reward.

Figure 8: wider reward packages for a range of NHS staff roles for 2024 to 2025



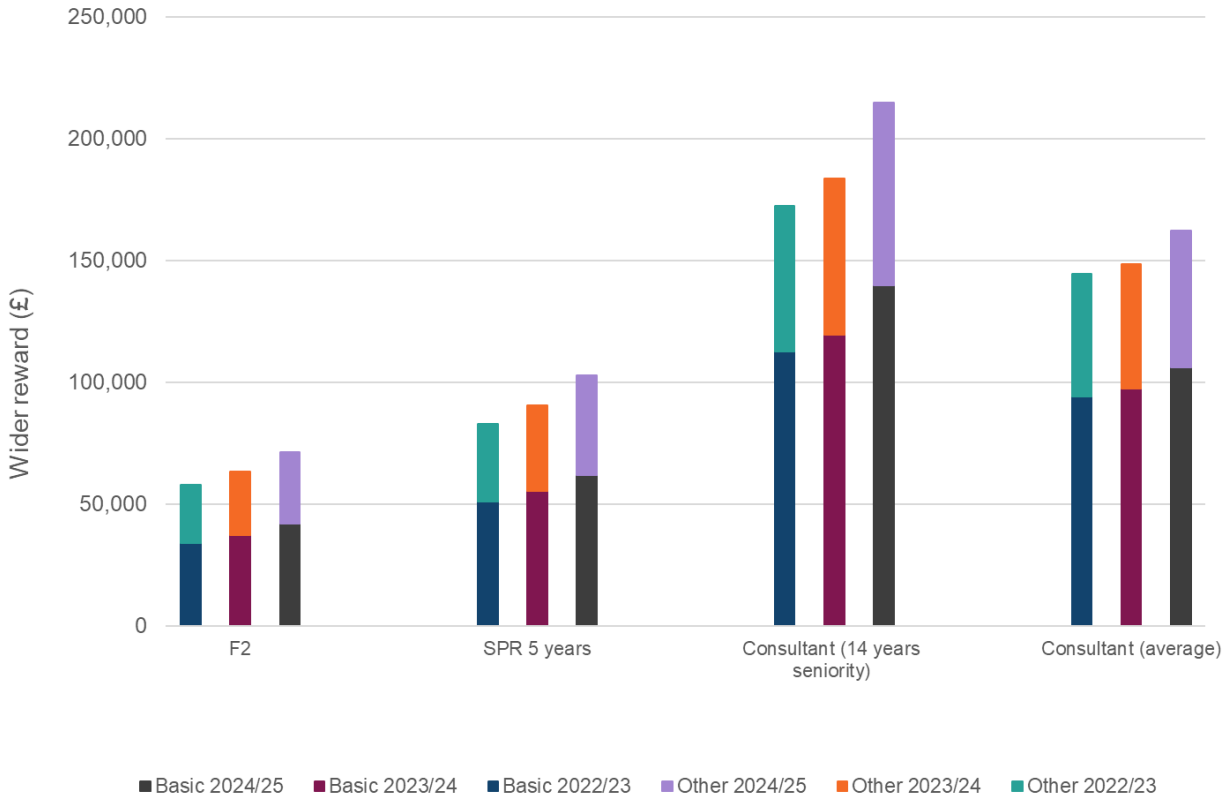
The above figure shows the wider reward package for a range of NHS staff roles. The wider reward package, as could be anticipated, correlates with the level of seniority of staff. It ranges from around £60,000 for F1 Doctors to approximately £190,000 for some consultants.

The wider reward package is calculated based on 2024 to 2025 pay terms and GAD included the same staff roles as adopted in last year's analysis.

The department also commissions GAD to provide analysis of the trend in wider reward for doctors over time. The chart below shows the split of total reward packages for NHS doctors between basic and other pay over the years 2022 to 2023, 2023 to 2024 and 2024 to 2025.

The analysis compares average reward at 30 June 2022, 31 March 2023 and 30 June 2024 with pay bands at 2022 to 2023, 2023 to 2024 and 2024 to 2025. GAD believes this is appropriate and will only cause a negligible difference for the purpose of comparison. This is also consistent with the approach used in previous years and reflects the availability of the relevant data.

Figure 9: wider reward trend over the period financial year 2022 to 2023 to financial year 2024 to 2025

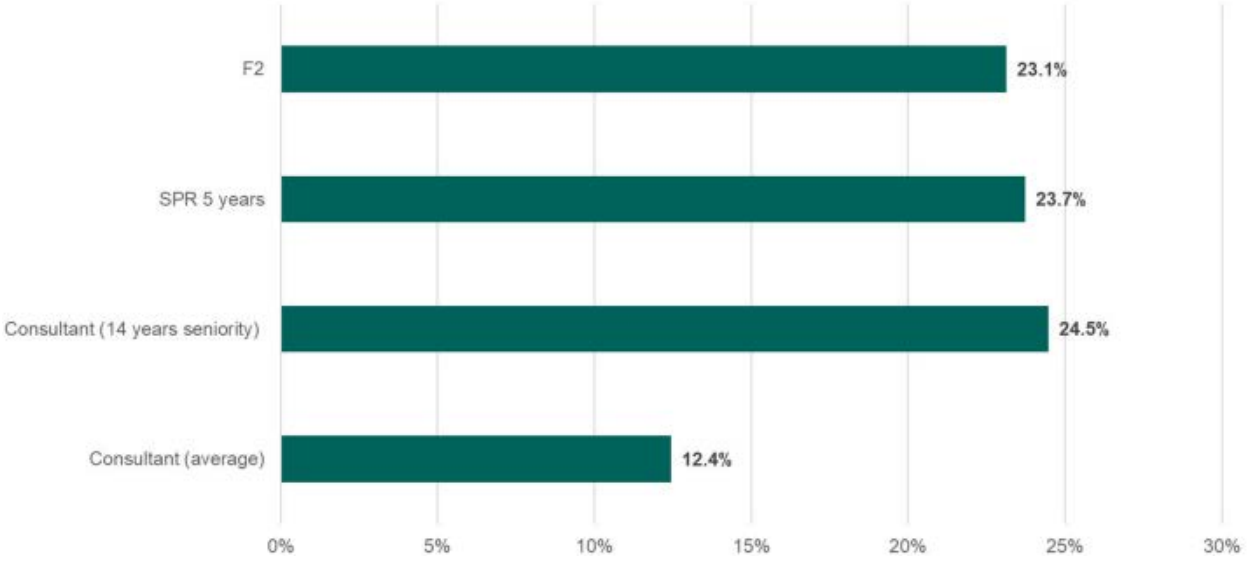


The above graph shows the level of wider reward received by various doctor roles. It shows this for the 2022 to 2023, 2023 to 2024 and 2024 to 2025 financial year periods.

This shows that all the doctor roles considered as part of this analysis have experienced an increase in total wider reward in monetary terms over the period 2022 to 2023 to 2024 to 2025.

For all of the roles considered, at least 34% of the total reward package is made up of non-basic pay.

Figure 10: summary of increases in wider reward over the total period financial year 2022 to 2023 to financial year 2024 to 2025



The above graph shows a summary of the increase in wider reward from the financial year 2022 to 2023 to the financial year 2024 to 2025. This shows the largest percentage increase was received by consultants with 14 years of seniority.

Enhanced parental leave

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

This estimate is provided for illustrative purposes only and represents the additional value of NHS staff entitlement in excess of statutory maternity leave. Maternity, adoption and shared parental pay depends on the individual's contractual entitlements and is calculated relative to the current statutory pay entitlements.

Other benefits

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

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

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

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

- childcare - subsidised childcare, on-site nurseries, government tax free child support scheme
- travel - free parking, transport season ticket loans, public transport subsidies, pay expenses weekly
- housing and utilities: rental deposit loan schemes, home electronics salary sacrifice scheme, fee-free mortgage brokering, discounted fixed fee conveyancing
- food and leisure - free or subsidised meals on site, signposting to emergency service discount sites, access to free sanitary products
- other financial support - saving schemes, will writing services, financial education workshops, budget planning guidance, early access to pay

Flexible working

'We work flexibly' is one of the elements on the People Promise and NHSE continue to focus on flexible working which reflects its importance to staff. Flexible working is a strong driver of retention and an important factor in improving the mental health and wellbeing of staff. Scores from the 2023 NHS Staff Survey show improvements in the ‘we work flexibly’ theme with an increase of 6.28 (out of 10) in 2023 compared to 6.06 in 2021. The publication of both the NHS LTWP and the NHS Equality, Diversity and Inclusion

Improvement plan last year will continue to be important factors in driving up accessibility to flexible working.

NHSE has continued to focus on flexible working, reflecting its importance to staff, which includes: changes to terms and conditions; a development programme for senior and organisational leaders; e-learning packages for staff and line managers to help drive culture change, support uptake, and promote usage of technical solutions, such as e-rostering; along with targeted interventions across different professions.

NHS England have a range of flexible working interventions and resources nationally to support local organisation to adopt flexible working practices across their organisations and will refer to these in their written evidence.

The NHS EDI Improvement Plan continues to be important in setting out ways in which organisations can improve the culture of the NHS workforce. These will help boost retention by addressing inflexible working practices that may deter people entering the workforce or leaving the workforce entirely.

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

The NHS Pension Scheme

The NHS Pension Scheme remains a valuable part of the total reward package available to NHS staff and is one of the most generous pension schemes available, with employer contribution rate of 23.7% of pensionable pay significantly higher than employer pension contribution rates typically available in the private sector.

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

Table 46: comparison of retirement ages and accrual rates for members of the 1995 Section, 2008 Section and 2015 Scheme

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

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

The public service pension schemes remedy (the ‘remedy’) for this discrimination has 2 parts. The first and prospective part closed the legacy public service pension schemes on 31 March 2022 and ensured equal treatment for all public service pension scheme members by moving all active members into the reformed public service pension schemes on 1 April 2022. The second and retrospective part of the remedy removed the effect of the transitional protections in legislation from 1 October 2023. The core element of the retrospective remedy is to provide 1.1 million impacted NHS Pension Scheme members with a choice between 1995/2008 and 2015 scheme benefits for the period the discrimination has effect.

One significant benefit of the 2015 scheme is that for active members, the pension they earn is increased every April by the Consumer Price Index (CPI) in the year before, plus an additional 1.5%. This is known as ‘in-service revaluation’. This means that pension benefits keep up with rises in the cost of living. As of April 2024, this rise was 6.7%.

Data from the NHSBSA shows that the median annual pension - taken as the pension at the 50th percentile - claimed by GPs (including assistants, locums, and principles) in the financial year 2023 to 2024 was £53,300.05. For medical doctors (non-specialists and specialists), this figure was £40,090.32. This is based on annual rates in payment as of 31 March 2024.

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

Due to the age profile of these members, it is likely that most of these doctors will have held the majority of their pension benefits in the 1995 Section, which features an automatic lump sum, with the option to commute more pension for additional lump sum.

NHS pension projections

GAD calculates that scheme members can generally expect to receive around £2 to £6 in pension benefits for every £1 contributed. This has changed from the £3 to £6 last year which reflects the results from the 2020 valuation. Looking ahead, GAD have produced a series of pension projections, which are based on example members with existing service in the NHS Pension Scheme built up prior to 2024. These example members are assumed to have continuous membership in the scheme from the point of joining, and to qualify in their respective fields in 2024. They assume that the example members remain in service and work full-time before retiring at age 65.

The GP partner and salaried GP examples are assumed to have joined the 2015 Scheme in 2019 aged 25 and to have qualified as GPs in 2024. The consultant example is assumed to have joined the 2008 Section in 2013 aged 25 before moving to the 2015 Scheme and qualifying as a consultant in 2024.

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

- the GP partner pay profile have changed compared to last year. GPs are earning higher pensionable pay in the first half of their career and lower pensionable pay in the second half, reflecting an increase in GP partner expenses. This means that there is more accrual earlier in a GPs career and this is not subject to the Annual Allowance and, in turn, increases the net pension

- as a result of the recent pay settlement, Salaried GPs and consultants are assumed to earn higher levels of pensionable pay throughout their future career than was adopted last year

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

Table 47: projected annual pensions for NHS doctors qualifying in their respective fields in 2024 and retiring age 65 (in today's monetary terms)

At retirement age	Year of joining the Scheme	Projected pension (pa)
GP partner	2019	£74,000
Salaried GP	2019	£57,000
Consultant	2015	£80,000

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

Table 48: projected annual pensions and lump sums for NHS doctors qualifying in their respective fields in 2024 and retiring age 65 (in today's monetary terms)

At retirement age	Year of joining the Scheme	Projected residual pension (pa)	Projected PCLS
GP partner	2019	£59,000	£177,000
Salaried GP	2019	£45,000	£136,000
Consultant	2015	£64,000	£192,000

NHS Pension Scheme membership

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

The table below shows the percentage of doctors, by grade, who were members of the scheme in June 2024, and in comparison to June 2023, June 2019 and June 2014.

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

In comparison, there have been large increases in consultant and staff grade membership rates. This may be a result of consultants and staff grade doctors who had previously opted out of the NHS Pension Scheme for pension tax reasons opting back into the Scheme following the April 2023 Budget. This saw the abolition of the Lifetime Allowance and increases an increase to the Annual Allowance from £40,000 to £60,000.

Table 49: NHS Pension Scheme membership for HCHS doctors

Profession	**June 2024**	**One year change (percentage point change)**	**5 year change (percentage point change)**	**10 year change (percentage point change)**
Associate specialist	89.6%	0	-2	-3.2
Consultant	91.8%	2.2	2.1	-1.1
Core training	76.8%	-3.9	-13.7	-17.8
Foundation doctor Year 1	90.3%	-1.1	-4.3	-6.6
Foundation doctor Year 2	85.7%	-1.5	-7.6	-10.1
Hospital practitioner and clinical assistant	68.6%	-1.8	-4.5	-12.7
Other and local HCHS doctor Grades	92.8%	0.7	-2.1	-1.4
Specialty doctor	82.3%	-2.5	-6.3	-7.5
Specialty registrar	87.6%	-1.2	-5.3	-7.2
Staff grade	93.5%	5.2	-0.9	2.2
Grand total	87.3%	-0.3	-3.8	-6.4

Table 50: NHS Pension Scheme membership for resident doctors in June 2024 by nationality

Nationality	**Membership rate**
European Union	87%
Rest of the world total	66%
UK total	96%
Total	84%

The table above shows the membership rates in June 2024 by nationality for doctors in training. This highlights that doctors from the United Kingdom have the highest membership rates, while the rate for doctors from the Rest of the World group is significantly lower.

NHS pensions claimed

We also monitor the number of pensions claimed each year, using data provided by the NHSBSA, the scheme administrator.

The tables below show the total numbers of GDPs, GPs, hospital dentists and hospital doctors claiming 1995 Scheme pension benefits, as well as the numbers of staff in these groups who claim their pension benefits earlier than their normal pension age (NPA). This is known as taking voluntary early retirement (VER). The data, from the NHSBSA, includes figures from 2008 to 2024 with the volume of VER awards compared to the total number of pensions claimed. For all groups, this figure has been relatively consistent across the years.

Table 51: NHS pensions claimed by GDPs in the 1995 Scheme

	Age awards	VER awards	Total awards	VER of total (%)
2008	297	193	490	39.4
2009	275	116	391	29.7
2010	291	177	468	37.8
2011	328	124	452	27.4
2012	303	151	454	33.3
2013	291	148	439	33.7
2014	274	138	412	33.5
2015	331	153	484	31.6
2016	256	121	377	32.1
2017	364	147	511	28.8
2018	351	108	459	23.5
2019	403	166	569	29.2
2020	405	156	561	27.8
2021	365	176	541	32.5
2022	381	116	497	23.3
2023	425	140	565	24.8
2024	434	132	566	23.3

Table 52: NHS pensions claimed by GPs in the 1995 Scheme

	Age awards	VER awards	Total awards	VER of total (%)
2008	892	245	1137	21.5
2009	1045	280	1325	21.1
2010	1166	347	1513	22.9
2011	938	405	1343	30.2
2012	837	503	1340	37.5
2013	692	492	1184	41.6
2014	735	774	1509	51.3
2015	641	593	1234	48.1
2016	456	453	909	49.8
2017	634	708	1342	52.8
2018	630	510	1140	44.7
2019	658	562	1220	46.1
2020	699	509	1208	42.1
2021	687	465	1152	40.4
2022	545	328	873	37.6
2023	792	489	1281	38.2
2024	755	371	1126	32.9

Table 53: NHS pensions claimed by hospital dentists in the 1995 Scheme

	Age awards	VER awards	Total awards	VER of total (%)
2008	44	9	53	17.0
2009	29	10	39	25.6
2010	55	12	67	17.9
2011	31	20	51	39.2
2012	47	16	63	25.4
2013	47	24	71	33.8
2014	36	12	48	25.0
2015	47	19	66	28.8
2016	37	25	62	40.3
2017	34	17	51	33.3
2018	47	28	75	37.3
2019	50	18	68	26.5
2020	55	14	69	20.3
2021	53	13	66	19.7
2022	31	15	46	32.6
2023	51	10	61	16.4
2024	42	11	53	20.8

Table 54: NHS pensions claimed by hospital doctors in the 1995 Scheme

	Age awards	VER awards	Total awards	VER of total (%)
2008	1176	138	1314	10.5
2009	1256	147	1403	10.5
2010	1425	185	1610	11.5
2011	1590	248	1838	13.5
2012	1502	272	1774	15.3
2013	1162	317	1479	21.4
2014	1424	334	1758	19.0
2015	1326	358	1684	21.3
2016	1408	376	1784	21.1
2017	1482	397	1879	21.1
2018	1481	341	1822	18.7
2019	1716	347	2063	16.8
2020	1790	409	2199	18.6
2021	1801	395	2196	18.0
2022	1912	352	2264	15.5
2023	2139	464	2603	17.8
2024	1579	321	1900	16.9

NHS Pension Scheme contributions

Members and employers are required to pay towards the cost of benefits built up in the NHS Pension Scheme. At present employers contribute 23.7% of each member's pensionable earnings, plus a charge of 0.08% to fund the administration of the scheme. This is far more generous than most pension schemes offered in the private sector.

When the NHS Pension Scheme moved from final salary benefits to career average revalued earnings (CARE) benefits, following the closure of the 1995/2008 Scheme, it was deemed an appropriate time to reform the member contribution structure. The department completed a review of member contributions and published its initial response on 15 February 2022.

As a result of the review, the number of contribution tiers was reduced from 11 to 6, and the range between the lowest and highest contribution rates was narrowed, ensuring that the costs and benefits of the scheme are more evenly shared. The department also confirmed that rates would be automatically increased annually. Earning thresholds for member contribution rates now increase each April in line with Consumer Prices Index (CPI) inflation in the previous September. These thresholds only ever increase; should CPI be negative, the earning thresholds will not decrease.

The contribution thresholds are also subject to a ‘better of’ policy so that they are first adjusted by the CPI figure and then further adjusted in line with the annual Agenda for Change (AfC) pay award for England, should that be higher. This helps reduce the likelihood of members falling into a higher contribution tier as a consequence of receiving a pay award. While doctors and dentists have different payscales, those working under AfC are the largest single group of NHS staff eligible to join the NHS Pension Scheme and in March 2024 there were around 1.4 million staff in England working on AfC conditions.

As of 1 April 2025, the following member contribution structure will apply for the 2025 to 2026 Scheme year, following the September 2024's CPI which announced an increase of 1.7%. These figures may be subject to change if the AfC pay award exceeds 1.7%.

Table 55: NHS pension Scheme member contribution structure from 1 April 2025

Pensionable earnings thresholds	Contribution rate from 1 April 2025
Up to £13,259	5.2%
£13,260 to £27,288	6.5%
£27,289 to £33,247	8.3%
£33,247 to £49,913	9.8%
£49,913 to £63,994	10.7%
£63,995 and above	12.5%

Retirement options

Doctors and dentists who wish to retire earlier than their Normal Pension Age (as set out at table 63) are able to do so via Voluntary Early Retirement (VER). This is an option for those who want to fully retire up to 10 years earlier than their NPA, although their pension will be actuarially reduced (by around 5% per year), to account for the fact it will be paid for longer.

The package of new retirement flexibilities introduced in 2023 for members of the 1995 Section of the NHS Pension Scheme also means that doctors and dentists now have increased options when it comes to their retirement.

Since 1 April 2023, doctors and dentists who claim their pension and later return to work can re-join the NHS Pension Scheme to build up more pension if they wish.

Also, since 1 October 2023, doctors and dentists can choose to take ‘partial retirement’ as an alternative to full retirement. This allows them to draw down some or all of their pension while continuing to work and build up further pension, subject to a change in terms and a reduction in pensionable pay of at least 10%, to be agreed with their employer.

Data on applications for partial retirement show that this new, more flexible retirement option has been welcomed by members and employers, with 17,972 applications received

as of 28 October 2024. As well as supporting doctors and dentists with their work/life balance later in their careers, partial retirement may also support NHS employers, by allowing them to retain experienced doctors and dentists for longer.

Pension tax

As discussed in previous evidence submissions, the generosity of the NHS Pension Scheme and well-remunerated careers has meant that some senior doctors and dentists previously exceeded the Annual Allowance (AA) and the Lifetime Allowance (LTA) for tax-free saving. In the 2023 Budget, the AA increased by 50% to £60,000 and the LTA was removed. The minimum tapered annual allowance also increased from £4,000 to £10,000 and the adjusted income threshold for the tapered annual allowance increased from £240,000 to £260,000.

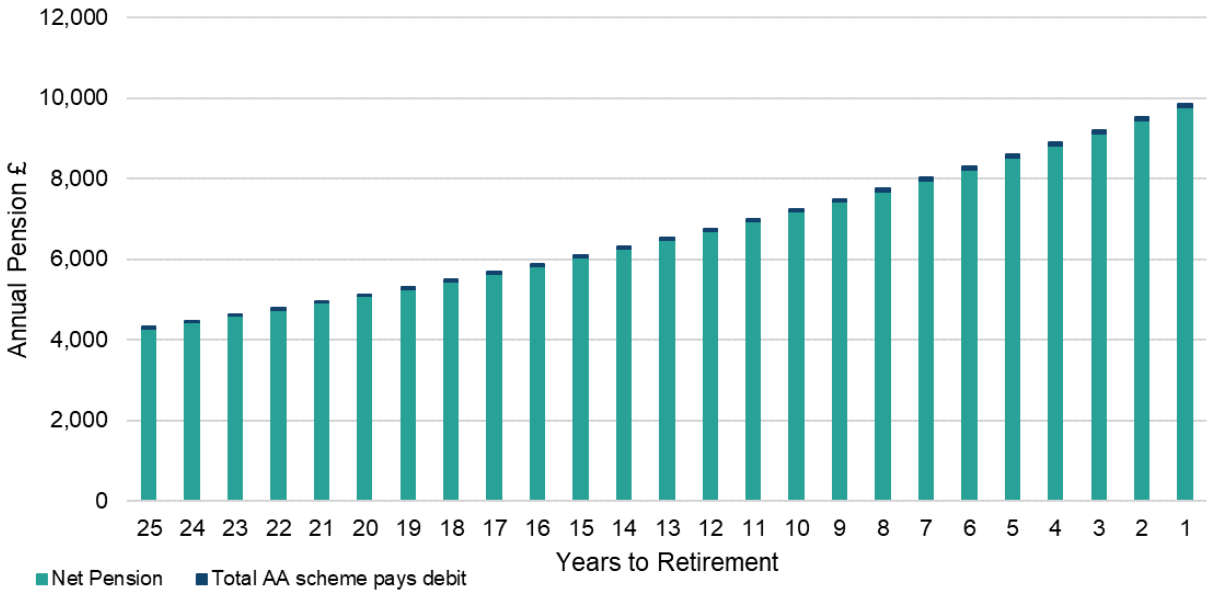
The abolition of the LTA removed the possibility of an annual allowance charge for thousands of doctors and dentists. The increase to the AA also means that fewer doctors and dentists are likely to breach this allowance now than in previous years, although the pay award made to consultants in financial year 2024 to 2025 and the recent high levels of CPI may offset this to some extent.

For clinicians who still receive AA charges, the ‘Scheme Pays’ facility allows them to meet the cost of a tax bill from the value of their pension benefits, without needing to find funds upfront. Where a member uses Scheme Pays, their tax charge is paid through a deduction to their pension benefits at retirement.

Analysis from GAD demonstrates that for most members Scheme Pays is a proportionate means of dealing with an AA charge, with the deduction to the member’s pension proportionate to the tax charge incurred. The analysis below shows that it may be a sound financial decision for clinicians to incur an AA charge and use Scheme Pays to deal with it, as in this case it will have a relatively small impact on the pension accrued. Although Scheme Pays will reduce the value of the pension accrued, the growth in benefits represents a good return on the contributions made.

The figure below considers a 43-year-old 2015 scheme member with pensionable pay of £195,000, no non-pensionable earnings, and 4 years of service in the 2015 scheme. Over 2025 to 2026, the member could be expected to accrue pension of £9,900 pa at retirement age 68. This would be reduced by 1% to £9,800 pa once the scheme pays debit is applied. The graph below illustrates the progression up to retirement of pension benefits accrued and the AA charges incurred over a single year. GAD calculated this using 2020 valuation assumptions for long-term CPI and salary increases.

Figure 11: example growth in pension earned over year 2025 to 2026 for a member with 2015 Scheme benefits and pensionable pay of £195,000



The highest earning doctors and dentists may also be subject to AA ‘tapering’, meaning that their AA decreases as their income increases. Following the changes made at the 2023 Budget, the minimum tapered AA is £10,000.

The tapered AA applies when an individual’s ‘threshold income’ is over £200,000 and their ‘adjusted income’ is over £260,000. Because of the generosity of the NHS Pension Scheme, DHSC estimates that most doctors and dentists who earn over £200,000 will effectively have an ‘adjusted income’ of over £260,000, and so will be subject to the tapered AA.

DHSC understands that this can create a cliff edge, where a small increase in earnings can trigger the taper and cause a large increase in the tax charge payable. The prospect of being ‘tapered’ may therefore reduce doctors’ willingness to take on additional work, as their income from this work could be significantly offset by pension tax charges.

The examples below, which have been provided by GAD, show the impact of the tapered AA for an NHS doctor aged 50, with pensionable pay of £139,882 (the top of the consultant pay scale). Example 2 demonstrates a possible cliff edge, where a £2 increase in non-pensionable pay could lead to hitting the tapered AA and receiving a larger AA charge.

Examples

Example 1

The member's threshold income is under £200,000, so while they breach the AA, it is not tapered and remains £60,000.

Pensionable pay: £139,882.

Non-pensionable pay £77,602.

Pension contributions paid by the member: £17,485.

Increase in accrued pension over the year: £11,628.

Pension growth: assessed against AA: £157,891.

AA: £60,000.

Total pay: £217,484.

Threshold income: £199,999.

AA charge: £44,051.

Example 2

The member’s threshold income is above £200,000, so their AA tapers down to £11,000.

Pensionable pay: £139,882.

Non-pensionable pay £77,604.

Pension contributions paid by the member: £17,485.

Increase in accrued pension over the year: £11,628.

Pension growth: assessed against AA: £157,891.

AA: £11,054.

Total pay: £217,486.

Threshold income: £200,001.

AA charge: £66,077.

Doctors and dentists who breach the tapered AA are also able to use Scheme Pays to pay tax charges. Scheme Pays debits (as demonstrated above) are likely to be larger for members with a tapered AA compared to those with a standard AA, although these debits are likely to be significantly smaller than their pension, which will continue to grow as they approach retirement.

Communicating the package

Total reward statements (TRS) are provided to NHS doctors and dentists to give them a better understanding of the benefits they have or may have access to as an NHS employee. TRS provide personalised information about the value of staff employment packages, including remuneration details and benefits provided locally by their employer.

NHS Pension Scheme members also receive an annual benefit statement (ABS), which shows the current value of their scheme benefits. On 21 September 2024, there were 3,054,253 statements available, with 374,657 views. In comparison, on 13 October 2023, the number of statements available was 2,734,642 and the number of views was 337,043.

The DWP UK Pensions Dashboard Programme provides an opportunity to enable members to access their pension information online, securely, and all in one place. The dashboard will provide clear and simple information about all an individual's pension savings, including their State Pension. The NHSBSA are taking forward the necessary work to prepare the scheme for connection to the dashboard architecture.

In addition to this, the department and NHSBSA are working together to improve the NHS Pensions App functionality. The app will provide members with user-friendly, clear access to their pension data, allow them to see their pension benefits accruing, and future retirement date options. Using technological communication tools will make information readily available to members as well as reduce the amount of time and costs spent on traditional communication such as sending letters to update members.

The department commissions NHS Employers to provide advice, guidance, and good practice to the NHS on developing a strategic approach to reward to support managers recruit and retain the staff they need. NHS Employers will provide further information on how employing organisations approach reward for their staff in their written evidence submissions.

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