Review Body on Doctors' and Dentists' Remuneration

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Fifty Third Report – 2025

Chair: Christopher Pilgrim

CP 1321

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

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

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

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

By Command of His Majesty

May 2025

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Review Body on Doctors' and Dentists' Remuneration

The Review Body on Doctors' and Dentists' Remuneration was appointed in its current form in July 1971. Its terms of reference were introduced in 1998, and amended in 2003, 2007 and 2024, and are reproduced below.

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

In reaching its recommendations, the Review Body is to have regard to the following considerations, evaluating the weight of each independently, in parallel and non-contingently:

- The need to attract, recruit, retain and motivate doctors and dentists, including consideration of local and regional labour market factors, in view of their contribution to the health of the nation.
- Developments in doctors' and dentists' earnings in the context of long-term trends in the wider labour market, alongside comparator professions, including relevant international comparators.
- Economic and other evidence submitted by the Government, and the funds available to the Government Health Departments.
- Economic and other evidence submitted by staff and professional representatives, and others.
- Wider macroeconomic factors.
- The overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.
- The legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief, and disability.

The Review Body may also be asked to consider other specific issues, where agreed by relevant unions and the Government.

These Terms of Reference are intended to give all parties, including the remit groups, confidence that the Review Body's recommendations have been independently, properly and fairly determined.

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

The members of the Review Body are:
Christopher Pilgrim (Chair)
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John Matheson CBE
Janette McCormick QPM
Dr Raj Patel MBE

The Secretariat is provided by the Office for the Pay Review Bodies.

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Executive summary

1. The Review Body on Doctors' and Dentists' Remuneration provides advice to ministers in the governments of the UK on the remuneration of all doctors and dentists employed by, or providing services to, the NHS in England, Scotland and Wales and the HSC in Northern Ireland. In this report, we make our recommendations for the 2025-26 financial year.

2. Our recommendations continue to be based on our independent assessment of the data and evidence, in line with our revised terms of reference. We consider each factor in our terms of reference independently and separately from the others, reflecting the evidence received.

3. Our terms of reference ask us to take into account the overall strategy that the NHS should place patients at the heart of all it does. We consider this carefully in our deliberations and it underpins our approach. High waiting lists, long waits in accident and emergency, and the struggle to access GPs and NHS dentists indicate that demand for healthcare significantly outweighs supply, which has a detrimental impact on the health of the nation. The sustainability of the NHS is dependent on achieving gains in productivity. Governments have made clear the constrained funding environment for the NHS, reflecting the challenging fiscal situation, and the impact that pay awards above affordability will potentially have on delivery, patient care, and the capacity for reform.

4. The economic outlook has become increasingly uncertain. Weak economic growth across the UK is constraining the amount that can be spent on public services. CPI inflation is forecast to be 3.3 to 3.5 per cent in the second quarter of 2025. Earnings growth at the upper quartile of the earnings distribution is around 4.5 per cent. Median pay settlements across the economy were at 3.0 to 3.4 per cent in the first quarter of 2025.

5. Recruitment and retention across most of our remit groups is strong and has shown signs of improvement over the last year. There has been substantial growth in the size of the medical and dental workforce in secondary care in recent years. Growth in GP numbers has been much slower. Substantial restructuring to contracts is needed to attract dentists to perform sufficient NHS work to meet patient demand.

6. Average earnings growth across secondary care has been strong over the last year, with additional pay uplifts on top of our 2024 recommendations, which will have served to improve the comparative position of our remit group. Earnings growth in primary care has been more mixed.

7. We are encouraged to see some improvement this year in motivation and morale among the medical and dental workforce. We understand, however, that industrial relations remain fragile, and many doctors are unhappy with their working environment.

8. Considering all these factors, **we recommend a 4 per cent increase to the salary scales, pay ranges and the pay element of contracts from 1 April 2025**. This applies to: consultants; SAS doctors and dentists; salaried dentists, including those working in Community Dental Services and the Public Dental Service; contractor general medical practitioners; salaried GP pay ranges; and the pay element of dental contracts. This applies to all the nations of the UK.

9. Ongoing poor morale alongside a worsening position in relative wages for resident doctors is of particular concern. It is important that resident doctors are motivated to stay in the NHS to continue their training and to provide high quality care to patients, but also to progress their careers as the consultants and GPs of the future. Reflecting these concerns, we again make a

different recommendation for resident doctors this year. **We recommend a 4 per cent increase plus a consolidated uplift of £750 to the pay points for resident doctors and dentists in England, Wales and Northern Ireland from 1 April 2025**. Reflecting the different pay scales, this represents an increase of 5.1 to 6.3 per cent across England, Wales and Northern Ireland, and again delivers a higher increase for lower-paid resident doctors.

10. We make a number of other recommendations targeted at specific parts of our remit group:

- **We recommend that governments consider a separate pay framework for locally employed doctors.**
- **We recommend the government reviews flexible pay premia in England to assess their value for money and effectiveness.**
- **We recommend an increase in national clinical impact awards in England and Wales from 1 April 2025 to: £10,500, £21,000, £31,500 and £42,000 across the four levels.**
- **We recommend that the four governments work with GPs' and dentists' representatives to develop an index of general practice costs and an index of dental costs.** These indices should then be used to construct changes over time and to determine the expenses element of the contract uplift in each nation.
- **We recommend that each government undertake a review of pay and progression for salaried dentists working in Community and Public Dental Services to assess whether the reward structure is appropriate to support recruitment, retention and service delivery.**

Chapter 1 Introduction and recommendations

The Review Body on Doctors' and Dentists' Remuneration

1.1 The Review Body on Doctors' and Dentists' Remuneration (DDRB) provides advice to ministers in the governments of the UK on the remuneration of all doctors and dentists employed by, or providing services to, the National Health Service (NHS) in England, Scotland and Wales, and Health and Social Care (HSC) in Northern Ireland. In this report, we make our recommendations and observations for the 2025 pay round, covering the 2025-26 financial year.

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

Our remits for this year

1.3 Our remit letters from each of the four governments are in appendix A. We received our remit letter from the Secretary of State for Health and Social Care on 30 September 2024. It asked us to make recommendations on the 2025-26 pay award for doctors and dentists. The letter also confirmed our amended terms of reference. Reflecting the 2024 agreement with resident doctors, the remit letter asked us to consider, as part of our 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.

1.4 The Cabinet Secretary for Health and Social Care wrote to us on 30 October 2024 asking for our advice and recommendations for medical and dental staff in Wales.

1.5 The Minister of Health wrote to us on 25 November 2024 asking for recommendations for doctors and dentists working in health and social care in Northern Ireland.

1.6 The Cabinet Secretary for Health and Social Care wrote to us on 11 December 2024 asking for our recommendations for all medical and dental staff in NHS Scotland, with the exception of resident doctors, who are covered by a separate pay deal.

Evidence

1.7 We received written and oral evidence from the following organisations which are parties to our process:

- The Department of Health and Social Care (DHSC).
- The Scottish Government.
- The Welsh Government.
- The Department of Health in Northern Ireland.
- NHS England.
- NHS Employers.
- NHS Providers.
- The British Dental Association (BDA).

- The British Medical Association (BMA).
- The Hospital Consultants and Specialists Association (HCSA).

1.8 We held separate oral evidence sessions with the ministers for primary and secondary care in England. We also held separate oral evidence sessions with the BMA for consultants, specialty, associate specialist and specialist (SAS) doctors, resident doctors, and general medical practitioners (GPs). We also received evidence from HM Treasury and the Association of Dental Groups.

1.9 We undertook six visits in autumn 2024 across England and Northern Ireland. This is not as many as we would have liked. Unfortunately, we were not able to organise visits to Scotland or Wales for this round due to a lack of response to our requests. The following visits were undertaken:

- Devon Local Dental Committee.
- Kernow Local Medical Committee.
- South Eastern Health and Social Care Trust.
- Newcastle upon Tyne Hospitals NHS Foundation Trust.
- King's College Hospital NHS Foundation Trust.
- United Lincolnshire Teaching Hospitals NHS Trust.

1.10 Across these visits, we held 12 discussion groups with consultants, SAS doctors and dentists, and resident doctors. We also held seven discussion groups with GPs and general dental practitioners (GDPs). Our visit to the South Eastern Trust in Northern Ireland included discussion groups with contractor and salaried GPs and GDPs, as well as members of the Community Dental Service (CDS). CDS dentists also joined some of the consultant, SAS doctors and dentists, and associate GDP sessions in England.

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

Our recommendations last year

1.12 Our 2024 report was published on 29 July 2024. We recommended:

- A 6 per cent increase to salary scales, pay ranges and the pay element of contracts from 1 April 2024. This recommendation applied to the following groups in all four nations of the UK: consultants; SAS doctors and dentists; salaried dentists, including those working in CDS/Public Dental Service (PDS); contractor GPs; salaried GP pay ranges; and the pay element of dental contracts.
- A 6 per cent increase plus a consolidated uplift of £1,000 to the pay points for resident doctors in England, Wales and Northern Ireland from 1 April 2024. Resident doctors in Scotland were not in remit for 2024. We calculated this increase as being worth 7.6 to 9.5 per cent on basic pay, although the out-turn was slightly different due to additional pay agreements effective for 2023-24.

Responses to our recommendations

1.13 The UK Government accepted our recommendations for England in full.[1] At the same time, an additional offer was made to resident doctors in England, with an average 4.05 per cent pay

[1] UK Parliament, *NHS Update*. https://questions-statements.parliament.uk/written-statements/detail/2024-07-29/hcws40

increase effective from 1 April 2023. Consequently, the DDRB uplift for 2024 was worth 7.5 to 9.0 per cent for this group for 2024-25.

1.14 The Welsh Government also accepted all our recommendations in September.[2] This followed a series of additional agreements for 2023-24 in June 2024. The DDRB uplift for 2024-25 was worth 7.6 to 9.3 per cent for resident doctors.

1.15 The Scottish Government did not formally respond to our recommendations. It reached direct pay agreements with consultants, resident doctors and SAS doctors. Pay agreements were made with each part of the workforce:

- Consultants received a 10.5 per cent pay increase from 1 April 2024. This reflected our recommendation plus the additional agreement for consultants in England.
- Specialty doctors on old and new contracts, and associate specialists, received an increase of 6 per cent from 1 April 2024. This reflected our recommendation. Specialists received increases of 7.1 or 10.1 per cent.
- Resident doctors received an increase of 11 per cent for 2024-25. This consisted of an 8.5 per cent increase from 1 April 2024 and a further 2.3 per cent from 1 October 2024.

1.16 The Health Minister in Northern Ireland committed to implement our recommendations in the November 2024 remit letter, but did not approve full payment until February 2025.[3] Separate agreements were reached with consultants, SAS doctors, and resident doctors on 2023-24 pay.

1.17 The BMA said that the 2024-25 pay awards were a first step towards reducing pay erosion but did not address the much wider issue of salary devaluation and the unfairness relating to this. The HCSA said that the 2024-25 pay award represented limited progress. It said that, without the separate, negotiated pay uplifts across England, Northern Ireland, Scotland and Wales, the DDRB award alone would have been greeted as wholly inadequate by the vast majority of hospital doctors.

1.18 The BDA said that the 6 per cent pay uplift was progress when compared to previous real terms pay cuts. It highlighted the delays to the implementation of uplifts for dentists in primary care, beyond those experienced in secondary care.

Additional pay agreements

1.19 Additional agreements on pay for 2023-24 were made in England, Wales and Northern Ireland last year in addition to our recommendations for 2024-25. Many of the agreements included a specific commitment to the (reformed) DDRB process for 2025-26.

1.20 In England:

- Resident doctors received an additional 4.05 per cent on average on 2023 pay scales. This was worth 3.71 per cent on most pay points, and 5.05 per cent on the core training 1 pay point.
- SAS doctors on new contracts received additional increases of 6.1 to 9.2 per cent from 1 April 2024. SAS doctors on old contracts received a consolidated increase of £1,400.

[2] Welsh Government, *Written Statement: Responding to the 37th NHS Pay Review Body and 52nd Doctors and Dentists Review Body reports*. https://www.gov.wales/written-statement-responding-37th-nhs-pay-review-body-and-52nd-doctors-and-dentists-review-body

[3] Department of Health, *Health Minister provides further update on pay*. https://www.health-ni.gov.uk/news/health-minister-provides-further-update-pay

- Consultants received additional increases ranging from zero to 12.8 per cent from 1 March 2024, with an average increase of around 5 per cent, of which 3.5 per cent was new money.

1.21 In Wales:

- Resident doctors received an additional 7.4 per cent increase for 2023-24, backdated to 1 April 2023.
- SAS doctors on new contracts received an additional 6.1 to 9.2 per cent for 2023-24, effective from 1 January 2024. Associate specialists on the old contact received an additional increase of 4.0 per cent, while specialty doctors on old contracts did not receive an additional pay increase.
- Consultants received an additional average increase of 5.2 per cent from 1 January 2024, with increases worth 0.2 to 10.9 per cent on basic pay.

1.22 In Northern Ireland:

- Resident doctors received an additional increase of 4.05 per cent, effective from 1 April 2023.
- SAS doctors on new contacts received additional increases of 6.3 to 9.2 per cent, effective from 1 April 2024. SAS doctors on old contracts received an increase of £1,400.
- Consultants received an additional pay uplift of between 0.4 and 12.3 per cent, with an average uplift of 5.26 per cent, effective from 1 March 2024.

Our terms of reference

1.23 The agreement with consultants in England brought in changes to our terms of reference, which are set out at the start of this report. This includes an additional factor to be considered in our recommendations:

- 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.

1.24 The revised terms of reference also ask us to evaluate the weight of each consideration independently, in parallel and non-contingently.

1.25 The 2024 agreement with consultants and SAS doctors in Scotland included a commitment to participate in the reformed DDRB process for the 2025-26 pay round and to utilise this process as a basis for further discussion to establish a financially sustainable mechanism to tackle pay erosion. The BMA reserved the right to seek direct pay negotiations with the Scottish Government and withdraw from the DDRB process in the future.

1.26 The pay agreements in Wales all said that the Welsh Government recognised and had engaged with the BMA on concerns regarding the DDRB and was committed to restoring the profession's confidence in the pay review body. There was a commitment by the Welsh Government to:

- Support all changes to the pay review process agreed as part of the England consultants pay deal in April 2024.
- Ensure that any remit letter is neutral and solely to start the process and indicate that Wales wants pay recommendations without reference to affordability.[4]
- Agree that recommendations of the DDRB are only rejected rarely and due to a compelling reason.

[4] The Welsh Government has confirmed that it is the letter that will not reference affordability, not the recommendations.

- Ensure that the Welsh Government participates in the review process in a timely manner in accordance with the timelines set out by the DDRB.
- Promptly implement the recommendations of the DDRB upon publication.

1.27 The agreements in Northern Ireland committed to a refresh of the DDRB process. The Department of Health in Northern Ireland said it supported all the changes to the pay review process agreed as part of the England consultants pay deal in April 2024. Additionally, there was a commitment from the Department:

- That remit letters shall not include any information in regard to inflation, economic performance or wider financial pressures; these shall, where appropriate, be addressed via the Department's written and oral evidence.
- To participate in the review process in a timely manner in accordance with the timelines set out by the DDRB.
- To implement the recommendations of the DDRB as rapidly as local processes allow upon publication.

1.28 The BMA said that the DDRB should not ignore the historic circumstances that necessitated the revision of the terms of reference. It expected that the DDRB would embrace the spirit of the reforms for the 2025-26 pay round. BMA Scotland said it was hopeful that a reformed DDRB would fundamentally address the BMA's longstanding concerns and deliver pay recommendations to establish a credible path to pay restoration.

1.29 The BDA said it was welcome that the revised terms of reference made clear that the component parts are evaluated independently, in parallel, and non-contingently. It was also welcome that the DDRB would have reference to comparator professions, including international comparators, when making its recommendations. However, it said that "the wider process remains fundamentally broken when governments fail to act as good faith partners and undermine the process through obfuscation, delay, and wilful negligence".

Timing of the pay round

1.30 The consultants' agreement in England said that the parties would agree a timetable which would see awards announced earlier than in recent years and which the Government would use its best endeavours to meet. As part of this, the Government agreed that it would look to implement the outcome of each year's DDRB process as soon as practically possible, with the aim of the pay award being known at the start of the financial year from the 2025-26 pay round.

1.31 We received our remit letters from governments for the 2025-26 pay recommendation between 30 September and 11 December 2024, a significant improvement on 21 December 2023 to 5 March 2024 for the 2024-25 pay recommendation. Our written evidence this round was received between late November 2024 and early February 2025, compared with mid December 2023 to late March 2024 for the previous round. We held 14 oral evidence sessions between late January and early March 2025, compared to mid February to late April in 2024. Consequently, we have been able to submit our report seven weeks earlier than last year.

Our comments on our terms of reference and the timing of the pay round

1.32 The DDRB has always been, and continues to be, an independent body. Our recommendations are based on our independent assessment of the data and evidence, in line with our terms of reference. In recent years, we have made recommendations that run contrary to some or all of the parties' positions, both governments and trade unions, and we do so again this year.

1.33 It is unhelpful if DDRB recommendations become the starting point for further negotiations. This is damaging to the credibility of the process and undermines the benefits of having an independent body to advise on pay.

Our revised terms of reference

1.34 We have reflected the changes made to the terms of reference in our deliberations this year. Discussions with the parties during oral evidence indicated that the changes were being understood differently by different parties. Interpretations varied from the new terms of reference making little difference, as it was felt that the DDRB already explicitly or implicitly considered many of these issues, to the new terms of reference providing the DDRB with a different operating context which would support recommendations leading to full pay restoration to 2008 levels of real earnings. This difference in interpretation is unhelpful if it leads to significant differences in expectations of the DDRB process. As always, we rely on our assessment of the evidence we receive and make our independent recommendations having fully considered that evidence.

1.35 Some parties have said that the revised terms of reference mean that we should no longer, or much less explicitly, consider affordability. Affordability has never been an overriding factor, as we have demonstrated over a number of years by making pay recommendations above governments' stated affordability levels, sometimes significantly so. However, the available funding to health departments is in our terms of reference and remains an equally important consideration, alongside all other factors. When setting pay levels, all organisations consider affordability alongside other factors.

1.36 As in the past, we consider each of the factors within our terms of reference on its own merits and take a balanced approach across them. In our deliberations, we continue to consider each factor independently and separately from the others, reflecting the evidence received. The importance each is given reflects the weight of the evidence. This is an element of the process that has been made more explicit in our new terms of reference.

1.37 Our revised terms of reference ask us to consider 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. Pay comparability has always been an important factor in our deliberations, and we consider trends over time against earnings across the economy, as well as current pay levels.

1.38 Reflecting our revised terms of reference, we are undertaking an external review of our approach to pay comparability. This will ensure our approach is up-to-date and uses the most appropriate comparators and data. More detail on this is set out in appendix E. This will be in place for our next pay round. Meanwhile, we commissioned additional pay comparability work to support our evidence base this round. The evidence on pay comparability for each part of our remit group is set out in chapters 3, 4 and 5. Similarly, we are reviewing how we can build a more robust evidence base on international comparators, which has previously been more limited and based on data provided by the Organisation for Economic Co-operation and Development (OECD). More information on international comparators is in chapter 3 and appendix F.

1.39 We were asked this year by the Secretary of State to consider, as part of our 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 the consultants and GPs of the future. This is reflected in our recommendations, and we discuss this below.

Timing of the pay round

1.40 We have set out the damaging impact of late pay awards in previous reports, and we were disappointed that again this year pay awards for our remit group, applying from 1 April 2024, were not paid until October and November 2024 in secondary care, and later in parts of primary care. We are particularly concerned about the situation in Northern Ireland, where the 2024-25 pay award was not agreed in full until February 2025. It was paid for most secondary care staff in March 2025, and later for resident doctors. This is not acceptable.

1.41 As we set out in last year's report, we fully endorse actions to bring the pay round forward. Our remit from the Secretary of State this year asked us to deliver our recommendations at the earliest point that allowed us to give due consideration to the relevant evidence. We have done this.

1.42 We expect parties to discuss and agree on a timetable for next year that will enable our recommendations to be submitted, agreed and implemented as close to 1 April as possible. This will require remit letters in the summer and the submission of written evidence by all parties in early September, in order that oral evidence sessions can be completed before Christmas. We address a great breadth of issues in our work and are committed to a full and detailed consideration of the evidence. This process takes time and needs to be built into a realistic timetable. Individual parties unilaterally declaring the timetable to which we must operate is unconstructive and misleading.

1.43 Last year's pay round was not concluded until the end of July in England, and later in the other three nations. Many of our parties spend considerable time and resource consulting with their members to provide us with high quality evidence. We also undertake a valuable visit programme between pay rounds. This meant that progress to improve the timing of the current pay round was constrained from the start. We have, however, been able to make a significant advance in the timeliness of our report compared to last year, and we appreciate the contributions of all parties in supporting this. We hope to make further progress next year and we urge all parties to commence their written evidence for the next round as soon as they can, so the process can start as promptly as possible on receipt of the first remit letter. We note, however, that an earlier pay round will affect the timing of, and in some cases limit, the evidence we are able to consider, such as the NHS staff survey in England, which is normally published in March.

Pay proposals from the parties

1.44 Most parties did not propose a specific figure for the pay recommendation outside the evidence on affordability, which is set out below. NHS Providers said that an uplift of at least 5 per cent was needed, along with an explicit recommendation for the government to commit to fully funding any pay uplifts it decided to award NHS staff, to ensure that cost pressures were not passed onto trusts.

1.45 The trade unions gave a range of figures for a pay uplift:

- The BMA requested a range of pay awards within their evidence covering different workforce groups and across different nations. These ranged from 10.7 per cent to 20 per cent plus inflation, with the emphasis being on a pay award that was above RPI inflation.
- The HCSA asked for a pay award of at least RPI inflation plus a meaningful uplift.
- The BDA asked for a 9.2 per cent uplift on pay.

Factors in making our recommendations

The broader context for the NHS

1.46 Both our old and new terms of reference ask us to take into account the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

1.47 While activity has increased across most areas of the NHS over the last year, the system is struggling to cope with the increasingly complex health needs of an ageing population, the backlog of elective care from the pandemic period, weak infrastructure, and insufficient capacity across secondary and primary care, which is compounded by significant pressures on social care causing delayed discharge from hospital settings.

1.48 The sustainability of the NHS is dependent on achieving gains in productivity. The Darzi report made clear the need to focus on improving productivity across the NHS, to enable clinicians to achieve better outcomes, and to invest in primary and community care. It is clear that this needs to be led by investment in infrastructure and technology.

1.49 The NHS workforce strategy and, in turn, the reward strategy, need to support the longer-term objectives for the NHS. This requires a clear plan of which medical and dental specialties, and how many of each, will be needed for the future NHS, and a set of incentives and levers to align doctors and dentists to the areas they are most needed. There are potential workforce gains to be made through restructuring of some contracts for the medical and dental workforce, which could also enable delivery and support productivity and long-term sustainability.

The macroeconomic picture

1.50 Our terms of reference ask us to look at wider macroeconomic factors. Weak economic growth across the UK is constraining the amount that can be spent on public services. Inflation has risen in recent months, and the lead indicator of inflation, the consumer prices index (CPI), is forecast to be 3.3-3.5 per cent in the second quarter of 2025, up from 2.1 per cent in the second quarter of 2024. There are signs of weakening in the labour market and a reduction in job opportunities. The economic outlook has become increasingly uncertain, in terms of growth prospects and inflation, since the Office for Budgetary Responsibility (OBR) made its last set of forecasts at the end of March.

1.51 In making our recommendations, we consider trends in average earnings growth and pay settlements across the wider economy which indicate the typical increases being received by other employees and provide a useful reference point. Regular average earnings growth across the whole economy was at 5.9 per cent at the start of 2025. Earnings growth at the upper quartile of the earnings distribution, which is a better match for most of our remit group, was around 4.5 per cent. Median pay settlements across the economy were at 3.0 to 3.4 per cent in the first quarter of 2025. The OBR forecasts average earnings growth to be 3.7 per cent over 2025-26.

NHS funding and affordability

1.52 Governments have prioritised health funding over other public services in recent years, and this is the case for 2025-26. The UK Government has committed to a nominal increase of 5 per cent in resource health spending for 2025-26, and a large increase in capital spending. This recognises the need for investment and the increased demand for healthcare.

1.53 Workforce growth, along with pay uplifts, meant that the increase in staff costs in the NHS in England was 10.5 per cent in 2023-24, and direct staff costs make up an increasing share of the NHS budget, at close to half in 2023-24.

1.54 The UK Government has made clear that 2.8 per cent has been set aside for pay increases across the NHS in 2025-26, and any pay award above this will need to be funded from within existing budgets. The Scottish Government has provisioned for a 3 per cent pay uplift in its 2025-26 budget. It said that any costs beyond this are not affordable and will result in additional system and financial pressure. The Welsh Government has committed to funding the pay increases needed for the NHS. In Northern Ireland, the Department of Health has built a pay uplift of 2.8 per cent into financial plans for 2025-26, reflecting the affordability figure set in England.

1.55 Affordability remains an important factor we take into account when making our recommendations. Our recommendations each year add substantial costs to the NHS paybill and have the potential to affect budgets throughout the health system. As a consequence, we consider the impact of our recommendations on the funding available to the health service, reflecting the evidence we receive on the financial position of NHS trusts and organisations, and consider the implications for patient care, which is also a factor in our terms of reference. It is important that decisions on pay consider the impact of taking resource away from innovation and investment, which are requirements for improving productivity. HM Treasury has said in the medium term that productivity gains will be necessary to be able to afford above-inflation pay rises.

1.56 The UK Government has made clear this year that recommendations above affordability will need to be funded by reducing spend in other areas of the NHS. However, affordability does not serve as a limiting factor, as we have demonstrated over a number of years. Pay needs to be set at such a level to sustain workforce recruitment and retention, to support a motivated workforce, and to ensure the long-term attractiveness of medical and dental careers.

Recruitment and retention

1.57 The recruitment and retention picture has improved across most parts of our remit group. There has been substantial growth in the size of the medical and dental workforce in secondary care in recent years, by between 16 and 27 per cent since 2019 across the nations, which has continued over the last year. Alongside this, leaving rates and vacancies are stable or falling. The average retirement age for consultants has increased and there has been a reduction in the numbers retiring.

1.58 Across all nations, growth in GP numbers has been much slower than the growth in doctors employed in secondary care. The picture over the last year is mixed, with increased numbers of GPs in England and Wales, little change in Northern Ireland, and a fall in Scotland. There is a shift in the GP workforce from partner to salaried GPs, with GP partnership becoming less attractive. We note the removal of targeted recruitment incentives for GP training in England and Scotland for 2025, following an improvement in recruitment to these programmes. There are increasing reports about unemployment and under-employment among newly qualified GPs in England.

1.59 The fall in applicants to study medicine recorded in 2023 had been a concern, but the increase recorded in 2024 suggests that medicine is a very attractive career choice. In 2024, the number of applicants to study medicine was 33 per cent higher than in 2019.

1.60 Dentistry overall remains an attractive career, with the number of undergraduate applications doubling over the last five years. However, there remain significant issues with attracting dentists to perform NHS work. In England, Scotland and Wales there are fewer dentists providing NHS services than prior to the pandemic. We do not directly set the pay of general dental practitioners, instead recommending on the uplift to part of the dental contract. The issue appears to be around the fees payable for NHS work. We discuss this in chapter 5.

Pay comparability and trends in the wider labour market

1.61 As set out in our terms of reference, we examine in detail developments in doctors' and dentists' earnings in the context of long-term trends in the wider labour market. We look at the earnings across our remit group alongside comparator professions. We do not, however, believe it is our role to ensure that pay for our remit group tracks inflation, or any other measure, irrespective of the broader recruitment and retention issues or the NHS context.

1.62 In our considerations this year we look at pay comparability for our remit group in three main ways: by comparing with inflation and average earnings over time; by tracking the position of earnings for doctors and dentists in the overall pay distribution; and by comparing earnings for roles in our remit group to matched roles in other sectors. For resident doctors, we also look at the earnings of other graduates which assists us in considering the relative attractiveness of medicine as a career.

1.63 We set out our approach to pay comparability in appendix E. Pending a wider review of our methodology, we have made a number of developments to our pay comparability approach this round:

- Average weekly earnings are included in our tracking of earnings over time.
- Earnings comparisons for salaried GPs include earnings from salaried employment only, rather than just total income.
- We commissioned Willis Towers Watson (WTW) to undertake a job levelling evaluation of 10 key medical and dental roles to enable us to benchmark against market data for comparably sized roles.

1.64 The consideration of earnings over time, and their relativity against inflation, are dependent on the start year chosen. For most of our remit groups, pay growth has not matched CPI inflation since 2010 (the first year with consistent earnings data available), although the picture is more mixed when looking at more recent starting years.

1.65 Pay growth across the higher end of the whole economy earnings distribution, where many of our remit group sit, has been lower than average earnings growth over this period. Reflecting this economy wide trend, consultants and SAS doctors have maintained their position in the earnings distribution for all employees over the longer term. Resident doctors have fallen back in the earnings distribution in recent years, a factor that has influenced our recommendations this year.

1.66 Pay comparisons against equivalent roles give a mixed picture across our remit group, with some comparator professions paid more and some less. However, earnings are typically within the interquartile range, suggesting that individual roles are not significantly out of line with the market. The full review of our pay comparability methodology will refresh our approach for the next pay round.

1.67 Pay and career progression mean that the majority of doctors working in secondary care have seen above-inflation pay growth over the last 10 years. The lower quartile of earnings growth for doctors in secondary care in England was 3.4 per cent a year over the 10 years to March

2024, at the median it was 4.1 per cent a year, and at the upper quartile it was 9.5 per cent a year. This is much higher than other NHS staff and above the average 2.9 per cent CPI inflation over the period. Strong earnings growth over the last year among hospital doctors will have enhanced this position.

1.68 Earnings growth for partner GPs over the longer term shows a mixed picture, with real-terms growth in earnings in some nations and falls in others. The recent picture has been shaped by additional payments for COVID-19 vaccinations. Since 2012-13, partner GPs in Scotland and England have seen real terms earnings growth, there has been little change in Wales, and real terms average earnings have fallen in Northern Ireland. For salaried GPs, average earnings have grown in real terms since 2012-13 in Scotland and Wales but have seen a fall in England. However, both partner and salaried GPs in England have improved their relative position in the earnings distribution over this period.

1.69 While we can track earnings for general dental practitioners over the longer term, we cannot separate NHS earnings from private work. Providing-performer dentists have seen real terms increases in average incomes since 2017-18 in Scotland and Wales, but falls in England and Northern Ireland. Associate dentists have seen increases in real average incomes since 2017-18 in Scotland, Wales and Northern Ireland, but falls in England. Both providing-performer and associate dentists have maintained, or improved, their position in the earnings distribution across all nations.

International pay comparisons

1.70 Our review of the evidence on international comparisons shows that the number of doctors leaving to work overseas saw a notable increase in 2022 and 2023. However, the numbers leaving the UK because they want to practice abroad are not unduly large each year and are dwarfed by the number of internationally qualified doctors joining the workforce. The number of international leavers also needs to be seen in the context of overall strong growth in the medical workforce. Over half of those leaving to work overseas are non-UK nationals, and the General Medical Council (GMC) reports that around half of the UK graduates that leave later return.

1.71 The key destination countries for UK nationals are Australia and New Zealand. The data we have on comparative earnings for specialists/consultants indicates that UK salaries are ahead of New Zealand but behind Australia, Canada and Ireland. Despite the land border with Northern Ireland, and the recently increased pay for consultants in the Republic of Ireland, there is little evidence of increasing numbers of UK doctors moving to Ireland.

1.72 Our objective is to set pay so that the NHS can recruit and retain the doctors and dentists it requires. It has long been the case that UK-trained doctors have moved to work overseas, either temporarily or permanently, especially to other English-speaking countries. This is part of the attraction of the medical profession. The appropriate balance of UK and internationally qualified doctors in the workforce is a policy decision for the governments. There are significant risks associated with an over-reliance on recruiting from the international market which policy makers should weigh up carefully.

Broader developments in reward

1.73 Our recommendations typically focus on base pay, but this is only one part of a much broader reward package for doctors and dentists that includes pay supplements and allowances, leave, additional benefits, pensions, working conditions, job security, and career development. All of these affect recruitment, retention, motivation and morale. In a number of these areas, such

as structured career and pay progression, job security, international mobility, and pensions, medical careers compare positively to other highly qualified roles in the private sector.

1.74 The changes to pension taxation in 2023 (which at the time the government said was driven by a desire to underpin workforce retention in the NHS) represented a significant improvement to the total reward package for higher earners, including many in the medical workforce. Along with the additional flexibilities brought into the NHS pension scheme, this should increase the incentives for senior doctors to continue working for longer and to undertake additional work.

1.75 The recent restructuring of consultants' pay in England, Wales and Northern Ireland delivered more rapid pay progression and a boost to career earnings, and should help to close the gender pay gap.

Motivation and morale

1.76 We are encouraged to see some improvement this year in motivation and morale among the medical and dental workforce. The NHS staff survey for England shows better results for medical and dental staff in 2024 than those recorded in both 2022 and 2023. However, the results for 2024 generally remain worse than those recorded in 2020. There were significant increases in satisfaction with pay across secondary care groups, especially among consultants.

1.77 We continue to see high levels of dissatisfaction among resident doctors with their working lives, which has been clearly expressed to us during our visit programme and in evidence this year. These concerns are widespread, from unhappiness with the immediate working environment, such as lack of facilities for hot food or rest, to the need to regularly relocate to enable training progression, with the associated cost and disruption, rising apprehension around job security and access to training places, and discontent with access to study time.

1.78 We have expressed our concern about resident doctors' working lives in previous reports and remain of the view that these problems need to be urgently addressed. There is now recognition of this by governments and employers, including announcements of reviews into both resident doctors' working lives and the availability of training places in England. Following these, it is vital that delivering tangible change to improve the working lives of resident doctors is a priority in the coming months. Investment in the working environment and arrangements for resident doctors is likely to be cost effective in terms of the improvement to motivation and commitment.

The industrial relations context

1.79 Resident doctors in England, Wales and Northern Ireland took strike action over pay in 2023 and 2024, and consultants in England took strike action in 2023. NHS analysis estimates that the waiting list in England could have fallen by an extra 430,000 from December 2022 to March 2024 without the strike action. GPs in England undertook industrial action starting in August 2024, which was recently resolved.

1.80 Industrial action is extremely costly to an already stretched NHS, and results in significant losses of activity that damage overall patient care. It also affects the morale and motivation of staff, which can again impact on the care the NHS is able to deliver. Finding a resolution to the recent disputes has been highly beneficial for the overall NHS and patient care. Given the high demands on the NHS and the significant transformation needed to support the future healthcare needs of the nation, it is important that future industrial action is avoided. The

evidence that was presented to us indicates that the industrial relations environment remains fragile.

Differences across nations

1.81 Our remit covers all four nations of the UK, and we receive separate evidence on each. When making our recommendations, we are cognisant of differences between the nations, in terms of the economy, the labour market, health services, and government policies. While many parties highlighted differences in pay between nations, none called for differential pay uplifts to resolve them.

1.82 The Welsh Government said that the ideal approach would be a hybrid model: maintaining core UK-wide reward principles for fairness and consistency, while allowing flexibility in specific aspects that addressed the unique objectives of each nation's health service, such as rurality and population needs. It said that diverging contract and reward structures across different parts of the UK could have a significant impact on the recruitment and retention of healthcare professionals.

1.83 NHS Employers said they were unaware of any evidence suggesting that contractual variations between the devolved nations were significant enough to impact recruitment and retention in England.

1.84 Differences in primary care are especially noticeable between the nations, in terms of the workforce position, contractual terms, average earnings and overall delivery. The Scottish Government has drawn attention to better provision of NHS dentistry in Scotland.

1.85 We consider the differential positions on health funding, affordability, earnings, recruitment, retention, motivation and morale across the nations to see if a differential approach is required. Given the strong views of parties on this issue, and the lack of a clear case to support differentiation, our core pay recommendation this year covers all four nations of the UK.

Our recommendations

Pay uplifts

1.86 We make our recommendations with regard to all the factors in our terms of reference. Recruitment and retention across most of our remit groups is strong and has shown signs of improvement over the last year. An exception to this is the unattractiveness of NHS dentistry. We are confident that both medicine and dentistry remain attractive careers, given the buoyant numbers seeking to study these subjects, and the very strong recruitment from overseas. Changes to the pensions regime have enabled a reduction in retirement rates, allowing valuable experience to remain in the NHS for longer.

1.87 Motivation and morale across our remit group has improved over the last year, although only back to 2021 levels, and there is much to be done in terms of enhancing the working environment across the NHS, which is of considerable concern to staff. We note the recent significant increase in satisfaction with pay across the remit group, albeit from low levels. Delivering governments' ambitions for health services across all four nations, and in particular the reforms recently announced by the UK Government, will require strong morale and the support of an engaged and motivated workforce.

1.88 Average earnings growth across secondary care has been strong over the last year, with additional pay uplifts on top of our recommendation, which will have served to improve the

comparative position of our remit group. Earnings growth in primary care has been more mixed. We note that primary care doctors and dentists did not receive the additional pay awards that were made in secondary care last year.

1.89 Significant additional resources have already been committed to general practice in England by the new government and the emphasis put on community care is welcome. Similar focus needs to be given to NHS dentistry, starting with a clear objective of what an appropriate level of provision is. The UK Government has recognised the need for widescale reform of the dental contract. Significant restructuring will be needed to attract dentists to perform sufficient NHS work to meet patient demand. The Welsh Government is consulting on changes to the dental contract to support access to dentistry and improve incentives to undertake NHS work.

1.90 Governments have made clear the constrained funding environment for the NHS, reflecting the challenging fiscal situation. Weak economic growth limits the nation's ability to find extra resource for the NHS. Governments have also set out the impact that pay awards above affordability will potentially have on delivery, patient care, and the capacity for reform. High waiting lists, long waits in accident and emergency, and the struggle to access GPs and NHS dentists indicate that demand for healthcare significantly outweighs supply, which has a detrimental impact on the health of the nation.

1.91 Although the labour market is showing signs of weakening, average earnings growth at the upper quartile remains strong, at 4.5 per cent in January 2025. Median pay settlements across the economy were at 3.0 to 3.4 per cent in the first quarter of 2025 and inflation is forecast to average 3.2 per cent over 2025-26, peaking at 3.7 per cent in the third quarter of 2025.

1.92 Considering all these factors, **we recommend a 4 per cent increase to the salary scales, pay ranges and the pay element of contracts from 1 April 2025**. This applies to: consultants; SAS doctors and dentists; salaried dentists, including those working in Community Dental Services and the Public Dental Service; contractor general medical practitioners; salaried GP pay ranges; and the pay element of dental contracts. This applies to all the nations of the UK.

Recommendation 1

We recommend a 4 per cent increase to salary scales, pay ranges and the pay element of contracts from 1 April 2025.

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

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

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

Resident doctors

1.94 We recommended higher pay awards for resident doctors compared to other parts of our remit group in 2023 and 2024. This followed resident doctors in England being out of our remit for the preceding three years, during a period of unusually high inflation. Additional pay awards from agreements between the unions and governments mean that this group has received pay uplifts of 21 to 25 per cent over the last two years in England and similar across the other nations.

1.95 Our higher pay recommendations in previous years were targeted in light of the particular working environment and pressures facing doctors and dentists in training, the poor morale, the increasing tendency to drop out of training, the very high disruption and costs that this group faces from job rotations, the cost of exams, and the fall in relative earnings compared to the broader economy for this group.

1.96 Earnings for resident doctors still show a fall in the position in the overall wage distribution compared to all employees, whereas for consultants, SAS doctors and dentists, GPs and GDPs, pay has remained in line with previous positions in the pay distribution. Falls have been greater at lower grades within the resident doctor pay scale. Resident doctor pay is also below median pay for most of the matched market comparators. While we expect this position to have improved over the last year, the evidence suggests that a further readjustment is required.

1.97 Resident doctors play a crucial role in patient care, while continuing their training. The working conditions and working lives of resident doctors continue to have a serious impact on their morale. Governments and employers have recognised this and are taking steps to address some of the underlying causes. Notwithstanding this, on our visits and in evidence this year we continued to hear high levels of concern about working lives and poor wellbeing. The GMC's training survey reports that over half of medical trainees described their work as emotionally exhausting, and the NHS staff survey in England shows that 35 per cent of resident doctors felt burnt out because of work. While satisfaction with pay among resident doctors has improved, it is still behind the other workforce groups.

1.98 This evidence of ongoing poor morale, alongside a worsening position in relative pay, is of particular concern. It is important that resident doctors are motivated to stay in the NHS to continue their training and to provide high quality care to patients, and also to progress their careers as the consultants and GPs of the future.

1.99 Reflecting these concerns, and that the decline in the position in the overall wage distribution is greater at the lowest resident doctor grades, we again make a different recommendation for resident doctors this year. We recommend a 4 per cent increase plus a consolidated uplift of £750 to the pay points for resident doctors and dentists in England, Wales and Northern Ireland from 1 April 2025. This represents an increase of 5.1 to 6.0 per cent in England, 5.1 to 6.3 per cent in Wales, and 5.1 to 6.2 per cent in Northern Ireland, and again delivers a higher increase for lower-paid resident doctors. Resident doctors in Scotland are not in our remit this year.

Recommendation 2

We recommend a 4 per cent increase plus a consolidated uplift of £750 to the pay points for resident doctors and dentists in England, Wales and Northern Ireland from 1 April 2025.

Locally employed doctors

1.100 Locally employed doctors represent a diverse and growing part of the medical workforce in secondary care. Our recommendation for resident doctors will also apply to locally employed doctors where they are on the same pay points. However, this group are not exposed to all the same pressures as doctors in training, including the impact of rotations, and many have chosen to work as locally employed doctors to avoid this.

1.101 The workforce data do not currently allow us to effectively separate out this group. This is important to understand how locally employed doctors are being used across the NHS, in order that an appropriate pay recommendation can be made. We expect this to be addressed and look forward to receiving more detailed evidence on locally employed doctors next year.

1.102 This group may have different needs, as they undertake different roles, and therefore require a different workforce and reward strategy to doctors in training. **We recommend that governments consider a separate pay framework for locally employed doctors**. This needs to be discussed and agreed with all parties. It would enable targeted pay recommendations for this group in future.

Recommendation 3

We recommend that governments consider a separate pay framework for locally employed doctors.

Flexible pay premia

1.103 Flexible pay premia for training specialties with shortages have been in payment in England since the introduction of the 2016 contract. Given the very high fill rates at core training, there is limited evidence to support their continued payment. There is also little evidence that payments are correctly targeted within higher levels of training. This funding might be better invested elsewhere in the training programme. We note that the targeted payments for GP training in certain localities are not being continued in 2025, due to the high fill rates.

1.104 A review of flexible pay premia to assess their value for money and effectiveness is long overdue. This review should be linked to a clear picture on future training place requirements from a refreshed workforce plan and should then feed into future contract negotiations.

Recommendation 4

We recommend the government reviews flexible pay premia in England to assess their value for money and effectiveness.

1.105 Flexible pay premia will by uplifted by 4 per cent, in line with our pay recommendation for 2025-26.

Clinical impact awards

1.106 The four nations are in different positions on discretionary pay and awards for consultants. This means that any recommendation we make on consultant reward schemes will have a differential impact across nations. Since 2019, we have declined to make a recommendation that uplifts should be applied to clinical excellence or clinical impact awards, as a result of concerns over their equity and effectiveness. Last year we said we would like to receive further evidence on the effectiveness of the national clinical impact award scheme, including its impact on patient care and productivity, and further reassurance on its equity, before we would make a recommendation.

1.107 We have now seen clear benefits from the national clinical impact award scheme in England and Wales in terms of the delivery of clinical excellence, innovation and leadership since its introduction in 2022. The clinical impact awards scheme can play a key role in both incentivising and recognising this work. To best achieve this, the scheme should not be allowed to erode in terms of its value and scale. The current value of the awards – £20,000 to £40,000 a year for five years, with a further £10,000 award level in Wales – are substantial. However, they have not been changed since the scheme's introduction.

1.108 Equality outcomes from clinical impact awards have generally shown improvement, although the scheme continues to show disproportionate awards going to men and to those from a white ethnic group. It is important to continue to monitor this scheme. Improving the understanding and accessibility of the clinical impact awards scheme across the medical workforce will help to maintain its credibility and effectiveness. Equality outcomes might be supported by extending the scheme to a broader range of clinicians.

1.109 To ensure the value of this important scheme is maintained, we therefore recommend an increase in the value of: the national 0 award to £10,500; the national 1 award to £21,000; the national 2 award to £31,500; and the national 3 award to £42,000. This applies to existing and new awards, with awards payable from 1 April 2025. This requires a commensurate increase in the overall budget for national clinical impact awards.

Recommendation 5

We recommend an increase in the value of national clinical impact awards in England and Wales from 1 April 2025 as follows:

- The level 0 award to be increased from £10,000 to £10,500.
- The level 1 award to be increased from £20,000 to £21,000.
- The level 2 award to be increased from £30,000 to £31,500.
- The level 3 award to be increased from £40,000 to £42,000.

1.110 This recommendation applies to England and Wales. There is not an equivalent active scheme in Scotland, although we note that discretionary points were increased in the recent pay agreement, having been frozen in value for some years. The Scottish Government has said it is

not making any new distinction awards as they do not align with its progressive pay principles. We would welcome future evidence from parties about the use of discretionary points in Scotland and will continue to review this in future to consider if a recommendation is appropriate.

1.111 There are no active incentive schemes in Northern Ireland. While the Department of Health is considering the findings of a consultation exercise in Northern Ireland, it may wish to look to the operation of the national clinical impact awards scheme in England and Wales.

1.112 We will continue to keep these schemes under review. We encourage all nations to explore how recognition of clinical excellence can drive improvements in health outcomes. We would also like the DHSC and the Welsh Government to explore whether the national clinical impact award scheme can be extended to include other senior clinicians, such as specialists and GPs.

Expenses in primary care

1.113 Appropriate uplifts in contracts are crucial in order to maintain primary care services. We expect uplifts for primary care contracts to be sufficient for the full value of our pay recommendations to be reflected in earnings for contractor GPs at typical general practices, and for NHS/HSC work done by providing-performer and associate dentists at typical dental practices.

1.114 We are not confident this has been the case in recent years, especially for dentistry in England. We note that in both Wales and Northern Ireland there were additional one-off payments made for 2024-25 to meet recent cost increases and support the viability of GP and dental services. There have also been significant recent increases in funding to general practice in England and Scotland to support the sustainability of services.

1.115 As we have noted in previous reports, one of the problems with the current uplift process for dental contracts in England, which uses the forecast GDP deflator made in the previous autumn as the figure for uprating the expenses element of contracts, is that there is no correction mechanism for when the forecast is significantly different to the out-turn. Persistent under-forecasting of inflation has led to a 7.1 percentage point gap over three years in the dental contract expenses uplift and the actual GDP deflator. The expenses element has a weight of 0.314 in the overall uplift, so using the out-turn GDP deflator would have given overall higher contract uplifts of 2.2 per cent.

1.116 Scotland, Wales and Northern Ireland have typically used the DDRB recommendation as the figure for uprating the expenses part of primary care contracts. While this will have been less detrimental in recent years, it is still unlikely to bear much relation to the actual costs experienced.

1.117 It is unlikely that an alternative measure of general inflation, such as the CPI, would do better than the GDP deflator; the GDP deflator is by definition the broadest measure of inflation that we have. Our analysis in chapters 4 and 5 shows that the change in expenses experienced by providing-performer dentists and partner GPs has little correlation with either the GDP deflator or consumer prices inflation. This is not surprising. The specific costs primary care faces, such as specialist equipment, are unlikely to relate strongly to average price changes across a range of goods and services, and many other factors will drive the change in expenses. These include a change in the price of specific inputs (such as equipment or energy costs); the need to use more or fewer inputs (as demand/activity changes); and a change in the composition of the expenses base (for example, greater use of higher-paid staff relative to lower-paid staff, or vice versa). It is likely to be a combination of these factors.

1.118 We note that the Department of Health in Northern Ireland has announced a cost-of-service review in 2025-26 to determine what it costs to provide dentistry. The Welsh Government has also told us that it is working on how to evidence increases in expenses in general practice. The Scottish Government has committed to a working group on expenses with BDA Scotland. While we do not have any further evidence on what these reviews encompass, we think they suggest a reasonable way forward.

1.119 We do not think the GDP deflator, other general measures of inflation, or our pay recommendation are appropriate mechanisms for uprating the expenses elements of primary care contracts**. We therefore recommend that all nations work together to develop an index of general practice costs and an index of dental costs**. These can be based on the NHS cost inflation index used by the ONS to inform its healthcare productivity estimates.[5] This work needs to be transparent and to engage stakeholders, to ensure its independence and credibility. These indices can then be used to construct changes over time and to determine the expenses element of the contract uplifts in each nation. This should form part of discussions on contract reform.

Recommendation 6

We recommend that the four governments work with GPs' and dentists' representatives to develop an index of general practice costs and an index of dental costs. These indices should then be used to determine the expenses element of the GP and dental contract uplifts in each nation.

1.120 Primary care will also be facing an increase in staffing costs from the increase in employers' national insurance contributions and increases to the national living wage. These should be reflected in the uplift to the staffing costs component of primary care contracts.

Community and Public Dental Services

1.121 We raised concerns last year about a lack of evidence for the Community Dental Service and the Public Dental Service. This inhibits our ability to make an informed pay recommendation. While the evidence base has improved this year, there are still significant evidence gaps, especially in England.

1.122 The Department of Health in Northern Ireland asked us to explore whether a higher uplift for salaried dentists in the CDS might be appropriate to attract and retain dentists. Parties had mixed views on whether this was necessary. We note that Northern Ireland has a lower minimum salary for band A than the other nations. The late payment of the 2024 uplift would have exacerbated the difference. If the bottom pay point was removed, this issue might be resolved.

1.123 During our visits we have heard significant concerns about the lack of career progression and development for CDS and PDS dentists, as well as issues around low staffing and high workloads, leading to poor morale. CDS dentists work with some of the most vulnerable

[5] ONS, *Methodological developments to public service productivity: healthcare, 2020 update*. https://www.ons.gov.uk/economy/economicoutputandproductivity/publicservicesproductivity/methodologies/methodologicaldevelopmentstopublicserviceproductivityhealthcare2020update#developments-to-deflators

members of our society, and it is important that they feel valued and are supported in their role.

1.124 We recommend that each government undertake a review of pay and progression for salaried dentists working in Community and Public Dental Services to assess whether the reward structure is appropriate to support recruitment, retention and service delivery.

1.125 This would include whether pay ranges are positioned correctly, and whether there is a sufficiently attractive career path to attract and retain high quality dentists. We would expect this to align with a broader workforce strategy which supports future service delivery and reviews the overall workforce size and skill mix.

Recommendation 7

We recommend that each government should undertake a review of pay and progression for salaried dentists working in Community and Public Dental Services to assess whether the reward structure is appropriate to support recruitment, retention and service delivery.

The reward package and career progression for resident doctors

1.126 As agreed with resident doctors in England, we were asked this year by the Secretary of State to consider, as part of our 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 the consultants and GPs of the future. This has been reflected in the consideration of our pay recommendations.

1.127 Undergraduate admissions data indicate that medicine remains an attractive career choice. In our consideration, we also note the strong pay growth experienced by resident doctors over the last year, driven by pay uplifts that have been well above the whole-economy median pay award. Resident doctors receive valuable pay and career progression, far above that seen in other graduate careers. Enhancements to pay progression for consultants agreed last year will benefit resident doctors as they progress through their career. The NHS pension scheme is also significantly more valuable than those on offer in private sector careers and should be seen alongside the beneficial removal of the lifetime allowance announced in 2023.

1.128 The NHS staff survey in England shows a low, albeit increasing, level of satisfaction with pay among resident doctors, and high reports of burnout. Pay comparisons show that resident doctors have fallen back in the overall earnings distribution in recent years. Comparisons against other professional roles show a mixed picture. In recognition of these issues, our pay recommendation this year gives an additional award to resident doctors compared to other parts of our remit group.

1.129 The 2024 agreement with resident doctors in England included a review of the training model. This includes: the number and frequency of rotations; the administrative and bureaucratic hurdles involved in rotating; relocation, logistics, travel and accommodation issues; the disruption to personal and family life; and the support systems across different rotations and geographies. It also includes a review of training numbers.

1.130 We strongly support this review and expect it to lead to an ongoing programme of work to improve the working lives of resident doctors, including addressing the issues that we have

highlighted in our recent reports. We think it is vital that progress is made quickly and communicated across the resident doctor workforce.

1.131 Resident doctors are increasingly choosing to work less than full time, especially at later stages of training. It is positive that employers are supporting this, and we would hope the current review also looks to understand how training programmes can be adapted to support flexible working.

Costs of recommendations

1.132 We estimate that implementing our recommendations will cost around £1.1 billion. It will add £900 million to the substantive HCHS paybill in England, against a total DHSC Resource Departmental Expenditure Limit in 2025-26 of £202 billion. We estimate that they will add £60 million to the paybill in Scotland, £60 million to the paybill in Wales, and £35 million to the paybill in Northern Ireland.

Chapter 2 Wider context

2.1 This chapter considers the wider context for our recommendations including the economy and the labour market, NHS activity and productivity, health spending and affordability, workforce planning, workforce equalities and diversity, and developments in pensions.[6]

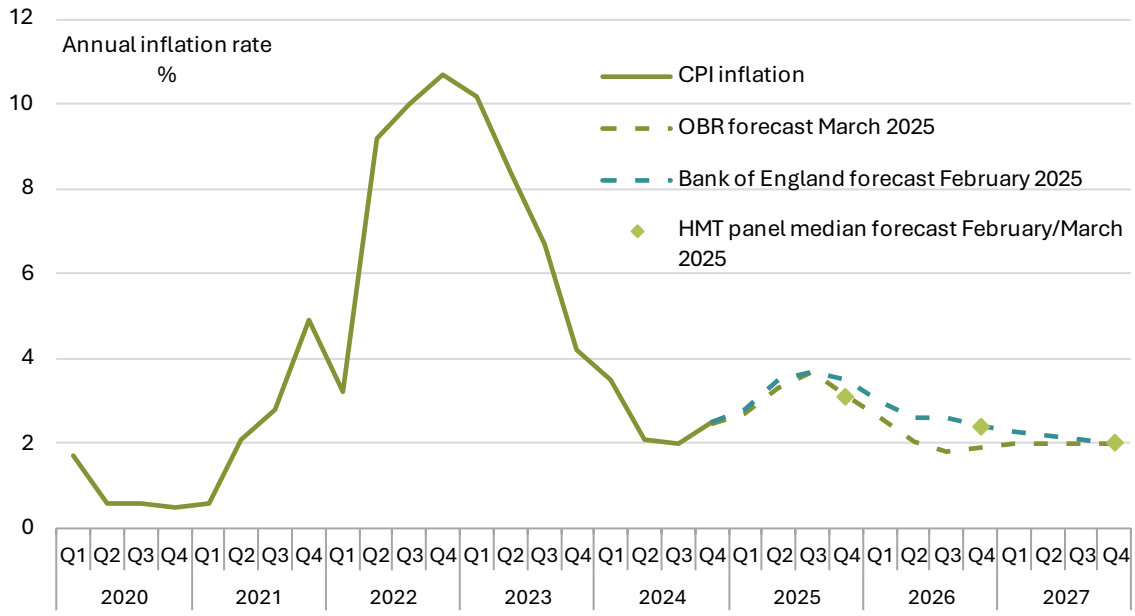
The economy and the labour market

2.2 UK economic growth remained weak in 2024, at 1.1 per cent for the year. Growth in gross domestic product was estimated to be 0.2 per cent in the three months to January 2025. Economic growth is forecast to remain weak, at 0.75 to 1.0 per cent in 2025.

2.3 Consumer Prices Index (CPI) inflation was 2.5 per cent overall in 2024 but increased to 2.8 per cent in February 2025. The Consumer Prices Index including owner occupiers' housing costs (CPIH) rate of inflation was 3.7 per cent in February 2025. The Retail Prices Index (RPI) rate of inflation was 3.4 per cent in February 2025.[7] Household costs indices show that inflation for those in private rented accommodation was 3.9 per cent in the year to December 2024.

2.4 Inflation is forecast to rise in the second and third quarters of this year, as higher global energy costs fed through to domestic prices. The Bank of England forecast CPI inflation to average 3.4 per cent in 2025-26, peaking at 3.7 per cent in the third quarter of 2025. The OBR forecast inflation to average 3.2 per cent in 2025-26, peaking at 3.8 per cent in July 2025.

Figure 2.1: CPI inflation and forecasts, 2020 to 2027



Source: Office for National Statistics (ONS), CPI inflation, quarterly (D7G7); Office for Budgetary Responsibility (OBR), *Economic and fiscal outlook*, March 2025, Bank of England, *Monetary Policy Report*, February 2025, HM Treasury, *Forecasts for the UK economy*, February/March 2025.

[6] This chapter contains data published up to the end of March 2025.

[7] The ONS has said that the retail prices index is not a good measure of inflation. The methods used to produce it are not consistent with internationally recognised best practice, a shortcoming that led to it losing National Statistics status in 2013. It also has other significant weaknesses, including how it measures housing costs, and its population coverage, which excludes certain households. ONS, *Measuring changing prices and costs for consumers and households: December 2023*. https://www.ons.gov.uk/economy/inflationandpriceindices/articles/measuringchangingpricesandcostsforconsumersandhouseholds/december2023

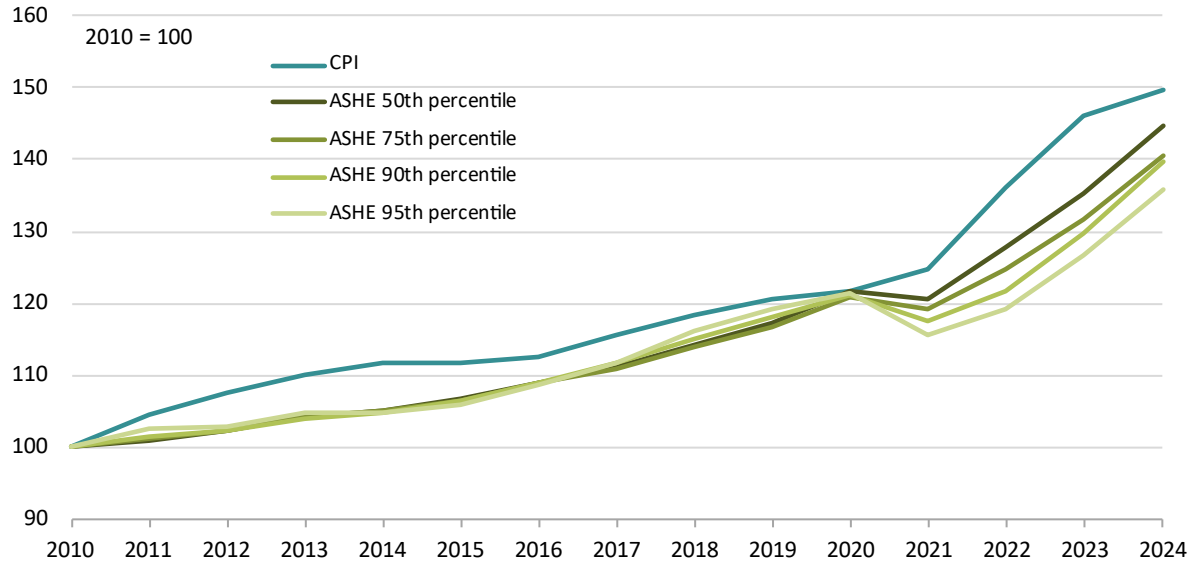
2.5 The labour market has shown signs of weakening over the last year. Pay as you earn (PAYE) real time information indicated that the number of employees on payrolls showed a small increase, of 67,000, in the year to February 2025, to 30.4 million. The ONS recorded 816,000 job vacancies in the three months to February 2025, in line with the pre-pandemic level. This was a notable fall from the peak of 1.30 million in May 2022 and from 914,000 in February 2024. The unemployment rate was at 4.4 per cent in the three months to January 2025, up from 4.1 per cent a year earlier. The unemployment level was estimated to have increased by 132,000 over the year to January 2025, to 1.55 million.

2.6 Average earnings growth has been strong over the last year, and above inflation. Whole economy annual average weekly earnings growth was at 5.8 per cent in the three months to January 2025. Regular earnings growth (i.e. excluding bonuses) was at 5.9 per cent; 6.1 per cent in the private sector and 5.3 per cent in the public sector. The OBR forecast average earnings to grow by 3.7 per cent in 2025-26.

2.7 We pay particular attention to earnings at the upper end of the wage distribution, as this is more relevant to the earnings of our remit group. PAYE data showed that earnings growth over the last year was stronger in the lower half of the earnings distribution and weaker at the top end. Annual earnings growth in the year to January 2025 was 8.3 per cent at the 25th percentile; 6.0 per cent at the median; 4.9 per cent at the 75th percentile; 4.5 per cent at the 90th percentile; 4.6 per cent at the 95th percentile; and 4.4 per cent at the 99th percentile.

2.8 Earnings have grown by less than inflation for all employees since 2010, in particular between 2020 and 2023. There has been real earnings growth across the earnings distribution over the last year.

Figure 2.2: ASHE percentiles for full-time employees and CPI index, 2010 to 2024



Source: ONS, Annual Survey of Hours and Earnings (ASHE), CPI.

2.9 Pay settlement medians were around 5 per cent in 2024. Data for the first quarter of 2025 show a range of 3.0 to 3.4 per cent. For the three months to February 2025: Brightmine reported a median pay award of 3.0 per cent; Incomes Data Research reported a median of 3.2 per cent; and the Labour Research Department reported a median of 3.4 per cent.

NHS activity

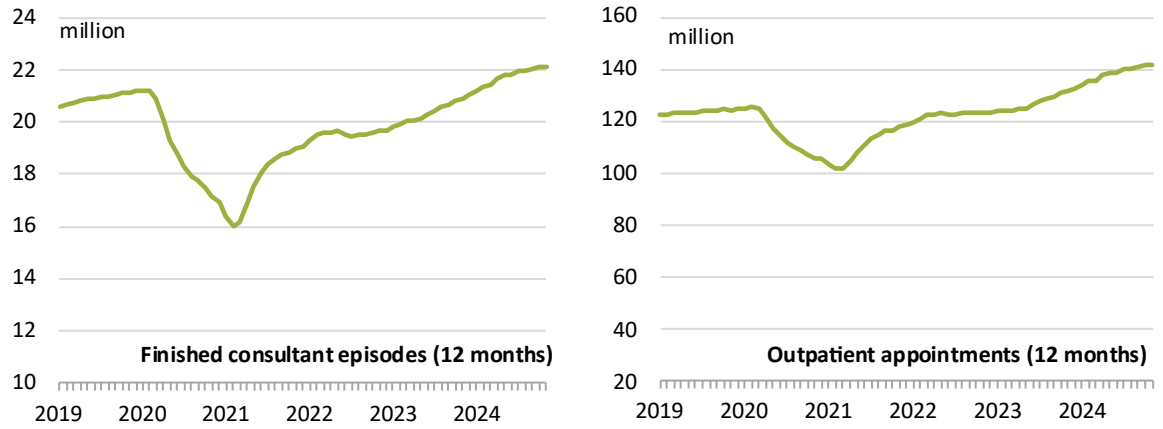
2.10 Overall, NHS activity has grown over the last year and is above the levels seen before the pandemic in 2019. However, waiting lists remain at much higher levels than before the pandemic, having fallen slightly over the last year.

Hospital activity

2.11 In the 12 months to November 2024, there were 22.1 million finished consultant episodes in England, up by 1.2 million (5.7 per cent) from the 12 months to November 2023 and by 1.0 million (4.7 per cent) from the 12 months to November 2019.

2.12 In the 12 months to November 2024, there were 141.8 million outpatient appointments in England, up by 10.0 million (7.6 per cent) from the 12 months to November 2023 and by 17.5 million (14.0 per cent) from the 12 months to November 2019.

Figure 2.3: Finished consultant episodes and total outpatient appointments, England, 2019 to 2024



Source: NHS England, Hospital Episode Statistics.

Notes: Total episodes/appointments over previous 12-month period. Finished consultant episodes are the total number of periods of care under a single consultant, not including regular day or night patients or episodes that are unfinished at the end of the reporting month. A single stay in hospital may consist of one or more episodes of care.

2.13 In Scotland, in the three months to September 2024, 314,961 new outpatient waits were completed when the patient involved was seen at their outpatient clinic, an increase of 1.6 per cent from the same quarter a year earlier.

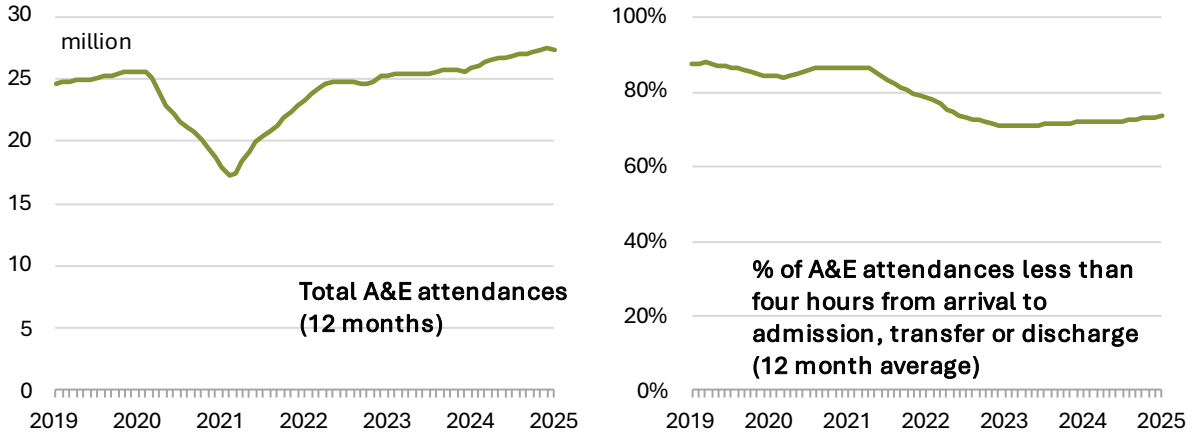
2.14 In Northern Ireland, in the year to March 2024, there were 1,303,000 outpatient attendances, an increase of 1.6 per cent from the previous year.

Accident and emergency

2.15 In January 2025, there were 2.21 million accident and emergency (A&E) attendances in England, down by 13,000 (0.6 per cent) from January 2020 but up by 103,000 (4.9 per cent) since October 2019.

2.16 The proportion of A&E attendances that took less than four hours was 73.0 per cent in January 2025, up from 70.4 per cent in January 2024, but down from 81.7 per cent in January 2020.

Figure 2.4: A&E attendance, England, 2019 to 2025



Source: NHS England, A&E Attendances and Emergency Admissions.

2.17 In Scotland, there were 125,692 A&E attendances in January 2025, down by 2,728 (2.1 per cent) from a year earlier, and down by 13,033 (9.4 per cent) from five years earlier.

2.18 In Wales, there were 85,064 A&E attendances in January 2025, down by 574 (0.7 per cent) from January 2024 and up by 3,117 (3.8 per cent) from January 2020. In January 2025, 67.6 per cent of patients attending A&E were admitted, transferred or discharged within four hours, down from 68.1 per cent in January 2024 and from 73.6 in January 2020.

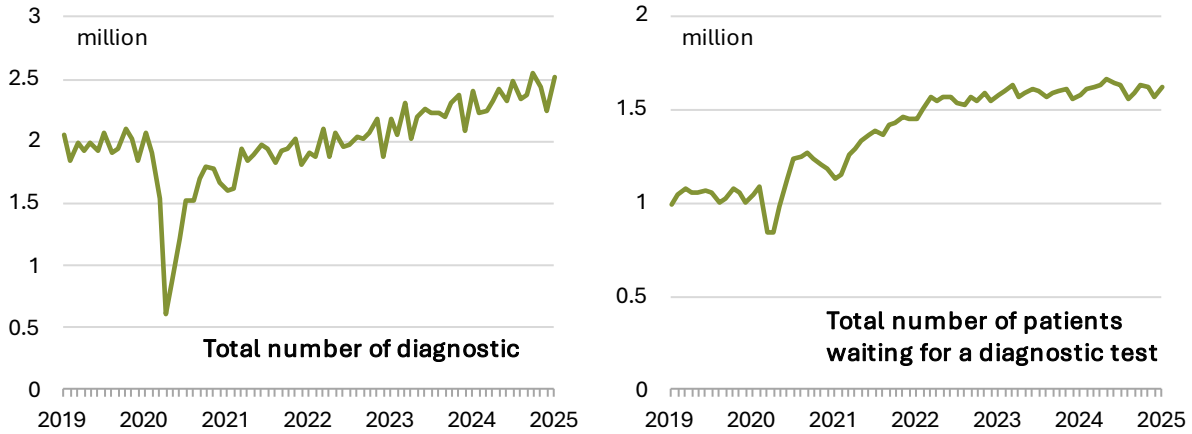
2.19 In Northern Ireland, there were 63,347 attendances at emergency departments in December 2024, an increase of 4,472 (7.6 per cent) from a year earlier.

Diagnostic tests

2.20 In January 2025, 2.51 million diagnostic tests were carried out in the NHS in England, up by 114,000 (4.8 per cent) from January 2024 and 437,000 (21.1 per cent) since January 2020.

2.21 The number of patients waiting for a diagnostic test was 1.62 million in January 2025, up by 41,500 (2.6 per cent) from January 2024 and by 576,600 (55.2 per cent) from January 2020. The number of patients waiting six weeks or more for a diagnostic test was 363,600 in January 2025, down by 51,300 (12.4 per cent) since January 2024 but up by 317,000 (685 per cent) since January 2020.

Figure 2.5: Diagnostic tests, England, 2019 to 2025



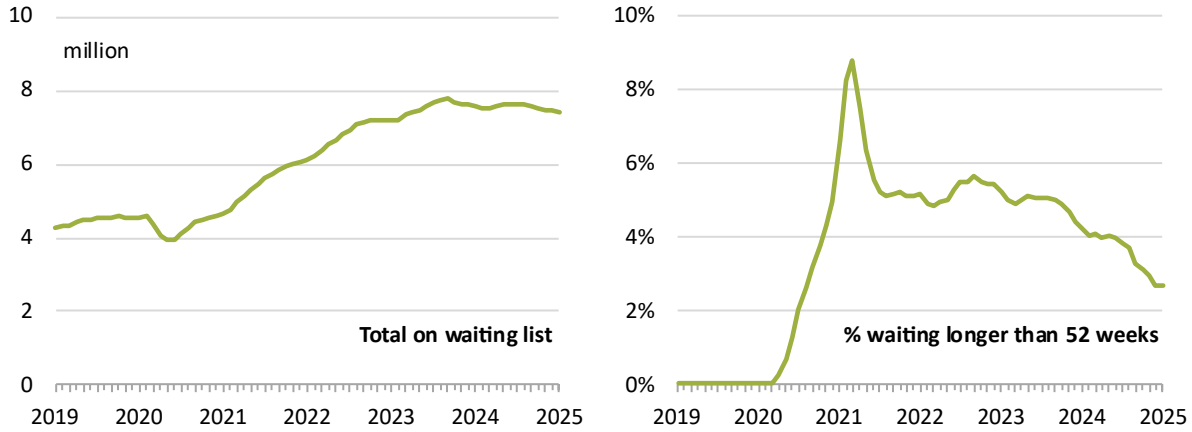
Source: NHS England, Monthly Diagnostics Data.

Waiting lists

2.22 The number of patients waiting for NHS treatment in England reached a record level of 7.77 million in September 2023, having grown rapidly since 2020. The number fell by 150,000 (1.9 per cent) over the year to January 2025, to 7.43 million. This was 2.86 million (62.7 per cent) higher than January 2020.

2.23 Of these, 2.7 per cent (198,900) had been waiting for over a year, down by 8.8 per cent (436,100) from March 2021, but up from levels close to zero seen before the pandemic.

Figure 2.6: Number of patients waiting for treatment and proportion waiting over one year, England, 2019 to 2025



Source: NHS England, Consultant-led Referral to Treatment Waiting Times Data 2024-25.

2.24 In Scotland, at the end of December 2024, there were 563,600 ongoing waits for a new outpatient appointment being experienced, an increase of 4.9 per cent from a year earlier.

2.25 In Wales, there were 800,400 patient pathways waiting to start treatment in December 2024, an increase of 5.8 per cent from December 2023, and 72.5 per cent higher than December 2019. The waiting list in Wales reached a record high of 802,300 in November 2024.

Primary care

2.26 In a recent report, Audit Scotland said that, unlike secondary care, where waiting lists and times were regularly monitored, it was not easy to define or measure demand for services provided by general practice.[8] However, it identified proxy measures that clearly indicated that pressure on general practice had increased: a growing and ageing population; more people with long-term health conditions and mental health issues; an increased impact of disease on the population (notably cardiovascular disease, cancers and neurological conditions); enduring and widening health inequalities; and longer waiting times for secondary care.

2.27 In England, activity in general practice has shown a steady increase in recent years, from an average of 1.31 million appointments each working day in 2022 to 1.45 million in 2024. Appointments with general medical practitioners (GPs), rather than other practice staff, have shown only a small increase, from an average of 631,000 per working day in 2022 to 640,000 in 2024.

[8] Audit Scotland, *General practice: Progress since the 2018 General Medical Services contract*. https://audit.scot/publications/general-practice-progress-since-the-2018-general-medical-services-contract

2.28 In NHS dentistry, the units of dental activity undertaken in England fell sharply from 79.7 million in 2019-20 to 24.4 million in 2020-21, when COVID-19 restrictions limited activity. Dental activity has since recovered, but not to the pre-pandemic level, with 72.5 million units of dental activity delivered in 2023-24.

Operational targets for 2025-26

2.29 NHS England published its priorities and operational planning guidance for 2025-26 at the end of January 2025.[9] This included targets to:

- Reduce the time people waited for elective care, with every trust expected to deliver a minimum 5 percentage point improvement in the proportion of patients waiting over 18 weeks for treatment.
- Improve A&E waiting times and ambulance response times.
- Improve access to general practice and urgent dental care.

2.30 In evidence, the Department of Health and Social Care (DHSC) said there had been an increase in elective activity, but activity levels were still lower than planned – the 2022 Elective Recovery Plan envisaged they would be 30 per cent higher by 2024-25. The DHSC said this had been due to slower productivity recovery, in part due to industrial action. NHS analysis estimated that the waiting list could have fallen by an extra 430,000 from December 2022 to March 2024 without strikes.

2.31 In evidence, The Department of Health in Northern Ireland said that waiting times for elective care services in Northern Ireland were among the worst in the UK. It said they were unacceptable and had significantly increased in recent years. This was due to the scale of the gap between funded health service capacity and patient demand and the impact of the wider financial position.

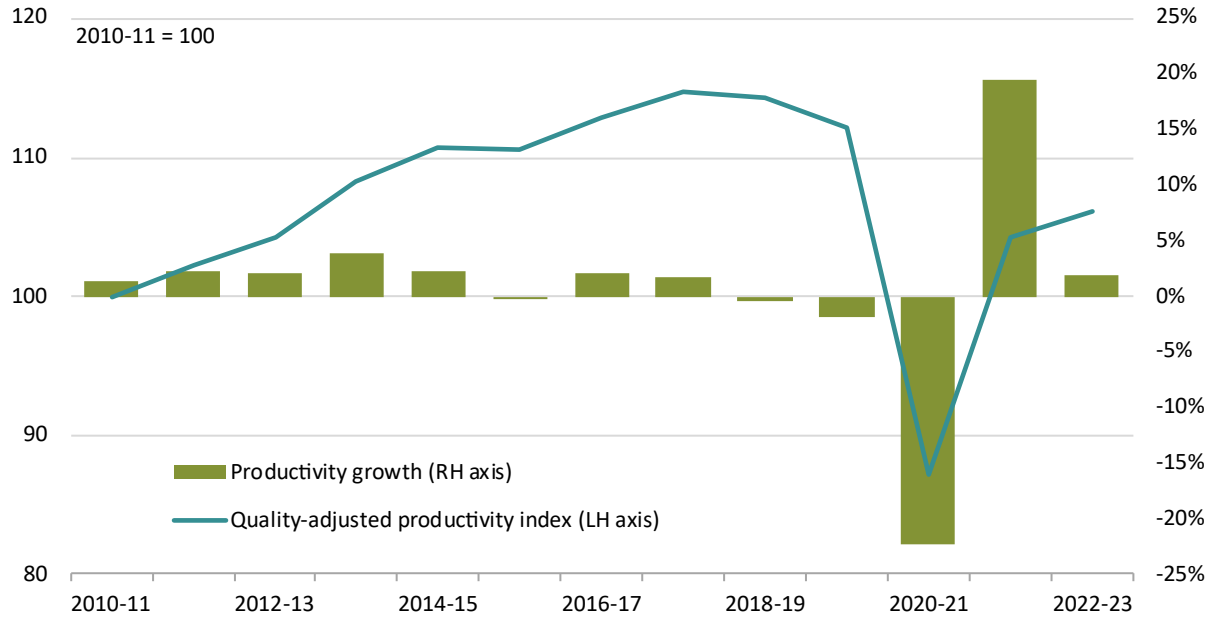
NHS productivity

2.32 Public service healthcare productivity is estimated by comparing growth in the total quantity of inputs used, such as staff, drugs and capital investment, with growth in the total quantity of healthcare output provided, such as A&E attendances or GP consultations, using inflation-adjusted volume measures.

2.33 Productivity can be adjusted to reflect the quality of outputs i.e. patient outcomes such as mortality rates. On this measure, quality-adjusted healthcare productivity grew by 12.1 per cent between 2010-11 and 2019-20 (1.3 per cent a year on average). Quality-adjusted healthcare productivity fell sharply in 2020-21, by 22.3 per cent, driven by the large increase in pandemic-related input but a fall in overall output. There was then recovery in 2021-22 and, to a lesser extent, in 2022-23, but overall productivity in 2022-23 was still 7.5 per cent below the peak seen in 2017-18.

[9] NHS England, *2025/26 priorities and operational planning guidance*. https://www.england.nhs.uk/publication/2025-26-priorities-and-operational-planning-guidance/

Figure 2.7: Public service healthcare productivity, England, 2010-11 to 2022-23



Source: ONS, Public service productivity, healthcare, England.

Reasons for weak NHS productivity growth

2.34 There was already debate before the pandemic about the poor growth in NHS productivity, which has been heightened by the out-turns since 2020. There have been a number of reports looking at the reasons for weak productivity growth, and multiple factors have been identified:[10]

- The slow flow of patients through hospitals including a lack of staff at critical points for patient flow, which in turn makes it harder to admit new patients.
- Lack of social care capacity, leading to delayed discharges.
- Increased patient acuity, with an ageing population and multiple health conditions, leading to longer length of stay and greater care needs.
- Reductions in bed capacity.
- Lack of diagnostic testing.
- Insufficient revenue funding to meet increasing demands and requirements.
- Lack of investment in capital and technology, so that staff are working with outdated equipment in buildings that are not fit for purpose.
- The composition of the workforce – a lower proportion of experienced practitioners, due to workforce expansion, higher turnover, and an increase in the proportion of staff trained overseas. There are also increased demands on existing clinical staff to train and develop newer staff.

[10] See: Institute for Government, *The NHS productivity puzzle: Why has hospital activity not increased in line with funding and staffing?* https://www.instituteforgovernment.org.uk/publication/nhs-productivity
The King's Fund, *Productivity in the NHS and health care sector*. https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/productivity-nhs-health-care-sector
NHS Providers, *What are the barriers to improving performance and productivity?* https://nhsproviders.org/stretched-to-the-limit/what-are-the-barriers-to-improving-performance-and-productivity
NHS Confederation, *Are people getting less from the NHS?* https://www.nhsconfed.org/articles/are-people-getting-less-nhs
Nuffield Trust, *Productivity in the NHS: what's getting in the way?* https://www.nuffieldtrust.org.uk/news-item/productivity-in-the-nhs-what-s-getting-in-the-way
NHS England, *NHS productivity*. https://www.england.nhs.uk/long-read/nhs-productivity/

- Increasing use of agency staff, in particular to cover sickness absence and industrial action.
- Staff sickness, burnout, low morale and a reduction in discretionary effort.
- Industrial action, leading to the postponement of appointments. NHS England has estimated that the industrial dispute reduced NHS productivity by around 3 per cent in 2023-24.
- A low rate of managers to staff, and managers that have insufficient ability and freedom to make consistent decisions.
- Specific skill shortages.

Improving NHS productivity

2.35 NHS England said it was focused on delivering the benefits of investment in new capacity; improving staff engagement and attendance while focusing on reducing expensive agency costs; improving flow through hospitals; and working with all partners in integrated care systems to ensure there was the right capacity in the right place to care for patients effectively.[11]

2.36 NHS England noted some specific areas of improvement in 2023-24, including 1.2 per cent higher productivity in the acute sector in 2023-24 than in 2022-23, with output (cost weighted activity) being 5.8 per cent higher.

2.37 The new government commissioned Lord Darzi to undertake a review of NHS performance, published in September 2024.[12] The report's recommendation for improvement on productivity included:
- Enhancing operational management, in particular improving the management of patient flow and operational processes.
- Capital investment in modern buildings and equipment.
- Investing in technology, including digital systems and artificial intelligence.
- Re-engaging and empowering NHS staff.

2.38 The DHSC said in evidence that increasing NHS productivity and efficiency remained essential to meet the growing demand for health services to support enduring improvements in performance and ensure financial sustainability. It said the NHS continued to face evolving challenges: the backlog for elective care due to the long-term effects of managing COVID-19; delays in discharge; longer non-elective lengths of stay; high staff sickness; staff vacancies; reliance on agency staff; and industrial action.

2.39 The DHSC noted that recent increases in funding and workforce levels had not yet translated into corresponding improvements in productivity. The 2 per cent productivity growth target aimed to address this gap. It said that, to realise this target, sustained reform was essential. A number of specific policies were proposed:
- Controlling spending on temporary staffing.
- Delivery of the same care in lower cost settings.
- Expanding the workforce with a diverse range of professional roles.
- Upskilling and retaining staff.
- Reducing the administrative burden on clinicians through technological advancement.
- Prioritising preventive care to reduce costly admissions.

[11] NHS England, *NHS productivity*. https://www.england.nhs.uk/long-read/nhs-productivity/
[12] Lord Darzi, *Independent Investigation of the National Health Service in England*. https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england

Productivity targets for 2025-26

2.40 In its operational planning guidance for 2025-26, NHS England said that providers needed to live within the budget allocated, reducing waste and improving productivity. This included:

- Delivering a balanced net system financial position for 2025-26.
- Reducing agency expenditure as far as possible, with a minimum 30 per cent reduction on current spending across all systems.
- Closing the activity/whole time equivalent gap against pre-COVID-19 levels.

2.41 NHS England said that providers needed to reduce their cost base by at least 1 per cent and achieve 4 per cent overall improvement in productivity before taking account of any new local pressures or dealing with non-recurrent savings from 2024-25. It said that integrated care boards and providers must demonstrate that all productivity and efficiency opportunities had been exhausted before considering where it was necessary to reduce or stop services.

2.42 It also said that, given the more focused set of national priorities, the DHSC and NHS England would reduce in size and reprioritise resources to support frontline services and improvements in productivity.

2.43 On 13 March 2025, the Secretary of State for Health announced that NHS England would be brought back into the DHSC.[13] This reform was expected to free up capacity, deliver savings of hundreds of millions of pounds a year, and give more power and autonomy to local leaders and systems.

2.44 The Department of Health in Northern Ireland said that, to reduce waiting list backlogs, it would be necessary to address elective care on three levels: through new sustainable, recurrent investment to increase capacity; through improved productivity and efficiency to increase capacity using existing resources; and through temporary, non-recurrent, investment in activity to clear the waiting list backlog.

2.45 The British Medical Association (BMA) agreed that productivity needed to improve in the NHS but said that the already stretched and overworked workforce was not to blame. It said that antiquated IT systems, poor working conditions, systemically poor workplace cultures, the backlog of care, fragmented systems and managerial over-complexities were all contributing to NHS inefficiencies. It did not want pay awards to be linked to productivity increases.

Health spending

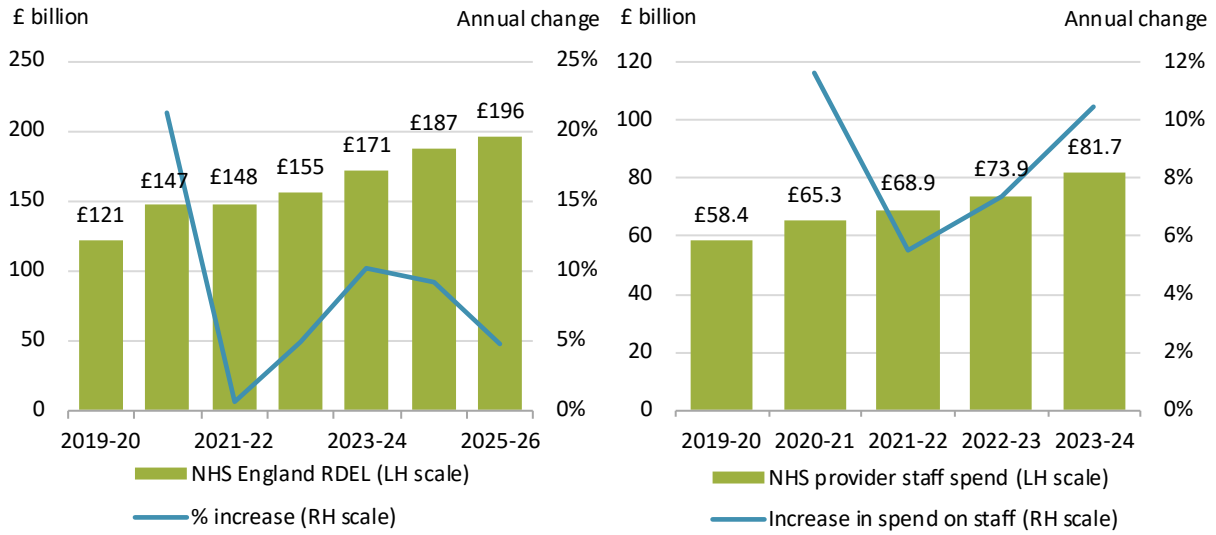
2.46 Total resource funding for the NHS was set at £195.6 million for 2025-26, an increase of 4.7 per cent on 2024-25.[14] The Spring Statement set out a nominal increase in health capital spending of 17 per cent, to £13.6 billion for 2025-26.[15]

[13] DHSC, *World's largest quango scrapped under reforms to put patients first*. https://www.gov.uk/government/news/worlds-largest-quango-scrapped-under-reforms-to-put-patients-first

[14] DHSC, *2025 to 2026 financial directions to NHS England* https://www.gov.uk/government/publications/2025-to-2026-financial-directions-to-nhs-england/2025-to-2026-financial-directions-to-nhs-england

[15] HM Treasury, *Spring Statement 2025*. https://www.gov.uk/government/publications/spring-statement-2025-document

Figure 2.8: Mandate funding for NHS England and NHS spend on staff, England, 2019-20 to 2025-26



Source: DHSC.

Notes: NHS England (RDEL) cash excluding ringfenced spending.

Spend on staff includes permanent and bank staff and excludes agency spend.

2.47 The DHSC said that the final spend position for the NHS (commissioners and providers in aggregate) showed a deficit of £1.31 billion in 2023-24, which was a marked deterioration on the £450 million deficit in 2022-23. It said that recent pay awards and pension costs had resulted in significant pressures on planned 2024-25 budgets.

2.48 The proportion of resource expenditure spent on staff increased from 46.9 per cent in 2021-22 to 49.2 per cent in 2023-24. The cash increase in staff costs was 10.5 per cent between 2022-23 and 2023-24. This will have been driven by a combination of pay growth and increased workforce numbers.

2.49 NHS England reported in February 2025 that systems had delivered £5.7 billion of savings at December 2024, which was £0.4 billion lower than planned.[16] This compared to £4.8 billion of efficiencies delivered at the same point last year. Overall workforce levels had reduced by 0.6 per cent since the end of the 2023-24 financial year. NHS England said spending on agency staff was lower than at any point in recent years and as a percentage of total pay was lower than at any point since at least 2017. Cash spending on agency staff was forecast to be £2.1 billion in 2024-25, a reduction of £1.4 billion (38 per cent) from 2022-23.

2.50 In evidence, NHS England said that the NHS would not be able to make material investments in new services and meet all its pressures from the 2 per cent increase in real terms funding [for 2025-26], including the usual growth in capacity that was necessary to meet demand growth. It said it was possible that some services would see real terms cuts in funding and activity after allowing for the pay settlement, depending on its scale.

2.51 The Scottish Budget set the overall spending for health and social care at £20.2 billion in 2025-26, a nominal increase of 5.9 per cent on 2024-25.[17] The Scottish Government said that funding to health boards would be £16.2 billion in 2025-26. This represented a 3 per cent cash

[16] NHS England, *Financial performance update*. https://www.england.nhs.uk/long-read/financial-performance-update-4/
[17] Scottish Government, *Scottish Budget 2025 to 2026 table A.07*. https://www.gov.scot/publications/scottish-budget-2025-2026/

uplift and a 0.6 per cent real terms increase. This included a minimum of 3 per cent recurrent savings for NHS boards. However, IFS analysis has shown that, due to late changes to the 2024-25 out-turn budget, the growth in health spending in Scotland will be essentially unchanged in real terms in 2025-26.[18]

2.52 The Welsh Government said that high inflation had placed substantial strain on its budget for 2022-23 to 2024-25, significantly eroding the settlement provided in October 2021. It said that the funding environment for public services in Wales remained highly challenging. The Welsh Government's resource budget was expected to be 3 per cent higher in 2025-26 than in 2024-25. A multi-year Spending Review would be published in Spring 2025. The draft Budget in Wales set the resource budget for health and social care at £11.9 billion for 2025-26, a nominal increase of 3.8 per cent on 2024-25.[19]

2.53 The Northern Ireland Budget for 2024-25 initially cut health funding by 2.3 per cent (to £7.8 billion) compared to expenditure in 2023-24. The Department of Health implemented over £200 million of savings measures. Despite implementing these savings, and receiving £472 million additional in-year funding, the Department was still forecasting a shortfall of £100 million.

2.54 The Northern Ireland Executive received an additional £609.3 million RDEL and £30.4 million capital DEL for 2024-25 from the UK Budget in October 2024. Coming on top of the £308.9 million of additional Barnett consequential funding received from the Spring Budget and Westminster Main Estimates, this made a total of £918.2 million additional RDEL funding in 2024-25. Despite this additional funding, Northern Ireland departments had spending overcommitments of £180 million for 2024-25. Evidence from the Department of Health said that overspend was not an option and departments faced difficult choices, including on public sector pay awards, as they took action to live within their agreed budget allocation. The Department said that Northern Ireland could not expect the same levels of additional funding to be provided in-year in 2025-26 as in 2024-25, and the financial position for 2025-26 remained equally as challenging.

2.55 It was also likely that the additional funding provided by HM Treasury for changes to national insurance would fall short of the level needed to address the increased costs to the public sector in Northern Ireland. Therefore, the 2025-26 budget outcome was anticipated to be extremely challenging for all departments. At the time of receiving evidence, a budget for Northern Ireland departments had not been set for 2025-26.

Affordability

2.56 In economic evidence to the pay review bodies, HM Treasury said that the spending envelope for the parliament and departmental budgets for 2025-26 had been fixed, and the government was committed to living within them. It noted that each additional 1 percentage point pay increase across all review body workforces cost an estimated £2.1 billion a year.

2.57 It said that departments would not be given additional funding for pay awards in 2025-26, should the review body recommendations exceed what departments could afford. If recommendations were above the level provisioned for, departments would need to reflect carefully on whether these additional costs could be borne either through offsetting savings on non-pay expenditure, including on frontline services, or through further productivity gains. It said the justification for the recommendations would need to be carefully weighed against

[18] IFS, *The IFS Scottish Budget Report – 2025–26.* https://ifs.org.uk/publications/ifs-scottish-budget-report-2025-26
[19] Welsh Government, *Draft Budget 2025 to 2026*. https://www.gov.wales/draft-budget-2025-2026

the impacts on other priorities. Departments would also need to consider the impact on their budgets of recurring pay costs beyond 2025-26.

2.58 HM Treasury said that the 2025-26 Reserve would only be available for genuinely unforeseen, unavoidable, and unabsorbable pressures. It noted that, in recent years, pay awards had also been funded by switching funding from capital budgets into resource budgets. The government had changed the fiscal rules to remove the incentive to make these kinds of switches and would be changing the guidance to explicitly rule them out.

2.59 In the medium to long term, HM Treasury said real terms pay increases were only sustainable if they were matched by productivity gains. Departments would be able to fund pay awards above inflation over the medium term if they became more productive, whether that was through driving better value from existing programmes or cutting areas of wasteful or inefficient spending.

2.60 The DHSC said it had set aside 2.8 per cent for pay for DDRB (and NHS Pay Review Body) remit groups. The DHSC viewed this as a reasonable amount based on the macroeconomic data and forecasts and taking into account the fiscal and labour market context.

2.61 The DHSC said that, in recent years, the government's affordability number had lost credibility, and the DDRB's recommendations were consistently above affordability. It said that, from now onwards, the government would set out a credible figure both to the review body, and to the NHS, to allow integrated care boards to plan ahead of the review body recommendations to support robust system financial planning.

2.62 It said that, in doing so, the government would need to factor in the fiscal and economic context, as well as a realistic estimate of the eventual uplift. It said this should end the period where the government's affordability number was seen as a floor for the review body recommendations. This approach should mean that in some years recommendations might be below the level of affordability, and sometimes slightly above, depending on other factors the review body considered. Accepting recommendations above what was budgeted for would mean stark trade-offs against activity and wider budgets or consideration as to whether productivity improvements could unlock further funding.

2.63 In its operational guidance for 2025-26, NHS England said that, while there was real-terms growth in the NHS budget, it must cover final pay settlements, increased employer national insurance contributions, faster improvement on the elective waiting list and mandated new treatments. Overall, it said this meant NHS organisations would need to reduce their cost base by at least 1 per cent, and achieve 4 per cent improvement in productivity, to deal with demand growth.

2.64 In evidence, NHS England said it proposed to set allocations for NHS planning on the basis of a 2.8 per cent pay settlement. It said that every 0.5 per cent increase above that would cost around £700 million [across the NHS workforce], which was the equivalent to around 2 per cent of elective activity (greater than 300,000 completed patient pathways).

2.65 NHS England said that pay awards above what had been allocated for would require further tough re-prioritisation of the decisions already made, significantly impacting patient care and making the day-to-day job of NHS staff even harder. It said the decision on headline pay awards was highly material to the affordable level of growth (or reduction) in NHS staffing and capacity to deliver planned activity or service improvements.

2.66 NHS Providers said that, despite a comparatively generous settlement for health in the October Budget, it was not yet clear whether trusts would stand to benefit from the significant funding uplift to day-to-day spending or how this uplift would be allocated across the health service. There were significant in-year pressures (such as the recurrent costs of the NHS pay awards), and manifesto commitments (e.g. 40,000 new appointments) which would likely absorb a sizeable portion of the revised settlement.

2.67 NHS Providers also noted that the Budget increased employer national insurance contributions from 13.8 per cent to 15 per cent from April 2025. While HM Treasury had assured the public sector that its costs would be covered, the detail on how this would be done was unclear. It noted that social and primary care providers would not have their national insurance costs covered, which was likely to impact their staffing positions, with consequences for secondary care demand.

2.68 The Scottish Budget noted that spending on workforce pay accounted for over half of the entire resource budget. It said that Scotland's public sector was relatively larger and better paid than the rest of the UK. As the Scottish Government's budget was primarily dictated by the levels of spending in the rest of the UK, and with relatively more public sector workers in Scotland, as well as higher pay for public sector workers, this placed a structural pressure on budgets.

2.69 The Scottish Government said that its 2025-26 budget included provision for a 3 per cent pay uplift across all portfolios including health and social care. It said that plans around pay in 2025-26 needed to be balanced against its continued commitment to no compulsory redundancies and developed in a manner that ensured health and social care services in Scotland could deliver high levels of public service on a sustainable financial basis.

2.70 The Scottish Government published its 2025-26 public sector pay policy in December 2024. This set out multi-year pay metrics of a 9 per cent pay envelope covering 2025-26, 2026-27 and 2027-28. It said this was set against an inflation forecast of 7 per cent, ensuring a level of pay restoration.

2.71 The expectation set out in the pay policy was that public sector employers would negotiate multi-year deals with trade unions and staff representatives. Any employer that did not agree a three-year pay deal would be restricted to a maximum 3 per cent pay uplift for 2025-26. Any costs beyond those budgeted would result in additional system and financial pressure.

2.72 The Scottish Fiscal Commission said that the changes to employer national insurance contributions added to the pay cost pressures as the compensation from the UK Government was unlikely to fully cover the cost.[20] It said that the combined risks for the budget from pay deals, the size of the workforce, and national insurance contributions were significant and might be difficult to manage.

2.73 The Welsh Government said that additional consequential funding was provided by the UK Government in 2024-25, which, alongside its own fiscal planning, meant that the above-inflation awards recommended by the pay review bodies could be funded. It said that, in the Autumn Budget, the UK Government made clear that departmental settlements would need to fund the next round of pay awards.

[20] Scottish Fiscal Commission, *Scotland's Economic and Fiscal Forecasts – December 2024.* https://fiscalcommission.scot/publications/scotlands-economic-and-fiscal-forecasts-december-2024/

2.74 In supplementary evidence, the Welsh Government said it had provided a 1.77 per cent uplift across the full allocation [i.e. funding to health boards], which equated to around £150 million. It had confirmed to the Welsh NHS that it would support the likely pay and pension increases needed for the NHS.

2.75 In oral evidence, the Welsh Government said it had a long-standing position that it did not give a proposal for the pay recommendation, or what was affordable, as that would go against the DDRB being independent. Anything above what was allocated in the budget for pay would need to be found from other areas of the health budget.

2.76 The Department of Health said that the current budgetary uncertainty in Northern Ireland had obvious consequences for pay planning and policy. It was anticipated that the future funding position would not significantly improve, with potential that budgets might be reduced due to overspending in 2024-25. It said there would be no capacity to afford a pay uplift in 2025-26 without implementing corresponding cuts to expenditure on services or additional funding being made available in-year. The latter would then perpetuate the funding issue into the future.

2.77 The Department said it was too early to say what the approach to pay setting for 2025-26 would be. This would be influenced by the UK Government's approach to pay, and dependent on the broader budget position. In oral evidence, the Department of Health said that an uplift of 2.8 per cent had been built into plans for 2025-26, reflecting affordability set in England. This meant trusts would need to make cuts to services and increase productivity. Recommendations above this would mean that trusts would need to make significant further cuts.

2.78 In oral evidence, the Hospital Consultants and Specialists Association (HCSA) said that the 2.8 per cent value was an aspiration by government and the DDRB should be independent of it. The HCSA said that the DDRB did not need to consider affordability, and that the government would need to find the money.

2.79 In oral evidence, the BMA consultants committees said that 2.8 per cent was a political choice, not an external necessity, and that funding for pay should not be at the expense of other parts of the NHS budget. They also said that affordability was not the DDRB's concern, and the government needed to worry about it after the recommendation was made.

Workforce planning

2.80 NHS England published the NHS Long Term Workforce Plan in June 2023.[21] This said the number of medical school places was required to increase by 60 to 100 per cent, 12,000 to 15,000 places, by 2030-31. This would begin with an increase in medical school places from 7,500 in 2022 to 10,000 by 2028-29.

2.81 The Plan said that there would need to be a 45 to 60 per cent increase in the number of GP specialty training places by 2033-34, with the aim of increasing the number of places from 4,000 in 2022 to 6,000 by 2031-32. The first expansion of 500 places would take place in 2025-26. There would also need to be expansions to foundation and specialty training, commensurate with the growth in undergraduate places. Under the Plan, training programmes for dentists would expand by 40 per cent by 2031-32; this would lead to the number of dental training places increasing from 809 to 1,133.

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

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

2.83 In oral evidence, NHS England said that the forthcoming 10-year plan for the NHS would set out the government's three shifts – hospital to community, treatment to prevention, and analogue to digital. A refreshed workforce plan would follow this and would need to align with financial and service planning.

2.84 In oral evidence, the DHSC said that the workforce could not just be expanded as it was. The shape of the workforce, their skills, and productivity assumptions were likely to change in a refreshed workforce plan. It expected that the 10-year plan would rebalance growth and set out a change in where doctors were required. The move to a community health service would encompass not just GPs in the community, but specialists as well.

2.85 In oral evidence, NHS England said that the government agreed with the focus in the original workforce plan on reducing the reliance on international graduates and temporary staff. It said a sustainable domestic workforce supply was important, as some specialisms currently needed to recruit half of their staff from overseas. It said that the reliance on international medical graduates was not sustainable given the expected increase in demand for global healthcare, especially if the USA and Canada could no longer internally sustain the number of doctors they needed.

2.86 NHS Employers said that any refresh of the workforce plan should be supported by sustainable funding. There would also need to be more explicit recognition of the role that pay and reward must play in the delivery of the three shifts and the attraction, recruitment, retention, morale and motivation of staff. NHS Employers said that, while the workforce plan had clear goals for staff recruitment into the NHS, the range of measures needed to better retain existing staff had been more difficult to secure, with high vacancy rates continuing across the medical and wider NHS workforce.

2.87 NHS Providers noted the importance of a robust plan for the educator workforce in the NHS. The BMA called for an expansion of clinical academic posts to ensure that there were sufficient clinical academics to teach and train the increased number of medical students and doctors.

2.88 Scotland's National Workforce Strategy for Health and Social Care was published in March 2022. This included a commitment to increase the number of GPs by 800 by 2027. The Scottish Government said it had made significant progress in a number of areas. It remained committed to providing a fuller update to the strategy at an appropriate time.

2.89 The BMA said it continued to be deeply worried about the lack of comprehensive workforce planning for the NHS in Scotland.

2.90 The Welsh Government said it was essential to develop a long-term workforce plan for Wales. It said this was multi-faceted and would require a coordinated, collaborative, whole system approach. The National Workforce Implementation Plan was published in 2023 and outlined a series of immediate actions to address some of the key workforce challenges. The Welsh Government said that, while the actions contained in the National Workforce Implementation

Plan had mostly been completed, the plan was not designed to address every workforce challenge but to serve as a foundational step towards initiating meaningful improvements. There were eight National Strategic Workforce Plans across NHS Wales, including one for primary care and one for dentistry.

2.91 The BMA raised concerns that work on a long-term workforce plan for health and social care in Wales had not yet been started. It said this was a crucial and fundamental piece of work, needed to address the long-term challenges and ensure sustainability of the medical workforce in Wales.

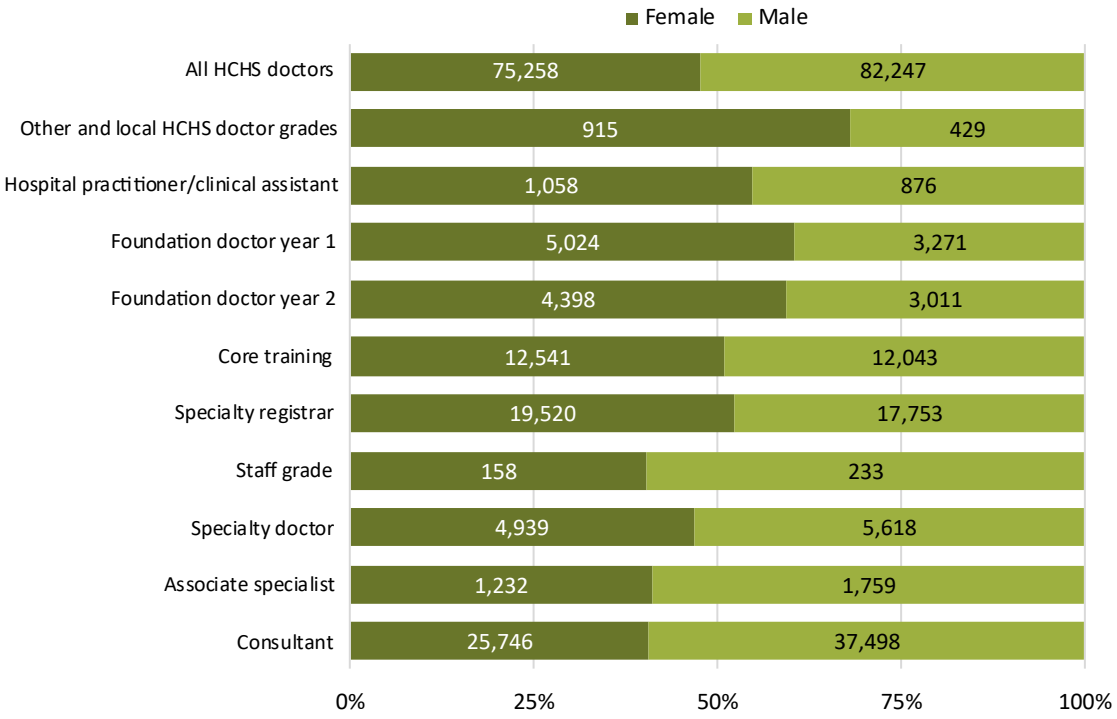
2.92 The Department of Health in Northern Ireland said that effective workforce planning was complex and challenging but was essential to contribute to ensuring services were both sustainable and delivered to the appropriate standard. The *Health and Social Care Workforce Strategy 2026* was published in May 2018, with the aim to meet workforce needs by 2026. The Strategy's second action plan was published in June 2022, with a range of strategic actions for progression over the period 2022-23 to 2024-25. Progress included an increase in both pre- and post-registration medical training places. A rolling programme of medical specialty workforce reviews was ongoing.

Workforce equalities and diversity

Secondary care

2.93 In December 2024, 48 per cent of medical and dental hospital and community health service (HCHS) staff in England were female. Although a majority of doctors and dentists in training were female, in the more senior positions, 41 per cent of associate specialists and consultants were female.

Figure 2.9: HCHS doctors and dentists, England, by gender and grade, December 2024, headcount



Source: NHS England.

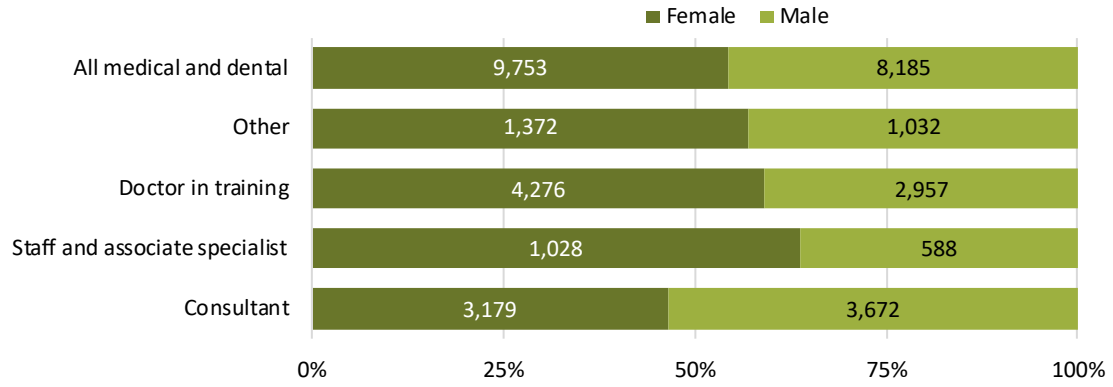
2.94 The proportion of medical and dental staff that were female increased by 2.4 percentage points (from 45.4 per cent to 47.8 per cent) between September 2019 and December 2024. There were increases across most grades over this period, with a small fall, of 0.4 percentage points in the proportion of specialty doctors that were female. Foundation doctors and consultants saw the largest growth in the proportion that were female.

2.95 In Scotland, 54.4 per cent of medical and dental staff were female in December 2024. At all grades a majority of staff were female, except at consultant, where 46.4 per cent were female. The proportion of staff that were female increased by 1.6 percentage points, from 52.8 per cent to 54.4 per cent, between 2019 and 2024.

2.96 In Wales, 46.9 per cent of medical and dental staff were female in September 2024, an increase from 46.0 per cent in September 2023, and from 45.7 per cent in September 2022.

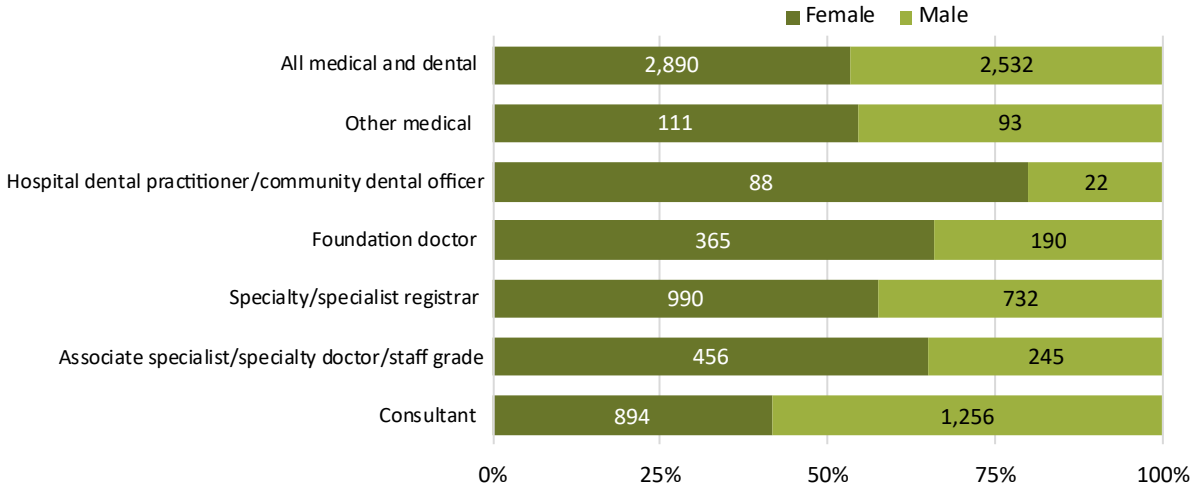
2.97 In Northern Ireland, 53.3 per cent of medical and dental staff were female in 2024. At all grades, a majority of staff were female, except at consultant, where 41.6 per cent were female. The proportion of staff that were female increased by 8.8 percentage points (from 44.5 per cent to 53.3 per cent) between 2019 and 2024. The percentage of staff that were female increased at every grade, by at least 5.4 percentage points.

Figure 2.10: HCHS doctors and dentists, Scotland, by gender and grade, December 2024, headcount



Source: NHS Education for Scotland.

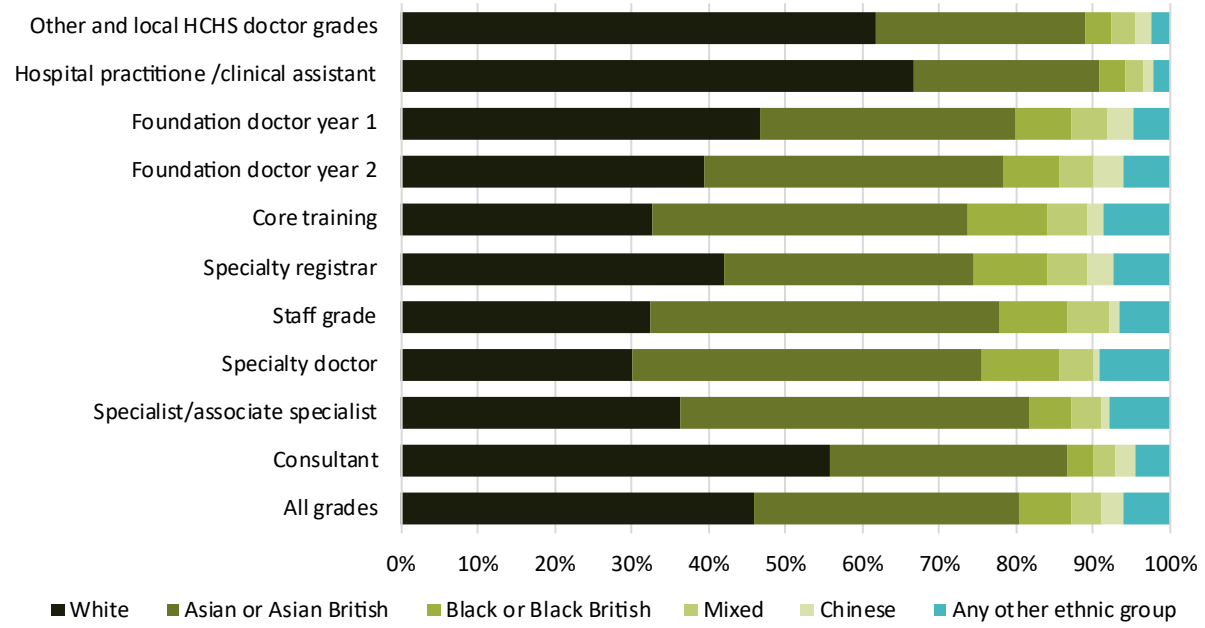
Figure 2.11: Health and Social Care doctors and dentists, by gender and grade, Northern Ireland, March 2024, headcount



Source: OPRB calculations based on data from Northern Ireland health and social care workforce census.

2.98 In December 2024, 45.8 per cent of HCHS medical and dental staff in England were White; 34.6 per cent were Asian or Asian British; 6.8 per cent were Black or Black British; 4.1 per cent had mixed ethnicity; 2.6 per cent were Chinese; and 6.2 per cent were from any other ethnic group.

Figure 2.12: HCHS doctors and dentists, England, by ethnicity and grade, December 2024, headcount



Source: NHS England.

2.99 Between September 2019 and December 2024, the proportion of HCHS medical and dental staff in England that were: Asian or Asian British increased by 4.7 percentage points (from 29.9 per cent to 34.6 per cent); Black or Black British increased by 1.9 percentage points (from 4.8 per cent to 6.8 per cent); any other ethnic group increased by 1.7 percentage points (from 4.5 per cent to 6.2 per cent); mixed ethnicity increased by 0.8 percentage points (from 3.3 per cent to 4.1 per cent); Chinese was unchanged (at 2.6 per cent); The proportion of White staff decreased by 9.1 percentage points (from 54.9 per cent to 45.8 per cent). The largest falls in the percentage of White staff, and the largest increases in the percentage of staff from all other ethnic groups, were in the least senior grades: foundation year 1; foundation year 2; and core training. The smallest changes were at the more senior levels: consultant and associate specialist.

2.100 In Wales, in September 2024: 48.3 per cent of medical and dental staff were White; 22.2 per cent were Asian/Asian British; 4.9 per cent were Black/African/Caribbean/Black British; 2.5 per cent were mixed/multiple ethnic groups; and 6.3 per cent were from other ethnic groups. There was no information on ethnicity for 15.9 per cent of staff. Compared with September 2022, the proportion of staff for whom there was no information decreased by 19.5 percentage points.

2.101 We do not have data on the ethnicity of medical and dental staff in Scotland or Northern Ireland.

2.102 In December 2024, 3.4 per cent of HCHS medical and dental staff in England said that they were disabled, compared with 7.1 per cent of all NHS staff. Foundation year 1 (6.7 per cent) and foundation year 2 (5.7 per cent) doctors were more likely to say they were disabled than

other medical and dental grades. There was no disability data for 17.8 per cent of HCHS doctors, compared with 11.9 per cent of all NHS staff.

2.103 Between September 2019 and December 2024, there was an increase in the proportion of HCHS medical and dental staff in England at all grades saying they were disabled, and an increase in the percentage saying they were not disabled, as the percentage of HCHS doctors with no known disability status fell from 28.4 per cent to 17.8 per cent.

2.104 In December 2024, 73.7 per cent of HCHS medical and dental staff in England were heterosexual or straight; 1.9 per cent were gay or lesbian; 1.2 per cent were bisexual; 0.1 per cent were undecided; and 0.1 per cent said their sexual orientation was not listed. No information was available for 23.2 per cent of medical and dental staff. Information on sexual orientation was available for a greater percentage of the workforce at all medical and dental grades in December 2024 (76.8 per cent) than in September 2019 (63.1 per cent). Information was more likely to be available for doctors and dentists in training than for more senior grades.

2.105 In December 2024, 23.8 per cent of HCHS medical and dental staff in England had Christian beliefs; 16.8 per cent had Islamic beliefs; 14.4 per cent were Atheists; and 10.5 per cent were Hindus. No information on religious belief was available for 27.2 per cent of medical and dental staff. Compared with NHS staff as a whole, medical and dental staff were more likely to be Muslims and Hindus, but less likely to be Christians. The percentage of HCHS doctors and dentists for whom there was no information fell from 39.9 per cent in September 2019 to 27.2 per cent in December 2024.

Primary care

2.106 Across primary care, women make up more than half of the medical and dental workforce, and the share is increasing. Female GPs made up 58.4 per cent of the GP workforce on a headcount basis in England in February 2025, up from 56.9 per cent in March 2020. On a full-time equivalent basic, female GPs made up 53.7 per cent of the workforce in February 2025, up from 51.5 per cent in March 2020.

2.107 In Scotland, the proportion of headcount GPs that were female increased from 59.4 per cent in 2019 to 62.4 per cent in 2024. On a full-time equivalent basis, the proportion of female GPs increased from 53.4 per cent in 2019 to 57.6 per cent in 2024. In Wales, female GPs made up 57.3 per cent of fully qualified GPs on a headcount basis in September 2024, a small reduction from 57.9 per cent in September 2021. In Northern Ireland, female GPs made up 60.5 per cent of the GP workforce on a headcount basis in 2024, up from 56.4 per cent in 2019.

2.108 Female general dental practitioners (GDPs) made up 53.7 per cent of the GDP workforce on a headcount basis in England in 2023-24, up from 50.6 per cent in 2019-20. In Scotland, female GDPs made up 56.1 per cent of the GDP workforce on a headcount basis in March 2024, up from 52.5 per cent in March 2019. In Wales, female dentists made up 51.4 per cent of the GDP workforce on a headcount basis in 2023-24, up from 47.6 per cent in 2019-20. In Northern Ireland, female dentists made up 59.6 per cent of the GDP workforce on a headcount basis in 2024, up from 56.5 per cent in 2019.

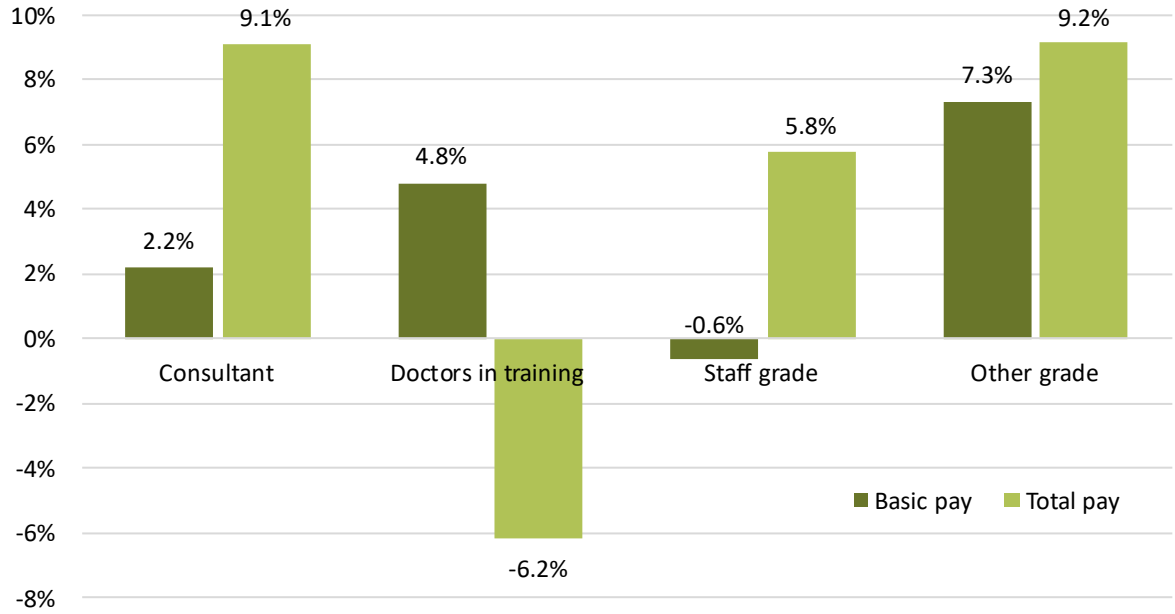
Gender pay gaps in secondary care

2.109 NHS England quoted ASHE data in evidence showing that the gender pay gap for doctors had reduced from 20.9 per cent in 2018 to 5.5 per cent in 2023. More recent data indicates a 9.9 per cent gender pay gap for medical practitioners in 2024.[22]

2.110 NHS England said it planned to build on its commitment to address the gender pay gap by asking all lead employers of postgraduate doctors in training to report annually on ethnicity and gender pay gaps.

2.111 The Scottish Government provided evidence on the gender pay gap by broad workforce group. This shows positive, but not large, gaps for most groups, favouring men, with an exception being total earnings for doctors in training.

Figure 2.13: Gender pay gap, Scotland, 2023-24



Source: Scottish Government.

Notes: Excludes temporary (bank and agency) staff.

Average basic pay is calculated as aggregate basic pay divided by aggregate year whole time equivalent. Average total pay is calculated as aggregate total pay divided by aggregate year whole time equivalent.

The gender difference in average basic and total pay uses the male amount as the starting point, so a positive difference means the male amount is higher than the female amount.

2.112 The DHSC said that an independently chaired Gender Pay Gap in Medicine Implementation Panel was established in 2021 to drive delivery of the 47 recommendations from the Dacre Report. No further update was provided.

2.113 The DHSC said that the reforms to the consultant pay contract, with a reduction in the number of pay points (from eight to five), and in the amount of time taken to reach the top of the pay scale (from 19 to 14 years), were expected to help to reduce the gender pay gap in the medium term.

[22] ONS, *Gender pay gap in the UK: 2024*. https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/bulletins/genderpaygapintheuk/2024

2.114 The HCSA said that the equalities impact of new pay progression pathways for consultants would need to be carefully monitored, including the potential for unconscious bias or direct discrimination in the review meetings that were mandatory for pay progression.

2.115 In oral evidence, NHS Employers highlighted that the long tail of pensionable local clinical excellence awards (CEAs), which mainly went to white men, would continue to impact the gender pay gap. NHS Providers agreed with this, pointing out that the gender pay gap was more of an issue when bonuses were included, driven by legacy local CEAs.

2.116 The BMA highlighted the changes agreed at the end of 2023 to the terms and conditions of service for consultants in Wales. Those whose training had been lengthened because they had trained less than full time, had undertaken a dual qualification, or had their training disrupted due to COVID-19, would be credited with additional seniority when appointed as consultants in Wales. It said this was likely to benefit female consultants.

2.117 The HCSA highlighted how frequent rotation and time away from family in training roles could make locally employed doctor roles appeal to those with caring responsibilities. It said that one of the most common reasons for taking time out of training was maternity leave.

Gender pay gaps in primary care

2.118 Average earnings of female contractor GPs were lower than those of male contractor GPs in each nation in 2022-23, by 23 per cent in Northern Ireland, 20 per cent in both Scotland and Wales, and 19 per cent in England. The pre-tax income gap narrowed in each nation between 2017-18 and 2022-23, except in Wales where there was little change. The gap widened in Northern Ireland in the latest year of data. This data does not adjust for working hours.

2.119 Average earnings of female salaried GPs in 2022-23 were lower than those of male salaried GPs in each nation, by 32 per cent in Wales, 29 per cent in Northern Ireland, 25 per cent in Scotland, and 24 per cent in England. In England, Scotland and Northern Ireland, the gap between male and female average incomes narrowed between 2017-18 and 2022-23, but it widened notably in Wales. Again, this data does not adjust for working hours, which may be driving much of the difference.

2.120 In England, Scotland and Northern Ireland, average pre-tax incomes of female providing-performer dentists were lower than those of male providing-performers in 2022-23, by 16 per cent, 14 per cent, and 22 per cent respectively. In Wales, in both 2021-22 and 2022-23, average pre-tax incomes for female providing-performer dentists were 2 per cent and 4 per cent higher respectively than those for male providing-performers.

2.121 Average pre-tax incomes of female associate dentists in 2022-23 were lower than those of male associates by 33 per cent in Northern Ireland, 27 per cent in both Scotland and Wales, and 25 per cent in England. In Scotland, Wales and Northern Ireland, the gap between male and female average incomes increased between 2019-20 and 2022-23, while the gap narrowed in England over the same period.

Ethnicity pay gaps

2.122 Despite the lack of ethnicity pay gap reporting being highlighted as an area of concern by the DDRB, the DHSC said there had been no data collection in 2024. It said this was being addressed by NHS England.

2.123 The HCSA highlighted the higher representation of doctors from ethnic minority backgrounds in the locally employed and SAS workforces and the more limited pay progression available to

these groups. The HCSA welcomed NHS Providers' publication in October 2024 of a guide for employers to tackle ethnicity pay gaps in their organisations.[23] It noted that the recommendations on career development did not address locally employed roles or disparities in the make-up of the medical workforce at different grades.

Socio-economic background

2.124 In last year's report we said that we would like to receive evidence on the socio-economic background of the medical and dental workforces, and how the expansion of training places might be used as an opportunity to increase socio-economic diversity.

2.125 The Sutton Trust published research on this issue in February 2025.[24] Using university admissions data, it found that the proportion of medicine entrants from independent schools decreased between 2012 and 2021, from 31 per cent to 22 per cent (compared to around 7 per cent of students attending independent schools overall). Over the same period, the proportion of non-selective state school entrants increased from 50 per cent to 56 per cent.

2.126 In 2021, individuals from higher socio-economic backgrounds (based on their parents' occupation) made up 75 per cent of entrants to medical schools, while just 5 per cent were from the lowest socio-economic group. While still very low, the proportion of those from lower socio-economic backgrounds had doubled since 2012. The proportion of applicants living in IMD1[25] areas grew considerably from 2012. By 2022, 20 per cent of applicants lived in IMD1 areas (the most deprived neighbourhoods) and 25 per cent of applicants lived in IMD5 areas (the least deprived/wealthiest quintile).

2.127 In 2021, individuals from the highest socio-economic group made up 69 per cent of applicants to medicine, 74 per cent of offer-holders and 75 per cent of entrants, while those from the lowest socio-economic group made up 6 per cent of all applicants, 5 per cent of offer-holders and 5 per cent of entrants.

Table 2.1: Applicants to undergraduate medical schools by socio-economic group, 2012 and 2021

Socio-economic group	2012 Number of applicants	2012 % of applicants	2021 Number of applicants	2021 % of applicants
High	5,480	74%	8,120	69%
Medium	900	12%	1,345	11%
Low	240	3%	680	6%
Unknown	780	11%	1,700	14%

Source: Sutton Trust

Notes: Counts are rounded to the nearest five. Per cent of applicants has a 95 per cent confidence interval of typically 1 percentage point around the estimate.

Socio-economic status was derived from the five-level National Statistics Socio-economic Classification (NS-SEC) groupings of parental occupation (NS-SEC 1 managerial and professional occupations; NS-SEC 2 intermediate occupations; NS-SEC 3 small employers and own account workers; NS-SEC 4 lower supervisory and technical occupations; NS-SEC 5 semi-routine and routine occupations). Sutton Trust re-categorised the five-level variable into a three-level variable (high=NS-SEC 1; medium=NS-SEC 2, 3 or 4; low=NS-SEC 5).

[23] NHS Providers, *Counting the cost: Understanding your ethnicity pay gap, October 2024*. https://nhsproviders.org/media/699509/counting-the-cost-pdf.pdf

[24] The Sutton Trust, *Unequal Treatment?* https://www.suttontrust.com/our-research/unequal-treatment/

[25] Index of Multiple Deprivation quintile 1, the 20 per cent most deprived neighbourhoods.

2.128 From 2012 to 2022, the proportion of applicants, offer-holders and entrants from non-selective state schools grew, and the proportion from independent schools dropped. This was a result of the absolute number of applicants from independent schools staying relatively stable, while numbers grew from the rest of the sector, particularly academy/state schools, further education colleges and sixth form colleges:

- In 2022, independent schools made up 16 per cent of applicants, down from 25 per cent in 2012.
- In 2022, non-selective state schools made up 59 per cent of applicants, up from 53 per cent in 2012.
- The proportion of applicants from grammar schools remained stable over the period, at around 4 per cent.

2.129 Between 2018 and 2021, six new medical schools admitted students for the first time. The Sutton Trust said these were established in areas with relatively few doctors per person, with the specific remit to recruit both locally and from typically under-represented groups. It said that the new medical schools had more balanced state/independent school intakes than established institutions, with only around one in 10 (11 per cent) of entrants independently educated, compared to around one in four (24 per cent) at established centres. However, newer medical schools still had considerable gaps between entrants from higher and lower socio-economic backgrounds, with only 7 per cent of entrants to new medical schools from the lowest socio-economic group and two-thirds (66 per cent) from the highest.

Pensions and retirement

2.130 Significant changes have been made to pension taxation, and the NHS pension scheme, in recent years, with an increase in the pension annual tax allowance, the removal of the lifetime allowance, increased flexibilities around retirement, and a reduction in pension contributions for those earning above £70,630. All of these serve to increase the value of the overall package, increase the incentives to work additional hours, stay in employment, and stay in the pension scheme.

2.131 In evidence, the DHSC shared data which showed that the median annual pension claimed by GPs in 2023-24 was £53,300. For hospital doctors, the median pension was £40,090. Projected annual pensions for doctors qualifying in 2024 and retiring age 65 (in today's monetary terms) were £74,000 for a GP partner, £57,000 for a salaried GP and £80,000 for a consultant.

2.132 The DHSC noted that, while overall pension scheme membership rates remained high, there had been reductions in the membership rates for doctors at some grades, most notably core training. It said this was mainly due to lower membership rates among doctors working in trust grades which might be included in this category, and there had been a substantial increase in the number of doctors employed in these roles. Of these doctors, many held non-British nationality and had lower membership rates than those with UK nationality. Pension scheme membership rates were 89 per cent for UK nationals, 87 per cent for EU nationals. and 66 per cent for those from the rest of the world.

2.133 There was an increase in pension scheme membership among consultants in the year to June 2024, which may be a result of consultants rejoining following the pension tax changes.

Table 2.3: NHS pension scheme membership for the HCHS medical workforce, England, June 2024

Profession	Membership rate	One-year change (percentage points)	Five-year change (percentage points)	10-year change (percentage points)
Foundation year 1	90.3%	-1.1	-4.3	-6.6
Foundation year 2	85.7%	-1.5	-7.6	-10.1
Core training	76.8%	-3.9	-13.7	-17.8
Specialty registrar	87.6%	-1.2	-5.3	-7.2
Specialty doctor	82.3%	-2.5	-6.3	-7.5
Associate specialist	89.6%	0.0	-2.0	-3.2
Consultant	91.8%	2.2	2.1	-1.1
Staff grade	93.5%	5.2	-0.9	2.2
Hospital practitioner and clinical assistant	68.6%	-1.8	-4.5	-12.7
Other and local grades	92.8%	0.7	-2.1	-1.4
All	87.3%	-0.3	-3.8	-6.4

Source: DHSC.

2.134 The DHSC estimated that most doctors and dentists who earnt over £200,000 would effectively have an adjusted income of over £260,000 and so would be subject to the tapered annual allowance. The DHSC said this could create a cliff edge, where a small increase in earnings could trigger the taper and cause a large increase in the tax charge payable. It said this might reduce doctors' willingness to take on additional work, as their income from this work could be significantly offset by pension tax charges.

2.135 The British Dental Association (BDA) said it would prefer a longer-term move towards a flat rate of member pension contributions. The BDA also advocated a system of flexible accrual that would allow members to determine how much pension they built up, coupled with a lower member contribution (and consequently lower levels of income tax relief), and a payment of the unused employer/government contribution as taxable pay.

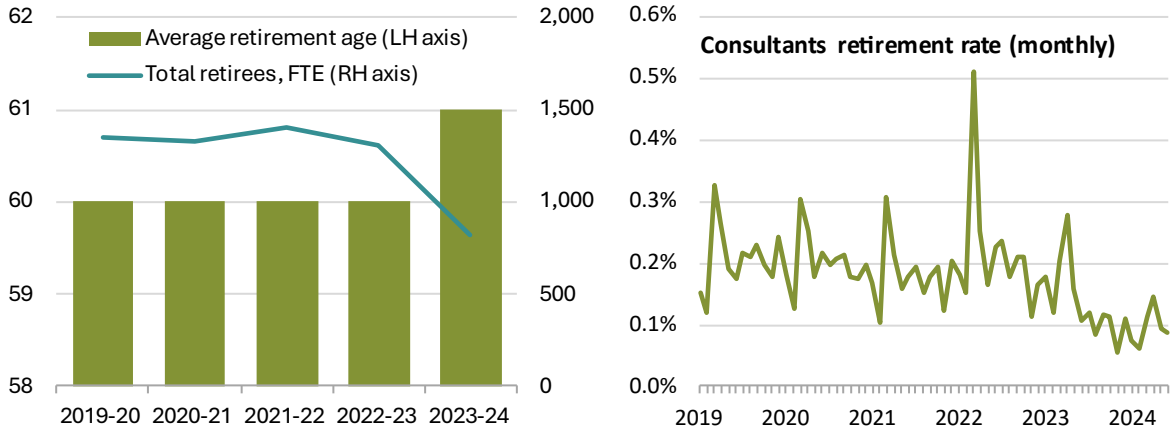
Retirement

2.136 Since 1 October 2023, doctors and dentists in England and Wales 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 per cent. The DHSC said that, as well as supporting doctors and dentists with work/life balance later in their careers, partial retirement could also support NHS employers, by allowing them to retain experienced doctors and dentists for longer. The DHSC said there were 17,972 applications for partial retirement across the NHS by 28 October 2024.

2.137 Pension flexibilities, including partial retirement, were introduced in the HSC from 1 April 2024. The Department of Health in Northern Ireland anticipated that the introduction of partial retirement was likely to have a significant impact on workforce capacity.

2.138 Data from NHS England showed a notable increase in the average retirement age for consultants, from 60 to 61, and a reduction in the numbers retiring.

Figure 2.14: Average retirement age, total retirees, and retirement rate, consultants in England, 2019 to 2024



Source: NHS England.

2.139 In oral evidence, NHS Providers highlighted that pension flexibilities allowed consultants to keep working longer, but they often wanted to take a more flexible role, for example with limited on-call and out-of-hours working.

2.140 The BDA said that the requirement for members to reduce NHS pensionable earnings (or commitment for practitioners) by at least 10 per cent to access flexible retirement was arbitrary, unnecessary, and unjustified and did not maximise the service potential of senior clinicians.

Our comments

The economic context

2.141 Economic growth remains weak. This inevitably curtails the resources the nation has to spend on healthcare. Despite this, the UK Government has committed to a cash increase of 5 per cent in health spending for 2025-26, and a significant uplift in capital spending. However, many trusts have been operating at a financial deficit, there are high waiting lists for treatment across the UK, and the demand for healthcare will continue to grow with our ageing population. The need for additional investment to deliver long-term productivity gains across the NHS is vital to meet our healthcare needs.

2.142 In making our recommendations, we consider trends in average earnings growth and pay settlements across the wider economy which indicate the typical increases being received by other employees and provide a useful reference point for our deliberations. Regular average earnings growth across the whole economy was at 5.9 per cent in the 12 months to January 2025 but was forecast to fall to 3.7 per cent over the 2025-26 financial year. Earnings growth at the top quartile of the earnings distribution, which is a better match for most of our remit group, was around 4.5 per cent. Median pay settlements across the economy were at 3.0 to 3.4 per cent in the first quarter of 2025.

NHS funding and affordability

2.143 The UK Government has said that 2.8 per cent has been set aside for pay increases across the NHS in 2025-26, and any pay award above this will need to be funded from within existing DHSC budgets. The Scottish Government has provisioned for a 3 per cent pay uplift in its 2025-26 budget. The Welsh Government has committed to funding the pay increases needed for

the NHS. In Northern Ireland, the Department of Health has built a pay uplift of 2.8 per cent into its financial plans for 2025-26, reflecting the affordability figure set in England.

2.144 Governments have been clear that pay awards above affordability will result in additional system and financial pressure, and impact patient care and the capacity to deliver service improvements. As we discuss in Chapter 1, affordability remains an important factor we take into account when making our recommendations. Our recommendations each year add substantial costs to the NHS paybill, and we consider the implications for patient care, which is also a factor in our terms of reference, as well as the impact of taking resource away from innovation and investment which are requirements for growing productivity. However, affordability does not serve as a limiting factor, as we have demonstrated over a number of years. Pay needs to be set at such a level to sustain workforce recruitment and retention, to support a motivated workforce, and to ensure the long-term attractiveness of medical and dental careers.

Productivity

2.145 Productivity growth in the NHS has been persistently weak in recent years. Activity measures are only just regaining their pre-pandemic levels, despite the substantial expansion in the workforce. Pandemic backlogs mean millions of people are waiting for treatment and diagnostic tests.

2.146 The sustainability of the NHS is dependent on achieving gains in productivity. This needs to be led by investment in infrastructure and technology. Without this there is a strong risk of not achieving the required efficiency targets that are needed to meet additional demand. As well as investment, there are potential workforce gains to be made through restructuring of some contracts, consultants in particular, to enable better use of incentives for the medical and dental workforce.

2.147 The use of agency and temporary staff has been set out as a target for savings. Gains have been made in other parts of the NHS workforce, and there are commitments across the nations to implement this for medical and dental staff. We have already seen significant falls in the use of locums in general practice. The increased use of permanent and directly employed staff, instead of agency and temporary staff, can deliver better service at lower cost and we support these initiatives.

Workforce planning

2.148 Workforce planning needs to be intrinsically linked to the productivity objectives and the broader shifts required across the NHS. There was little focus on workforce planning in evidence from any of the nations this year. Many of the issues and problems that have been raised with us can be addressed through workforce planning. The NHS is a vast organisation, and this can lead to high-level workforce objectives, without the detailed planning that is required. For example, the Long Term Workforce Plan committed to an increase in undergraduate medical and dental training. But beyond this, there needs to be far better planning around where in healthcare these doctors and dentists are best trained and employed when they graduate to ensure we have the right number in all specialties to meet the needs of the population and to support enhanced productivity. A refreshed workforce plan will also need to be costed, so that appropriate prioritisation can be given to the areas that will deliver the greatest improvements in healthcare outcomes.

2.149 There needs to be work undertaken to align the expectations of doctors in the early parts of their career with the overall needs of the NHS, in terms of where, and in which specialties,

training places are needed. Specific plans need to be prioritised for those specialties where there are most notable shortages, such as psychiatry, and where there has been a reliance on international recruitment to fill training places, such as general practice.

2.150 Capacity will need to be expanded across the system to train our future specialists. Significant concerns have been raised around capacity in GP training practices in particular. As we said last year, we would like to see a greater focus on whether appropriate reward and incentives are in place for experienced members of the medical and dental professions to deliver the required increase in training.

2.151 The DHSC has assured us that there is a high level of co-operation and collaboration between the four nations, and that any future workforce planning, while continuing to be devolved, will reflect this. At the same time, it is hard for us to reconcile the recognised shortage of training places in England with the failure to fill training places in Northern Ireland, for example. There may be a requirement for additional incentives within the training system to support doctors to work in the localities where they are most needed. Similarly, the shortage of doctors and dentists in rural and remote areas, and the subsequent detrimental impact on health outcomes, has been recognised. A targeted workforce plan, aligned with appropriate support and incentives, can address these issues.

Workforce equalities

2.152 Key to understanding gender and ethnicity pay gaps within our remit group is data. It is extremely disappointing that five years after the important Dacre report, we are not seeing regular reporting on gender pay gaps within each grade for hospital doctors and dentists.[26] Valuable detailed data on average pay by gender across specialties was included in the Dacre report. Relying on ASHE data to report on the gender pay gap is inadequate, when reporting average pay for female and male consultants, for example, would be a straightforward task. The progress toward equal pay appears to be slow, although parties have indicated that the recent shortening of the pay scales for consultants will reduce the gender pay gap; we need evidence to see if this has happened. The data published by the Scottish Government provides a useful template for this. We recommend that all nations follow a similar approach.

2.153 Similarly, the progress on publishing ethnicity pay gaps is poor. This would not be difficult to achieve, as the workforce data will allow this. We recommend that all nations publish average earnings by ethnicity and grade for our remit group, where sample sizes allow. We also wish to see data on the ethnicity of the medical and dental workforce in Scotland and Northern Ireland.

2.154 The report from the Sutton Trust on the socio-economic background of undergraduates studying medicine is very welcome. New medical schools have been an opportunity to enhance the diversity of the workforce. We would like to see policy engagement with this issue across all four governments and plans to further develop workforce diversity with any future expansion of medical school places.

[26] UK Government, *Independent review into gender pay gaps in medicine in England*. https://www.gov.uk/government/publications/independent-review-into-gender-pay-gaps-in-medicine-in-england

Chapter 3 The Hospital and Community Health Service workforce

3.1 Hospital and Community Health Service (HCHS) doctors and dentists are those directly employed by NHS trusts and foundation trusts in England, NHS boards in Scotland, health boards in Wales, and Health and Social Care (HSC) trusts in Northern Ireland. This includes resident doctors,[27] specialty, associate specialist and specialist (SAS) doctors and dentists, and consultants, as well as doctors and dentists employed on local contracts. Salaried dentists working in the Community Dental Services or Public Dental Services, most of whom are also part of the HCHS workforce, are discussed in chapter 5.

3.2 This chapter looks at trends in the HCHS medical and dental workforce, recruitment and retention indicators, developments for specific parts of the workforce including earnings and pay comparisons, motivation and morale. Our comments on the data and evidence are at the end of the chapter.

Workforce

3.3 The full-time equivalent (FTE) medical and dental HCHS workforce has shown strong recent growth. The workforce growth was especially strong in Wales (5.8 per cent in the year to September 2024), England (5.4 per cent in the year to December 2024), and Northern Ireland (4.3 per cent in the year to December 2024), but weaker in Scotland (1.6 per cent in the year to December 2024).

Table 3.1: HCHS doctors and dentists by nation, FTE, December 2024

	England	Scotland	Wales	Northern Ireland
Total	147,218	15,968	8,569	4,986
Annual growth	*+5.4%*	*+1.6%*	*+5.8%*	*+3.2%*
Resident doctors	74,904	6,820	4,473	2,181
Annual growth	*+6.6%*	*+1.2%*	*+8.0%*	*+4.0%*
SAS doctors and dentists	12,394	1,289	990	619
Annual growth	*+6.5%*	*+3.9%*	*+3.6%*	*+9.8%*
Consultants	58,382	6,204	3,031	2,013
Annual growth	*+3.8%*	*+1.1%*	*+2.9%*	*+2.1%*

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

Notes: Data for Wales is from September 2024. Data for Northern Ireland is from March 2024 as the workforce breakdown is only published once a year (at March).

3.4 Since December 2019, just before the pandemic, the medical and dental HCHS workforce has grown by 30,100 (25.7 per cent) in England, by 2,300 (16.7 per cent) in Scotland, by 1,828 (27.1 per cent in Wales) and by 716 (16.0 per cent) in Northern Ireland.

3.5 Data for England show especially strong growth in the number of FTE core trainees, of 10.7 per cent in the year to December 2024. Locally employed doctors are included in this group and are probably responsible for much of the growth, given there was a smaller increase (of 7.1 per cent) in the number of foundation doctors and the number of specialty registrars (of 3.7 per cent). The number of specialist/associate specialist doctors also showed strong growth in England, of 10.3 per cent.

[27] This group encompasses foundation doctors and dentists, core and specialty trainees, and locally employed doctors on equivalent national contracts.

3.6 Participation rates among the HCHS workforce in England (the ratio of FTE to headcount) remained high, at 93 per cent in 2024 (95 per cent for men and 91 per cent for women), one percentage point lower than a decade earlier. This indicates that there has not been a large increase in part-time working.

Table 3.2: Participation rates of HCHS doctors and dentists, England, December 2024

	Participation rate (ratio of FTE to headcount)			Percentage point change over past decade*		
	All	Male	Female	All	Male	Female
All HCHS doctors	93%	95%	91%	-1%	-1%	0%
Consultant	92%	94%	90%	-2%	-3%	-1%
Associate specialist	88%	93%	82%	0%	-1%	1%
Specialty doctor	89%	94%	83%	4%	2%	7%
Staff grade	92%	93%	90%	12%	5%	25%
Specialty registrar	95%	98%	92%	-1%	-2%	-1%
Core training	97%	99%	96%	-1%	-1%	-2%
Foundation doctor year 2	99%	99%	98%	0%	0%	0%
Foundation doctor year 1	99%	100%	99%	0%	0%	0%
Hospital practitioner/ clinical assistant	37%	38%	35%	9%	10%	8%
Other and local grades	62%	62%	62%	-3%	-1%	-5%

Source: NHS England.

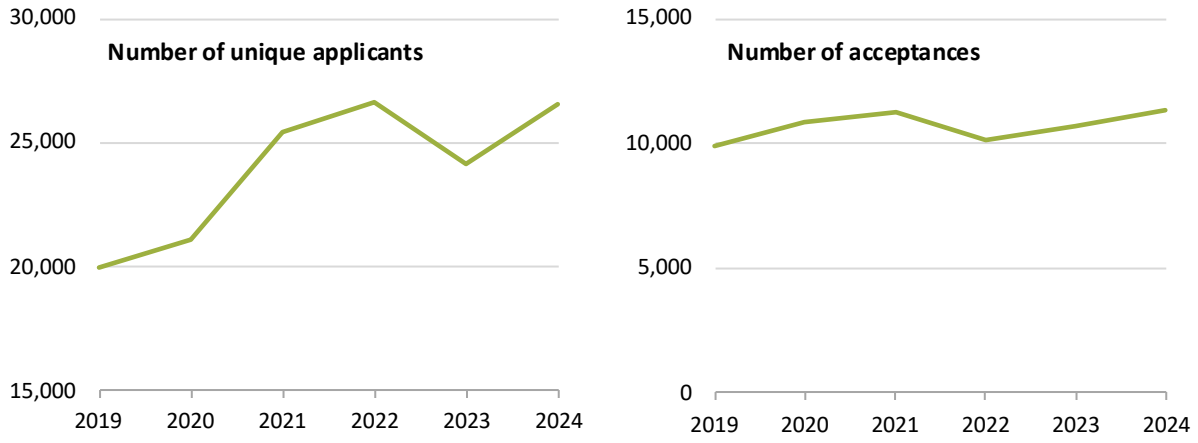
*Change over decade for men and women uses data at September 2014.

3.7 The Scottish Government said the recent levels of workforce growth were not expected to continue either in the short or long-term considering the difficult fiscal situation and projected population growth.

Undergraduate medical training

3.8 There were 26,590 applicants to study medicine in 2024, an increase of 10.1 per cent from 2023. This follows a decrease of 9.3 per cent in the number of applicants in 2023. In 2024, the number of applicants was 33.2 per cent higher than in 2019.

Figure 3.1: Number of applicants and acceptances for medicine degrees, UK, 2019 to 2024



Source: UCAS.

3.9 There were 11,380 acceptances to study medicine in 2024, an increase of 6.3 per cent from 2023. In 2020 and 2021, the numbers accepted on to courses were higher than expected, because of the increase in A-Level grades that resulted from centre-assessed grading, but this was followed by a 10.1 per cent fall in the number accepted onto courses in 2022. The number accepted on to courses to study medicine in 2024 was 15.1 per cent higher than in 2019.

3.10 The Universities and Colleges Admissions Service (UCAS) data do not show a marked change in the proportion of students studying medicine coming from overseas. Between 2019 and 2024, the UK-domiciled share of applicants increased from 77 per cent to 78 per cent of the total, and acceptances were 88 per cent of the total in each year.

3.11 The Department of Health and Social Care (DHSC) said that 205 and 350 additional medical school places were allocated in England for the 2024-25 and 2025-26 academic years respectively. This brought the total number of government-funded medical school places in England for the 2025-26 academic year to approximately 7,800.

3.12 The DHSC said that the number of government-funded places at medical schools would be further increased. The geographical distribution of places would also be considered to ensure there was greater equity across the country. The DHSC said there was a commitment to increasing opportunities for students from socially and economically disadvantaged backgrounds to study medicine.

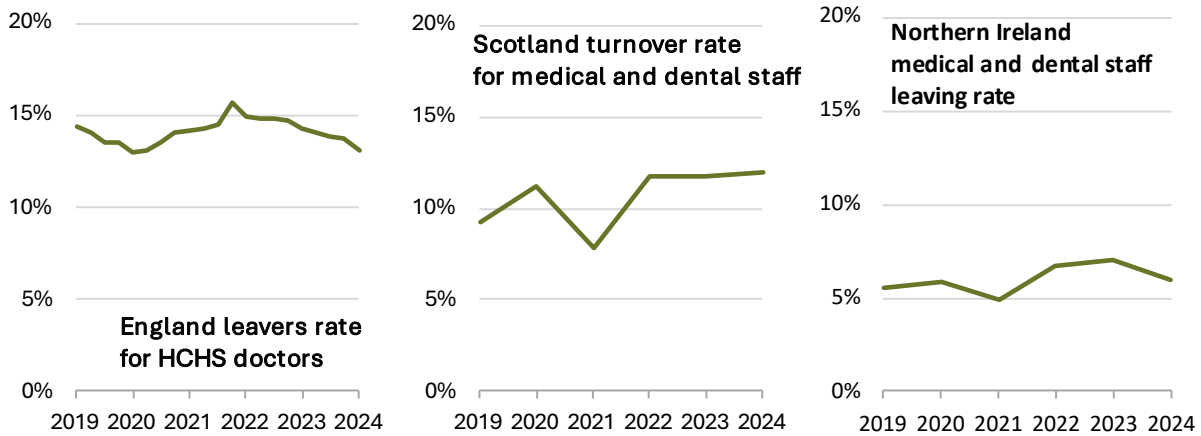
3.13 The Scottish Government said there was a medical undergraduate intake of 1,417 for 2024-25. This was a 67 per cent increase on the 2015-16 intake of 848.

3.14 The British Medical Association (BMA) said that evidence suggested that medicine was no longer an attractive career path, with the sharp drop in medical school applicants [in 2023] driven in part by increasingly uncompetitive professional remuneration.

Recruitment and retention

3.15 Outflow rates in England are on a downward trend. Leaver rates for consultants and associate specialists in England are at their lowest for over a decade. In Scotland, outflow for medical and dental staff is at its highest rate for over a decade. The leaving rate in Northern Ireland is stable and relatively low. Turnover in Wales has seen a small increase.

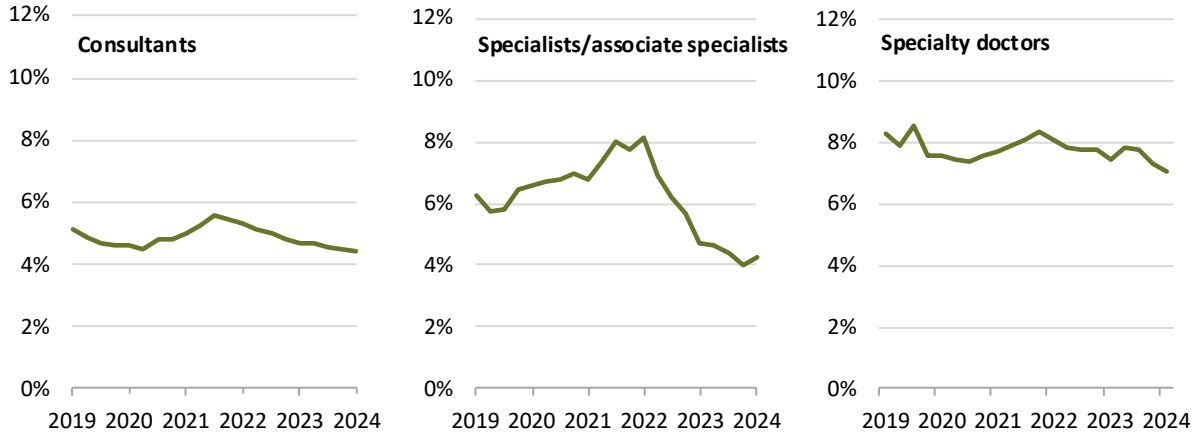
Figure 3.2: Leaving/turnover rates for medical and dental staff, 2019 to 2024



Source: NHS England, NHS Education for Scotland, Department for Health.

3.16 The leaving rate for all hospital medical and dental staff in England was 13.1 per cent in the year to December 2024, a reduction from 14.3 per cent in the previous year, and the lowest since the year to March 2021.[28] The stability index, which measures the percentage of staff there at the start of the year who do not leave during the year, was 86.6 per cent in December 2024, up from 85.4 per cent in the previous year, and the highest rate since March 2021.

Figure 3.3: Leaving rates, consultants, specialists and specialty doctors, England, 2019 to 2024



Source: NHS England.

3.17 The leaving rate for consultants in England was 4.4 per cent in the year to December 2024, down from 4.7 per cent a year earlier, and the lowest rate for over a decade. The leaving rate for specialists/associate specialists was 4.3 per cent in the year to December 2024, down from 4.7 per cent a year earlier. The leaving rate for specialty doctors was 7.1 per cent in the year to December 2024, down from 7.5 per cent a year earlier, the lowest rate for over a decade.

3.18 The turnover rate for Scotland has been on an upwards trend since 2015-16, increasing from 6.8 per cent in 2015-16 to 11.2 per cent in 2019-20. The turnover rate dipped to 7.8 per cent in 2020-21, affected by COVID-19, but increased to 11.7 per cent in both 2021-22 and 2022-23, and increased further to 12.0 per cent in 2023-24.

3.19 Medical and dental turnover in Wales was 11.1 per cent in July 2024, up slightly from 10.8 per cent in July 2023.

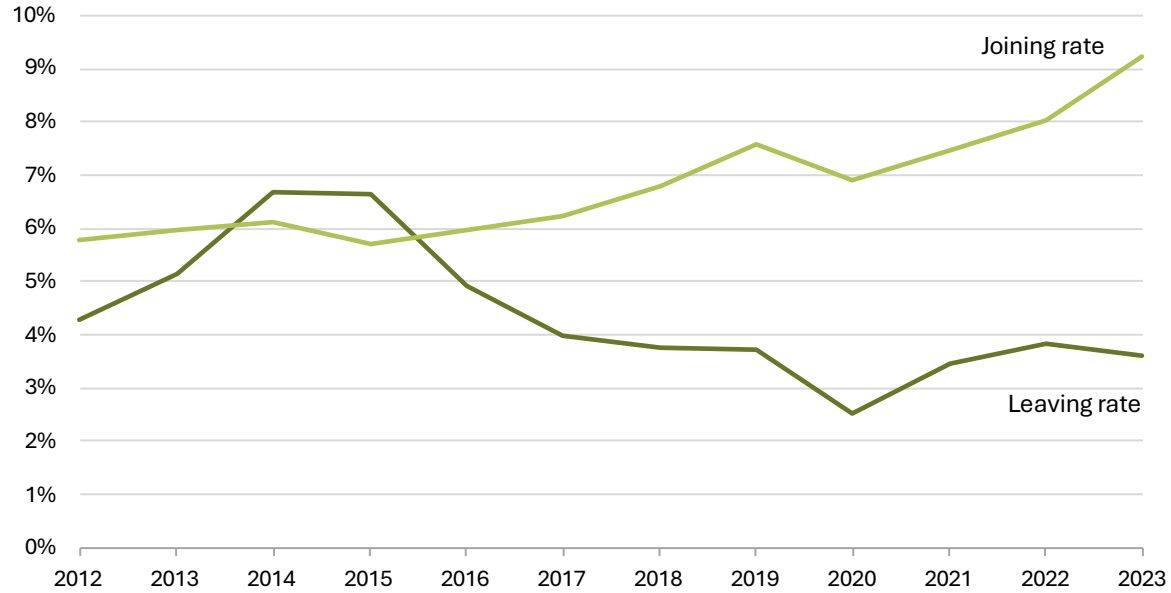
3.20 The Department of Health in Northern Ireland said that the leaving rate for consultants in the year to March 2024 was 5.3 per cent, compared to 4.3 per cent in March 2019. The stability rate (the proportion still employed one year later) for consultants in March 2024 was 92.6 per cent, compared to 92.5 per cent in March 2019. The leaving rate for SAS grades in March 2024 was 5.4 per cent, compared to 7.5 per cent in March 2019. The stability rate for SAS grades in March 2024 was 84.9 per cent, compared to 88.8 per cent in March 2019.

3.21 The General Medical Council (GMC) monitors the number of joiners to and leavers from its register each year. In 2023, there were 313,829 licensed doctors, an increase of 6.0 per cent on 2022. The GMC said this was the fastest growth rate in the number of licensed doctors since it started reporting in 2011. The number of specialists on the GMC register increased by 3.3 per cent over the year, general practitioners (GPs) by 3.0 per cent, and doctors in training by 4.2 per cent. The number of doctors who were on neither the GP or specialist register and

[28] Some resident doctors are counted as a leaver and a joiner when they move from one training grade/contract to the next. This means that the overall leaving rate probably overstates the 'real' flows. The outflow rates for specialty doctors, associate specialists and consultants are not affected by this issue.

were not in training grew by 13.1 per cent. This group includes SAS and locally employed doctors.

Figure 3.4: Leaver and joiner rates from the GMC register, 2012 to 2023



Source: GMC.

Note: Leaving and joining rates are the number of licensed doctors joining or leaving the register as a percentage of doctors on the register in the end year.

3.22 In 2023, 3.6 per cent of the workforce left the GMC register, down from 3.8 per cent in 2022. The GMC said that a very similar number of doctors left in 2023 (11,309) as in 2022 (11,319). It said there was no evidence of any post-pandemic increase in doctors leaving.

3.23 Overall, 3 per cent of doctors on the specialist and GP registers left in 2023. Doctors in training had the lowest leaving rate (1 per cent). The leaving rates for doctors in locally employed roles fell from 7 per cent in 2017 to 4 per cent in 2023. Doctors on neither register and not in training had the highest leaving rate in 2023 (8 per cent). This was driven by doctors leaving England and Wales who did not hold an NHS contract.

3.24 Analysis by the DHSC showed that around two-thirds of those working as consultants in 2014 were still working as consultants 10 years later. While most of the remainder appeared to no longer be working in the HCHS sector, it said this likely reflected the age profile of the consultant workforce and included retirements. Around 40 per cent of those who were working at resident level in 2014 were either consultants (37 per cent) or SAS (3 per cent) doctors after 10 years. Just under half were not working in the secondary care sector, which the DHSC said was consistent with the numbers expected to move into general practice.

3.25 The DHSC said that, while the pay system allowed the use of recruitment and retention premia to alleviate specific issues, these flexibilities were very rarely used. NHS England earnings data suggested that fewer than 0.5 per cent of the medical workforce were in receipt of a recruitment and retention premium in 2023-24.

3.26 The Welsh Government said that differences in recruitment and retention due to rurality were evident. Rural areas often struggled to retain staff due to travel distances, lifestyle differences, and limited career advancement opportunities compared to city centres. A study by Health Education and Improvement Wales indicated that rural locations required targeted

incentives to attract cross-border workers. The Welsh Government said the North Wales Medical School at Bangor University, which opened in September 2024, was key to helping address the challenges of training and retaining doctors in North Wales.

3.27 The Welsh Government said it did not support the use of targeted pay to specific staff groups. It said that, although there were shortages of staff in specific specialties, evidence showed that these were UK-wide issues and related to the numbers of staff training in these areas, rather than the financial rewards. The Welsh Government said that the challenge of recruiting to particular specialties needed to be addressed through workforce planning, recruitment initiatives and changing the way roles were designed. It did not wish to consider the use of targeted pay until it had evaluated the impact of wider measures designed to address the underlying causes of recruitment challenges.

3.28 The Department of Health said that health and social care across Northern Ireland continued to face significant challenges in recruiting and retaining clinical staff. Despite constant recruitment activity, medical and dental vacancy levels remained high. Trusts were experiencing significant shortages across all specialties, which generated additional pressures and workloads on wards and departments. Retention difficulties were further evidenced by rising banding supplements for many trainees and increasing programmed activities (PAs) for other medical staff. A number of specific recruitment and retention issues were raised, especially in the more rural areas. Psychiatry appeared to be a notable shortage specialty with no applicants for vacant posts in one trust, and additional premia in place in some areas.

3.29 In oral evidence, the Department said that there had not been the surge of consultants moving to the Republic of Ireland that were initially raised as a risk by some parties following the implementation of the new Sláintecare contract for consultants. There had also not been a significant increase in requests to the GMC for certificates of good standing.

Vacancies

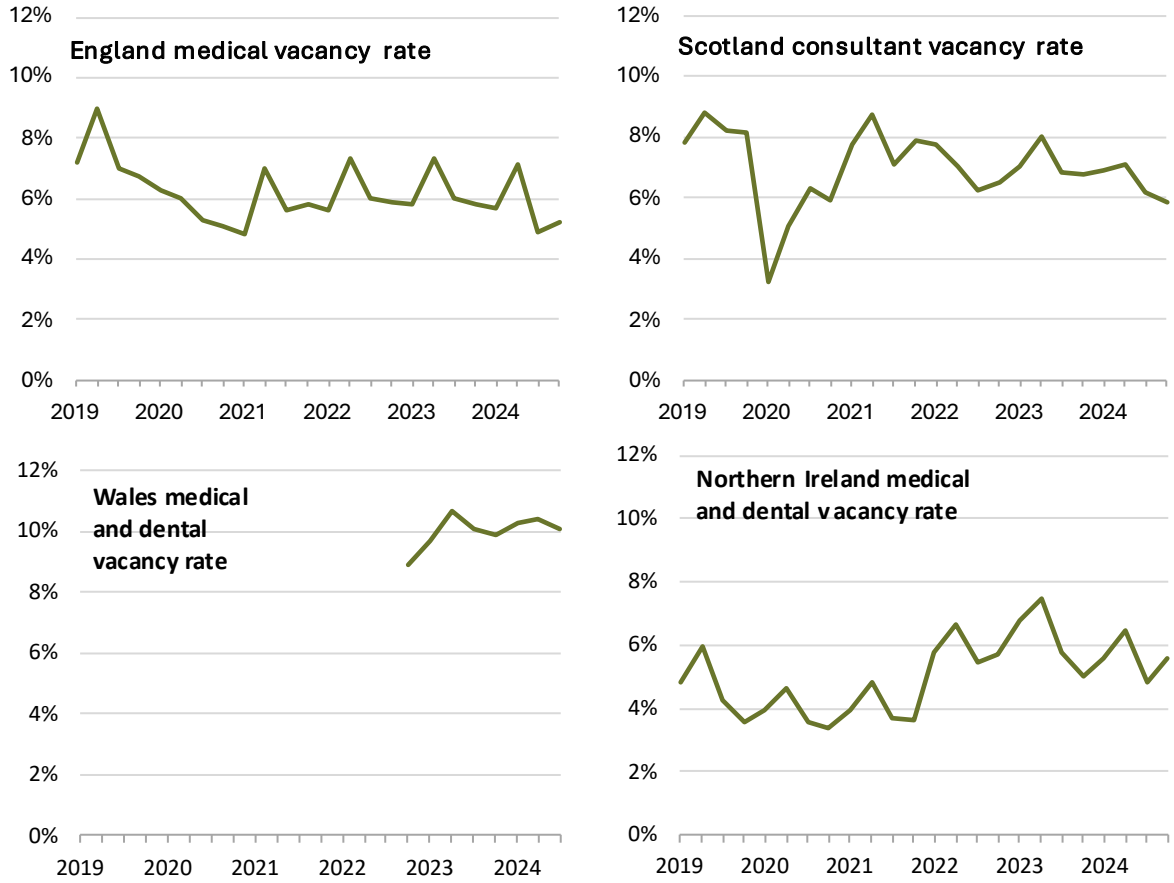
3.30 The latest data for England and Scotland show lower vacancy rates than a year earlier. The latest data for Wales show an unchanged vacancy rate in the year to September 2024, while there was an increase in the vacancy rate in Northern Ireland in the year to December 2024.

3.31 There were 8,330 medical vacancies in England in the third quarter of 2024-25, a reduction from 8,867 a year earlier. The medical vacancy rate in England was 5.2 per cent in the third quarter of 2024-25, a reduction from 5.8 per cent a year earlier, and the lowest rate at this time of the year since 2020-21. The BMA said that these figures were skewed downward by the way a vacancy was classified, such as being dropped from official figures when a post remained unfilled, or when a doctor post had been substituted by a non-doctor on a medical rota.

3.32 There were 378 consultant vacancies in Scotland in December 2024, a reduction from 436 a year earlier. The consultant vacancy rate in Scotland was 5.9 per cent in December 2024, a reduction from 6.8 per cent a year earlier, and the lowest rate for a decade, except for a short period of time in 2020, during COVID-19.

3.33 There were 522 medical and dental vacancies in Wales in September 2024, an increase from 506 a year earlier. The medical and dental vacancy rate in Wales was 10.1 per cent in September 2024, unchanged from a year earlier.

Figure 3.5: Medical and dental vacancy rates, by nation, 2019 to 2024



Source: NHS England; NHS Education for Scotland; Stats Wales; Department of Health.

Notes: Data for Wales is only available from December 2022. Vacancy data for Scotland is for consultants only.

Differences between the nations may reflect different ways of measuring vacancies.

3.34 There were 338 medical and dental vacancies in Northern Ireland in December 2024, an increase from 288 a year earlier. The medical and dental vacancy rate in Northern Ireland was 5.6 per cent in December 2024, an increase from 5.0 per cent a year earlier. The BMA suggested this was an underestimate of the vacancy rate.

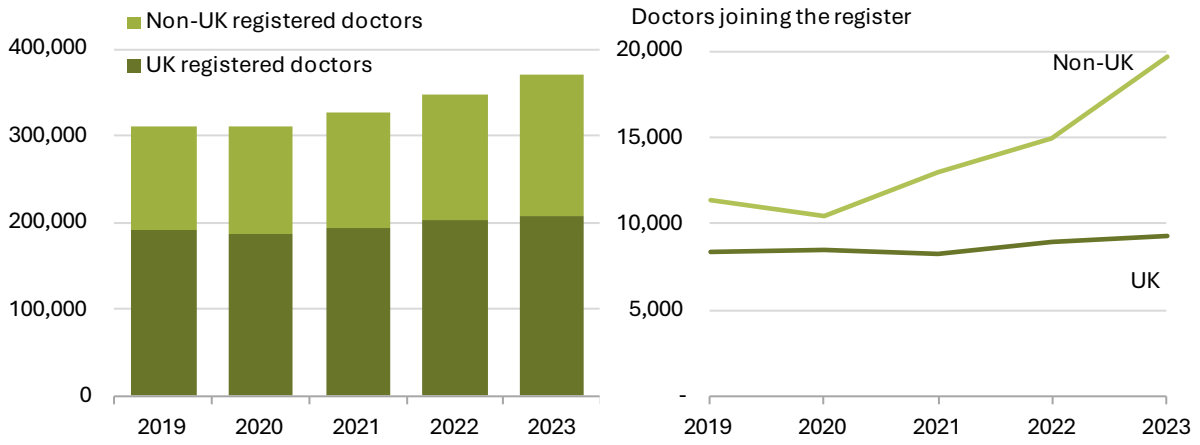
International recruitment

3.35 In 2023, over two-thirds of joiners to the GMC register (68 per cent) were non-UK graduates. This was an increase from 47 per cent in 2017. The number of UK graduate joiners increased by 5 per cent from 2022 to 2023, while the number of non-UK joiners increased by 32 per cent. Non-UK graduates made up 41 per cent of the medical workforce in 2023, up from 33 per cent in 2017.

3.36 Health and care worker visa data for doctors showed significant growth in visa grants between 2021 and 2022, rising from 5,773 visas in 2021, to 8,487 visas in 2022.[29] There was a further small increase to 8,805 visas in 2023, but a fall to 7,395 visas in 2024. The DHSC suggested that the fall in visa grants might be due to changes in demand for international staff. It said that doctors were most likely to come from India, Pakistan, Egypt and Nigeria.

[29] UK Government, *Immigration system statistics data tables*. https://www.gov.uk/government/statistical-data-sets/immigration-system-statistics-data-tables

Figure 3.6: Registered doctors and joiners to the GMC register by region of primary medical qualification, 2019 to 2023



Source: GMC.

3.37 In England, the proportion of the secondary care medical and dental workforce with a UK nationality fell from 69.0 per cent in December 2019 to 63.2 per cent in December 2024. The proportion of staff with a non-UK nationality varied by grade: 22.6 per cent of foundation year 1; 33.1 per cent of foundation year 2; 58.0 per cent of core trainees; 43.5 per cent of registrars; 57.2 per cent of specialty doctors; 40.0 per cent of specialists/associate specialists; and 21.6 per cent of consultants.

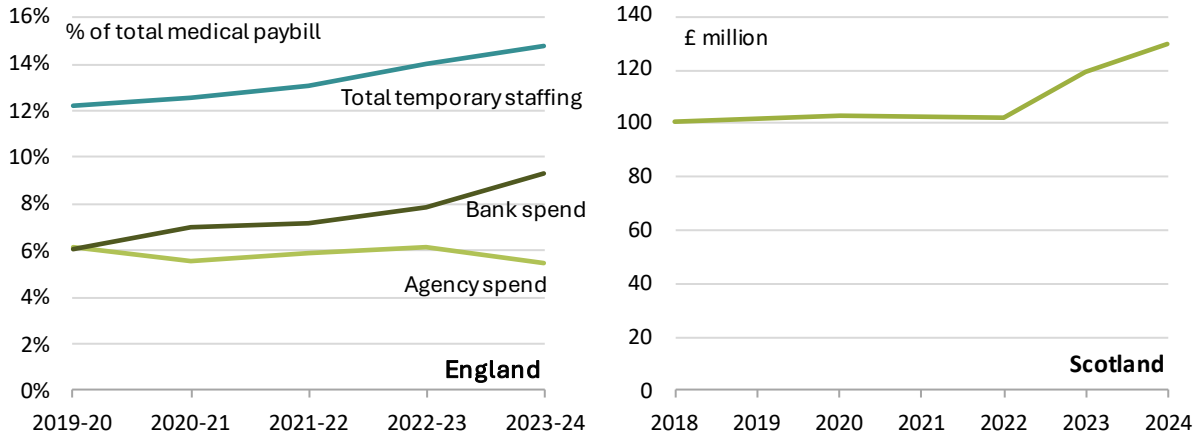
3.38 NHS England noted the increasing dependence of the NHS medical workforce on international recruitment across all medical groups. It said it was not sustainable to continue recruiting staff from overseas at the level the NHS had been in recent years. It said that pandemics, armed conflict, and climate change all posed risks to staff supply, and the international labour market was likely to become increasingly competitive as healthcare systems around the world faced increasing demand. The path for international medical graduates (IMGs) to obtain medical employment in this country could be difficult, and they often reported a poorer workplace experience than those with a UK primary medical qualification.

3.39 The Department of Health in Northern Ireland said there had again been an increase in the number of international doctors applying directly to HSC trusts. Medical recruitment of international doctors was especially high in the Western and Southern trusts i.e. the border trusts. Individual HSC trusts had well-established international medical recruitment teams and there were no current concerns around being able to continue attract international doctors to work in Northern Ireland.

Use of temporary staffing

3.40 The use of agency and temporary staffing is a useful measure of the excess demand for the medical workforce. NHS England said that total expenditure on medical temporary staffing increased by 18 per cent (£470 million) in 2023-24, largely due to an increase in spending on bank staff. Bank medical staffing costs increased by 34 per cent (from £1.4 billion to £1.9 billion) in 2023-24, and bank staff as a proportion of the overall medical paybill increased by 1.5 percentage points, from 7.8 per cent to 9.3 per cent. Agency costs made up 5.5 per cent of the medical NHS paybill in 2023-24, down from 6.2 per cent in 2022-23, representing a cost reduction of approximately £12 million (1.1 per cent).

Figure 3.7: Temporary medical staffing spend, England and Scotland, 2018 to 2024



Source: NHS England, Scottish Government.

3.41 NHS England said that, while the BMA withdrew its rate card guidance as part of the recent pay deals, the NHS was left grappling with bank and agency locum rates that were significantly out of line with substantive pay rates. It said the BMA's suggested minimum rates were more than triple the estimated basic hourly rate for a consultant and more than what employers typically paid for additional activity. Trusts were encouraged to develop and improve their strategy, procurement and commercial negotiation for temporary staffing.

3.42 NHS Employers described difficulties in returning to pre-industrial action extra-contractual rates. They said that affordability concerns were a real driver for employers when resetting local medical and non-medical staff rates. Employers reported that the BMA repeatedly challenged them to enhance those rates for doctors.

3.43 NHS Providers noted that agency spending across the NHS had been significantly reduced in 2024, following sustained focus on this area from trust leaders, and was at its lowest since 2017 (2.8 per cent of total pay costs). Trusts were on plan to meet the target reduction in agency spending of £500 million for 2024-25.

3.44 Agency spend on medical staff in Scotland increased by 8.3 per cent (£10.0 million) in 2024, and by 92 per cent since 2014, from £67.4 million to £129.6 million. The Scottish Government said that a working group had been established to ensure that NHS Scotland had a resilient supply pipeline of medical practitioners, thereby reducing reliance on medical locums. A specific focus was on psychiatry, which had significant vacancy rates and high locum usage.

3.45 BMA Scotland drew attention to the commitment to negotiate a national rate for internal short-term cover in the recent pay deal. It said this had the potential to encourage consultants to undertake more extra-contractual work but relied on the rate being attractive. If successful, it could reduce the heavy reliance on external locums being recruited at significant cost. However, it said that an attractive rate of pay for short-term cover was not the only obstacle in reducing agency/bank spending and significant workforce shortages in some specialties, notably psychiatry, were a large part of this spending.

3.46 The Welsh Government said it had delivered a new control framework for agency expenditure, with concerted action to encourage people to work for the NHS bank or in substantive NHS employment. It was forecasting a reduction in overall agency spend across NHS Wales of £81 million, from £262 million in 2023-24 to £181 million in 2024-25; £61 million of the forecast agency spend was medical and dental staff.

3.47 The Welsh Government said it was using international recruitment, better rostering, and flexible working to increase the workforce supply to replace agency capacity to ensure service delivery, quality and safety. A joint government, employer and BMA group was aiming to develop all-Wales extra-contractual rates for consultants and SAS doctors, with the goal of implementing these rates during 2024-25.

3.48 The Department of Health in Northern Ireland said that, to cope with the staffing shortfall, trusts in Northern Ireland employed a significant number of locums at training grades and specialty doctor levels, as well as agency staff. Medical and dental agency/locum expenditure was £136.1 million in 2023-24, a rise of 18 per cent (from £114.9 million) from 2022-23. Agency/locum costs for medical and dental staff in 2023-24 were 17.4 per cent of the HSC medical and dental paybill. Directly employed medical locum expenditure was a further £28.7 million in 2023-24.

3.49 The Department recognised that this expenditure was not sustainable, particularly at a time of serious financial pressures across the public sector. In October 2022, the Health Minister stated that off-contract expenditure was not a cost-effective use of taxpayers' money. A number of strategies were being progressed to address this, including the development and implementation of a medical and dental agency locum framework and a medical locum bank.

Resident doctors

Foundation training

3.50 The UK Foundation Programme allocated all 10,634 eligible applicants for the 2025 programme to a Foundation School, with 84 per cent of those applicants getting their first preference. In 2024, 9,702 applicants were placed and 75 per cent got their first preference. The DHSC said that all four nations had increased the number of foundation posts in recent years to ensure all eligible applicants were allocated to a programme.

3.51 NHS England said that, in response to feedback, a new allocation model for medical graduates had been introduced based on their geographic preference. This aimed to give more graduates, including overseas applicants, their first-preference location. NHS England said the new model had placed more applicants in their first-choice locations and given a more even distribution of overseas applicants. This had resulted in a more consistent withdrawal rate across the country and reduced vacancy hotspots in less popular regions and trusts.

3.52 There were 900 foundation places in Wales in the 2023-24 academic year (a fill rate of 102 per cent).

3.53 The Scottish Government said it had been increasing the number of foundation training places to meet the increased undergraduate cohort. There were 1,002 established foundation year 1 training places in Scotland in 2024; 48 additional posts had been made available in 2024 to accommodate undergraduate output. In total, 1,007 foundation year 1 posts were advertised and 976 (98 per cent) were accepted. This compared to 918 posts filled in 2023 (93 per cent fill rate) and 968 filled in 2022 (95 per cent fill rate). The Scottish Government said the new foundation posts would provide an opportunity both to support fragile rotas and to innovate.

3.54 The Scottish Government projected that it would need to increase the foundation year 1 intake by 231 posts between 2024 and 2027 (from 1,002 to 1,233 posts) to accommodate expected graduate output. This included 99 additional posts in 2025. Further expansion would likely be required after 2027 to accommodate more graduates arising from sequential and ongoing growth at undergraduate level.

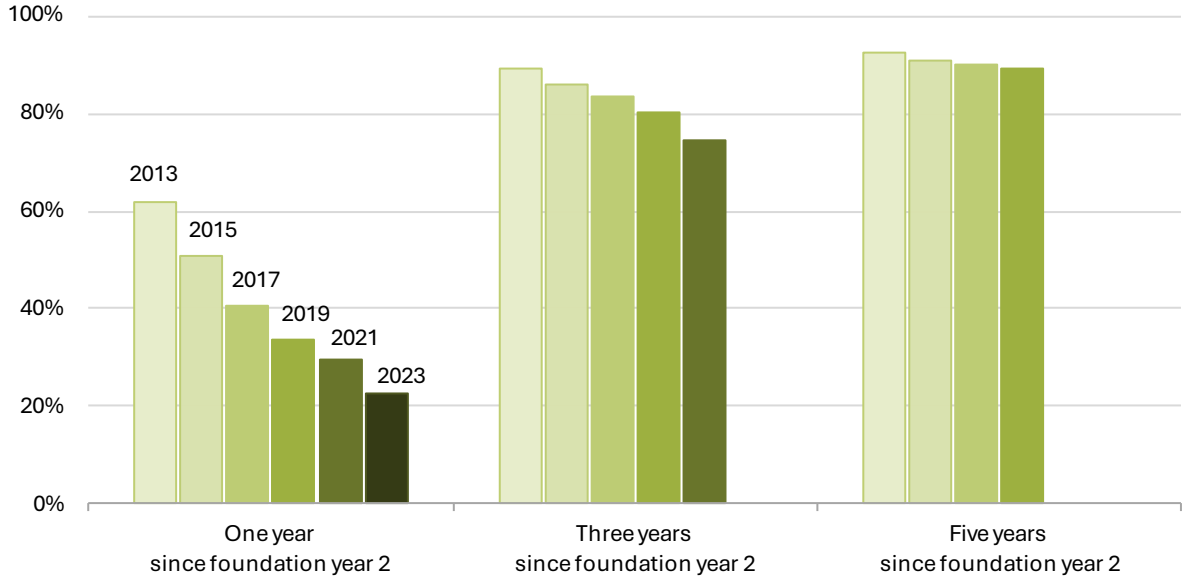
3.55 The Department of Health in Northern Ireland said that the foundation programme was expanded in August 2023 to meet university output locally, with the number of foundation places increased from 252 to 294. There were a number of withdrawals in August 2023, which resulted in only 248 foundation year 1s commencing. For August 2024, there were a further 61 placeholders in addition to the 294 places, which equated to Northern Ireland's proportion under the Barnett formula of the excess number of applicants to places available. A total of 30 Republic of Ireland graduates applied, 27 of whom subsequently withdrew. This was similar to 2023, when 28 of the 31 Republic of Ireland students withdrew. Following withdrawals and deferrals, a total of 294 foundation year 1s commenced in August 2024.

Time out of training

3.56 GMC data show that a large and growing proportion of doctors take increasing periods of time away from formal postgraduate training after foundation year 2. Three-quarters (75 per cent) of the 2022 foundation year 2 cohort did not immediately enter core or specialty training in 2023, compared to 34 per cent of those completing foundation year 2 in 2011.

3.57 The GMC highlighted the growing pool of doctors who had completed foundation year 2 in the preceding 12 years and had never entered core or specialty training. In 2023, there were 11,757 licensed doctors who had completed foundation year 2 but not subsequently started specialty training.

Figure 3.8: Proportion of doctors in training each year following completion of foundation year 2, 2013 to 2023



Source: GMC.

3.58 The GMC also looked at training programmes to track the proportion of doctors that previously took time away. In most programmes in 2023, over 65 per cent of foundation year 2 doctors had taken between one and three years away from training.

3.59 In its Workforce report, the GMC said that, of all the cohorts from 2017 to 2021, only 8 per cent of foundation year 2 doctors did not receive any offer after applying in the same year they completed foundation.

Core and specialty training

3.60 There were 7,929 core training places in England in 2024, up from 7,385 in 2023. The overall fill rate was 99.6 per cent. There were 2,942 specialty training places, with a fill rate of 86.5 per cent.[30]

3.61 The BMA said there was clear stagnation in the career progression from graduation to certificate of completion of training (CCT) and beyond, as there were insufficient training posts and consultant jobs. It said that there were 59,698 applications for 12,743 core/specialty training posts in 2024; an overall competition ratio of 4.7:1. It said this was an increase of 39.5 per cent on the 42,794 applications in 2023.

3.62 The Scottish Government said that, at July 2024, 1,035 training posts had been advertised in Scotland and 980 had been accepted (a 94.7 per cent fill rate). At the same stage in 2023, 1,061 posts had been filled from 1,137 advertised (93.3 per cent). In oral evidence, the Scottish Government said it was not aware of any issues with resident doctors finding training positions.

3.63 At core/ST1 level in Scotland, 719 posts were advertised and 718 (99.9 per cent) were filled. This included recruitment into general practice specialty training. At the same stage in 2023, 762 posts had been advertised and 750 (98.4 per cent) had been filled. At ST3 level and above, 316 posts were advertised and 262 (or 82.9 per cent) were filled. At the same stage in 2023, 375 posts had been advertised and 311 (82.9 per cent) had been filled.

3.64 There were 153 extra training places in Scotland in 2024. The Scottish Government said that the fundamental principle that trainee numbers and training establishments were determined by the need for future consultant output, not by need to cover gaps in rotas, had remained central to its modelling assumptions and decisions on training numbers.

3.65 There were 1,890 secondary care training places overall in Wales in the 2023-24 academic year, with a fill rate of 92 per cent for 379 out of 412 posts advertised. There were 800 GP training places, with a fill rate of 92 per cent.

3.66 There were 1,805 overall training places in Northern Ireland in 2024; 1,643 were filled and 162 vacant (9.0 per cent) at August 2024. Vacant posts had decreased from 12 per cent in August 2023. Vacancies were across a range of specialties. Fill rates for core/specialty training were: 369 out of 396 in 2024 (93.2 per cent); 365 out of 426 in 2023 (85.7 per cent); and 361 out of 399 in 2022 (90.5 per cent).

3.67 The Department of Health in Northern Ireland said that the number of foundation year 2s entering specialty training immediately following foundation training remained low. Data from the Single Lead Employer 2023 exit survey found that 10.8 per cent of trainees progressed directly into GP or hospital specialty training in Northern Ireland in August 2022, reducing to 7.2 per cent in August 2023 and 8.0 per cent in August 2024.

3.68 One trust In Northern Ireland reported that there were growing gaps within training rotas as well as increasing numbers of doctors in training working less than full time and those with restrictions on their duties. These gaps had traditionally been filled with locum doctors but there had been a move to recruit clinical fellows in locally employed posts to provide more stable and cost-effective cover.

[30] NHS England, *Fill rates*. https://medical.hee.nhs.uk/medical-training-recruitment/medical-specialty-training/fill-rates

3.69 The Department of Health said there was no additional funding to expand hospital specialty training programmes. Any increase in training posts would be subject to assessment of affordability in light of available funding and in line with workforce planning. The Department maintained a list of new medical specialty training posts, identified as required to meet workforce review requirements, for which funding had not been provided; 41 of these posts had been identified as a priority for August 2024. In oral evidence, the Department said it was looking at current and future funding models for training places and how they could be used to attract medical and dental staff to Northern Ireland.

3.70 The Department reported that 19.8 per cent of doctors in training in Northern Ireland were working less than full time in September 2024: 27.0 per cent of women, 9.6 per cent of men. This had increased from 17.4 per cent in September 2022. Less-than-full-time working was much more prevalent among later stages of training: 2.9 per cent of foundation year 1s; 4.6 per cent of foundation year 2s; 11.0 per cent of core trainees, and 30.0 per cent of specialty trainees (39.4 per cent of women, 15.5 per cent of men). At August 2024, there were 219 trainees on a period of out of programme or on long-term statutory leave or parental leave.

3.71 The BMA highlighted the unpopularity of Northern Ireland as a place to train and work. It said that many resident doctors were choosing to locum instead at a significant cost to HSC. The reasons they gave for this were greater flexibility over their working lives and better pay.

3.72 We are not provided with specific turnover data for resident doctors. The GMC workforce report said that, between 2012 and 2022, less than 1 per cent of doctors in training relinquished their licence and left the workforce following CT1/ST1. A slightly higher proportion of doctors left core or early specialty training stages to take up locally employed or SAS posts. Between 2012 and 2019, the number of doctors in training who became locally employed doctors following CT1 to CT3 or ST1 to ST4 was 2,429; about 2 per cent of all doctors in specialty training in that period.

3.73 In oral evidence, the DHSC acknowledged the anxiety among resident doctors about tightening competition ratios and the number of training places. It said that, while the number of training places had gone up, further expansion was needed. It said there would be decisions in the 10-year plan and the long-term workforce plan on the number of training places required. Work needed to be done on where training places were located, the use of community roles, and whether they were prioritised for UK doctors.

3.74 In oral evidence, NHS England acknowledged that there were not enough specialty training posts for the doctors coming through. One of the reasons for the increased competition ratio, however, was due to multiple applications by individual doctors, with some doctors applying for up to 10 places.

3.75 In oral evidence, the BMA said that a lot of resident doctors were worrying about job security during all of their time in training. It said that doctors were stretching out their training due to these concerns. It highlighted that the availability of training places changed in 2019 when medicine was put on the shortage occupation list. This opened all training places to doctors from across the world and meant that roles could be offered directly to IMGs, rather than only vacancies in the second round.

3.76 In oral evidence, the Welsh Government said that training places in some specialties were not filled, such as in geriatric medicine and genitourinary medicine. It noted the forthcoming increase in the number of medical graduates in Wales and said that there needed to be a view

of what specialties were needed, taking into account affordability. It noted that 28 per cent of doctors across all training programmes were working less than full time.

International recruitment to training

3.77 The GMC reported that 27 per cent of those on training programmes in 2023 were non-UK graduates, up from 18 per cent in 2019. The specialties with the highest proportion of non-UK graduates were general practice (52 per cent) and psychiatry (39 per cent).[31]

3.78 Northern Ireland was reliant on recruitment of non-UK graduates to fill its training posts. In August 2021, 61 new trainees required a visa to commence a training programme in Northern Ireland, with a total of 181 trainees requiring visa sponsorship. This increased to 188 new trainees from August 2024 (39 per cent of the overall August 2024 intake) and a total of 369 trainees requiring visa sponsorship. Sponsored trainees were most likely to be in general practice or internal medicine training (IMT). They were most likely to be from Nigeria, Pakistan, India, Malaysia, Egypt, Canada and Sri Lanka.

Flexible pay premia

3.79 Flexible pay premia were introduced with the resident doctors' contract in England in 2016. The purpose was both to reduce pay differences that might occur between specialties (general practice and oral-maxillofacial surgery), and to incentivise recruitment into underfilled specialties (psychiatry and emergency medicine). Since then, they have been increased in line with the main uplift for resident doctors. From 1 October 2018, flexible pay premia were extended to include histopathology.

3.80 Data from NHS England indicated very high fill rates across core training specialties (CT/ST1), at 99.5 per cent in 2024, and very few unfilled training places in any specialty. There were more vacancies for specialty training (ST3+), with an overall fill rate of 86.5 per cent in 2024. The specialties with the lowest fill rates – emergency medicine (acute care common stem), genitourinary medicine, general (internal) medicine – were not in receipt of flexible pay premia. Out of 47 specialties at ST3 level, 13 had fill rates below 75 per cent. Within the specialties with flexible pay premia, there was substantial variation in fill rates by region.

3.81 NHS England said a £20,000 recruitment incentive had been introduced for paediatric and perinatal pathology training. It said this incentive had not resulted in increased applications to ST3 paediatric and perinatal pathology.

3.82 In oral evidence, the DHSC said there needed to be a review of flexible pay premia to see if they were working to incentivise UK doctors to specialties with a high dependence on IMGs. NHS Employers said that a review of flexible pay premia should be commissioned, which should be aligned with the 10-year plan and the long-term workforce strategy.

3.83 As part of a Welsh Government incentives initiative, core psychiatry trainees in Wales are eligible to receive reimbursement for the costs of the first sitting of the MRCPsych exam, worth £2,143.

Recent pay agreements

3.84 Resident doctors in all nations received pay awards in addition to the DDRB recommended uplift of 6 per cent plus £1,000 last year. Alongside the government's acceptance of the 2024

[31] General Medical Council, *The state of medical education and practice in the UK: workforce report 2024*. https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk/workforce-report

DDRB recommendation, resident doctors in England accepted an additional average uplift of 4.05 per cent on 2023 pay scales (which was then uprated by the DDRB pay recommendation for 2024). This was worth 3.71 per cent on most pay points, and 5.05 per cent on the core training 1 pay point. The 3.71 per cent uplift was also applied to the closed 2002 contracts and local pay scales which mirrored the 2016 and 2002 contracts, all backdated to 1 April 2023. This meant that resident doctors received increases to basic pay of between 13.0 per cent at foundation year 1 and 11.5 per cent at registrar level.

3.85 Among other elements, this agreement included commitments to clarify the position on exception reporting (the mechanism to ensure doctors are compensated for work performed and agreed educational opportunities are upheld) and to withdraw the BMA rate card for resident doctors in England.

3.86 Agreement was reached with resident doctors in Wales in June 2024 to provide an additional 7.4 per cent pay increase, backdated to 1 April 2023. This took the overall increase for 2023 to 12.4 per cent, in line with the uplift resident doctors in Scotland received. Resident doctors in Wales also received the 6 per cent plus £1,000 DDRB recommended uplift for 2024.

3.87 Resident doctors in Northern Ireland reached an agreement in January 2025 which mirrored the England agreement: 4.05 per cent effective from 1 April 2023. They also received the DDRB recommended 6 per cent plus £1,000 uplift for 2024.

3.88 Resident doctors in Scotland were outside our remit last year. An 11 per cent uplift for 2024 was agreed, consisting of an 8.5 per cent increase from 1 April 2024 and a further 2.3 per cent from 1 October 2024.

Contract reform

3.89 The current contract for resident doctors in England was introduced in 2016. It brought in a different structure (with fewer increments, higher basic pay and changes to premium pay) to the contract in Scotland, Wales and Northern Ireland.

3.90 In oral evidence the Scottish Government said that contract reform talks with resident doctors had started, though they were paused last year for pay negotiations and restarted in November 2024. It was hoped that negotiations would finish by April 2026.

3.91 The agreement with resident doctors in Wales included a commitment to re-enter contract negotiations. The Welsh Government said this had the ambition of reaching an agreement that would begin implementation in 2025-26. It said the contract negotiations would build on the contract rejected in 2022, while recognising that significant changes would be required. Talks were scheduled to start in January 2025, once a mandate and funding envelope was confirmed. In oral evidence, the Welsh Government said a new contract could be a way to resolve unsafe shift patterns and improve working conditions.

3.92 The BMA said that little further progress had been made on contractual issues in Wales since 2022, although it remained convinced that contract reform was necessary to address unsustainable workloads and unsafe rotas. It said it hoped to begin new contract negotiations in January 2025 and had agreed to focus on working time premia and pay progression.

3.93 The Northern Ireland agreement also included a commitment to establish a timetable for contract reform discussions. In oral evidence, the Department of Health said it would like to move the banding payments into base pay, with a more modernised form of allowances based on shift rotas.

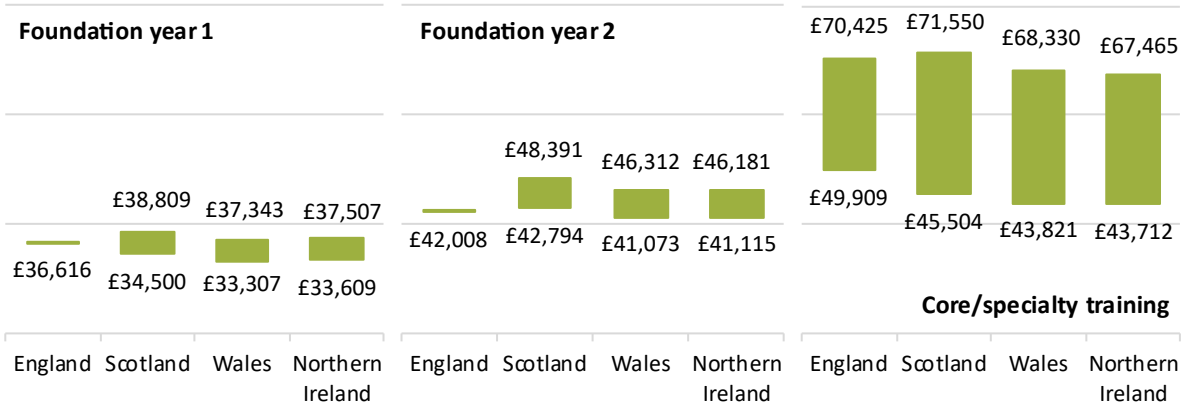
Pay and earnings

3.94 Basic pay scales for resident doctors vary across the nations, reflecting the different contracts. Additional payments also vary, which will affect earnings. Under the 2016 contract, resident doctors in England receive pay for additional hours at plain time (i.e. 1/40th of basic pay), up to a maximum of 48 hours worked. There are a number of other payments:

- Hours worked at unsociable times i.e. between 9pm and 7am on any weekday receive an enhancement of 37 per cent.
- A 3 to 15 per cent allowance for weekend working.
- An 8 per cent on-call allowance.
- Flexible pay premia, worth £3,260 to £10,961, for hard-to-fill training programmes.

3.95 The 2002 contract in Wales, Scotland and Northern Ireland uses a banding system, which reflects: the number of additional hours worked; the degree to which these hours are unsociable; the on-call commitment; and the workload. The premium ranges from 20 per cent for those working 40-48 hours a week/least anti-socially to 100 per cent for those working more than 56 hours a week/most anti-socially.

Figure 3.9: Resident doctor pay scales, 2024-25



Source: NHS Employers; Scottish Government; Welsh Government; Department of Health.

3.96 There are separate earnings data for foundation year 1, foundation year 2, core trainees and registrars in England. In the year to December 2024:

- Average earnings per head for foundation year 1 were £41,523, 10.7 per cent higher than a year earlier. Basic pay increased by 11.6 per cent over the year, while non-basic pay increased by 7.5 per cent. Non-basic pay made up 22 per cent (£9,100) of foundation year 1 average earnings per head.
- Average earnings per head for foundation year 2 were £50,393, 12.1 per cent higher than a year earlier. Basic pay increased by 13.5 per cent over the year, while non-basic pay increased by 7.7 per cent. Non-basic pay made up 24 per cent (£12,200) of foundation year 2 average earnings per head.
- Average earnings per head for core trainees were £64,906, 11.8 per cent higher than a year earlier. Basic pay increased by 13.4 per cent over the year, while non-basic pay increased by 7.3 per cent. Non-basic pay made up 25 per cent (£15,700) of core trainee average earnings per head.
- Average earnings per head for registrars were £72,698, 10.6 per cent higher than a year earlier. Basic pay increased by 12.2 per cent over the year, while non-basic pay increased by 6.0 per cent. Non-basic pay made up 25 per cent (£18,200) of registrar average earnings per head.

3.97 In 2023-24, average total pay per FTE for resident doctors (covering foundation doctors, specialty training and clinical fellows) in Scotland was £80,332, 11.8 per cent higher than in 2022-23. Basic pay increased by 9.8 per cent. Non-basic pay made up 46 per cent of FTE earnings.

3.98 In Northern Ireland, earnings at September 2024 were:

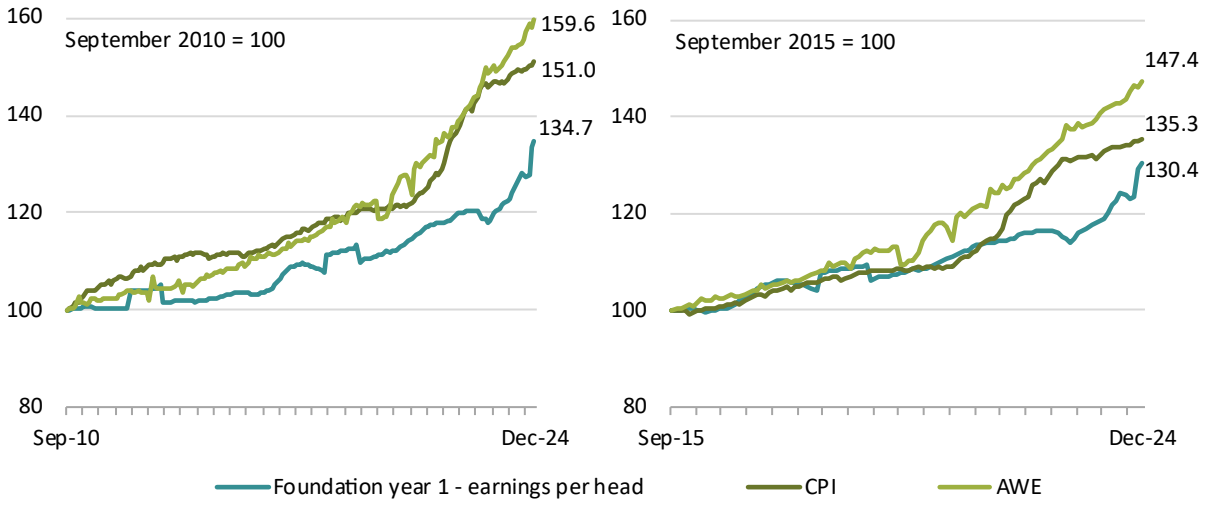
- Foundation year 1: £29,620 average FTE unbanded (i.e. basic); £47,936 banded (i.e. total).
- Foundation year 2: £36,491 average FTE unbanded; £53,802 banded.
- Core training: £43,096 FTE unbanded; £65,271 banded.
- Specialty training: £48,695 FTE unbanded; £72,792 banded.

3.99 In England, non-basic pay adds 28-33 per cent on average for resident doctors. In Scotland, it adds 84 per cent on average. In Wales, it adds 32-44 per cent on average. In Northern Ireland, it adds 47-62 per cent on average.

3.100 Comparisons of changes in earnings and prices over time are sensitive to the base year chosen. Between the year to September 2010 (the first point with consistent earnings data available) and the year to December 2024, the Consumer Prices Index (CPI) increased by 51 per cent and average weekly earnings (AWE) increased by 60 per cent. Over the same period:

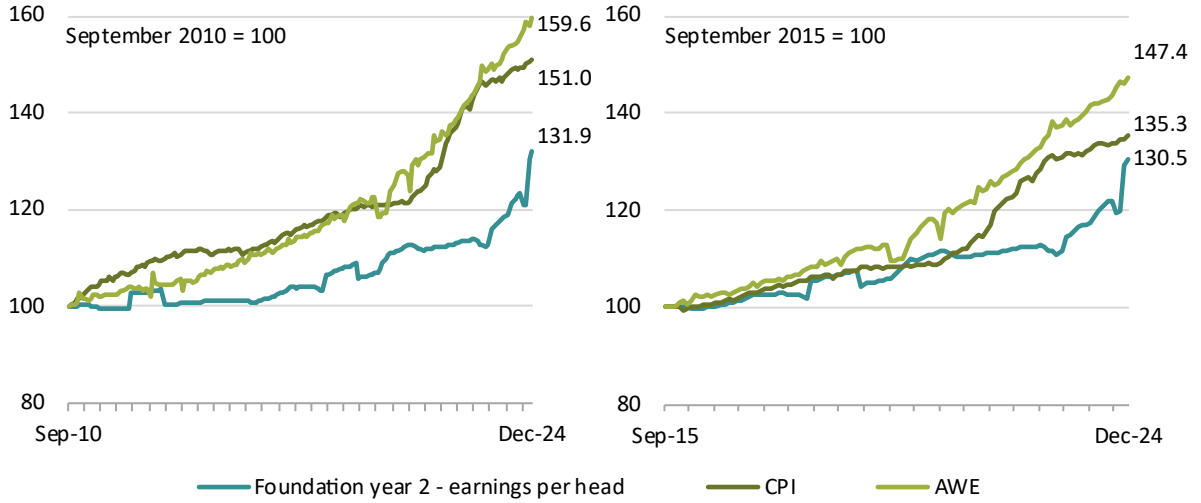
- Foundation year 1 earnings per head in England increased by 35 per cent.
- Foundation year 2 earnings per head in England increased by 32 per cent.
- Core trainee earnings per head in England increased by 39 per cent.
- Registrar earnings per head in England increased by 32 per cent.

Figure 3.10: Foundation year 1 doctors, mean earnings per person, CPI and AWE, England, September 2010/September 2015 to December 2024



Source: OPRB analysis of NHS England and ONS data.

Figure 3.11: Foundation year 2 doctors, mean earnings per person, CPI and AWE, England, September 2010/September 2015 to December 2024

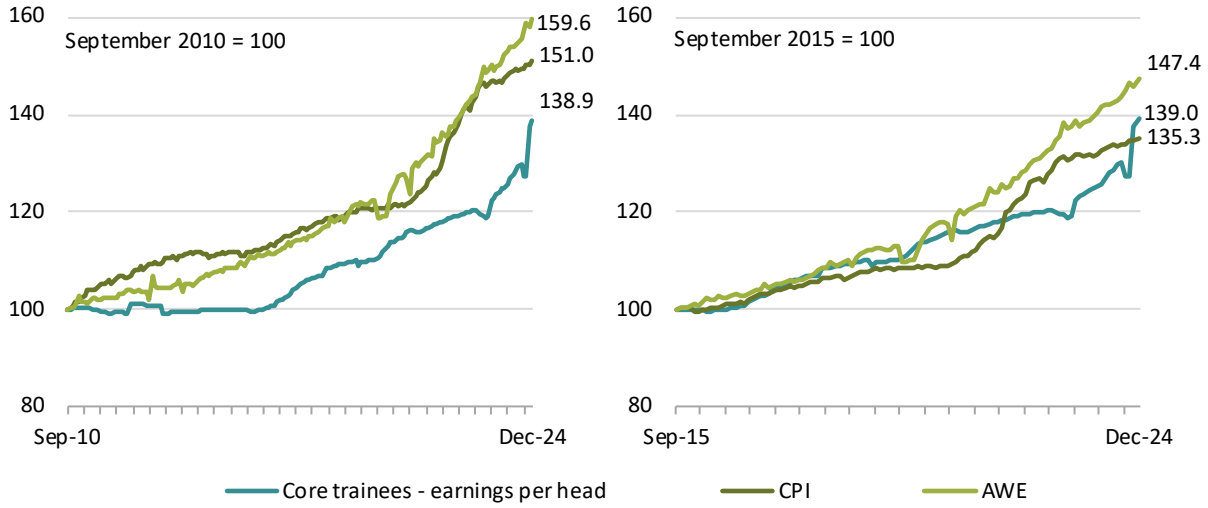


Source: OPRB analysis of NHS England and ONS data.

3.101 Between the year to September 2015 and the year to December 2024, the CPI increased by 35 per cent and average weekly earnings increased by 47 per cent. Over the same period:

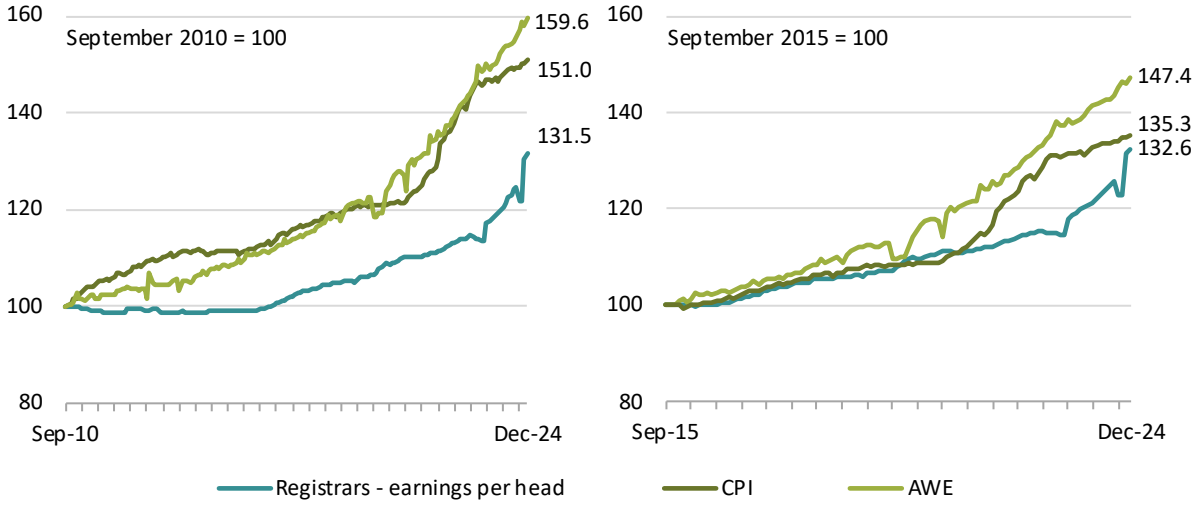
- Foundation year 1 earnings per head in England increased by 30 per cent.
- Foundation year 2 earnings per head in England increased by 31 per cent.
- Core trainee earnings per head in England increased by 39 per cent.
- Registrar earnings per head in England increased by 33 per cent.

Figure 3.12: Core trainees, mean earnings per person, CPI and AWE, England, September 2010/September 2015 to December 2024



Source: OPRB analysis of NHS England and ONS data.

Figure 3.13: Registrars, mean earnings per person, CPI and AWE, England, September 2010/September 2015 to December 2024



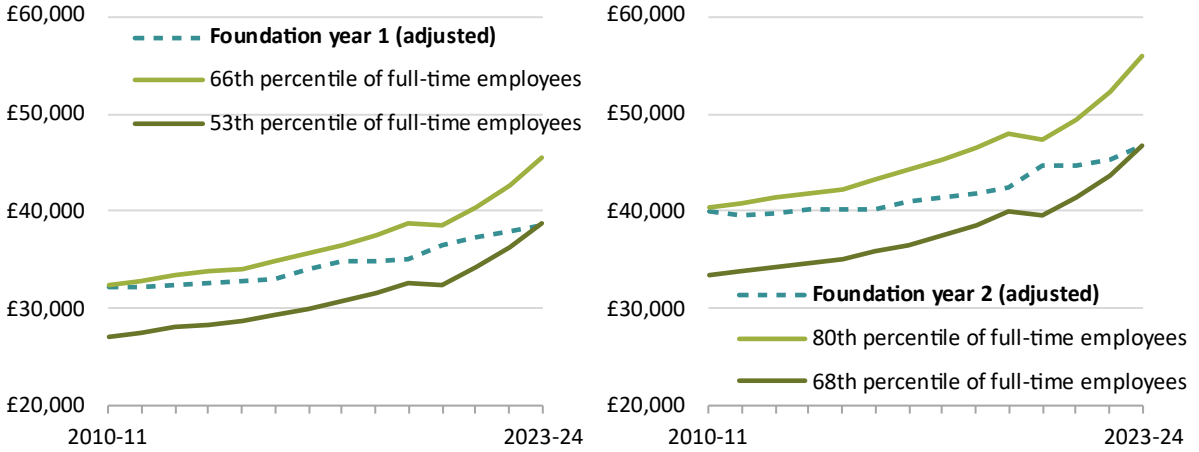
Source: OPRB analysis of NHS England and ONS data.

Pay comparability

3.102 Estimated average earnings per FTE for foundation year 1 were just below the 66th percentile of all full-time employees in 2010-11. By 2023-24 average earnings for foundation year 1 had fallen to the 53rd percentile.

3.103 Estimated average earnings per FTE for foundation year 2 were just below the 80th percentile of all full-time employees in 2010-11. By 2023-24 average earnings for foundation year 2 had fallen back to the 68th percentile.

Figure 3.14: Average total FTE earnings for foundation doctors, England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2023-24



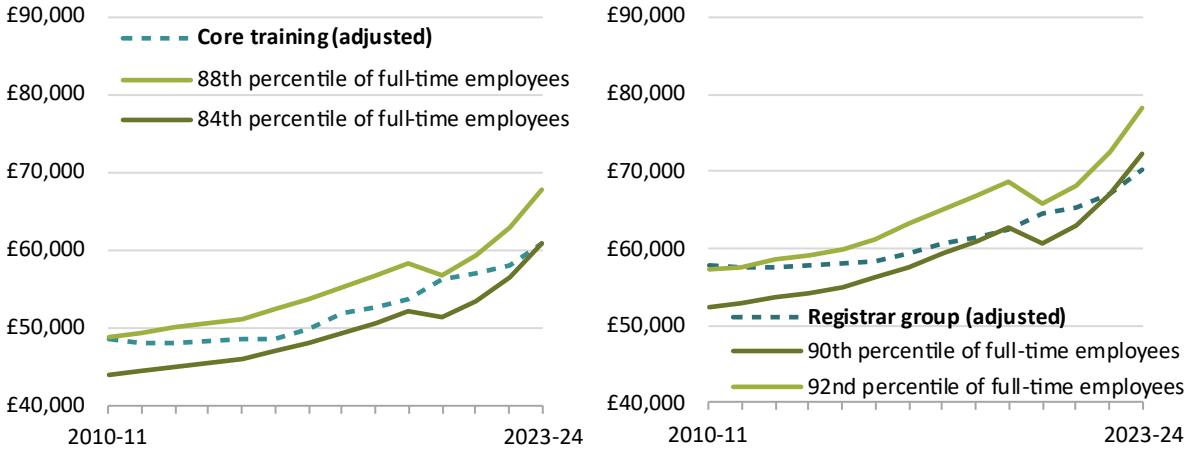
Source: OPRB analysis of NHS England and ASHE data.

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

3.104 Estimated average earnings per FTE for core trainees were just below the 88th percentile of all full-time employees in 2010-11. By 2023-24 average earnings for core trainees had fallen back to the 84th percentile.

3.105 Estimated average earnings per FTE for registrars were just above the 92nd percentile of all full-time employees in 2010-11. By 2023-24 average earnings for registrars had fallen back to slightly below the 90th percentile.

Figure 3.15: Average total FTE earnings for doctors in core training and registrars, England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2023-24

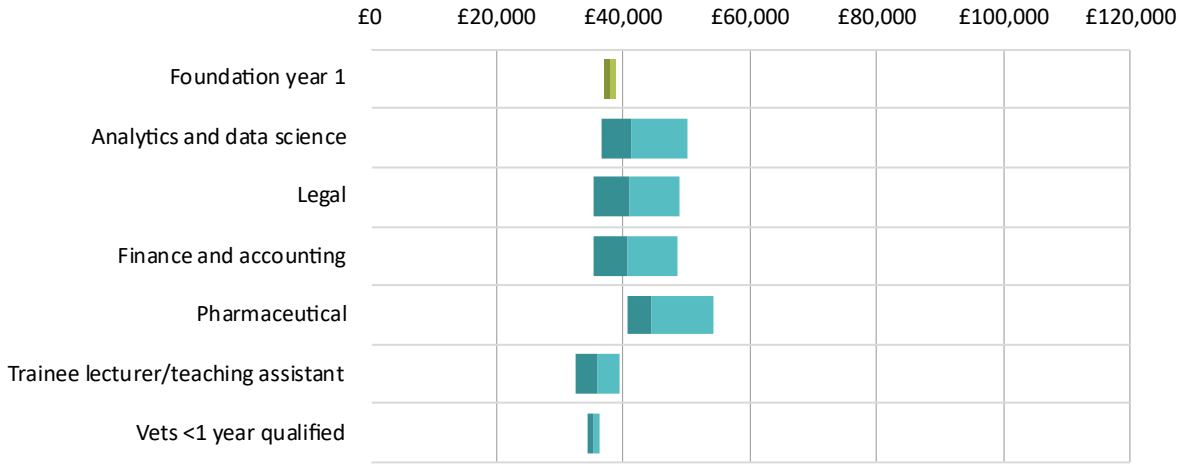


Source: OPRB analysis of NHS England and ASHE data.

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

3.106 Using job evaluation, we compare medical roles to equivalent roles in analytics/data science, finance/accounting, pharmaceutical, academic and veterinary sectors. This is based on an evaluation conducted in 2017. Pending a wider-scale review, we have supplemented this analysis with job evaluation from Willis Towers Watson (WTW) and have compared roles to their main industry database. For resident doctors, we also look at the earnings of other graduates.

Figure 3.16: Interquartile range of total earnings of foundation year 1 doctors, headcount, England, compared with professional comparator groups, 2024



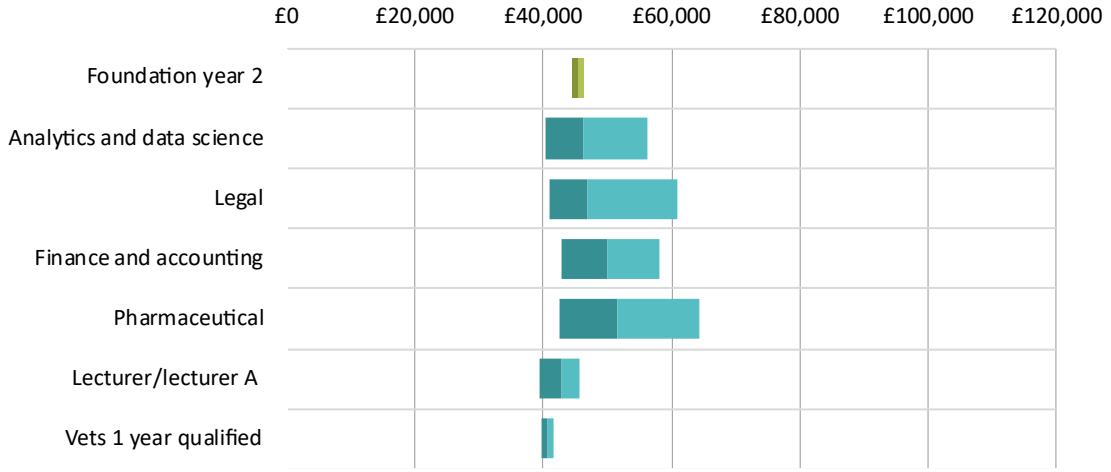
Source: OPRB analysis of data from Kornferry; Universities and Colleges Employers Association; the Society of Practising Veterinary Surgeons; NHS England; ONS.

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

3.107 Using comparisons based on job size, earnings for foundation year 1 doctors in England are behind some market comparators (legal, finance, pharmaceutical and analytical/data science),

and ahead of academic and veterinary roles. Foundation year 2 doctors in England are behind some comparators (finance and pharmaceutical), in line with legal and analytical/data science, and ahead of academic and veterinary roles. Registrar earnings in England are behind equivalent analytics/data science, legal, finance and pharmaceutical roles, but ahead of academic and veterinary equivalents.

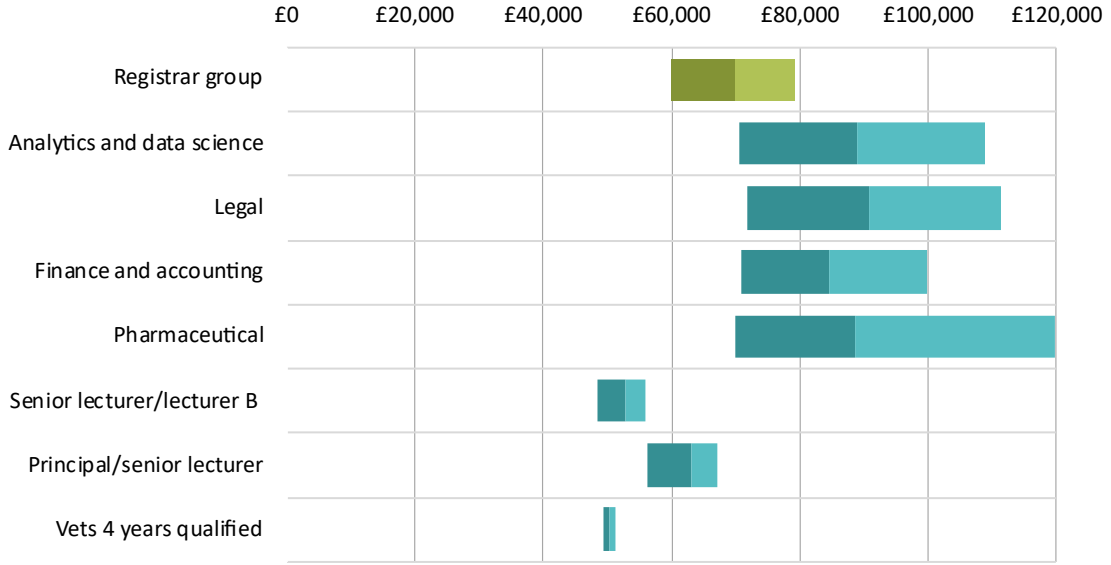
Figure 3.17: Interquartile range of total earnings of foundation year 2 doctors, headcount, England, compared with professional comparator groups, 2024



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

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

Figure 3.18: Interquartile range of total earnings of registrars, headcount, England, compared with professional comparator groups, 2024



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

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

3.108 Job levelling and market data from WTW indicate that base pay for resident doctors (at foundation, core and specialty training levels) is very close to market median pay for the same job level. Total pay for resident doctors is just above market median pay at the same job level.

3.109 Longitudinal Education Outcomes (LEO) data show that, in 2021-22, median earnings for those with a medical or dentistry degree one year after graduation (£39,100) were substantially higher than the upper quartile earnings for any other subject. Lower quartile earnings for medical and dental students three years after graduation (£41,500) were higher than the median for any other subject. Lower quartile earnings for those who studied medicine or dentistry five years after graduation (£46,400), were greater than those at the median for any other subject studied, except for economics. Median earnings for those who studied medicine or dentistry 10 years after graduation (£59,100), were greater than those at the median for any other subject studied, except economics.

Pay progression

3.110 The DHSC highlighted the extent of pay progression for doctors. Within-grade pay progression was worth 92 per cent for resident doctors, 61 per cent for specialty doctors and 33 per cent for consultants in England. Foundation year 1 to the maximum of the consultant scale saw 282 per cent base pay progression (£36,616 to £139,882).

Table 3.3: Change in basic pay per FTE for HCHS staff employed in both March 2014 and March 2024

	Count	25th percentile earnings growth (annualised growth)	Median earnings growth (annualised growth)	75th percentile earnings growth (annualised growth)
Consultant	47,700	39.9%	44.8%	154.6%
		(3.4%)	(3.8%)	(9.8%)
Associate specialist	2,000	34.5%	43.7%	61.4%
		(3.0%)	(3.7%)	(4.9%)
Specialty doctor	3,400	39.4%	58.3%	101.6%
		(3.4%)	(4.7%)	(7.3%)
Specialty registrar	5,900	73.7%	101.1%	144.4%
		(5.7%)	(7.2%)	(9.3%)
Core training	900	65.3%	97.1%	124.9%
		(5.2%)	(7.0%)	(8.4%)
All medical staff	60,800	39.9%	49.3%	147.3%
		(3.4%)	(4.1%)	(9.5%)
All NHS	564,000	26.3%	45.0%	64.2%
		(2.4%)	(3.8%)	(5.1%)
CPI		33.4%	33.4%	33.4%
		(2.9%)	(2.9%)	(2.9%)

Source: OPRB analysis of data from DHSC and ONS.

3.111 Analysis by the DHSC looked at the 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. The median increase in basic pay per FTE was over 49 per cent over 10 years (4.1 per cent a year) while 25 per cent of the workforce experienced an annual increase of over 9.5 per cent, associated with promotion to more senior grades. For example, the upper quartile figure for consultants (155 per cent earnings growth over 10 years, equivalent to 9.8 per cent a year) was 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.

The training experience and resident doctors' working lives

3.112 The 2024 agreement with resident doctors in England included a commitment for the DHSC to work in partnership with the BMA Resident Doctors Committee, NHS England, devolved administrations, the Medical Royal Colleges, the GMC, and employers to reform the current system of training and rotational placements.

3.113 This would review the training model with regard to the number and frequency of rotations and to review and, where needed, redesign curriculums. It would seek to: prioritise the experience of resident doctors; minimise the administrative and bureaucratic hurdles involved in rotating; address relocation, logistics, travel and accommodation issues; reduce and minimise disruption to personal and family life; and ensure more consistent support systems across different rotations and geographies.

3.114 This work included a separate NHS England review of training numbers, both to address the training bottlenecks which already existed and the planned expansion of medical school places.

3.115 In addition to these reviews, NHS England outlined a number of actions to improve the working lives of doctors in postgraduate training:

- Board ownership of issues, including having a named lead reporting to trust boards. In an NHS England survey of trusts, 93 out of 95 had appointed a lead reporting to the trust board, typically the chief people officer or the chief medical officer.
- Exploring the lead employer model, including assessing the feasibility and cost of a single employer for all doctors throughout their training.
- Compliance with the rota code of practice. This included providing work schedules at least eight weeks in advance, and duty rosters six weeks in advance.
- Reducing payroll errors.
- Payment of course fees.
- Reducing the need to repeat statutory and mandatory training as doctors rotated between organisations.

3.116 NHS England said that the desire to work more flexibly was an increasing aspiration of newer generations of trainees, and policy makers and workforce and service planners must look to develop strategies to accommodate these preferences. It said it was committed to improving flexibility across training pathways. NHS England said it had improved access to less-than-full-time training and other flexible approaches, including opportunities to take time out of training, flexible portfolio training, and fellowship offers. Some limitations had been removed from the out-of-programme pause scheme, including the length of time a doctor could take out of training.

3.117 In the GMC's 2024 National Training Survey, 83 per cent of trainees said the quality of experience in their post was good or very good, unchanged from 2023. Over a quarter of trainees in secondary care posts (26 per cent, down from 29 per cent in 2023), said their training was adversely affected because rota gaps were not dealt with appropriately.

3.118 NHS Employers said they were aware of a range of actions to improve the trainee experience. Examples included making physical improvements to on-call rooms and out-of-hours facilities; positive developments in rota oversight and management (including explorations of technical solutions such as those that supported self/preferential rostering approaches); providing

greater access to health and wellbeing resources; and some work to improve payroll functions for new trainees in an effort to ensure their basic pay and enhancements were correct before the first payroll.

3.119 The agreement with resident doctors in Wales included a commitment to a task and finish group (of Welsh Government, the BMA, NHS Wales Employers and Health Education and Improvement Wales) to agree changes to the study leave and study budget system. There was also a recommitment to implementing the NHS Wales Fatigue and Facilities Charter across health boards and trusts, which sets out standards to address the systemic causes of sleep deprivation and fatigue among doctors.

3.120 The Department of Health in Northern Ireland said that the employment relationship with trainees following implementation of the Single Lead Employer had been positive with good feedback. For example, issues with pay were greatly reduced and the onboarding process far better. On the negative side, there was some confusion regarding who was responsible for different issues such as rota issues and management.

3.121 A number of recommendations to improve the experience of doctors in training in Northern Ireland were being developed, including:

- An initial one hour a week self-development time.
- Fair and timely rota design.
- Improved provision of rest and on-call facilities.
- A trial of over-recruitment into a medical specialty training programme.
- Active support of less-than-full-time training across all medical training programmes.
- A transparent methodology for the review of the current distribution of medical training posts across Northern Ireland (starting with psychiatry) including a review into rotational training.

3.122 In oral evidence, the Department of Health in Northern Ireland said it was looking to over recruit to certain training specialties to take account of increasing less-than-full-time working. This was being trialled with internal medicine. It said that over-recruitment should give a better work-life balance, increase the opportunities for less-than-full-time working, offset some of the vacancies, and make the training programme more rewarding.

Locally employed doctors

3.123 The GMC holds data which enables it to identify locally employed doctors in England and Wales. It said that locally employed doctors were the fastest growing part of the profession, driven mostly by those who graduated outside of the UK and recently joined from abroad. The number of locally employed doctors in England and Wales grew by 75 per cent between 2019 and 2023, from 21,000 in 2019 to 36,831 doctors in 2023.

3.124 The GMC said that 66 per cent of doctors in locally employed roles in England and Wales had a non-UK primary medical qualification in 2023. There were 11,757 licensed doctors who had completed foundation year 2 but not subsequently started core or specialty training.

3.125 NHS England said that locally employed doctors had a wide range of job titles, including trust grade, foundation year 3/F3, clinical fellow, teaching fellow or locally employed doctor. This lack of consistent naming and the way they were coded on the electronic staff record created challenges when looking at data. NHS England said that these challenges needed to be addressed to better understand this diverse group's needs, career choices and aspirations.

3.126 NHS Employers accepted that providing accurate national data on the employment of locally employed doctors was crucial in understanding this area of the workforce but said this was likely to be a complex and time-consuming task for many employers.

3.127 The BMA called for information on the distribution of locally employed doctors across the NHS and their terms and conditions, and for research to map the use of SAS and locally employed doctors.

3.128 The Welsh Government said that work to review locally employed doctors began in August 2024. An all-Wales coding system had been agreed, and a significant effort was underway to recode locally employed doctors. Once the recoding process was completed, it would enable more comprehensive analysis of the terms and conditions for locally employed doctors across Wales.

Use of locally employed doctors

3.129 The DHSC said that locally employed doctor posts were likely to be occupied by doctors who had stepped out of formal training, many of whom would return to training. It said this arrangement allowed flexibility for doctors to continue to provide services to the NHS and build their experience while taking a pause from training. This also benefitted employers who could retain experienced doctors.

3.130 The DHSC said that the increase in locally employed doctors would become concerning if significant numbers 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.

3.131 NHS Employers said that locally employed doctors were those employed directly by trusts on terms different to those provided by national contracts and were excluded from the DDRB's remit. They said that NHS employers could recruit staff on terms and conditions as they saw fit, to respond to local needs as necessary. They said that locally employed doctors often had similar seniority and working hours as doctors in training, although there were exceptions such as postgraduate clinical fellowships.

3.132 NHS Employers said that the rise in the number of locally employed doctors was partly driven by increased less-than-full-time working for doctors in training, gaps in training allocations, and increased clinical/workload pressures. It said the increase in locally employed doctors was seen as neither positive nor negative by employers, but simply as a consequence of changing needs for medical staffing.

3.133 NHS Employers said there were several aspects that made employing a locally employed doctor attractive to employers. Employers had greater control over working patterns, and this ensured a more consistent and present workforce as there was no requirement to rotate, unlike doctors in training. The disadvantage was the lack of NHS England funding for such posts so that any associated costs were covered by the employer. Additionally, the majority of locally employed doctors were IMGs. For many of these individuals, a locally employed doctor post was their first experience of working in the NHS, so additional support was often needed to ensure that they could work safely at the required level.

3.134 In oral evidence, NHS Providers said that the use of locally employed doctors was different depending on the area of the country and the type of provider. Some trusts only had a few locally employed doctors who were on clinical fellowships which fitted within a career pathway.

Terms and conditions for locally employed doctors

3.135 The DHSC said it understood that the majority of locally employed doctors were employed on terms and conditions which mirrored national contracts and national pay scales. NHS Employers agreed that many locally employed doctors worked under terms based on national contracts, with the 2016 doctors in training contract being the most common. They said this contract was particularly appropriate where locally employed doctors worked directly alongside doctors in training, as it ensured parity in remuneration and consistency around safe working hours.

3.136 NHS Employers said there had been an increase in trusts moving to mirror the 2016 contract in their local pay scales, away from local contracts that mirrored closed grades. A key driver in this was to meet the expected rates of pay in the Certificate of Sponsorship application process which was based on the 2016 pay scales. NHS Employers said that existing points of contention remained where the national contract did not correlate easily with a local contract, particularly around pay progression, study leave and access to the guardian of safe working hours. Many trusts took local approaches to these points, which could lead to inconsistencies.

3.137 NHS Employers said that concerns had been raised about the short-term contracts offered to locally employed doctors, often as brief as four months, which created insecurity and financial burdens especially for IMGs who needed to reapply for work rights. Some employers had introduced 'rotational' locally employed doctor roles, allowing for longer-term positions while providing varied experience.

3.138 NHS England said the expectation was that employers would increase pay for locally employed doctors in line with our recommendations. Where locally employed doctors were paid according to national pay scales, they would have received an uplift. Systems were funded to implement the impact of pay awards to locally employed doctors through the cost uplift factor.

3.139 In oral evidence, NHS Providers suggested there might be scope for a national contract or model terms and conditions. The HCSA said there needed to be a national framework for locally employed doctors that trusts were obliged to put in place.

3.140 The BMA called for the issue of non-standard contracts for doctors working at resident doctor level to be ceased and for the use of the 2016 resident doctors' terms and conditions to be mandated. It said that working hours for locally employed doctors should be monitored in line with the contract.

Progression for locally employed doctors

3.141 Valuable analysis from the DHSC identified 11,800 locally employed doctors in England on terms mirroring the 2016 resident doctor contract in 2023. This indicated that doctors may use locally employed roles as a bridge to other parts of the career structure (see table 3.4).

3.142 Of the 5,100 locally employed doctors working at a level equivalent to nodal point 3 (ST1-2) in 2023, 30 per cent were in a training post one year later. Of the 1,400 locally employed doctors working at a level equivalent to nodal point 5 (ST6+) in 2023, 18 per cent were working at consultant level one year later.

3.143 There was some movement between nodal points especially for those working at a foundation level.

Table 3.4: Movement of locally employed doctors between 2023 and 2024

	Nodal point in 2023					
	1 (FY1 level)	2 (FY2 level)	3 (ST1-2 level)	4 (ST3-5 level)	5 (ST6+ level)	All levels
Count	240	980	5,100	4,100	1,400	11,800
Locally employed doctor	62%	66%	50%	51%	43%	51%
Same point	7%	17%	43%	45%	43%	41%
Higher point	55%	49%	7%	6%	0%	10%
Other national contracts	16%	15%	31%	29%	34%	29%
Resident doctor in training	16%	14%	30%	19%	11%	22%
SAS	0%	0%	2%	6%	4%	3%
Consultant	0%	0%	0%	4%	18%	4%
Closed 2002 resident doctor contract/other contract	7%	3%	2%	3%	3%	3%
Not in HCHS organisation	15%	16%	17%	17%	21%	16%

Source: DHSC analysis of Electronic Staff Record.

Career development for locally employed doctors

3.144 The 2024 agreement for SAS doctors in England included a joint piece of work to determine how locally employed doctors could be better supported to progress in their careers. This included gathering more reliable data to understand the make-up of the locally employed doctor workforce, the types of roles locally employed doctors were undertaking, the reasons why employers used local terms and conditions and how they differed from national terms and conditions.

3.145 As part of the agreement, the SAS Implementation Group would develop a process by which locally employed doctors in roles comparable to SAS doctors for more than two years could be offered a national SAS contract. The process would also cover how locally employed doctors who did not fulfil these criteria, but had been on a fixed-term contract for more than two years, could be offered a permanent contract. The DHSC said it anticipated that this would reduce the number of doctors employed on local contracts over the long-term. It said the aim was to ensure that local contracts were not being used as a long-term solution if it was not in the best interests, or not the choice, of the doctor concerned.

3.146 NHS England said that locally employed doctors played an important role in service delivery and were also a potential future supply of consultants and SAS doctors, provided that appropriate support and career structures were put in place. It said it was important to help locally employed doctors to advance in their careers by opening routes into SAS roles and into training pathways.

3.147 NHS Employers said there was a growing focus on supporting locally employed doctors in their education and career development. While locally employed doctors were crucial for service provision, ensuring they had access to educational resources and career development opportunities could improve retention, patient safety, and support training programmes.

3.148 NHS Employers said that access to training for locally employed doctors was inconsistent, largely because their posts were trust-funded without designated training budgets. Some

employers offered support voluntarily, but this varied widely. Some trusts had begun to designate locally employed doctor tutors or leads to oversee their educational development.

3.149 The BMA highlighted a number of issues facing locally employed doctors, including limited training opportunities, hampered progression, isolation, lack of supervision, and job insecurity. It said that locally employed doctors should be provided with access to study leave and a study leave budget; access to a guardian of safe working hours and exception reporting; and offered regular clinical supervision to ensure they were supported and enabled to progress.

3.150 The BMA said that the SAS Charter for Wales stated that a doctor working on a non-standard contract, whose role mirrored that of a specialty doctor and who met the eligibility criteria considered for the 2021 specialty doctor, should be considered for substantive appointment. It said that NHS Wales Employers had committed to undertake a stocktake of locally employed doctors' terms and conditions and to explore the feasibility of transitioning eligible locally employed doctors to appropriate national contracts.

SAS doctors

Recent pay agreements

3.151 Prior to our report last year, an agreement was reached with SAS doctors in England effective from 1 April 2024. This uplifted pay points on the 2021 contract by between 6.10 and 9.22 per cent. Pay for those on pre-2021 contracts increased by £1,400. There was also agreement to withdraw the BMA rate card for SAS doctors in England.

3.152 NHS England said the agreement was designed to address the imbalance between old and new contracts, speed up the delivery of some of the key objectives of the 2021 deal, and encourage more existing SAS doctors to take up the new contracts.

3.153 Agreement was reached with SAS doctors in Wales in June 2024, effective from 1 January 2024. This gave an increase of 7.2 per cent to the lower four pay points on the 2021 specialty doctor pay scale, and 9.2 per cent for the top pay point. The lowest pay point on the 2021 specialist pay scale was increased by 9.0 per cent and the other two points by 6.1 per cent. This brought the total increase on 2022-23 to 9.6 to 17.1 per cent. There was no increase for specialty doctors on the (closed) 2008 pay scale.

3.154 The agreement in Wales also changed the definition of out-of-hours working to any time outside 7am to 7pm Monday to Friday, on a weekend or a public holiday. Plain time had been 7am to 9pm on weekdays under the 2021 contract. It also included withdrawal of the BMA rate card and a commitment to work to develop all-Wales extracontractual rates for SAS doctors.

3.155 Agreement was reached with SAS doctors in Northern Ireland in December 2024 to increase the 2021 specialty doctor pay points by 6.3 or 9.2 per cent and the 2021 specialist pay points by 9.0 per cent, effective from 1 April 2024. Closed pay scales received an uplift of £1,400. This brought pay scales into line with those in England.

3.156 SAS doctors in England, Wales and Northern Ireland all received our 6 per cent recommended pay uplift from 1 April 2024.

3.157 SAS doctors in Scotland agreed a 6 per cent uplift for specialty doctors and a 7.1 or 10.1 per cent uplift for specialist doctors on the new contract from 1 April 2024. The agreement

included a commitment to discussions to agree a national rate for internal short-term cover and the withdrawal of the BMA rate card.

3.158 BMA Scotland said that, while rates for the first 72 hours of cover were included in the 2022 specialty doctor contract, agreeing rates for other short-term cover could potentially encourage SAS doctors to undertake more extracontractual work and reduce the heavy reliance on external locums.

Contractual issues

3.159 Our report last year set out two main issues with the pay structure for SAS doctors and dentists in England, Wales and Northern Ireland:

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

3.160 The recent additional pay agreements have largely resolved both these issues. The pay scale for the specialist grade is now the same in all nations. The pay scale for specialty doctors on the new contract is now the same in England and Northern Ireland. The pay scale minimum in Wales is slightly (0.9 per cent) higher, while the minimum in Scotland is 4.3 per cent higher. The maximum is the same in England, Wales and Northern Ireland, while the Scotland pay scale maximum is slightly (0.8 per cent) higher.

3.161 BMA Scotland said that the 2022 SAS contracts in Scotland established the highest salaries in the UK deliberately to aid recruitment and retention of SAS doctors in Scotland. It said there was now no pay differential for specialists between Scotland and the other UK nations.

3.162 NHS England said that 60 per cent of specialty doctors were on the new 2021 contract at August 2024 (6,326 out of 10,599), an increase from 50 per cent in August 2023. The DHSC said that only 16 per cent of doctors on the 2021 specialty doctor contract had transferred from the 2008 contract.

3.163 NHS Employers described a recent increase in requests from SAS doctors to transfer to 2021 contracts, which they linked to the recent SAS pay deal. NHS England said it was keen for any pay award for 2025-26 to support the transition to the 2021 SAS contract.

3.164 The DHSC said there were likely to be reasons beyond pay which discouraged 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 had been looking at where improvements could be made to the transfer process.

3.165 The BMA said that the 2024 SAS doctor pay deal in England addressed some of its biggest concerns around closed and open contract pay disparities. It said that there were still several points on the old pay scales that were higher than the equivalent position on the new pay scale and that the old contract had a preferable definition of plain time.

3.166 The 2021 specialty doctor contract in England, Wales and Northern Ireland extended the definition of plain time, from 7am to 7pm to 7am to 9pm on weekdays. The BMA said that SAS doctors in England remained wary about the remunerative impact of moving to 2021 contracts and that plain time remained a key issue. It said it appeared to have taken on a

symbolic importance connected to how SAS doctors were treated more widely. The BMA said that the cost of changing this would be fairly minimal but would provide a real benefit in sending a clear message to SAS doctors that they were valued.

3.167 The BMA also highlighted that some trusts had a misguided belief that transferring contracts was no longer an option for SAS doctors, and that there were also instances where individuals had waited a long time to transfer. It said that recent guidance on contract transfer would help improve the process and enable more SAS doctors to move onto the new contracts.

3.168 The HCSA said that, of those SAS doctors that were yet to move to the 2021 contract, over half had not done so because of changes to terms and conditions, with a similar number citing losses in pay. It said that those who had not switched faced deep unfairness, with attempts to browbeat them into changing to new terms by suppressing their pay.

3.169 The Welsh Government said that, to ensure specialty doctors were incentivised to transfer, changes were required to the terms and conditions so the benefits of the 2021 contract were fully realised by the workforce and the service. The key change agreed was to amend the agreed definition of out of hours, to cover any time outside of the period 7am to 7pm Monday to Friday.

3.170 The Welsh Government said that an implied contractual right for doctors on the 2008 contract to transfer to the 2021 specialty doctor contract was also agreed. In August 2024, 63.0 per cent of specialty doctors were on the 2021 contract, up from 57.2 per cent in August 2023. As a result of the regrading policy, ongoing work on locum consultants, and initiatives involving locally employed doctors, a significant increase in doctors transitioning to substantive SAS contracts was anticipated over the next 12 months.

3.171 The BMA acknowledged that the open specialty doctor contract in Wales now provided higher pay than the closed contract. It said that the end of plain time hours from 7pm to 9pm on weekdays was a positive change that would improve the pay of those undertaking shifts.

3.172 The Department of Health in Northern Ireland said that a high proportion of SAS doctors on the old contracts were longer in post, more often female and UK graduates. The department said that this population was less likely to accept a proposal which was seen as not recognising them or their pay discrepancy if it did not improve pay on the old contracts. Any perceived attempt to force them to move to new contracts would likely meet with an unfavourable response.

3.173 The Department said that SAS doctors on the new contracts were primarily new starts rather than transfers. Trusts said that the new contract remained unfavourable, due to the lower pay scale and the extension of plain time working. The recent agreement in Northern Ireland included a new two-year window to apply to move to the 2021 contract, closing in April 2027.

3.174 The BMA said that the majority of SAS doctors in Northern Ireland had stayed on the 2008 contracts despite the benefits of the new contracts in relation to protected supporting professional activities time and safeguarding around out-of-hours working. It said that the Department of Health would not countenance a reversal to the plain time policy during the pay talks. It said only 32 doctors had transitioned to new contract, and all other 2021 specialty doctors were newly created posts.

3.175 In oral evidence, the Scottish Government said that 85 per cent of SAS doctors that were on the old contract had moved to the new one.

Specialist roles

3.176 The pay increase on moving from the top pay point of the 2021 specialty doctor contract to the specialist role is £1,590 in England, Wales and Northern Ireland, and £861 from the top of the 2022 specialty doctor contract in Scotland. From the top of the closed 2008 specialty doctor contract, the pay increase is £2,200 to £3,200.

3.177 In August 2024, there were 1,367 specialists in England, and 1,591 associate specialists. NHS England said it had worked with the DHSC, NHS Employers and the BMA to develop guidance on establishing the specialist role. NHS Employers reported that funding for specialist posts remained an issue due to current financial restraints.

3.178 The DHSC recognised that specialist roles were being created at a slower rate than had been anticipated. It said that just under 45 per cent of specialist posts were filled by doctors transferring from one of the specialty doctor contracts, and around 10 per cent had moved from the associate specialist grade. The DHSC said it would have anticipated that a larger proportion of the roles would have been specialty doctors, given that the specialist post was created to offer career progression for this group.

3.179 In oral evidence, the Scottish Government said that 30 specialist roles had been created, and employers were enthusiastic about them. It said that part of the 2024 pay deal involved employers and the BMA looking at options to regrade specialty doctors to specialist roles. It said that posts created needed to fit the requirements of the health service.

3.180 BMA Scotland said it remained a significant disappointment that progress in creating and appointing to specialist roles in Scotland was glacially slow. It said it was positive that 86 per cent of the new specialists had previously been in specialty doctor posts and 9 per cent had been associate specialists.

3.181 The 2024 agreement in Wales included a commitment to develop a policy that enabled specialty doctors to request that their employer assessed them against the generic capabilities of the specialist grade. If the doctor had the skills and experience, and the grade was required against service need, then the doctor would progress to the specialist grade. There were 72 specialist doctors in Wales in August 2024, up from 49 a year earlier. This compares to 148 associate specialists in August 2024, down from 160 a year earlier.

3.182 There were a reported 25 specialist posts in Northern Ireland, out of 701 SAS doctors overall.

SAS career development

3.183 The 2024 agreement in England included three priority actions to support the career development and progression of SAS doctors. The first action was to develop advice and guidance specifically to support career progression for SAS doctors.

3.184 The second action was to explore what national levers were available to encourage, establish and embed specialist roles. This included the creation of guidance to employers recommending that: vacant associate specialist roles were converted into specialist role vacancies; that specialist roles were advertised internally first to give local specialty doctors more opportunities to progress within their trust; and that SAS advocates had an opportunity to review relevant vacancies and make the case for them to become specialist roles. It also included commissioning research into why more specialist roles were not being created.

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

3.186 NHS Employers said that stakeholders were: reviewing how employers could create more specialist roles; promoting job planning for SAS doctors; and helping SAS doctors to progress through the portfolio pathway.

3.187 A BMA survey of SAS doctors in England found that the main barriers to applying for a specialist role were: a lack of specialist roles to apply to; the department/trust seeming unwilling to engage with the idea of a specialist grade on principle; and that the department/trust prioritised funding for consultant roles over specialist roles.

3.188 The BMA said that there was a clear need to expand the number of specialists. It said a process was needed that better recognised the expertise of senior specialty doctors and reinforced the pathway to the specialist grade. It said this would best be achieved by a single pay spine that allowed a doctor to progress to a more senior position by demonstrating their capacity for it, rather than forcing them to wait for a role to open up.

3.189 The agreement in Scotland included the development of a mechanism for the regrading of specialty doctors to specialists. This would be used where a doctor believed that they had the skills, experience and demonstrable evidence required to meet the criteria for the grade. Where there was demonstrated service need for the post, the doctor could progress to the specialist grade. The principles of the policy were improving career progression and retention of senior doctors and assist with delivering NHS Scotland service needs.

3.190 BMA Scotland said that a major stumbling block for employers was the requirement to have open recruitment, with the associated risk of increasing headcount and salary costs. It said it would welcome the option to begin with internal advertisement before progressing to open recruitment. It also encouraged the option for senior specialty doctors, who could demonstrate that they were already working at a high level and equivalent to the requirements of a specialist, to be re-graded to specialist.

3.191 BMA Wales said that, although there had been an improvement in specialist recruitment, access to the grade, its scope of practice and level of recognition remained below its expectations. It said that the SAS career progression policy would outline steps employers and managers should be taking to develop specialist doctors as they reached the most senior pay points of their scale, as well as the regrading process itself.

3.192 The 2024 agreement in Northern Ireland included a commitment for employers to actively review current service delivery models with a view to the introduction of more specialist posts, along with guidance from the Department of Health on the creation of specialist posts.

3.193 The Department of Health said that, with imaginative team job planning, SAS grades could fill vacant consultant posts as specialists, if there was some adjustment of the scope of the role, and deliver significantly towards reducing waiting lists. Short-term funding which was used for locum cover needed to be shifted to long-term recurrent funding.

3.194 The BMA said progress on the creation of specialist roles in Northern Ireland was disappointing. It said this was compounded by the Department of Health's refusal to introduce a commitment, similar to that introduced in Wales, to allow specialty doctors to request a transfer to the specialist post. It said this would have shown a significant commitment to specialty doctors' career progression and unlocked further potential among

this group to assist with tackling the huge waiting lists in HSC. The BMA also noted that the specialist role was not in the workforce census.

Earnings

3.195 In the year to December 2024:

- Average earnings per head for specialty doctors in England were £85,424, 6.2 per cent higher than a year earlier. Basic pay increased by 9.1 per cent over the year, while non-basic pay fell by 5.5 per cent. Non-basic pay made up 18 per cent (£15,000) of specialty doctor average earnings per head.
- Average earnings per head for specialist/associate specialist doctors in England were £112,656, 5.9 per cent higher than a year earlier. Basic pay increased by 6.9 per cent over the year, while non-basic pay increased by 1.7 per cent. Non-basic pay made up 18 per cent (£20,400) of specialist/associate specialist average earnings per head.

3.196 In 2023-24, average total pay per FTE for staff grades (including specialty doctors and associate specialists) in Scotland was £97,826, 9.0 per cent higher than 2022-23. Basic FTE pay increased by 8.1 per cent over the year. Non-basic pay made up 16 per cent of FTE earnings.

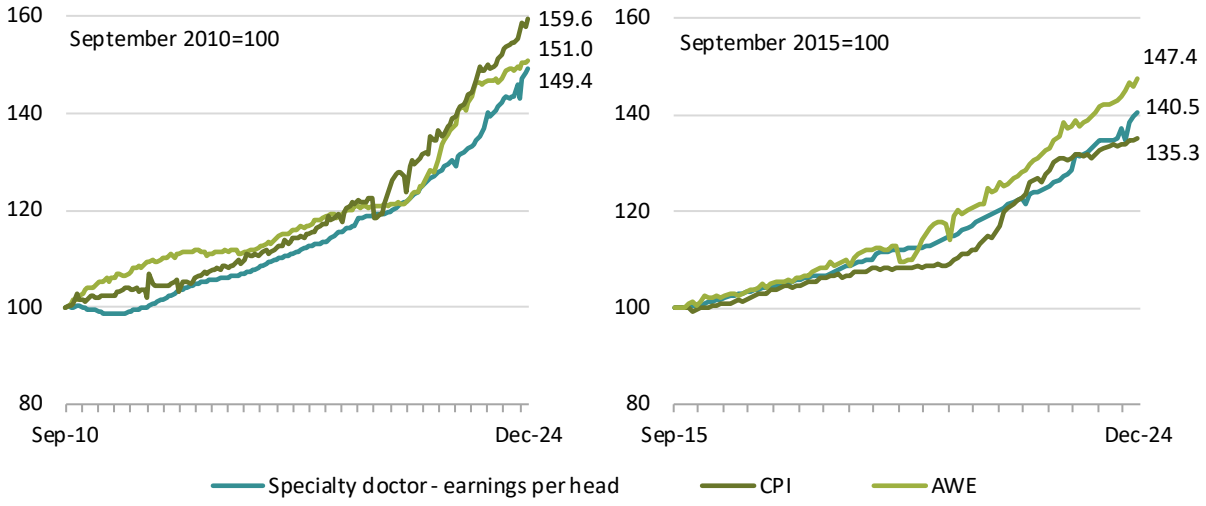
3.197 Comparisons of changes in earnings and prices over time are sensitive to the base year chosen. Between the year to September 2010 and the year to December 2024, the CPI increased by 51 per cent and average weekly earnings increased by 60 per cent. Over the same period:

- Specialty doctor earnings per head in England increased by 49 per cent.
- Specialist/associate specialist earnings per head in England increased by 43 per cent.

3.198 Between the year to September 2015 and the year to December 2024, the CPI increased by 35 per cent and average weekly earnings increased by 47 per cent. Over the same period:

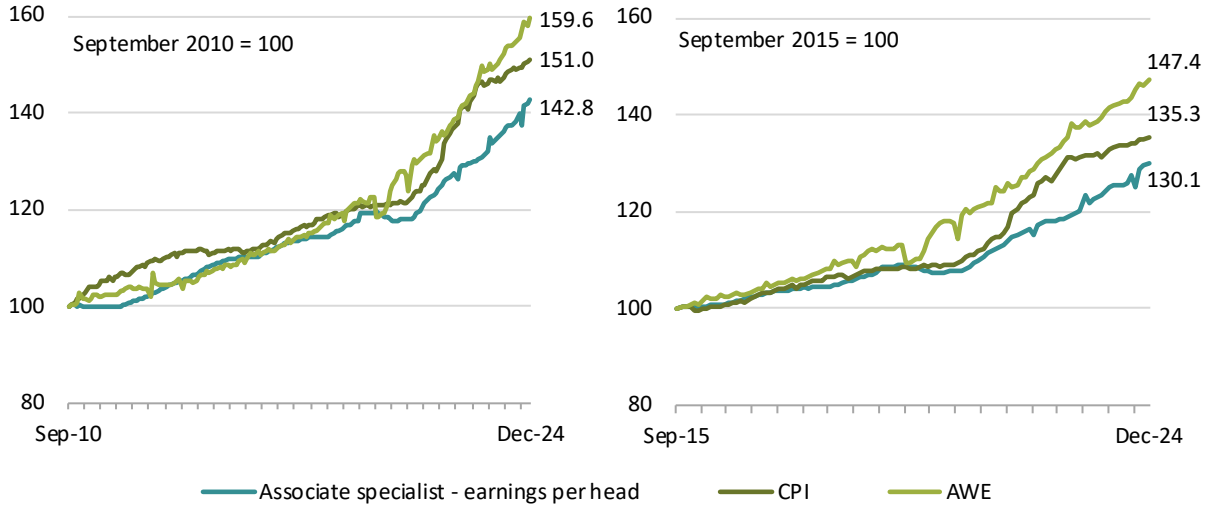
- Specialty doctor earnings per head in England increased by 41 per cent.
- Specialist/associate specialist earnings per head in England increased by 30 per cent.

Figure 3.19: Specialty doctors, mean earnings per person, CPI and AWE, England, September 2010/September 2015 to December 2024



Source: OPRB analysis of NHS England and ONS data.

Figure 3.20: Specialist/associate specialist doctors, mean earnings per person, CPI and AWE, England, September 2010/September 2015 to December 2024



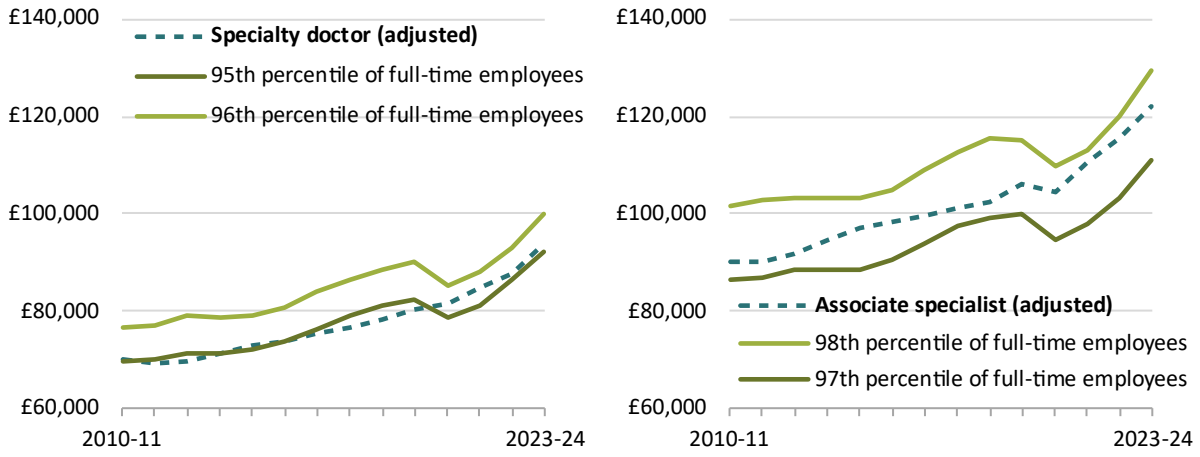
Source: OPRB analysis of NHS England and ONS data.

Pay comparability

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

3.200 Estimated average earnings per FTE for specialists/associate specialists have been consistently between the 97th and 98th percentile of all full-time employees since 2010-11. After falling back towards the 97th percentile between 2015-16 and 2018-19, associate specialists' average earnings have been closer to the 98th percentile than the 97th percentile since 2020-21.

Figure 3.21: Average total earnings per FTE of SAS doctors, England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2023-24



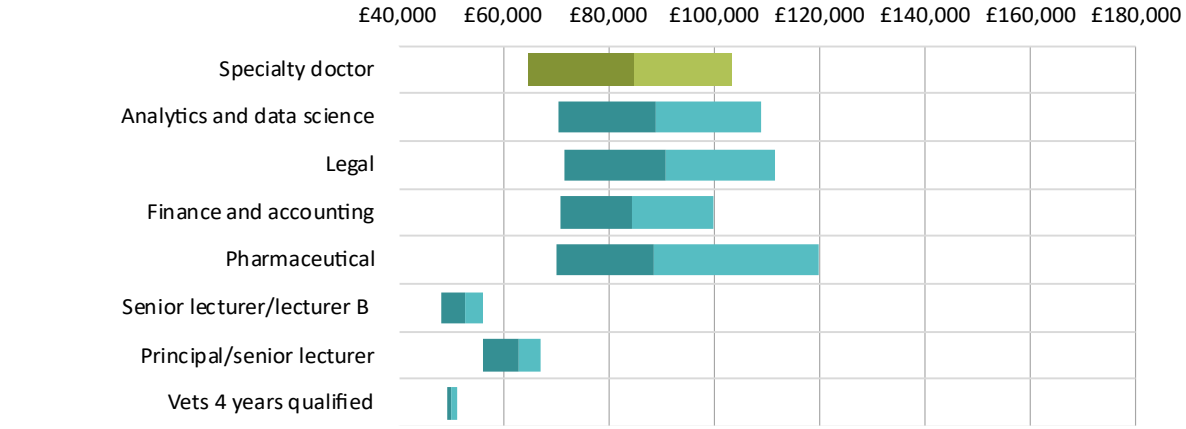
Source: OPRB analysis of NHS England and ASHE data.

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

3.201 Specialty doctors in England have similar earnings to other professional comparators (analytics/data science, legal, finance/accounting, pharmaceutical) and earn more than their veterinary and academic comparators. The position is broadly unchanged over the year. Associate specialist/specialist doctors in England earn more than their veterinary and academic comparators, but less than their other professional comparators (analytics/data science, legal, finance/accounting, pharmaceutical). The gaps have increased since last year.

3.202 Job levelling and market data from WTW indicate that base pay and average earnings for both specialty and specialist doctors are significantly above both the market median and the market upper quartile.

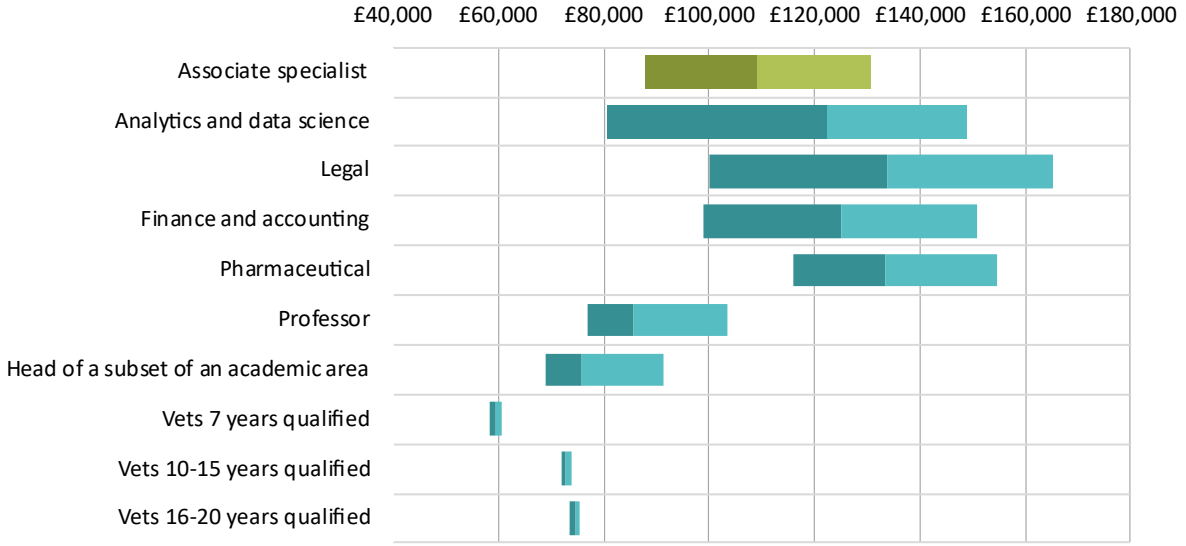
Figure 3.22: Interquartile range of total earnings of specialty doctors, headcount, England, compared with professional groups, 2024



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

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

Figure 3.23: Interquartile range of total earnings of associate specialist/specialist doctors, headcount, England, compared with professional groups, 2024



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

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

Working lives

3.203 On our visits, SAS doctors raised issues with a lack of recognition from senior doctors and a sense of isolation from decision making.

3.204 NHS Employers said that the role of the SAS advocate, introduced with the 2021 SAS contracts, was crucial for maintaining engagement and collaboration among SAS staff. In organisations where this role had been fully supported, it had led to improvements in recruitment, retention and the overall wellbeing and morale of SAS doctors. Employers had noted positive experiences and increased visibility for SAS doctors with access to an advocate. NHS Employers said their shared intention with the BMA was to encourage all NHS organisations to appoint an SAS advocate.

3.205 In the recent agreement in Northern Ireland, the Department of Health committed to fund the introduction of SAS advocates in each trust and to provide recurrent funding for the associate dean and SAS leads.

3.206 The BMA noted that the demographics of the SAS group could mean they were more likely to be the recipients of not only gradeism, but also racist and xenophobic behaviour. It said that, despite the creation of the SAS advocate role, many doctors still had no access to this resource.

Consultants

Recent pay agreements

3.207 Prior to our report last year, an agreement was reached with consultants in England effective from 1 March 2024. This reduced the number of pay points from eight to five, and the time taken to reach the top pay point from a minimum of 19 to 14 years. Increases to individual pay points ranged from zero to 12.8 per cent. Including the DDRB-recommended 6 per cent from 1 April 2023, this equated to uplifts to basic pay of between 6.0 per cent and 19.6 per cent for 2023-24.

3.208 Agreement was reached with consultants in Wales in June 2024 which reduced the pay scale from 14 points (including commitment awards) to eight. Commitment awards became part of the main scale (having been frozen in value in recent years). The time taken to reach the pay maximum was reduced from 18 to 15 years. There was a 5.2 per cent overall increase to the consultant paybill. Increases to basic pay ranged from 0.2 per cent to 10.9 per cent, effective from 1 January 2024, in addition to the 5 per cent uplift paid in 2023. The agreement included withdrawal of the BMA rate card and a commitment to work in social partnership to develop all-Wales extra-contractual rates for consultants with a view to being implemented during 2024-25.

3.209 Agreement was reached with consultants in Northern Ireland on a basic pay uplift of between 0.4 and 12.3 per cent, depending on the pay point, with an average uplift of 5.26 per cent effective from 1 March 2024. The pay scale was reduced from seven to five points, so it now takes 14 rather than 18 years to reach the maximum. The agreement also included the withdrawal of the BMA rate card; changes to shared parental leave to bring it in line with the rest of HSC; and a commitment by employers to roll out (previously agreed) pension flexibilities.

3.210 Consultants in England, Wales and Northern Ireland also received our 6 per cent recommended pay uplift from 1 April 2024.

3.211 Agreement was reached with consultants in Scotland on the 2024 pay uplift in November. This included a 10.5 per cent increase on basic pay from 1 April 2024. Discretionary points were increased by 12.4 per cent from £3,204 to £3,600.

3.212 The agreement in Scotland included a commitment to undertake further work via task and finish groups under the Joint Negotiation Committee between Scottish Government, BMA Scotland and NHS Employers. These groups will seek to conclude in 2025-26 and will be tasked with:

- Discussions on the balance of different elements of the job plan for consultants to facilitate attractive employment opportunities within NHS Scotland and to enable retention of the existing workforce.
- Discussions to agree a national rate for internal short-term cover to improve continuity of care and help alleviate agency and locum spend within NHS Scotland. The agreement included the withdrawal of the BMA rate card.

Contract reform

3.213 The DHSC said in evidence that, despite the recent agreement, there remained elements of the consultant contract that were out of date and out of step with the rest of the NHS workforce and it remained its ambition to modernise terms and conditions.

3.214 NHS Employers said that no further funding was expected to be available to invest in any significant reform of the 2003 contract in the short-to-medium term. Employers had described the 2003 contract as 'outdated', with its provisions making it challenging to deliver services that met the needs of the more varied and complex range of working patterns that had developed since the contract's inception.

3.215 In supplementary evidence, NHS Providers said that the job planning process for consultants could be refined. It said it would be useful to think about the difficulties NHS trusts might face in allocating programmed activities between direct clinical care and supporting professional activities. This might be through offering a greater degree of accompanying national guidance on how to ensure job plan flexibility (subject to service need) where possible. It also said it would be useful to re-examine (and update where necessary) national guidance on managing interactions between private and NHS work within employment contracts, so that the freedom for consultants to practice privately was upheld, while also ensuring that trusts had the necessary resources available to them during periods of high pressure. Furthermore, any refresh of the consultant contract should look at flexible working and out-of-hours payments.

3.216 In oral evidence, NHS England suggested that contract reform could cover provision of unsocial hours and the ability to opt out from weekend work. It said this restrained the NHS's ability to deliver 24/7 care. It also noted that the job planning process could be more flexible and responsive to service needs.

3.217 The BMA said that, as a result of the agreement in England, the consultants' pay scale had an anomaly at pay threshold 2, which was split between pay point 2a (three years completed as a consultant) and 2b (four years completed as a consultant). The BMA said it expected this additional pay point to be temporary.

3.218 BMA Scotland said it sought a similar approach to other nations, to reduce the length of pay scales and improve pay progression and lifetime earnings. It said the Scottish Government was unable to supply adequate workforce and pay information to enable accurate modelling of proposals.

3.219 The agreement with consultants in Wales included a commitment to undertake scoping work on contract reform during 2024-25. The Welsh Government said this would consider the need for reform, timetable, and level of investment required, with a view to developing a future mandate. In oral evidence, the Welsh Government said it would like to create flexibility on 24/7 working without significant extra-contractual rates.

3.220 The Department of Health in Northern Ireland noted that there had been no real progress made on consultant contract reform. In oral evidence, it said it would like to move consultants onto a seven-day-a-week service, with changes to premium and plain time.

Pay and earnings

3.221 Under 2024-25 pay scales for consultants:

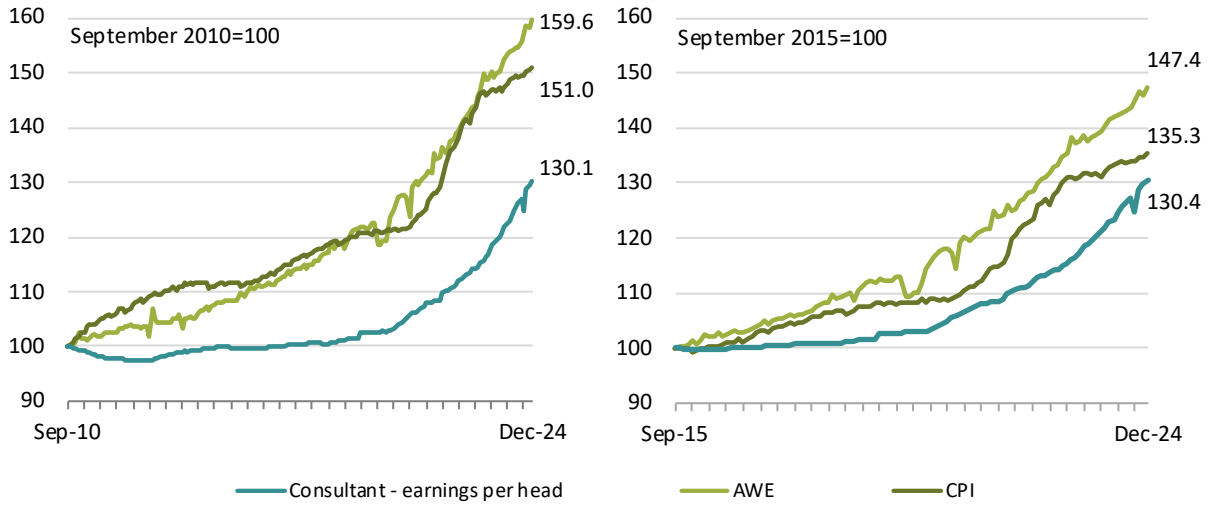
- Scotland has the highest minimum salary at £107,144, 1.6 per cent higher than the lowest minimum of £105,504 in England.
- Wales has the highest maximum salary at £154,760, 10.6 per cent higher than the lowest maximum of £139,882 in England. This follows the recent pay agreement in Wales, which made commitment awards part of the main pay scale.

3.222 The BMA noted that the top pay point for consultants in England was the lowest across the UK and called for it to be uplifted so it was at least equal to Wales.

3.223 In the year to December 2024, average earnings per head for consultants in England were £145,133, 8.4 per cent higher than a year earlier. Basic pay increased by 11.0 per cent over the year, while non-basic pay increased by 0.6 per cent. Non-basic pay made up 23 per cent (£32,800) of consultants' average earnings per head.

3.224 In 2023-24, average total pay per FTE for consultants in Scotland was £150,132, 4.4 per cent higher than 2022-23. Basic pay increased by 4.4 per cent. Non-basic pay made up 26 per cent of FTE earnings.

Figure 3.24: Consultants, mean earnings per person, AWE and CPI, England, September 2010/September 2015 to December 2024



Source: OPRB analysis of NHS England and ONS data

3.225 Comparisons of changes in earnings and prices over time are sensitive to the base year chosen. Between the year to September 2010 and the year to December 2024, consultant earnings per head in England increased by 30 per cent, compared with an increase in average

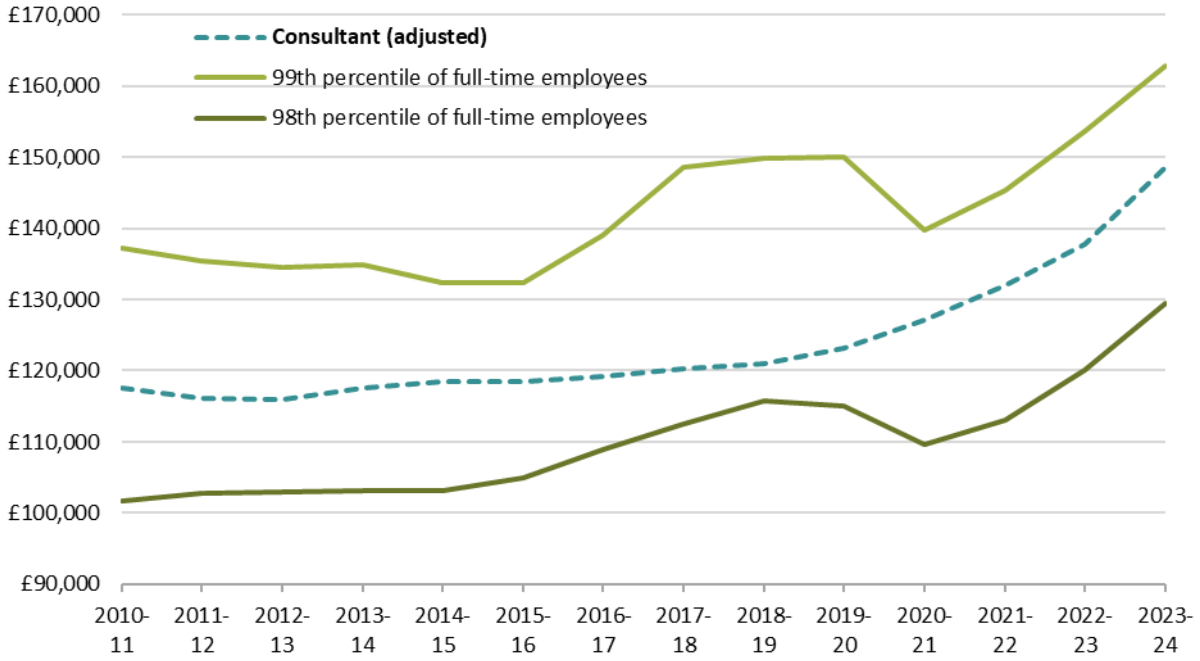
weekly earnings of 60 per cent, and in the CPI of 51 per cent over the same period. The differences have narrowed since May 2023 (CPI) and June 2023 (AWE).

3.226 Between the year to September 2015 and the year to December 2024, consultant earnings per head increased by 30 per cent, compared with an increase in average weekly earnings of 47 per cent, and in the CPI of 35 per cent over the same period.

Pay comparability

3.227 Since 2010-11, estimated average earnings per FTE consultant have been consistently between the 98th and 99th percentile of all full-time employees. Between 2015-16 and 2018-19, consultant average earnings fell back towards the 98th percentile. This was reversed between 2018-19 and 2020-21 as consultant average earnings continued to grow while earnings at the 98th and 99th percentiles fell.

Figure 3.25: Estimated average total earnings per FTE of consultants, England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2023-24



Source: OPRB analysis of NHS England and ASHE data.

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

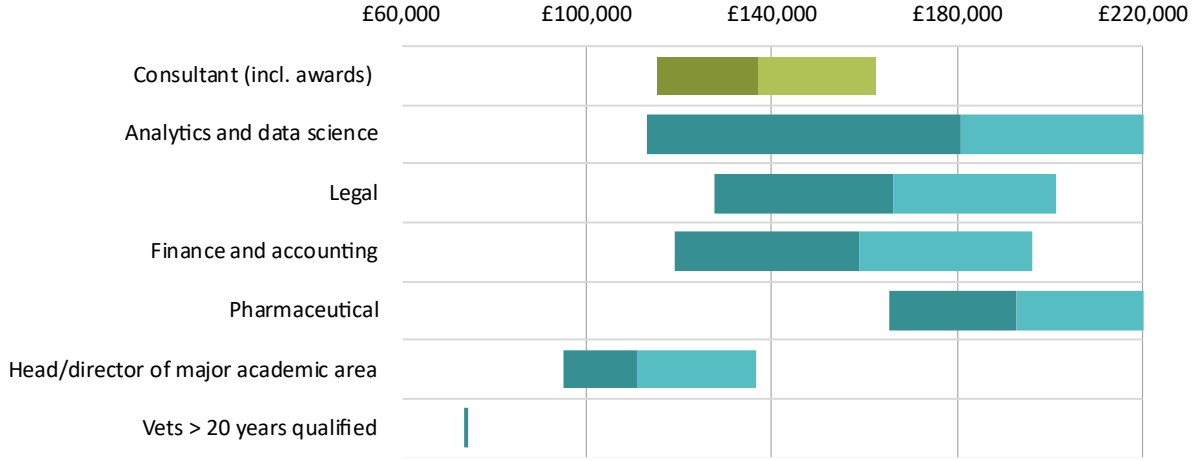
3.228 Using job evaluation, we compare consultant roles to equivalent roles in analytics and data science, finance/accounting, pharmaceutical, academic and veterinary sectors. This is based on an evaluation conducted in 2017. Consultants earn more than their veterinary and academic comparators, but less than their other professional comparators (analytics/data science, legal, finance/accounting and pharmaceutical).

3.229 Pending a wider-scale review, we have supplemented this analysis with job evaluation from WTW and have compared roles to their main industry database. Job levelling and market data from WTW indicate that base pay and average earnings for consultants are broadly in line with the market median (97-112 per cent).

3.230 The data we have on comparative earnings for specialists/consultants (set out in appendix F) indicate that UK salaries are ahead of New Zealand but behind Australia, Canada and Ireland.

The BMA said that take-home pay for consultants in Ireland was 50 to 70 per cent higher than in Northern Ireland.

Figure 3.26: Interquartile range of total earnings of consultants, headcount, England, compared with professional comparator groups, 2024



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

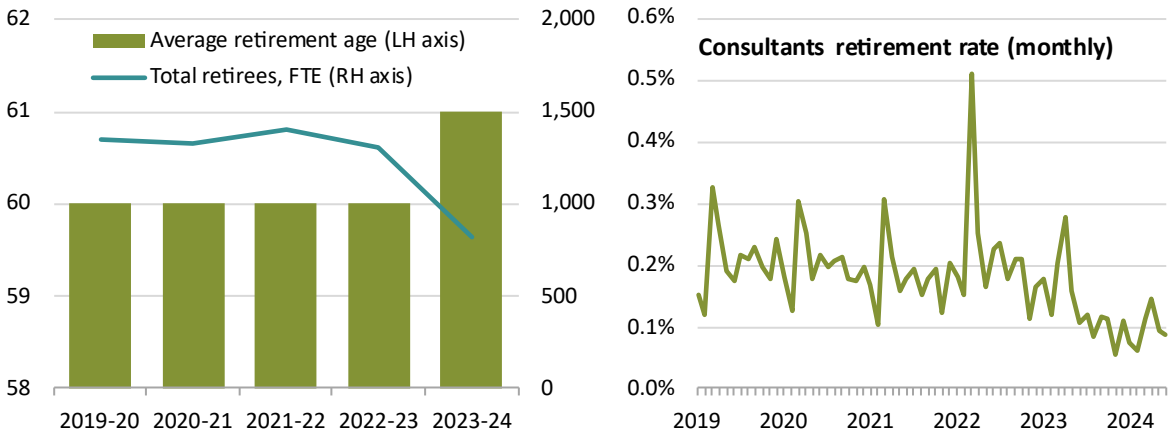
Notes: Pay for other professions is on a full-time equivalent basis, whereas for consultants it is on a headcount basis, and so is lower than it would be on an FTE basis. Individual medical and dental roles are matched by job size to market data.

Working lives

3.231 The Department of Health in Northern Ireland said there were increasing requests from consultants seeking to reduce intensive out-of-hours/on-call patterns, which the Department said was challenging and problematic to facilitate given the impact on the service. It said it continued to encourage team job plans and innovative job planning approaches to help facilitate better work-life balance while also meeting the needs of the service. Average programmed activities for consultants in Northern Ireland were 11.3 PAs, with 43 consultants contracted for above 12.5 PAs.

3.232 Data from NHS England showed a notable increase in the average retirement age for consultants, from 60 to 61, and a reduction in the numbers retiring.

Figure 3.27: Average retirement age, total retirees, and retirement rate, consultants in England, 2019 to 2024



Source: NHS England.

Consultant reward schemes

3.233 Historically, each nation has operated a different system of discretionary pay for consultants, with typically a lower and a higher award scheme: local clinical excellence awards (CEAs) and national clinical impact awards (CIAs) in England; commitment awards and national CIAs in Wales; a paused CEA scheme in Northern Ireland; and discretionary points and distinction awards (which have not been awarded since 2010) in Scotland.

3.234 There have been a number of recent developments to these schemes:

- The 2024 agreement with consultants in England ended the local clinical excellence award scheme, moving the funding into basic pay. Some awards are still in payment under the old scheme.
- The 2024 agreement with consultants in Wales made commitment awards, which were additional discretionary pay points at the top of the pay scale, part of the main pay scale.
- The Scottish Government said it was not seeking any recommendations from DDRB on discretionary points or discretionary awards. While both had been frozen in value since 2010, discretionary points were increased in the 2024 pay agreement with consultants.
- There are no active clinical excellence award schemes in Northern Ireland, although there has been a recent consultation on their reintroduction.

National clinical impact awards in England and Wales

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

3.236 The total cost of awards in England in 2023-24 was £110.8 million, including £6.9 million of new awards granted in the 2023 round.

3.237 The Advisory Committee on Clinical Impact Awards (ACCIA) annual report said that consultants granted awards in the 2023 round: led research that contributed to national treatment protocols for COVID-19; helped establish new training and education pathways for the next generation of doctors; validated novel uses of artificial intelligence in clinical decision making; as well as thousands of other examples that made a real difference to patients and staff in the NHS.

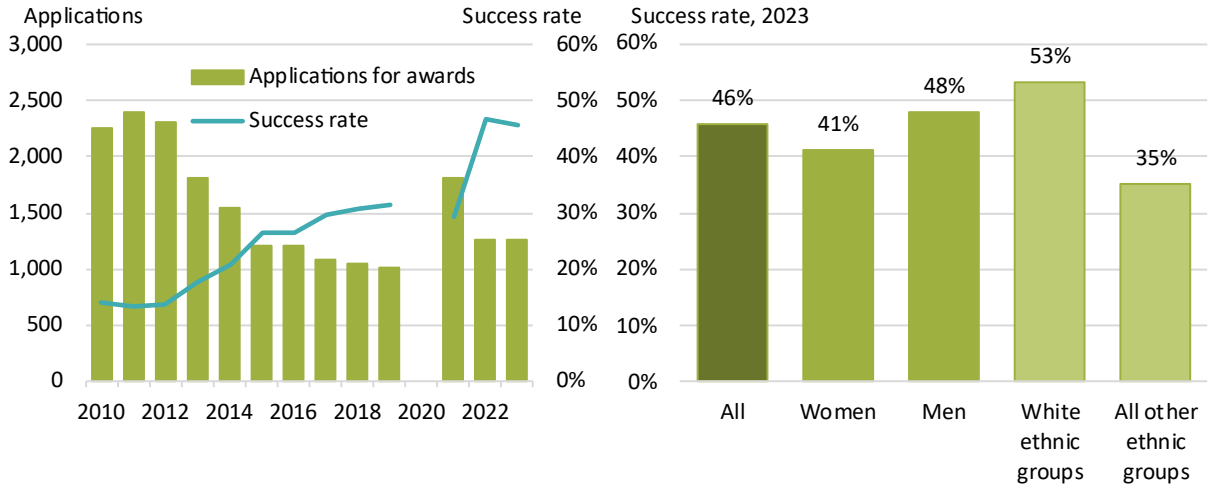
3.238 In 2023, there were a total of 1,257 applications for new awards: 1,170 in England and 87 in Wales.[32] A total of 576 new awards were granted – 539 in England and 37 in Wales – resulting in an overall success rate of 46.1 per cent in England and 42.5 per cent in Wales. Just over half (50.9 per cent) of new awards were given to applicants with no previous award, down from 54.7 per cent in 2022.

3.239 ACCIA said that it received 33.5 per cent of applications from women and 64.1 per cent from men in England and Wales in 2023, representing a 0.2 percentage point increase in the share of applications from women from 2022. In total, 67.2 per cent of awards granted were to men (up by 0.1) and 30.0 per cent to women (down by 0.7). There was a 5.2 per cent increase in applicants identifying as other or preferring not to say. The success rate was 48.0 per cent for men and 41.1 per cent for women. The success rate gap between men and women widened

[32] UK Government, *Advisory Committee on Clinical Impact Awards: annual report for the 2023 awards round*. https://www.gov.uk/government/publications/accia-annual-report-for-the-2023-awards-round/advisory-committee-on-clinical-impact-awards-annual-report-for-the-2023-awards-round

from 1.2 percentage points in 2021, to 5.5 percentage points in 2022 and 6.9 percentage points in 2023.

Figure 3.28: Applications and success rates for new clinical impact awards, England and Wales, 2010 to 2023



Source: ACCIA.

3.240 ACCIA noted that there was still an under-representation for women in both application and award rates when compared to the wider consultant population. It said that although it had seen a positive increase in applications from women, there was still more to be done to encourage and empower this cohort to apply.

3.241 Of the total applications in 2023, 58.6 per cent were from white ethnic groups, 38.2 per cent were from all other ethnic groups combined, and 3.3 per cent came from those who did not specify their ethnicity. The success rate among white ethnic groups was 53.1 per cent, compared to 35.0 per cent for all other ethnic groups. ACCIA said there was an over-representation of white ethnic groups, both in applications and in success rates, but that the proportion of applications received was very close to the balance of the consultant workforce. However, it said the widening of the gap in success rates between 2022 and 2023 was cause for concern.

3.242 The proportion of CIA applicants declaring a disability was higher than the wider consultant workforce, with a slightly higher success rate (48.9 per cent).

3.243 The DHSC said that reforms to national CIAs had shifted the scheme's focus to acknowledge those who had made a substantial impact on the NHS at a national level, rather than merely considering the status or activity input of a clinician. Examples included system reports on how the NHS could function more efficiently, with recommendations that had been endorsed and implemented nationwide. It said that clinicians had delivered research that had fundamentally changed national and international guidelines, introduced new therapies and treatment pathways, and positively impacted patients globally. They had also served as role models and mentors for other clinicians, providing training for emerging researchers and fellows. Additionally, they had delivered innovative local work that had demonstrated increased productivity and better patient outcomes, which had subsequently been adopted across the country.

3.244 The DHSC said that awards were granted to applicants from major teaching hospitals, medical schools, smaller trusts in underdoctored areas and, increasingly, consultants employed by organisations such as charities who delivered contracted-out NHS services.

3.245 The DHSC said that removing the pro-rating of less-than-full-time applicants had been crucial to its retention strategy. It said that less-than-full-time consultants made up 19 per cent of clinicians awarded a CIA since 2022.

3.246 NHS England said it lacked an evidence base to evaluate the effectiveness of the national CIA scheme in supporting the recruitment and retention of medical staff or its impact on patient care and productivity. However, it said that national CIAs were an attractive part of the wider total reward offer for the consultant workforce.

3.247 NHS Providers said that national CIAs were generally viewed by human resources directors as a good way to recognise high performing doctors. However, there was an overall sense that the scheme did not positively affect as many colleagues as it could, perhaps pointing to a need to widen access and/or participation.

3.248 The BMA raised a number of concerns around national CIAs [in comparison to the closed schemes]: the lower value of the national awards, their non-pensionability; and the inability of consultants to hold a national award concurrently with a local award. It said this negatively impacted total compensation and would impede recruitment and retention. It called for the overall pot for CIAs and award values to be uplifted so that the real-terms value of awards did not erode over time.

3.249 The HCSA said that 38 per cent of members it surveyed did not know what a national CIA was, while 48 per cent knew what one was but had no intention of applying in the future. Of those who currently held a national CIA, one in 10 said the award had made them significantly more motivated, but 77 per cent said it had made no difference. Only 3.5 per cent of respondents said the scheme's existence made them more motivated and 18.5 per cent said it reduced their level of motivation. The HCSA was concerned that national CIAs could not be an important component of the potential reward package if awareness was so low.

3.250 In oral evidence, the Welsh Government said there had been an increase in equality and diversity in those applying for the awards and representation across health boards had increased. It said the scheme was still settling in, but it had worked as an incentive. It noted that if the level of the award went up, causing fewer awards, then this might set things back.

Interaction with local CEAs and pensions

3.251 The BMA said that, because holders of pre-2018 pensionable local CEAs needed to give these up for a national CIA (which was non-consolidated and non-pensionable), this was financially disadvantageous. It called for the removal of the restriction on holding both a local and national award concurrently. It also called for payment protection for those moving from an old CEA, so that payment of the new CIA was in the form of a local CEA to ensure doctors were not financially worse off than if unsuccessful.

3.252 ACCIA said that, in the 2023 round, 12 individuals granted a national CIA declined the award after application outcomes had been announced, as they stated that they wished to retain their local CEA for financial reasons.

3.253 NHS Employers said they would continue to work with stakeholders to resolve residual issues associated with the reform of local CEAs, primarily concerned with interactions between pre-

2018 local CEAs (which were retained and remained pensionable and consolidated) and national CIAs.

3.254 The DHSC said that changes to pension rules had enabled clinicians to keep their national CIA and remain working in the NHS while claiming pension benefits. It said that, as a result of these changes, around 10.4 per cent of award holders, who would have otherwise lost their award, remained in the pension scheme (and the NHS).

Local clinical excellence awards in England

3.255 The DHSC said that, in the context of a limited envelope available for reform, it was agreed that redeploying local CEA funding into basic pay supported the shared ambitions of significantly reforming the pay scale. Consolidated local CEAs awarded prior to reform in 2018 have been retained. The DHSC said that the value of these awards would be frozen, and it was not seeking recommendations on an uplift. As part of the 2024 agreement, the review process for these awards was removed.

3.256 In oral evidence, most parties supported the closing of the local CEA scheme in England, saying it created division within multi-disciplinary teams, that it did not drive excellence, and that its removal had a positive impact on equalities. However, it was acknowledged that there was now no lever to incentivise consultants locally, in particular for taking additional roles such as educators. It was noted that, without the local scheme, the national scheme might need to refocus its awards in terms of what was being recognised. The BMA noted the much lower maximum value in consultants pay than under past schemes.

Discretionary points and distinction awards in Scotland

3.257 The Scottish Government said that no new distinction awards had been made as these did not align with its progressive pay principles. Consultants who received awards prior to the freeze were still in receipt.

3.258 The availability of new discretionary points increased in line with the number of consultants in post and they were uplifted from £3,204 to £3,600 as part of the 2024 consultant pay agreement. The Scottish Government said this ensured that Scotland continued to offer a competitive pay package for consultants, so it was not seeking any recommendations on distinction awards or discretionary points.

3.259 BMA Scotland said that the 12.35 per cent uplift to discretionary points in 2024 was a significant step in the overall compensation package for consultants. It said that discretionary points had not previously been uplifted since 2010 and had therefore fallen significantly in real terms value. It said they were worth £7,500 on average to consultants. The BMA said that any future DDRB award that did not include an uplift to discretionary points in Scotland would be inconsistent with the principles established for the 2024-25 pay uplift.

Commitment awards in Wales

3.260 The 2024 pay agreement for consultants in Wales made commitment awards part of the main pay scale, so that they are no longer discretionary.

Clinical excellence awards in Northern Ireland

3.261 The Department of Health said that the clinical excellence awards scheme in Northern Ireland had been on pause for a number of years, with no new awards being made. Existing awards continued to be paid where applicable. The Department was considering responses to a consultation on reforming the clinical excellence award scheme. The aim was to introduce a

new scheme which was affordable, modernised the arrangements for making awards, and rewarded the highest-performing consultants who went over and above the standards expected of them. The consultation also sought views on expanding the awards scheme to other senior medical staff.

3.262 BMA Northern Ireland said it had been lobbying for many years for the reintroduction of CEAs, including starting a legal case against the Department of Health. This resulted in mediated discussions on the development of a new scheme throughout 2023.

3.263 In terms of affordability, the Department said it was facing an impossible position. The proposed scheme would require a further allocation of funds for which Ministerial approval would be required. In oral evidence, the Department said that work on clinical excellence awards was paused until they had more capacity and possibly an identified funding stream.

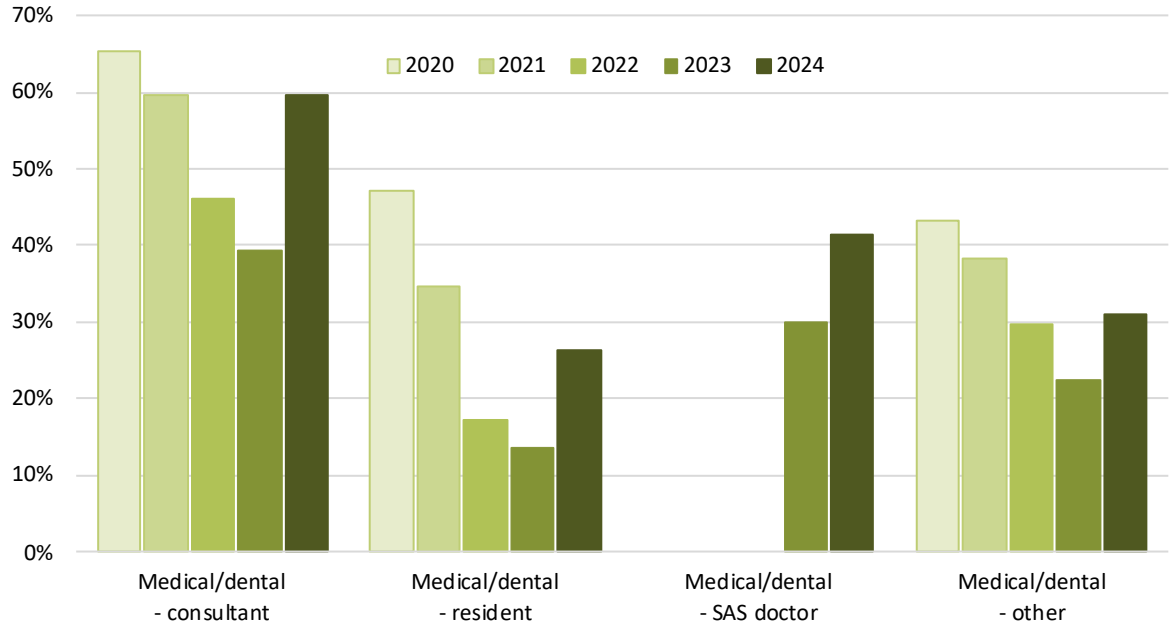
Motivation and morale

3.264 The NHS staff survey for England showed better results for medical and dental staff in 2024 than in both 2022 and 2023. However, the results for 2024 generally remained worse than those recorded in 2020.

3.265 The survey showed an increase in satisfaction with pay. In 2024, 48 per cent of medical and dental staff said they were satisfied or very satisfied with their pay, an increase of 16 percentage points from 32 per cent in 2023. A larger proportion of consultants said they were satisfied with their pay than other groups of medical and dental staff:

- 60 per cent of consultants said they were satisfied with their pay, an increase of 20 percentage points from 2023.
- 28 per cent of resident doctors and dentists said they were satisfied with their pay, an increase of 13 percentage points from 2023.
- 41 per cent of SAS doctors said that they were satisfied with their pay, an increase of 11 percentage points from 2023.

Figure 3.29: HCHS doctors and dentists, satisfaction with pay by grade, England, 2020 to 2024



Source: NHS Staff Survey

3.266 Compared with 2023, there were increases in the percentages of medical and dental staff saying that: they were looking forward to going to work; were enthusiastic about their job; felt their line manager and their organisation valued their work; and that they would recommend their organisation as a place to work. There were also reductions in the percentage saying that: they had considered leaving the NHS; and that they had experienced harassment, bullying or abuse from patients, relatives or the public.

3.267 Compared with 2023, there were increases in the percentage of medical and dental staff saying that: they could meet the conflicting demands on their time; there were adequate supplies and staff for them to do their job properly; and that they were able to achieve a good balance between work and home life. There were also reductions in the percentage saying that they had felt unwell as a result of work-related stress and that they felt burnt out because of work. There was a reduction in the percentage of staff saying that they had worked hours over and above their contracted hours (both paid and unpaid).

3.268 Further detail on the NHS staff survey results for medical and dental staff is in appendix H.

3.269 The HCSA said that its annual Hospital Doctors at Work survey painted a stark picture of consistently low morale and dangerous levels of stress and burnout. The survey found that almost half of hospital doctors had struggled with their mental health in the last 12 months. Nearly half (44 per cent) had suffered from anxiety, 20 per cent from depression, and 7.5 per cent had had suicidal thoughts. The HCSA said these figures suggested there was an ongoing mental health crisis among hospital doctors.

3.270 In Scotland, the Health & Social Care Staff Experience Survey 2024 showed a consistent picture for medical and dental staff.[33] In 2024, 81 per cent of medical and dental staff said their work gave them a sense of achievement, unchanged from 2023. In 2024, 82 per cent of medical and dental staff said they were treated fairly and consistently, also unchanged from 2023. In 2024, 74 per cent of medical and dental staff felt appreciated for the work they did, compared to 75 per cent in 2023.

3.271 The NHS staff survey for Wales does not give separate results for the medical and dental workforce.

3.272 There is no HSC-wide staff survey for Northern Ireland. The Belfast Health and Social Care Trust conducted its most recent Staff Experience Survey in March 2024. The trust-wide engagement score increased from 3.62 in 2021 to 3.71 in 2024 (on a five-point Likert scale). The medical and dental workforce score was 3.36 in the 2024 survey, decreasing from a score of 3.40 in 2023. It remained the lowest score in any professional grouping within the trust and well below the pre-COVID-19 score of 3.62.

Resident doctors

3.273 In the GMC's 2024 National Training Survey, 21 per cent of trainees (down from 23 per cent in 2023) were measured to be at high risk of burnout, and 52 per cent (down from 55 per cent in in 2023) described their work as emotionally exhausting to a very high or high degree.[34]

3.274 The BMA said that workforce shortages and increasing patient demand meant resident doctors had been faced with an unrelenting amount of work which had now become

[33] Scottish Government, *iMatter Health & Social Care Staff Experience Survey 2024.* https://www.gov.scot/publications/imatter-health-social-care-staff-experience-survey-2024/

[34] General Medical Council, *National training surveys reports*. https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/national-training-surveys-reports

unsustainable. It said that rota gaps were a persistent problem, with resident doctors expected to work overtime and miss breaks to cover gaps. It said resident doctors were burnt out, exhausted, suffering from poor mental health, relatively underpaid and demoralised. The BMA said that pay remained a central concern and driver for resident doctor satisfaction.

3.275 The HCSA said that nearly a third of resident doctors surveyed had missed an event of major life significance owing to being unable to get leave approved. Resident doctors were unable to use their full leave allowance.

3.276 HCSA members who were resident doctors considered the frequency of rotations to be excessive and unnecessary and highlighted the financial costs and impact on family life. Rotations often left doctors living some distance from their workplaces, with extended commutes prior to or following lengthy, tiring shifts, compounded by a lack of access to parking.

Our comments

3.277 There has been substantial growth in the size of the medical and dental workforce in secondary care in recent years, which has continued over the last year. Since 2019, the medical and dental HCHS workforce has grown by 26 per cent in England, by 17 per cent in Scotland, by 27 per cent in Wales, and by 16 per cent in Northern Ireland.

3.278 Alongside this, there is a notable improvement in recruitment and retention in most areas, with falling leaving rates and falling or stable vacancy numbers. Of particular note is the increase in the average retirement age for consultants in England and a reduction in the numbers retiring. The fall in applicants to study medicine seen in 2023 had been a concern, but the increase in 2024 indicates that medicine remains a very attractive career choice.

Working lives

3.279 We are encouraged to see some improvement this year in indicators of motivation, morale and wellbeing. The NHS staff survey for England showed better results for medical and dental staff in 2024 than those recorded in 2022 or 2023. However, the results for 2024 generally remain worse than those recorded in 2020. There was a significant increase in satisfaction with pay across the secondary care groups in 2024, especially among consultants, although satisfaction with pay among resident doctors remains low.

3.280 We continue to see high levels of dissatisfaction among resident doctors with their working lives, which has been clearly expressed to us during our visit programme. These concerns are widespread, from unhappiness with the immediate working environment, such as a lack of facilities for hot food or rest, to the need to regularly relocate to enable training progression, with the associated cost and disruption, and rising apprehension around job security and access to training places. We are also concerned to hear the ongoing high emotional toll of working as a resident doctor, and of the considerable impact on personal and family lives.

3.281 It is welcome that these concerns are being recognised by NHS Employers and NHS England. Improving the working lives of resident doctors needs to be a priority for employers in the coming months. We would expect the current review to set clear and measurable objectives for progress. Investment in working facilities and arrangements for resident doctors is likely to be cost effective in terms of the improvement to motivation and commitment.

3.282 We continue to lack evidence on motivation, morale and wellbeing among HCHS doctors and dentists in Wales and Northern Ireland. This is important in improving the effectiveness of the

workforce and we hope it can be addressed. We understand there is an NHS staff survey in Wales; we would like to see these results for the medical and dental workforce.

Training places

3.283 There are a number of contradictions in the evidence on training places. While there is increasing concern among resident doctors about a lack of training places in England in particular, and core training fill rates are at 100 per cent, the evidence that UK doctors are applying for, and failing to get, a training place is weak. One of the factors contributing to high competition for training places is multiple applications, especially from non-UK applicants. We also note the high level of international recruitment that has been used to fill training places in recent years. Alongside a recognised shortage of training places in England is growing use of locally employed doctors to perform similar work, many of whom have been recruited internationally.

3.284 By contrast, in Northern Ireland and, to a lesser extent, Scotland, training places are unfilled. There is extensive use of locums to support the resident doctors' rota in Northern Ireland.

3.285 NHS England announced a review of postgraduate medical training in February 2025, which is due to report this summer.[35] We would expect this to look at whether there are the appropriate number of training places to address current and future service need, how many UK graduate doctors are not getting a training place, and plans for the increased number of medical graduates coming through. We would also expect the review to examine the impact rotational training has on the lives and wellbeing of doctors in training. This review needs to link to detailed workforce planning, as we discussed in chapter 2.

Flexible pay premia

3.286 Some training specialties and localities are more popular than others. Additional payments play an important role in incentivising trainees to the less popular training places. For some specialties, such as general practice and oral-maxillofacial surgery, flexible pay premia are in place to compensate for lower potential earnings capacity (due to less opportunity to earn additional pay or longer training).

3.287 Despite the DDRB consistently calling for evidence on the effectiveness of flexible pay premia since 2018, none has been received. No evidence was provided by the DHSC or NHS England on flexible pay premia at all this year.

3.288 It is hard to support the continued payment of flexible pay premia at core training level, given the very high fill rates. While there are vacancies at higher training levels in some specialties. fill rates are largely a function of the numbers coming through core training, so the effectiveness of flexible pay premia is limited. There is also little evidence on whether payments are correctly targeted. We note that the targeted payments for GP training in certain localities are not being continued in 2025, due to the high fill rates.

3.289 We estimate the cost of flexible pay premia to be close to £100 million in England, funding which might be better invested elsewhere in the training programme. A review of these payments to assess their value for money and effectiveness is long overdue. This should be linked to a clear picture on future training place requirements from a refreshed workforce plan and would then need to feed into future contract negotiations.

[35] NHS England, *Medical training review*. https://www.england.nhs.uk/postgraduate-medical-training-review/

Locally employed doctors

3.290 Locally employed doctors, as doctors who are working in the NHS, are part of our remit. The group covers a diverse range of roles. The evidence we have received on locally employed doctors has improved, although we need to see this group clearly distinguished in the workforce data, separate from doctors on training programmes. This will enable a better understanding of the needs of locally employed doctors and how they can support patients and service delivery. We understand these doctors are more likely to be international medical graduates and from ethnic minority backgrounds. Workforce data on this group will help to highlight and address any issues around unfair treatment.

3.291 The evidence indicates strong growth in the number of locally employed doctors in recent years. The GMC reports that the number of locally employed doctors in England and Wales grew by 75 per cent between 2019 and 2023. This is driven by local decisions, rather than as a result of broader workforce planning. GMC data indicate that the locally employed doctor workforce is split roughly two-thirds/one-third between internationally recruited doctors and doctors that have completed foundation training in the UK but are not in core or specialty training. The group includes locally employed doctors at several different grades, such as registrars who have not yet secured a consultant post.

3.292 Locally employed doctors can bring benefits to trusts, providing a more consistent workforce than doctors in training. For individual doctors, the roles can offer more flexibility and a better work-life balance. While they are typically on terms which mirror the 2016 resident doctor contract, most posts are temporary and development in role is limited. Evidence from the DHSC shows that around half of locally employed doctors in 2023 were still locally employed doctors in 2024. A further 22 per cent moved into a training post and 16 per cent were not in the NHS in England one year later.

3.293 The 2024 agreement for SAS doctors in England included a joint piece of work to determine how locally employed doctors could be better supported to progress in their careers. We support this work. The growing use of locally employed doctors may have a positive impact on the NHS and patient care, especially where doctors are on appropriate terms and conditions to prevent unfair treatment and support development. Better evidence is needed to understand this.

3.294 This group may have different needs, as they undertake different roles, and therefore require a different workforce and reward strategy to doctors in training. The benefits of a separate pay framework for locally employed doctors should be seriously considered, which would enable a targeted workforce and reward strategy for this group in future.

SAS doctors and dentists

3.295 The 2024 pay agreements for SAS doctors across England, Wales and Northern Ireland have moved the pay scales on the new contracts very close together (or the same) across the four nations. They have also resolved some of the disparities between old and new contracts which we have highlighted previously. While the numbers on the new contracts are increasing, progress has been fairly slow across England, Wales and (in particular) Northern Ireland. Beyond pay, there are issues around process and understanding of the new terms that are slowing the uptake of the new contract. The recent agreements recognise and aim to resolve these. While it is important that the benefits of the new contract are clearly communicated to individual SAS doctors, as well as the mechanism for moving across, employers have made clear that there is little justification to further incentivise the new contract over the old one.

3.296 On our visits, SAS doctors frequently expressed dissatisfaction with recognition and development and described unfair treatment. These issues have been acknowledged, and we support the initiatives in the recent agreements on career development and the expansion of specialist roles. It is important that the potential of these roles is delivered across the health service, and these initiatives should be monitored.

3.297 A number of parties have highlighted the slow pace of creation of specialist roles. The recognition of this in the 2024 agreement in England, and the commissioning of research on why more specialist roles are not being created, is welcome. We hope to see progress in this area over the next year.

Pay comparability

3.298 This chapter has set out in some detail the earnings for doctors in secondary care relative to broader economic indicators and comparator salaries. Comparisons of changes in earnings and prices over time are sensitive to the base year chosen and the inflation measure used to adjust for real earnings. Between September 2010 and December 2024, average earnings for HCHS medical workforce groups have grown by between 1 per cent and 14 per cent less than CPI inflation. This does not account for changes in working hours or additional work. Since 2015, average earnings growth for the different groups has ranged from 5 per cent below to 5 per cent above CPI inflation.

3.299 Consultants and SAS doctors have maintained their position in the earnings distribution over the longer term. Consultant average earnings in England have been consistently between the 98th and 99th percentiles of all full-time employees since 2010-11, specialist doctors have been between the 97th and 98th percentiles, and specialty doctors have stayed at the 96th percentile.

3.300 Resident doctors have fallen back somewhat in recent years compared to all employees: registrar average earnings in England have fallen back from the 92nd to the 90th percentile of all full-time employees since 2010-11; average earnings in core training have fallen back from the 88th to the 84th percentile; average earnings at foundation year 2 have fallen back from the 80th to the 68th percentile; and earnings at foundation year 1 have fallen back from the 66th to the 53rd percentile. We note that even at the start of their careers, earnings for doctors are above the median for all employees.

3.301 Comparisons against equivalent roles in other sectors give a mixed picture, with some comparator professions paid more and some less. Mean average earnings for HCHS doctors showed strong growth in the year to December 2024, up 8.4 per cent to £99,700 in England. This will have improved the relative position of our remit group. Pay and career progression mean that the majority of individual doctors working in secondary care have seen above-inflation pay growth over the last 10 years. Median pay growth across medical and dental staff has been 4.1 per cent over the 10 years to March 2024, compared to an average inflation rate of 2.9 per cent.

Consultant reward schemes

3.302 The four nations are currently in different positions on discretionary pay and awards for consultants. Scotland is the only nation with an active local discretionary pay scheme. The Scottish Government has said it does not want a recommendation in this area. It has said that distinction awards do not align with its progressive pay principles. The BMA in Scotland has asked for an uplift to discretionary points in line with our main pay recommendation. An uplift was part of the recent pay agreement, recognising the priority the BMA gives to this. We

would welcome future evidence from parties about the use of discretionary points in Scotland and will continue to review this in future to consider if a recommendation is appropriate.

3.303 England and Wales have made local awards part of basic pay and no longer discretionary, so our main pay recommendation will apply by default. Northern Ireland does not have an active clinical excellence award scheme.

3.304 This means that any recommendation we make in this area will have a differential impact across nations, as the reward schemes are at different levels of operation. Since 2019, we have declined to make a recommendation that uplifts should be applied to consultant reward schemes, as a result of concerns over the schemes' equity and effectiveness. Last year we said we would like to receive further evidence on the effectiveness of the clinical impact award scheme, including its impact on patient care and productivity, and further reassurance on its equity, before we made a recommendation.

3.305 The national clinical impact awards scheme continues to show disproportionate awards going to men and to those from a white ethnic group, although outcomes have generally shown improvement. ACCIA have recognised that there is still much to do to ensure the scheme reflects the full diversity of the consultant workforce. It said it will continue to encourage more applications from consultants from diverse backgrounds and from all NHS specialties and would be conducting a review of processes to identify barriers to certain groups. We support this work, and the continued close monitoring of awards across workforce groups.

3.306 There are clear examples of the delivery of clinical excellence, innovation and leadership that are being rewarded by clinical impact awards. The scheme can play a key role in both incentivising and recognising this work. To best achieve this, the scheme should not be allowed to erode in terms of its value and scale. The current value of the awards – £20,000 to £40,000 a year for five years, with a further £10,000 award in Wales – are substantial. However, they have not been changed since the scheme's introduction.

3.307 We note that a number of consultants are reluctant to take a clinical impact award due to their relative lower value than under the previous pensionable and consolidated payments. We do not wish to unpick the recent reforms, not least given the damaging impact these closed schemes had on the gender pay gap, but this does add to the need to maintain the value of the current clinical impact awards.

3.308 Improving the understanding and accessibility of the clinical impact awards scheme will help to maintain its credibility, visibility and effectiveness. Equality outcomes might be supported by extending the scheme to a broader range of clinicians. We will continue to review the scheme, in particular how it might be used to drive overall productivity and improved health outcomes across the NHS.

3.309 We also said last year that we would like to see the other nations complete the reforms of their schemes and provide a clear statement on their future reward policies for discretionary pay for consultants. The situation is now clearer in Wales, although there has not been progress in Northern Ireland. We encourage all nations to explore how recognition of clinical excellence can drive improvements in health outcomes.

3.310 We would also like the DHSC and the Welsh Government to explore whether the national clinical impact award scheme can be extended to include other senior clinicians, such as specialists and GPs. Furthermore, while the Department of Health is considering the findings

of the consultation exercise in Northern Ireland, it may wish to look to the operation of the national clinical impact awards scheme in England and Wales as a way forward.

Chapter 4 General medical practitioners

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

4.2 This chapter looks at trends in the general practice workforce, recruitment and retention, general practice training, developments in GP contracts in each nation, earnings and pay comparisons, and motivation and morale. Our comments on the data and evidence are at the end of the chapter.

Workforce

4.3 In December 2024, there were 37,777 regular full-time equivalent (FTE) GPs in England, including those in training. This was 3.1 per cent higher than a year earlier and 12.7 per cent higher than five years earlier. There were 27,610 qualified permanent FTE GPs (excluding those in training) in England in December 2024, 2.9 per cent higher than a year earlier and 1.8 per cent higher than five years earlier.[36]

4.4 In England, the headcount of GPs has increased more quickly than the number of FTEs. This means it takes a greater number of headcount GPs to generate the same number of FTE GPs. In December 2016, it took 122 headcount qualified permanent GPs to generate 100 FTE qualified permanent GPs. By December 2024, this had increased to 136, up from 133 in December 2023.

Table 4.1: GPs, England, December 2024

	Headcount	Annual growth	FTE	Annual growth
All regular GPs	47,783	4.7%	37,777	3.1%
Qualified permanent GPs	37,456	4.8%	27,610	2.9%
Partner GPs	18,425	-2.7%	15,703	-3.2%
Salaried GPs	18,557	13.4%	11,613	12.4%
GPs in training	10,524	4.6%	10,167	3.4%
GP retainers	707	6.3%	295	6.8%
Locums	1,365	-11.4%	587	-11.2%

Source: NHS England.

4.5 Within the population of qualified permanent GPs, there has been a difference in the growth of GP partners and salaried GPs.[37] In December 2024, there were 15,703 FTE qualified permanent partner GPs in England, a fall of 3.2 per cent from a year earlier and a fall of 14.0 per cent over five years. In December 2024, there were 11,613 FTE qualified permanent salaried GPs, an increase of 12.4 per cent from a year earlier and an increase of 33.9 per cent over five years.

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

4.6 On average, GP partners work longer hours than salaried GPs. GP partners had a participation rate (the ratio of FTE to headcount) of 85.2 per cent at December 2024, compared to 62.6 per cent for salaried GPs. The change in the composition of the workforce means a larger headcount of GPs are required to generate a given number of FTE GPs.

4.7 NHS England said there was growing evidence that new GPs were not as inclined to become partners, resulting in a drop in the number of partners. The British Medical Association (BMA) said that the clinical and financial risks, unlimited liability and rising costs that GP contractors took on was no longer sufficiently rewarding to make the role attractive. NHS England said that other factors included the reduction in salaried GPs' appetite for raising the finance required to join practice partnerships (adding to their outstanding student loans) and managing the business activities and premises of a practice.

4.8 NHS England said that the number of new GP registrants with a non-UK primary medical qualification (PMQ) was 46 per cent in 2024 and was expected to exceed 50 per cent within the next two years. It said that GP headcount growth was largely due to international medical graduates (IMGs) completing their GP specialty training in the UK, rather than joining from abroad with recognised GP qualifications.

4.9 The number of FTE locum GPs in England has fallen substantially, by 11.2 per cent over the year to December 2024, and by 41.6 per cent over five years.

4.10 In March 2024, there were 3,453 FTE qualified GPs in Scotland, a fall of 0.7 per cent over the year, and fall of 4.7 per cent over five years. The FTE number of salaried GPs in Scotland grew by 5.6 per cent in the year to March 2024, while the number of FTE GP performers fell by 2.7 per cent.

4.11 The Scottish Government said the reduction in the number of GP performers reflected a broader trend towards fewer and larger practices incorporating multi-disciplinary teams to provide a wider range of services.

4.12 In 2024, just 12 per cent of salaried GPs in Scotland were contracted to work eight or more sessions per week, unchanged from 2023, while 32 per cent of salaried GPs were contracted to work four or fewer sessions per week, down from 34 per cent in 2023. Performer GPs in Scotland had an average 0.82 full-time equivalent in 2024, while salaried GPs had an average 0.67 full-time equivalent.

Table 4.2: GPs, Scotland, March 2024

	Headcount	Annual growth	FTE	Annual growth
All qualified GPs	4,438	-0.8%	3,453	-0.7%
Performers	3,105	-2.8%	2,554	-2.7%
Salaried	1,299	4.0%	875	5.6%
Retainers	53	3.9%	25	-5.3%

Source: General Practice Workforce Survey 2024.

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

4.13 In September 2024, there were 1,937 FTE GPs employed in Wales, 3.0 per cent more than a year earlier, and 3.2 per cent higher than December 2021.

Table 4.3: GPs, Wales, September 2024

	Headcount	Annual growth	FTE	Annual growth
All GPs	2,666	5.8%	1,937	3.0%
Partner GPs	1,365	-1.2%	1,024	-3.6%
Salaried GPs	739	17.7%	438	15.3%
Retainers	32	14.3%	13	13.3%
Registrars	534	10.1%	463	8.1%

Source: StatsWales.

4.14 In 2024, there were 1,454 qualified GPs in Northern Ireland, 0.4 per cent higher than a year earlier and 9.0 per cent higher than five years earlier. The headcount number of principal GPs fell by 3.9 per cent over the year and by 3.9 per cent over five years. The headcount number of salaried GPs increased by 20.3 per cent over the year and by 121.1 per cent over five years.

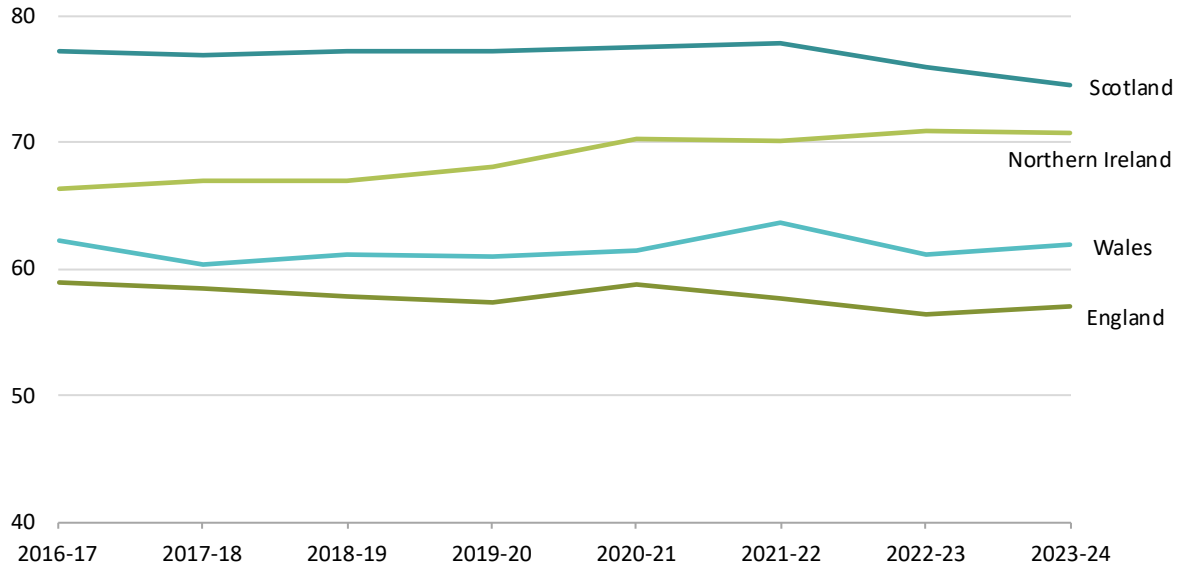
Table 4.4: GPs, Northern Ireland, 2024

	Headcount	Annual growth
All qualified GPs	1,454	0.4%
Principals	1,129	-3.9%
Salaried	314	20.3%
Retainers	11	-8.3%

Source: Department of Health Northern Ireland.

4.15 In 2023-24, the number of GPs per 100,000 registered patients was: 74.6 in Scotland; 70.8 in Northern Ireland; 61.9 in Wales; and 57.0 in England. The ratio showed a small increase in England and Wales in 2023-24, although it remained below the level seen in 2021-22. The ratio in Northern Ireland was unchanged. Scotland has seen a notable fall in the number of GPs per 100,000 registered patients over the last two years, although it remained higher than the other three nations.

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

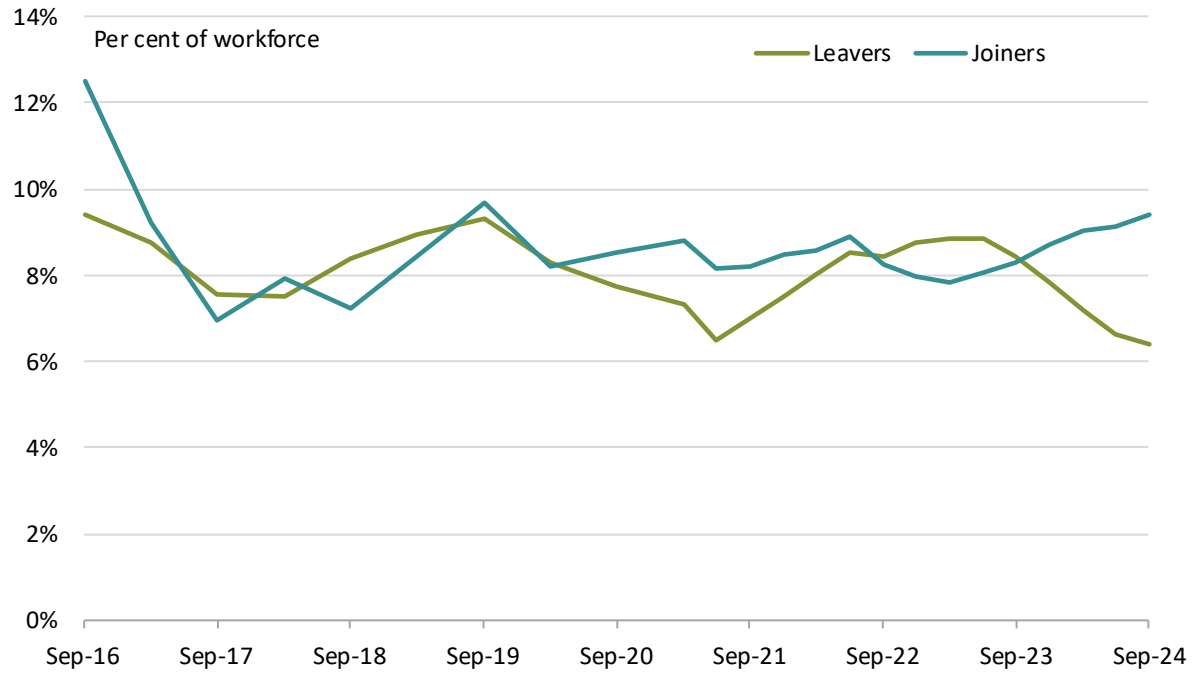


Source: General Medical Services for Northern Ireland, Family Practitioner Services Information Unit.

Recruitment and retention

4.16 The numbers of GP joiners and leavers in England have tracked each other closely since 2016, with a divergence in 2024 as the number of joiners increased and the number of leavers fell. Data is not collected in England on practice-level vacancies.

Figure 4.2: GPs joining or leaving the workforce, England, 2016 to 2024



Source: NHS England.

Note: FTE qualified permanent GPs (excludes GPs in training grades and locums). Percentage of workforce leaving/joining over 12-month period. Excludes transfers between practices. A GP recorded as a leaver in these figures may have left one practice and joined another practice with poor data completion (and vice versa).

4.17 NHS England said that the number of entrants to the GP register increased from 2,230 in 2013 to 3,434 in 2024. This growth was mainly due to doctors with a non-UK PMQ: from 620 new entrants in 2013 to 1,589 in 2024. GP register data showed that around 90 per cent of GPs had a licence to practise 10 years after initial registration. The rate of GP registrant retention was lower among non-UK PMQs than UK PMQs (81 per cent 11 years after registration, compared to 91 per cent for UK PMQs). Among non-UK PMQs, initial registrant attrition was highest in the early years post GP registration.

4.18 The Department of Health and Social Care (DHSC) said that the government had committed to increasing the number of GPs and doing more to address GP retention and the reasons GPs were leaving the profession. The DHSC said it recognised that it was vital for roles to be satisfying, rewarding and sustainable so that experienced GPs continued to contribute throughout their career.

4.19 NHS England said there had been reports from the GP profession of fewer salaried jobs and locum sessions being advertised and greater competition for those jobs. It said that, while practices did not have fixed establishment positions against which they reported vacancies, NHS England was working with the NHS Business Services Authority to release data on job adverts placed on the NHS Jobs website by practices.

4.20 The DHSC said that changes were made to the Additional Roles Reimbursement Scheme (ARRS) in August 2024, with ring-fenced funding of £82 million, allowing primary care networks to recruit over 1,000 newly qualified GPs through the scheme. The DHSC said this change was intended to address urgent issues around GP unemployment and patient access, following reports of significant numbers of newly qualified GPs currently looking for employment. The DHSC said this was an issue which partly resulted from more GPs qualifying after an increase in training places. By 31 March 2025, 1,500 (headcount) GPs had been recruited though the scheme, equivalent to 851 FTE GPs.[38]

4.21 The DHSC said the ARRS change was a short-term emergency measure for 2024-25, and the government was working to identify longer-term solutions to address recruitment and ensure opportunities for newly qualified GPs.

4.22 The BMA said that the ARRS changes failed to provide longer-term solutions to the current GP under/unemployment crisis and did nothing to ensure the retention and recruitment of already established and experienced GPs.

4.23 The BMA highlighted the issue of locum and sessional GPs wanting to work more sessions but not being able to find work. It said it started hearing reports of locum GPs struggling to find work in autumn 2023. These recruitment issues started to spread to salaried roles at the start of 2024, with limited employment opportunities and rates of pay being driven down.

4.24 From a Practice Finance Survey, BMA reported that 76 per cent of respondent practices said they had reduced their locum usage, or intended to, due to cashflow problems, and 27 per cent of respondent practices said they were already hiring fewer salaried GPs than they required, with a further 25 per cent considering doing so. In a BMA survey of locum GPs in May/June 2024, 53 per cent of locum GPs wanted to work more hours in the NHS but could not find suitable opportunities, and 25 per cent of respondents were unable to find any GP work at all. In oral evidence, the BMA estimated that 3,500 GPs were affected by unemployment or under-employment.

4.25 In 2024, 22 per cent of practices in Scotland reported GP vacancies, a fall from 39 per cent in 2023. The vacancy rate was 7.6 per cent in 2024, down from 10.9 per cent in 2023. By health board, the proportion of practices with a least one vacancy in 2024 ranged from between 4 per cent (Forth Valley) to 56 per cent (Western Isles).

4.26 The Scottish Government said that golden hello incentive payments for GPs were available, worth up to £10,000 for remote or rural areas, £7,500 to £12,500 for deprived areas, and £5,000 for other areas with recruitment difficulties. Seniority payments were paid to GPs to reward experience: £600 a year after six years; £5,129 a year after 21 years; £10,358 a year after 36 years, and £13,900 a year after 47 years. The annual bill for seniority payments to GPs was £16.4 million in 2022-23, down from £16.9 million in 2021-22.

4.27 The Scottish Government published a GP recruitment and retention action plan in November 2024 to attract, train, employ and nurture the GP workforce. It said progress would be reviewed annually.[39]

[38] NHS England, *GPs recruited through the Additional Roles Reimbursement Scheme (ARRS)*. https://digital.nhs.uk/supplementary-information/2025/arrs-claims-for-gps---to-31-march-2025
[39] Scottish Government, *General Practitioner recruitment and retention: action plan 2024-2026*. https://www.gov.scot/publications/general-practitioner-recruitment-retention-action-plan-2024-2026/

4.28 The BMA said that the GP job market in parts of Scotland appeared to have significantly changed in the last two years. It said that the availability of locum work, salaried GP positions and partnerships had markedly reduced, leading to anecdotal reports of GPs struggling to find work, largely in some urban parts of Scotland. Where previously it was the case (and in some parts of the country it remained so) that there were not enough GPs to fill vacancies, it said there were now GPs who could not find sufficient work due to a lack of practice funding to create positions. The BMA said the marked fall in GP vacancy rates, coupled with the reduction in GP numbers, was a clear indication that GP posts were being removed in response to inadequate funding.

4.29 The Welsh Government said that its evidence did not indicate that GPs had significant issues in finding work. It said that sufficient numbers of new GPs were going into salaried positions, with smaller numbers becoming partners or working as locums.

4.30 The Welsh Government said that, of the GP partners in post at 30 September 2022, it was estimated that 98.2 per cent were also GP partners a year later. The remaining 1.8 per cent were split between GP locums (1.0 per cent) and salaried GPs (0.8 per cent).

4.31 The Welsh Government said it had taken a number of steps to keep GPs in the profession. Incentives were offered to support doctors to continue working in general practice as they approached retirement or wished to undertake other commitments.

4.32 The partnership premium scheme was introduced on 1 October 2019 in Wales as an incentive for GPs to take up partner roles, with payments made based on clinical sessions undertaken. Annual payments for 2023-24 totalled £6 million. The Welsh Government said that an increasing number of GPs and potential GPs saw the model of practice partnerships as owner-occupiers of premises as being a barrier to continuing to be or becoming a GP.

4.33 Data from the Department of Health in Northern Ireland showed that the annual number of GP leavers had increased in recent years, from an average of 97 a year over the period 2014-15 to 2020-21, to an average of 196 a year in the period from 2021-22 to 2023-24.

4.34 The Department said that a scheme was launched in 2023 to support recruitment and retention in hard-to-recruit areas. GP practices could apply for a number of packages including golden hello payments, relocation costs, recruitment costs, management costs, reimbursement costs for applying to the performers list, and funding for international GPs. The Department said that 106 practices had received approval in principle or final approval for payments.

General practice training

4.35 There has been strong recent growth in the number of GP trainees in England, with FTE growth of 3.4 per cent over the year to December 2024 and 59.1 per cent over five years. The slower growth over the last year may reflect an increase in the numbers completing GP training from earlier larger intakes. Over this five-year period, the proportion of GP trainees in England with a primary medical qualification from outside the UK increased sharply, from 28.4 per cent in December 2019 to 52.0 per cent in December 2024.

4.36 The DHSC said that, in 2022, 4,032 trainees accepted a place on GP training in England, up from 2,671 in 2014. For 2023, 3,427 trainees accepted a place on GP training in recruitment rounds 1 and 2 in England, a fill rate of 99.8 per cent for 3,433 places. In 2024, 3,535 trainees accepted a place on GP training in England, a fil rate of 99.9 per cent for 3,537 places.

4.37 In oral evidence, NHS England said the number of training places was expected to increase by 250 in 2025, not the 500 originally announced, in part in recognition of capacity constraints.

4.38 NHS England said that IMGs made up an increasing proportion of the future GP workforce due to the ongoing expansion of GP specialty training. The number of UK PMQ graduates choosing GP specialty training as their first or subsequent preference had remained largely unchanged. In oral evidence, NHS England stressed the need to promote general practice careers to encourage more people into GP training.

4.39 In oral evidence, DHSC said there was no solid evidence that IMGs were more or less likely to stay in post. However, IMG pass rates were often lower than for UK graduates which meant that they could take longer to qualify.

4.40 All 275 general practice training places in Scotland in 2024 were filled successfully. Additional places had been recently advertised. At the same stage in 2023, 277 places had filled from 279 advertised (99.3 per cent). The Scottish Government said it had been increasing the number of general practice specialty training places to support the commitment to have 800 additional GPs in post by 2027; 100 extra places were created in 2016, and a further 35 places were added in 2024.

4.41 The Welsh Government said that the recruitment target of 160 new GP trainees each year was consistently being achieved (134 trainees appointed in 2018; 186 in 2019; 200 in 2020; 182 in 2021; 175 in 2022; and 199 in 2023). In oral evidence, the BMA drew attention to the fall in GP training places in Wales, from 200 to 160.

4.42 The Department of Health said the annual number of GP training places in Northern Ireland increased from 65 in 2015-16 to 121 in 2024-25, an increase of 86 per cent. The total number of GPs in training had increased from 213 in 2014-15 to 475 in 2024-25. The Queen's University Belfast undergraduate medical curriculum had been restructured to increase the time spent in primary care from 7 per cent to 25 per cent by 2025. The Ulster University's Magee Graduate Entry Programme placed a very significant emphasis on primary care placements, with a high concentration of clinical placements in rural settings in the west of Northern Ireland.

4.43 Of the 475 trainees in the GP training programme in Northern Ireland, 184 undertook their primary medical qualification outside the UK. A significant challenge was that increasing numbers of GP trainees required visa sponsorship and, given the short three-year timeline for GP training, these GPs then needed to find a visa sponsor on completion of training to allow them to remain and work in Northern Ireland.

4.44 In oral evidence, the BMA noted that Northern Ireland was unable to fill all of its GP training places.

The Targeted Enhanced Recruitment Scheme

4.45 The Targeted Enhanced Recruitment Scheme (TERS) was introduced in 2016. It offered a £20,000 payment to GP trainees who committed to work in locations which had a history of under-recruitment or were in under-doctored or deprived areas. Similar schemes have operated in England, Wales and Scotland.

4.46 The DHSC said that the fill rates of places under TERS had been consistently high overall and that there was evidence that the scheme had helped to attract people to these areas and that many doctors chose to stay in those locations after training. NHS England said the TERS had

had some success in attracting GP trainees, but it was not clear whether it made GP training more attractive or helped fill all GP specialty training places. It said longitudinal tracking was needed to determine whether trainees stayed in areas after qualification.

4.47 Since the publication of its evidence to us, NHS England decided not to fund TERS places in England for the current recruitment round.[40] It said that TERS had in the past proved successful in encouraging individuals to train in hard-to-recruit areas of the country. Record numbers of applicants, including in those areas where take up had been historically low, meant that there was not currently a need to financially incentivise trainees to train in those areas.

4.48 The Scottish Government said that the TERS bursary was introduced in 2016 when the fill rate to GP specialty training was 64 per cent. The intention at that time was to provide an incentive to candidates to take up posts in areas which were historically hard to fill and/or in remote and rural locations. In August 2024, 47 posts were advertised which attracted a TERS bursary payment. This resulted in a 97.9 per cent fill rate for those posts.

4.49 The Scottish Government noted that fill rates had improved significantly and had been close to 100 per cent over the past five years. It said that the TERS bursary could not justifiably be claimed to support an increasing GP headcount. As a result, it would not be offered in the 2025 recruitment round or in future years. It said it would monitor closely the impact stopping the bursary had on GP specialty training recruitment.

4.50 Financial incentives for GP training were introduced in Wales in 2017. The scheme provides £20,000 to GP trainees who take up a training post in north Wales (three training schemes – Bangor, Dyffryn Clwyd, Wrexham), Ceredigion, Pembrokeshire and Powys. These training schemes historically had a trend of low fill rates – less than 75 per cent over a five-year period. Trainees receive £10,000 on commencing their training, with the second payment made after they complete one year of practice in the incentivised region. The scheme was extended to Carmarthenshire from August 2023. The Welsh Government said that an independent review of the current financial schemes would be undertaken in 2025.

Access to GP services and general practice sustainability

4.51 There were around 1.50 million appointments with general practices in England every working day in January 2025, up by 1.8 per cent from January 2024. The number of daily appointments increased by 17.0 per cent from 1.28 million in January 2022. The number of daily appointments with a GP (as opposed to other health professionals) fell by 0.3 per cent over the year to January 2025, to a daily average of 669,000, but was up 1.8 per cent since January 2022. The proportion of all general practice appointments that were with GPs was 45.2 per cent in January 2025, down from 46.1 per cent in January 2024 and from 51.2 per cent in January 2022.

4.52 There was a decline in the proportion of appointments that were face-to-face to 64.4 per cent in January 2025 from 66.6 per cent in January 2024, although this was higher than January 2022, when 60.1 per cent of appointments were face-to-face. There was also a decline in the proportion of appointments that took place within seven days of the appointment being made, to 71.1 per cent in January 2025, from 72.0 per cent in January 2024 and 73.9 per cent in January 2023. The proportion of appointments seen on the same day was little changed, at

[40] NHS England, *Targeted Enhanced Recruitment Scheme (TERS)*. https://medical.hee.nhs.uk/medical-training-recruitment/medical-specialty-training/general-practice-gp/how-to-apply-for-gp-specialty-training/targeted-enhanced-recruitment-scheme

44.8 per cent in January 2025, 44.7 per cent in January 2024, and 45.3 per cent in January 2023.

Figure 4.3: Number of appointments per working weekday in general practice, England, 2022 to 2025

Source: NHS England, Appointments in General Practice.

4.53 The DHSC said that ARRS had enabled primary care networks to recruit a diverse range of professionals into primary care. It said that, between March 2019 and June 2024, 37,000 additional primary care professionals were recruited into general practice. The DHSC said the scheme had allowed patients to be seen by a wider range of professionals and access the care they needed while freeing up capacity for GPs to focus on the work that only GPs could do.

4.54 Between December 2019 and December 2024, while the number of GPs in England grew by 12.7 per cent, the number of other direct patient care staff grew by 37.8 per cent. The largest groups of staff in this category were healthcare assistants, dispensers and pharmacists. There were also substantial increases in the number of physician associates, pharmacy technicians, nursing associates, advanced pharmacist practitioners, advanced paramedic practitioners, paramedics and phlebotomists, reflecting the development of multi-disciplinary teams in GP practices.

4.55 GPs in England began collective action over funding on 1 August 2024. In oral evidence, NHS England said this was about the contract, workload, and the interface between primary and secondary care, and not pay. It said the action had not caused a big difference in metrics such as accident and emergency attendances, but there had been some local pockets of impact.

4.56 There were 897 GP practices in Scotland in October 2023, 83.5 per cent of which were on the national General Medical Services contract. The number of practices in Scotland had decreased by 9.8 per cent from 994 practices in 2013. The Scottish Government said this reflected a trend towards larger practices with more GPs serving a larger number of patients.

4.57 The Scottish Government said it had significantly expanded the multi-disciplinary primary care workforce since 2018, with total FTE staff of 4,731 working in multi-disciplinary team services including physiotherapy, pharmacy and phlebotomy in March 2023.

4.58 The Health and Care Experience Survey in Scotland asked respondents to rate the overall care provided by their general practice.[41] In 2023-24, 69 per cent of respondents rated it as good or

[41] Scottish Government, *Health and Care Experience Survey 2023/24: National Results*. https://www.gov.scot/publications/health-care-experience-survey-2023-24-national-results/

excellent, up from 67 per cent in 2021-22, but down from 79 per cent in 2019-20. Of those who needed an urgent appointment, 84 per cent were able to see or speak to a doctor or a nurse within two working days. This was slightly lower than the results from 2021-22 (85 per cent) and 2019-20 (86 per cent).

4.59 The Welsh Government said there were 372 active GP practices in Wales at 30 June 2024, a decrease of seven (1.8 per cent) since 30 June 2023. It said that, if a contract was not in place between the health board and a GP partner, the local health board could manage a general practice. On 30 June 2024, there were 20 local health board managed practices, six fewer than on 30 June 2023. These practices employed 74 FTE fully qualified GPs and 361 FTE wider practice staff.

4.60 The Welsh Government said that the long-term sustainability of General Medical Services (GMS) in Wales remained an ongoing concern. It said that while the number of GPs in Wales had remained relatively steady, there was a reduced number of practices, as a result of contract hand-backs or mergers. This meant that practices were serving a larger number of patients. It said it was continuing to take steps to support capacity within GMS and to reduce demand on GPs. It said the new unified GP contract would help to reduce bureaucracy and free up more time for GPs to see patients.

4.61 The Welsh Government said it remained closely engaged with local health boards on emerging GMS sustainability issues and contract hand-backs. Its view was that the GMS model needed to adapt in response to current sustainability pressures and in anticipation of future demand for services. There was a shift towards larger GP practices, with a wider mix of professionals in one setting, providing a greater range of services. This suggested greater sustainability for practices through operating at scale.

4.62 Northern Ireland had 312 active GP practices at 31 March 2024. This was a reduction of five (1.6 per cent) compared to 2023 and a reduction of 38 (10.9 per cent) since 2014. The Department of Health said that stabilisation and the sustainability of GP practices was a key concern and one which it was pro-actively taking steps to address. The Department said that GP contract hand-backs had increased significantly in recent years. There were 11 contract hand-backs in 2023-24 and three in 2024-25 (to the start of October).

4.63 The Department said that difficulties attracting and retaining GPs was often the main reason given when a GP contract hand-back occurred. Other reasons included partnership issues, for example fear of being the ‘last person standing’, and workload pressures that were deemed to be unmanageable.

4.64 A range of measures had been put in place in Northern Ireland to address the pressures facing primary care, including focusing on increasing capacity, reinforcing the GP workforce, increasing the range of healthcare professionals working in primary care, and the implementation of new and innovative ways of working.

4.65 The Department said that the multi-disciplinary team model remained key to stabilising and strengthening GP services to ensure they could continue to provide high quality care. Patients could see a member of the multi-disciplinary team without first having to be assessed by a GP. With ongoing challenges with GP retention and recruitment, it said this was key in helping to meet rising demand in primary care.

4.66 The Department of Health said that feedback from senior GPs indicated that multi-disciplinary teams had been critical in stabilising GP services and averting further practice closures. Of the

14 contract hand-backs in 2023-24 and 2024-25, none had been from practices with a full multi-disciplinary team in place.

4.67 The Department was seeking to work with GP federations to explore how they could play a role in the longer-term sustainability of GMS, including moving away from the locum-reliant model that had been in place in some trust-run practices, and implementing a more sustainable salaried GP model.

GP contracts in England

4.68 The global sum element of the GP contract in England was increased by 7.4 per cent in 2024-25, including the 6 per cent increase in pay.[42] Changes to the GP contract in England for 2025-26 were announced at the end of February.[43] This included an overall increase in funding of £889 million across the core practice contract and the Network Contract Directed Enhanced Service. This represented a 7.2 per cent increase in the total estimated contract value, to £13.2 billion in 2025-26. NHS England said this included funding to cover cost growth pressures, including from premises and list growth, and to reflect the increased level and complexity of activity. It assumed an increase in salaries of 2.8 per cent in 2025 and noted that a further uplift might be made following the government's response to the DDRB for 2025-26.

4.69 Changes to the contract for 2025-26 also included:

- A further £80 million for advice and guidance to incentivise closer working between general practice and secondary care.
- The removal of points from the Quality and Outcomes Framework (QOF), with funding moved into the global sum.
- A 20 per cent increase in the fee for routine childhood immunisations.
- A requirement for practices to keep their online consultation tool open for the duration of core hours (8am-6.30pm) for non-urgent appointment requests, medication queries and admin requests, from 1 October 2025.

4.70 The new contract also increased the salary element of the maximum reimbursement amount that primary care networks could claim through ARRS for GPs by 12.7 per cent from £73,113 in 2024-25 (the bottom of the salaried GP pay range) to £82,418 plus on-costs. NHS England said this represented the lower quartile of the salaried GP pay range. There would also be no restrictions on numbers or type of staff who were covered by ARRS, including GPs and practice nurses. The eligibility criteria for GPs would remain those individuals who had obtained their Certificate of Completion of Training (CCT) within the last two years (at the point of recruitment) and who had not been previously substantively employed as a GP in general practice.

4.71 The 2025-26 contract also increased locum reimbursement payments relating to parental leave, sickness absence, prolonged study leave (including the educational allowance payment) and suspended doctors. NHS England said these payments were increased by 6 per cent in 2024-25, following the DDRB recommendation, but had not been increased for a number of years previously. The payments were increased in line with previous pay uplifts (effectively unwinding the previous freeze). The overall cost of this was around £12 million in 2025-26, with funding drawn from a portion of the removed QOF indicators.

[42] UK Parliament, *General Practitioners: Finance*. https://questions-statements.parliament.uk/written-questions/detail/2024-10-24/11046/

[43] NHS England, *Changes to the GP Contract in 2025/26*. https://www.england.nhs.uk/publication/changes-to-the-gp-contract-in-2025-26/

4.72 In oral evidence, the DHSC said it was committed to increasing the share of NHS funding going to primary care. It said the new contracts aimed to support increasing capacity and address financial pressures.

4.73 The BMA said the independent contractor model was not broken but was being broken. It said the model was still well placed to deliver the most cost-effective patient continuity of care via the family doctor, but it had been under-resourced for too long.

GP contracts in Scotland

4.74 The Scottish Government said it uplifted GP pay net of expenses by 6.5 per cent for 2024-25. This included a 5.5 per cent uplift to practice staff expenses, and a 6 per cent uplift to wider practice expenses. It also included £7.6 million funding to cover population growth. The BMA acknowledged this was above the rate of inflation and was therefore a small benefit to practices. An additional £13.6 million funding for general practice was announced in November 2024, to support GPs to retain and recruit key staff.[44]

4.75 The Scottish Government said it was committed to phase two of the 2018 GP contract reform and was developing a refreshed plan and revised timeline for delivery. This included a commitment to introducing an agreed income range with pay progression for GPs comparable to consultants and directly reimbursing practice expenses. It said that data on income and expenses would underpin any business case for further investment in general practice. Workforce modelling for phase two of the contract reform would provide updated evidence on the GP capacity required to meet future population needs.

4.76 The BMA in Scotland said that, while nearly 5,000 new members of multi-disciplinary teams had been recruited, phase one of the GP contract reform – to transfer services that could reasonably be delivered by other professionals from GP practice responsibility to direct delivery by health boards – was years behind schedule. The BMA said that the Scottish Government was not sufficiently confident in multi-disciplinary team service delivery and that additional funding, and further pursuit of phase 1, would not be good value for money.

4.77 The BMA said that negotiations on phase two of contract reform, to reduce the financial risks of GP partnership by directly reimbursing practice expenses and ensuring that GPs would be able to earn a comparable income to consultants in Scotland, had not progressed. The BMA said it was time to draw a line under the implementation phase of the contract, to find a level of service that could be consistently delivered by multi-disciplinary teams, and to pursue a model of improved reimbursements to practices, centred around non-staff expenses rather than also including mechanisms around staffing.

GP contracts in Wales

4.78 The Welsh Government said that an established principle was that annual pay and expenses uplifts were linked to progress with contract reform. Agreement was reached over the 2024-25 contract uplift at the end of January 2025.[45] This included a 6 per cent uplift to the GP pay element of the contract, and the same uplift for staff costs. The overall additional funding was £52.1 million for 2024-25, which included a one-off practice stabilisation payment of £23

[44] Scottish Government, *Additional investment in general practice*. https://www.gov.scot/news/additional-investment-in-general-practice/

[45] Welsh Government, *Written Statement: General Medical Services Contract Reform for 2024-25*. https://www.gov.wales/written-statement-general-medical-services-contract-reform-2024-25

million. In oral evidence, the BMA said the in-year uplift was worth 10 per cent of the total contract, including the non-recurrent payment.

GP contracts in Northern Ireland

4.79 The total spend on general practice in Northern Ireland, including the reimbursement of dispensed drugs, was £388 million in 2023-24. This was a cash increase of 3.6 per cent on 2022-23, but a real terms fall of 2.5 per cent. There were higher levels of COVID-19-related spending in 2020-21 and 2021-22.

4.80 The Department of Health in Northern Ireland said there was a growing view that the funding model for GMS required a more fundamental review given the rising pressures, driven by long term trends such as an ageing population, growing waiting lists in secondary care, increasing demands for services, and the impact of COVID-19. The agreement reached for the 2023-24 GMS contract included a commitment to work with the Northern Ireland General Practitioners Committee to review how services were delivered and the contractual arrangements that underpinned the delivery of service.

4.81 In oral evidence, the Department said the contract uplift for 2024-25 was 6 per cent for GP and staff pay and 2.5 per cent for other expenses. It said that the expenses uplift was based on how much the Department could afford. For 2023-24, the expenses uplift was 7.3 per cent, of which only 3 per cent was recuring into the following year.

4.82 The Department said that an aim of the 2024-25 GMS contract, agreed in May 2024, was to support stability in general practice by providing GPs with greater certainty over their income through the year, reducing the administrative burden and associated cost to GP practices, and providing dedicated funding to practices for the costs of their indemnity. Under the 2024-25 contract, £38.9 million funding was released for re-purposing as a result of the incorporation of the Quality and Outcomes Framework and specified enhanced services into the core contract, and with funding for clinical waste also moving into core funding.

4.83 The Department acknowledged that GP indemnity was an issue of concern for GPs. Of the £38.9 million released funding, £5 million was re-purposed towards the cost of GP indemnity and shared among GP practices on a per capita basis as an interim solution, pending identification of the long-term model for future provision.

Earnings for contractor GPs

4.84 Earnings data for contractor (partner/principal) GPs and salaried GPs comes from His Majesty's Revenue and Customs (HMRC) and the most recent data available is for 2022-23. In 2022-23, average taxable income for contractor GPs fell significantly in England, by 8.6 per cent, and in Northern Ireland, by 5.9 per cent. Changes in Scotland and Wales were much smaller, with average taxable income up by 0.4 per cent in Scotland and down by 0.6 per cent in Wales.

4.85 In 2022-23, pre-tax incomes of contractor GPs in England were higher than in the other nations. Median pre-tax incomes in Scotland, Wales and Northern Ireland were between £103,500 and £115,000, compared with £128,700 in England. There was a substantial range in contractor GP incomes within each nation. The highest paid 10 per cent of contractor GPs in England earned three times the lowest paid 10 per cent. The ratio was 2.3 to 2.5 in the other nations.

Table 4.5: Contractor GPs, pre-tax income, headcount, 2022-23

	England	Scotland	Wales	Northern Ireland
Mean (average)	£140,200	£120,000	£115,300	£108,300
Median	£128,700	£115,000	£113,200	£103,500
Lower quartile	£98,000	£92,400	£86,800	£83,100
Upper quartile	£167,400	£142,200	£137,300	£128,900
Lowest 10%	£72,800	£73,500	£67,700	£64,200
Highest 10%	£216,100	£167,600	£167,400	£153,200

Source: NHS England.

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

4.86 The pre-tax income estimates are on a headcount basis and take no account of hours worked. NHS England estimates show that the number of FTE contractor GPs in September 2022 was 0.857 of the headcount number of contractor GPs, slightly down from 0.858 a year earlier. Applying this ratio to the income estimates gives an estimated FTE mean pre-tax income for contractor GPs in England in 2022-23 of £163,500 rather than £140,200 on a headcount basis, an 8.5 per cent fall from 2021-22.

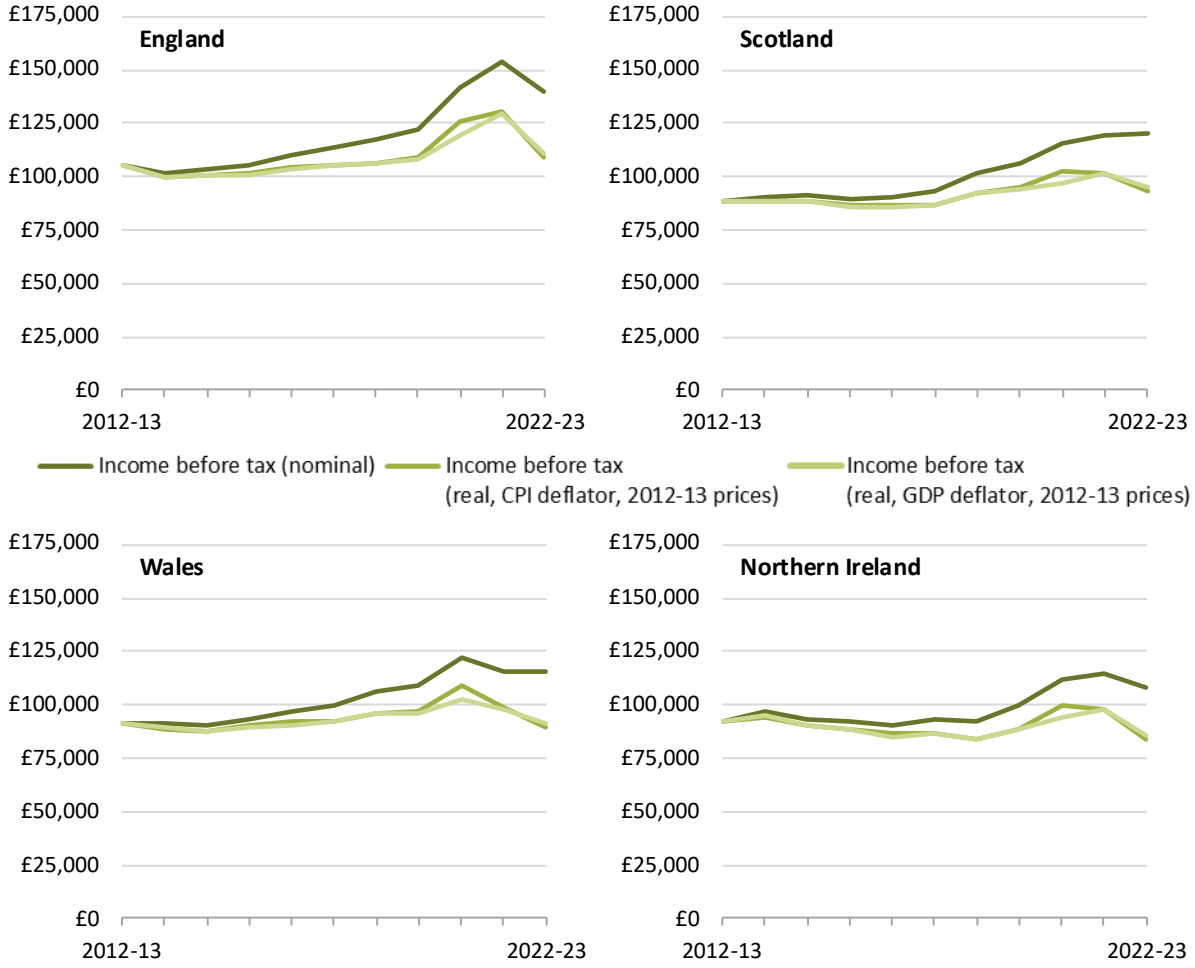
4.87 Each of the four nations had different measures in place to mitigate the impacts of COVID-19, and varied the extent to which GP contractors were involved with and reimbursed for providing vaccination programmes. This means that recent year-to-year changes in pre-tax incomes may be short-term COVID-19 impacts, rather than longer-term changes.

4.88 Although there were significant falls in nominal pre-tax incomes between 2021-22 and 2022-23 in England and Northern Ireland, and little change in both Scotland and Wales, pre-tax incomes in 2022-23 remained higher than in 2019-20, by: 15 per cent in England; 13 per cent in Scotland; 9 per cent in Northern Ireland; and 6 per cent in Wales.

4.89 After accounting for inflation, by adjusting for the consumer prices index (CPI) and the GDP deflator, pre-tax incomes in 2022-23: remained above 2019-20 levels in England; were broadly in line with 2019-20 in Scotland; and were below 2019-20 levels in Wales and Northern Ireland.

4.90 Over the 10 years since 2012-13, after adjusting for CPI, average pre-tax incomes gained value in England (by 4 per cent) and Scotland (by 5 per cent), but lost value in Wales (by 2 per cent) and Northern Ireland (by 9 per cent). After adjusting for the GDP deflator, over the 10-year period, average pre-tax incomes gained value in England (by 6 per cent), Scotland (by 7 per cent) and Wales (by 1 per cent), but lost value in Northern Ireland (by 7 per cent).

Figure 4.4: Contractor GPs, average pre-tax income, headcount, nominal and adjusted by CPI and the GDP deflator, England, Scotland, Wales, Northern Ireland, 2012-13 to 2022-23



Source: OPRB analysis of NHS England and ONS data.

Note: Earnings are not adjusted for hours worked.

4.91 The DDRB recommended a 4.5 per cent uplift for 2022-23 for contractor GPs in Scotland, Wales and Northern Ireland. Average pre-tax incomes for contractor GPs generally grew by more than the DDRB recommendation between 2016-17 and 2022-23. Over the period since 2016-17, the increase in average pre-tax incomes in each of the nations (between 18 per cent and 34 per cent) at least matched the DDRB recommendations (18 per cent).

Table 4.6: GP contractors' changes to average pre-tax income by nation, 2016-17 to 2022-23, compared with DDRB recommendations

	2016 -17	2017 -18	2018 -19	2019 -20	2020 -21	2021 -22	2022 -23	Increase over the period
DDRB recommendation	1%	1%	2%	2.5%	2.8%	3%	4.5%	18%
England	4.5%	3.5%	3.4%	3.8%	16.6%	8.0%	-8.6%	34%
Scotland	1.5%	2.5%	8.8%	4.7%	8.8%	3.6%	0.4%	23%
Wales	3.3%	3.4%	6.4%	2.4%	12.6%	-5.4%	-0.6%	18%
Northern Ireland	-1.6%	3.2%	-1.2%	7.9%	12.4%	2.7%	-5.9%	25%

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

4.92 NHS England said that the 8.6 per cent reduction in contractor GP earnings between 2021-22 and 2022-23 was mainly due to the reduction in additional funding provided for the COVID-19 vaccination programme. In oral evidence, the DHSC said that partner earnings had seen a significant increase since 2019, possibly due to the decline in the number of partners. It did not expect that there would be a further decline in earnings, and said the fall in earnings was not a cause for concern.

4.93 The BMA said average contractor income in England was the lowest it had been in real terms (using the retail prices index) since the current contract was introduced in 2004-05. It expected the average to have dropped further in 2023-24. In oral evidence, the BMA said the fall in 2022-23 was due to rising GP expenses, insufficient additional investment, and contractors being excluded from the DDRB's pay award that year. It said that any recovery in 2023-24 would be unlikely as, despite contractors being included in the DDRB's pay award, practices were still contending with rising staffing and running costs.

4.94 In Scotland, the BMA said that the limited increase in GP contractor earnings between 2021-22 and 2022-23 became a cash terms reduction when converted to projected whole-time equivalent figures, from £146,450 to £146,214 in 2022-23. It said that GP contractor earnings were being maintained by the declining number of whole-time equivalent GPs available to divide resources between.

4.95 The Welsh Government said that, unlike the previous two years, where comparisons were complicated by COVID-19 vaccination payments, the 2022-23 data offered a clearer reflection of baseline activity, allowing for more accurate comparisons to pre-COVID earnings. It said that, in real terms, earnings were 16.8 per cent lower than the 2008 peak.

4.96 The BMA said that underfunded contract uplifts meant that the DDRB recommendation for GP partner pay could not be realised. It said that, in 2024-25, contractors had to choose whether to give their staff a pay uplift, leaving nothing for themselves, or split the increase in income between themselves and their staff.

Earnings for salaried GPs

4.97 Earnings data for GPs comes from HMRC and the most recent data available is for 2022-23. In 2022-23, average taxable income for salaried GPs grew by 1.8 per cent in England, by 3.9 per cent in Scotland, by 1.6 per cent in Wales, and by 7.7 per cent in Northern Ireland. Earnings for salaried GPs showed much less variation by nation than contractor GPs.

4.98 Pre-tax incomes for salaried GPs in 2022-23 were higher than in 2019-20, by: 18 per cent in Wales; 13 per cent in Scotland; 12 per cent in Northern Ireland; and 9 per cent in England.

Table 4.7: Salaried GPs, pre-tax income, headcount, 2021-22

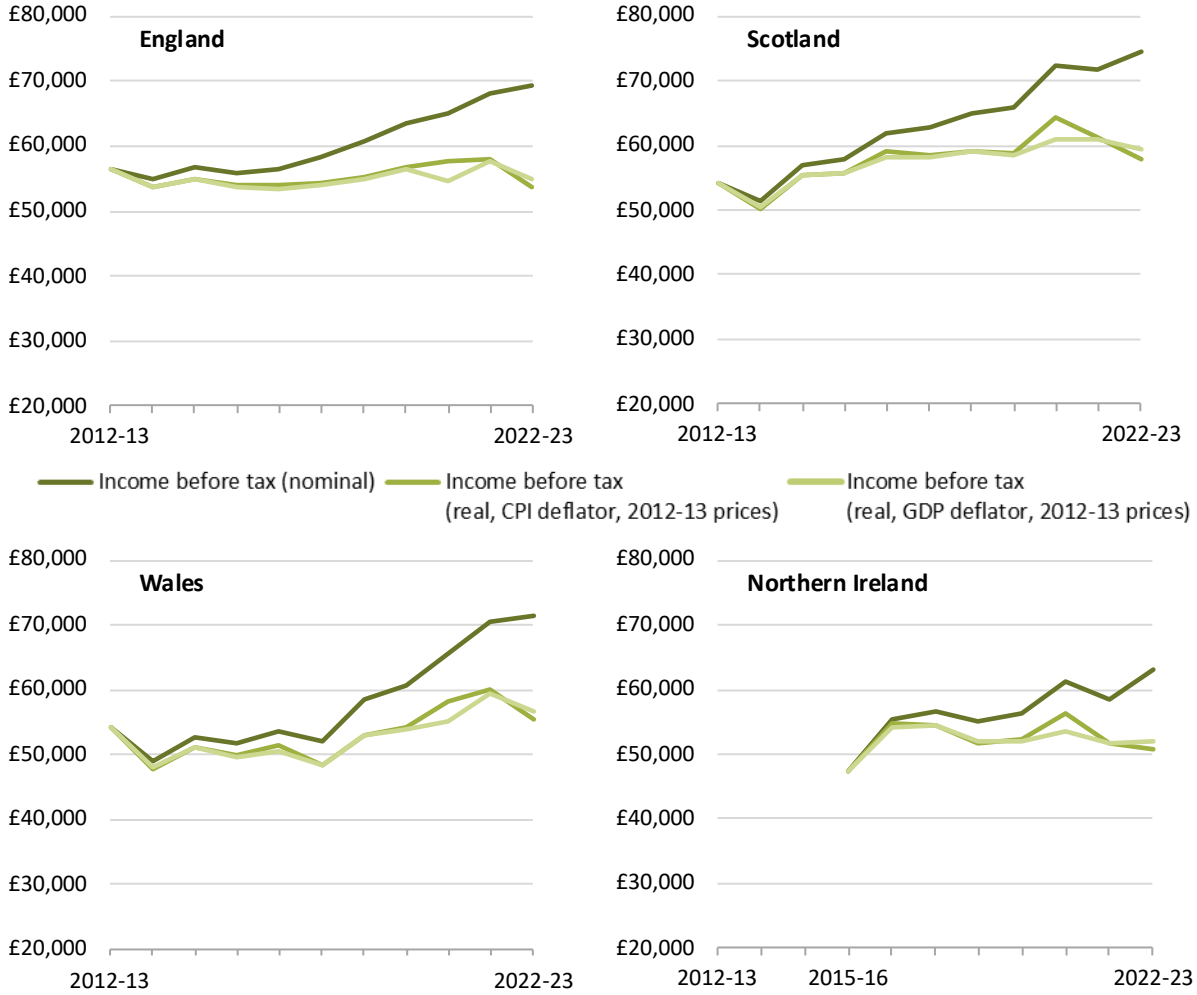
	England	Scotland	Wales	Northern Ireland
Mean (average)	£69,200	£74,700	£71,500	£63,100
Median	£64,200	£69,700	£61,700	£60,200
Lower quartile	£48,000	£51,900	£48,900	£45,800
Upper quartile	£84,400	£91,900	£87,100	£74,200
Lowest 10%	£33,300	£39,400	£34,700	£33,900
Highest 10%	£109,200	£115,300	£116,200	£95,600

Source: NHS England.

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

4.99 The mean pre-tax income estimates are on a headcount basis and take no account of hours worked. NHS England estimates show that the number of FTE salaried GPs in September 2022 was 0.639 of the headcount number of salaried GPs (unchanged from a year earlier). If the relationship for mean pre-tax income on an FTE basis were calculated in the same way, this would give an approximate FTE mean pre-tax income for 2022-23 of £108,300 in England rather than £69,200 on a headcount basis.

Figure 4.5: Salaried GPs, average pre-tax income, headcount, nominal and adjusted by CPI and the GDP deflator, England, Scotland, Wales, Northern Ireland, 2012-13 to 2022-23



Source: OPRB analysis of NHS England and ONS data.

Note: Earnings are not adjusted for hours worked. Northern Ireland uses 2015-16 prices.

4.100 Over the 10 years since 2012-13, after adjusting for CPI, average pre-tax incomes gained value in Scotland (by 7 per cent) and Wales (by 3 per cent), but lost value in England (by 5 per cent). After adjusting for the GDP deflator, over the 10-year period, average pre-tax incomes gained value in Scotland (by 10 per cent) and Wales (by 5 per cent), but lost value in England (by 3 per cent).

4.101 The DDRB recommended a 4.5 per cent increase to the minimum and maximum of the salaried GP salary range for 2022-23 in each nation. Except in 2022-23, average pre-tax incomes generally grew by more than the DDRB recommendation each year. Since 2016-17, the increase in average pre-tax incomes in each of the nations (between 24 per cent and 38 per cent) has been greater than the DDRB recommendations (18 per cent).

Table 4.8: Salaried GP changes to average pre-tax income by nation, 2016-17 to 2022-23, compared with DDRB recommendations

	2016 -17	2017 -18	2018 -19	2019 -20	2020 -21	2021 -22	2022 -23	Increase over the period
DDRB recommendation	1%	1%	2%	2.5%	2.8%	3%	4.5%	18%
England	1.3%	3.2%	3.8%	5.0%	2.0%	4.8%	1.8%	24%
Scotland	6.9%	1.8%	3.5%	1.2%	9.7%	-0.6%	3.9%	29%
Wales	3.9%	-3.0%	12.1%	4.1%	8.1%	7.2%	1.6%	38%
Northern Ireland	16.9%	2.5%	-2.8%	2.5%	8.5%	-4.4%	7.7%	33%

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

4.102 The BMA wrote to the DDRB in September 2024, pointing out that the HMRC data pre-tax incomes for salaried GPs included income from both employment and self-employment. It said that income from self-employment should be excluded from any assessment and recommendations made by the DDRB. It said this additional self-employed income was likely to come from several different sources, including out-of-hours, locum, private and educational roles.

4.103 NHS England data on salaried GP earnings from direct employment and self-employment is set out in table 4.9. Salaried GPs earned 85 to 91 per cent of their pre-tax income from direct employment. Although most salaried GPs' income comes from salaried employment, most of their expenses are incurred in their non-salaried activity.

Table 4.9: Salaried GPs, breakdown of earnings and expenses data, between self-employed and employment earnings, by nation, 2022-23

	Income measure	England	Scotland	Wales	Northern Ireland
Gross earnings	Total	79,700	80,800	76,000	69,400
	Employed	59,600	66,200	66,600	57,700
	Self employed	20,100	14,600	9,500	11,700
	Employed as % of total	75%	82%	88%	83%
Expenses	Total	10,500	6,100	4,500	6,400
	Employed	900	1,100	1,300	1,900
	Self employed	9,500	5,000	3,200	4,500
	Employed as % of total	9%	18%	29%	30%
Pre-tax income (gross earnings minus expenses)	Total	69,200	74,700	71,500	63,100
	Employed	58,700	65,100	65,300	55,800
	Self employed	10,500	9,600	6,300	7,300
	Employed as % of total	85%	87%	91%	88%
Pre-tax income, change between 2021-22 and 2022-23	Total	1.8%	3.9%	1.6%	7.7%
	Employed	2.1%	4.8%	3.2%	12.5%
	Self employed	0.0%	-1.0%	-11.3%	-18.9%
	Employed as % of total (percentage points)	+0.3	+0.8	+1.4	+3.8

Source: NHS England.

4.104 Income from self-employment for salaried GPs was either flat or falling between 2021-22 and 2022-23. Annual earnings growth from direct employment was therefore higher than the

figures set out in paragraph 4.97: 2.1 per cent in England; 3.2 per cent in Wales; 4.8 per cent in Scotland; and 12.5 per cent in Northern Ireland. Our analysis of pay comparability for salaried GPs has been extended to include FTE-adjusted pre-tax income from direct employment, as well as total earnings, for salaried GPs.

4.105 The BMA noted that the bottom of the salaried GP range in England, at £73,114, was only £593 more than GP registrars at the end of their training at ST3 (£72,516), which had increased in the recent pay agreement. It said that salaried GPs had not received a pay award close to the 10.5 per cent in Scotland for 2024-25 or the 6.0-19.6 per cent pay uplift for 2023-24 accepted for consultants in England.

4.106 The BMA said that the full-time salary for GPs employed through ARRS was the minimum of the salaried GP pay range of £73,114 which was derisory, uncompetitive, and did not adequately value fully qualified GPs. This has been changed for the 2025-26 contract.

Pay uplifts

4.107 The DHSC said that the GP contract in England was uplifted for 2024-25 to provide a 6 per cent uplift for all salaried general practice staff, including GPs, nurses and admin. It said that, as independent contractors, it was for GP partners to determine uplifts in pay for themselves and their employees. It acknowledged there was a trade-off between contractor GP earnings, uplifts to salaried GP pay, and other pressures on practice finances.

4.108 NHS England said that the pay recommendations for salaried GPs were usually also applied to all practice staff, and it recommended that this continued.

4.109 The Welsh Government said that a priority outcome from its contract negotiation was to ensure via a declaration from practices that any agreed staff pay uplift had been passed on to practice employees.

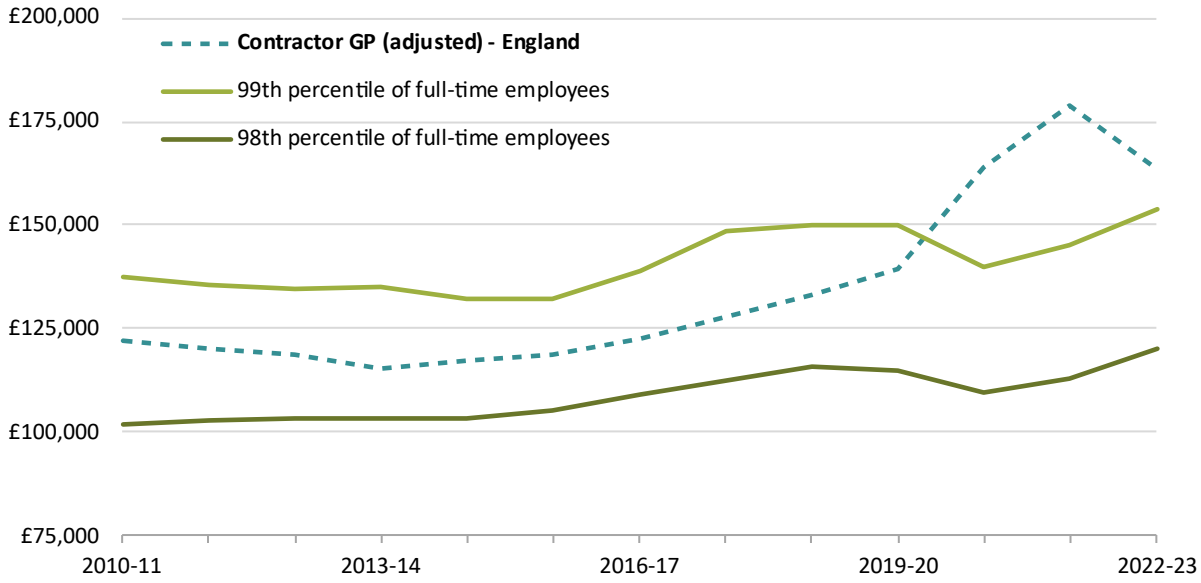
4.110 In oral evidence, the Department of Health in Northern Ireland said there was a mechanism in the GP contract where practices confirmed that the pay uplift had been passed on to salaried GPs and other practice staff.

Pay comparisons

4.111 After adjusting for full time equivalence, estimated average earnings per FTE for contractor GPs in England were between the 98th and 99th percentiles of all full-time employee earnings between 2010-11 and 2019-20, but moved above the 99th percentile in 2020-21, and remained above the 99th percentile in 2022-23 despite a fall in nominal earnings.

4.112 For salaried GPs, estimated average earnings (from employment and self-employment) per FTE in England were between the 96th and 97th percentiles of all full-time employee earnings between 2010-11 and 2019-20, but have moved above the 97th percentile since 2020-21. Estimated FTE average earnings for salaried GPs from employment only were above the 94th percentile of all full-time employee earnings in 2013-14, the first year data broken down in this way was available, but have been at around the 96th percentile since 2020-21.

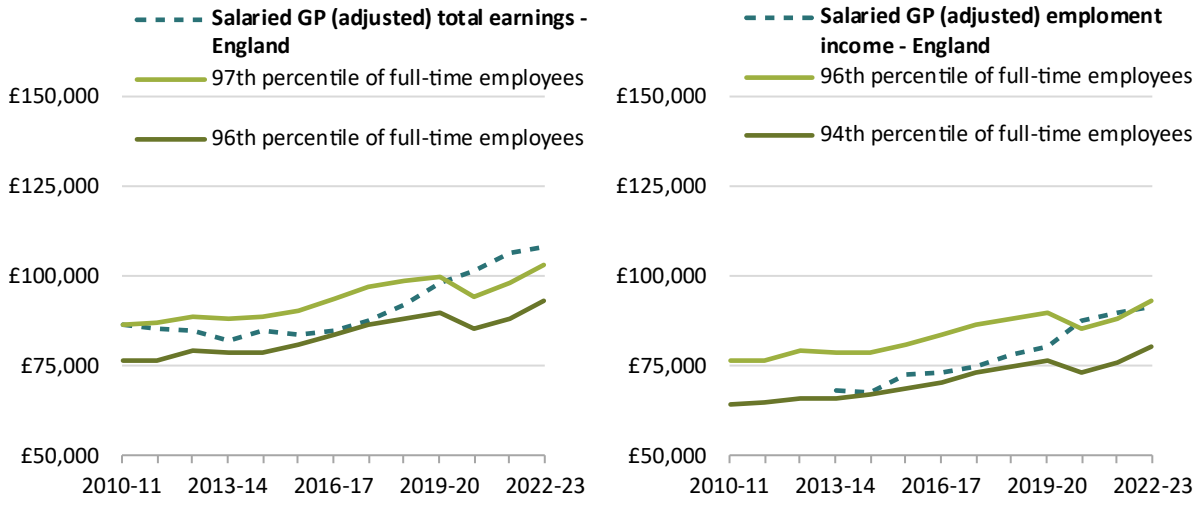
Figure 4.6: Estimated average total earnings per FTE of contractor GPs, England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2022-23



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

Note: GP earnings are adjusted for full-time equivalence.

Figure 4.7: Estimated average earnings per FTE of salaried GPs, England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2022-23



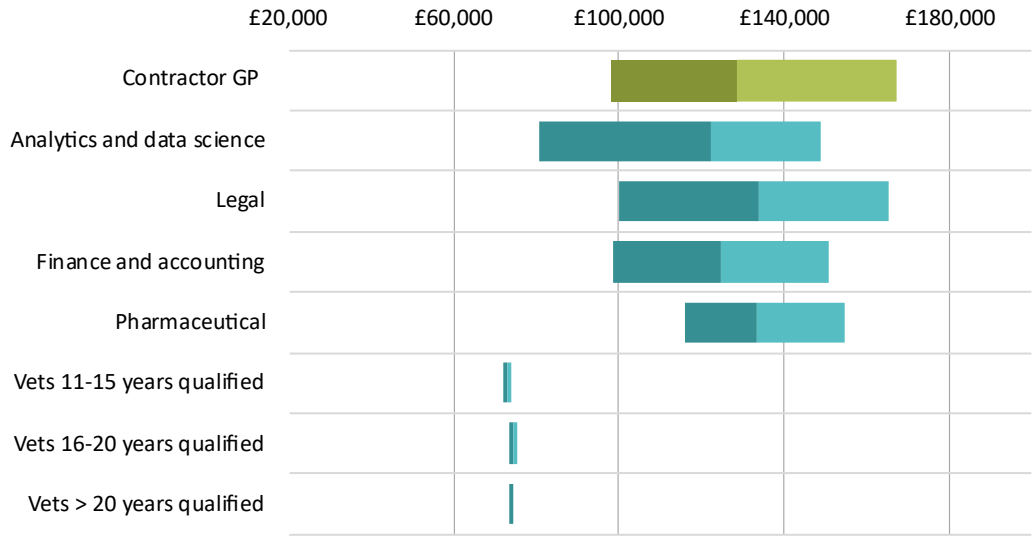
Source: OPRB analysis of data from NHS England and ONS.

Note: GP earnings are adjusted for full-time equivalence.

4.113 At median earnings, contractor GPs earned at similar levels to most of their professional comparators, and significantly more than equivalent academics or vets.

4.114 Salaried GPs earned less than most of their professional comparators, and at a similar level to associate dentists and vets. However, these comparisons are affected by the high level of part-time working among salaried GPs, as the data for comparator professions is on an FTE basis, while GP pay is on a headcount basis and is therefore lower than the FTE equivalent.

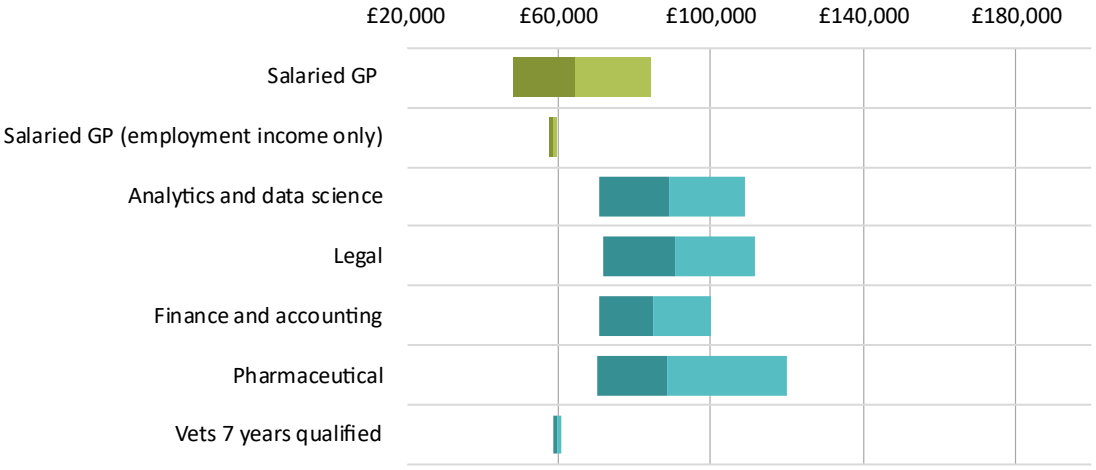
Figure 4.8: Interquartile range of total earnings of contractor GPs, headcount, England, compared with professional groups, 2024



Source: OPRB analysis of data from Kornferry; the Society of Practising Veterinary Surgeons; NHS England; ONS.

Notes: Pay for comparator professions is on an FTE basis, while GP pay is on a headcount basis and is therefore lower than the FTE equivalent. GP earnings are from 2022-23, while comparator earnings are from 2024. Individual medical roles are matched by job size to market data.

Figure 4.9: Interquartile range of total earnings of salaried GPs, headcount, England, compared with professional groups, 2024



Source: OPRB analysis of data from Kornferry; the Society of Practising Veterinary Surgeons; NHS England; ONS.

Notes: Pay for comparator professions is on an FTE basis, while GP pay is on a headcount basis and is therefore lower than the FTE equivalent; this is especially significant for salaried GPs. GP earnings are from 2022-23, while comparator earnings are from 2024. Individual medical roles are matched by job size to market data.

4.115 Job levelling and market data from Willis Towers Watson (WTW) indicate the GP salary band (£73,113 to £110,330) is above the market median equivalent for base pay, even at the minimum of the band. Average earnings for direct employment for salaried GPs (adjusted for full-time equivalence) are at the market upper quartile.

GP earnings by gender

4.116 Average earnings of female contractor GPs were lower than those of male contractor GPs in each nation in 2022-23, by 23 per cent in Northern Ireland, 20 per cent in both Scotland and Wales, and 19 per cent in England. The pre-tax income gap narrowed in each nation between

2017-18 and 2022-23, except in Wales where there was little change. The gap widened in Northern Ireland in the latest year of data. This HMRC data does not adjust for working hours.

Table 4.10: Contractor GPs pre-tax income, headcount, by gender and nation, 2017-18 to 2022-23

		2017-18	2018-19	2019-20	2020-21	2021-22	2023-23
England	Male	£125,600	£130,000	£134,300	£156,100	£168,100	£153,700
	Female	£97,300	£101,200	£106,400	£125,200	£136,300	£124,800
	Difference	*-23%*	*-22%*	*-21%*	*-20%*	*-19%*	*-19%*
Scotland	Male	£107,800	£117,200	£120,800	£131,400	£135,900	£135,000
	Female	£80,800	£88,700	£94,400	£103,200	£107,300	£108,600
	Difference	*-25%*	*-24%*	*-22%*	*-21%*	*-21%*	*-20%*
Wales	Male	£111,000	£118,800	£122,300	£135,600	£130,400	£129,400
	Female	£87,700	£93,300	£96,100	£109,100	£103,200	£102,900
	Difference	*-21%*	*-21%*	*-21%*	*-20%*	*-21%*	*-20%*
Northern Ireland	Male	£107,900	£104,500	£113,800	£126,500	£128,900	£124,100
	Female	£79,600	£81,400	£87,400	£100,000	£103,300	£96,000
	Difference	*-26%*	*-22%*	*-23%*	*-21%*	*-20%*	*-23%*

Source: OPRB analysis of data from NHS England.

Note: Does not adjust for working hours.

4.117 Average earnings of female salaried GPs in 2022-23 were lower than those of male salaried GPs in each nation, by 32 per cent in Wales, 29 per cent in Northern Ireland, 25 per cent in Scotland, and 24 per cent in England. In England, Scotland and Northern Ireland, the gap between male and female average incomes narrowed between 2017-18 and 2022-23, but it widened notably in Wales. Again, this data does not adjust for working hours, which may be driving much of the difference.

Table 4.11: Salaried GPs pre-tax income, headcount, by gender and nation, 2017-18 to 2022-23

		2017-18	2018-19	2019-20	2020-21	2021-22	2023-23
England	Male	£75,100	£76,900	£79,800	£81,100	£83,100	£83,800
	Female	£52,600	£55,000	£58,000	£59,200	£62,500	£63,700
	Difference	*-30%*	*-28%*	*-27%*	*-27%*	*-25%*	*-24%*
Scotland	Male	£85,200	£85,900	£85,400	£93,000	£89,200	£92,300
	Female	£55,800	£57,000	£58,600	£65,000	£66,900	£69,600
	Difference	*-35%*	*-34%*	*-31%*	*-30%*	*-25%*	*-25%*
Wales	Male	£62,800	£68,200	£72,800	£80,500	£84,300	£95,100
	Female	£49,200	£55,700	£57,800	£61,100	£65,400	£64,400
	Difference	*-22%*	*-18%*	*-21%*	*-24%*	*-22%*	*-32%*
Northern Ireland	Male	£92,900	-	£70,100	£85,100	£83,500	£83,900
	Female	£51,800	£51,500	£53,900	£55,400	£52,300	£59,200
	Difference	*-44%*	-	*-23%*	*-35%*	*-37%*	*-29%*

Source: DDRB analysis of data from NHS England.

Note: Does not adjust for working hours.

Expenses

4.118 Expenses accounted for: 72 per cent of gross earnings in England; 66 per cent in Wales; 58 per cent in Northern Ireland; and 57 per cent in Scotland. The bespoke contract arrangements for

GMS across the four nations will account for some of the differences in gross earnings and expenses. This proportion increased in all nations in 2022-23, with the largest (3.5 percentage point) increase in England. Employee costs were the largest single category, accounting for between 58 per cent (Northern Ireland) and 73 per cent (Scotland) of all expenses.

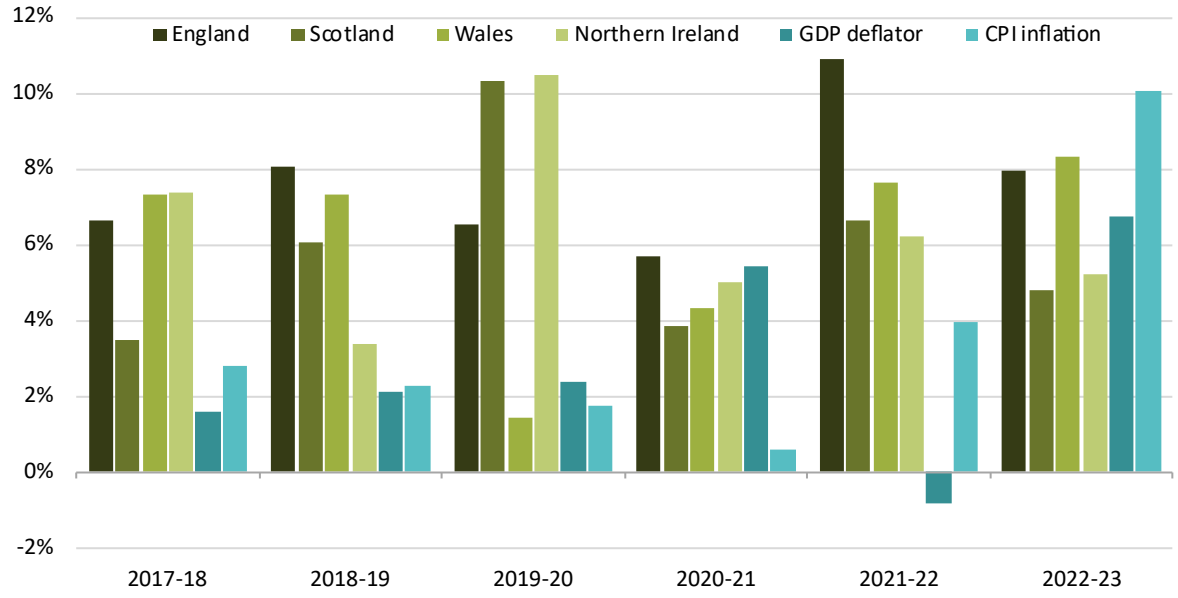
Table 4.12: Contractor GPs, average gross earnings, expenses and pre-tax income, 2022-23

	England	Scotland	Wales	Northern Ireland
Average gross earnings	£495,400	£276,600	£342,500	£259,000
Average expenses	£355,200	£156,700	£227,200	£150,700
Income before tax (average)	£140,200	£120,000	£115,300	£108,300
Expenses % of gross earnings	72%	57%	66%	58%

Source: NHS England.

4.119 Over time, the change in overall expenses each year shows a low correlation with both CPI inflation and the GDP deflator. The average expenses change also varies across nations. The change in expenses may result from: a change in the price of inputs (i.e. hourly wage rates or energy costs); the need to use more/fewer inputs (as demand/activity changes); or a change in the composition of the expenses base (e.g. greater use of higher-paid staff relative to lower-paid staff). It is likely to be a combination of each of these factors. The weak correlation between price indices and expenses growth continues when only looking at non-staff costs.

Figure 4.10: Annual change in average general practice expenses by nation, GDP deflator and CPI inflation, 2017-18 to 2022-23



Source: NHS England, ONS.

4.120 The BMA said that delivering core contractual services was increasingly expensive, and global sum payments had not kept up with the cost. It said that the global sum payment per weighted patient was £112.50 in England for 2024-25. It said that, since the introduction of the current contract in 2004, these payments had generally kept up with inflation and were now 18.9 per cent higher in real terms than they were in 2004-05. However, a period of comparatively high inflation had caused erosion between 2021-22 and 2023-24. It said that the 2024-25 uplift had partially, but not fully, reversed this erosion (real-terms payments were 2.7 per cent higher in 2020-21 than 2024-25).

4.121 The RCN wrote to the DDRB in December 2024 to say that a 7.4 per cent uplift had been applied to the global sum, to provide sufficient funding to ensure a 6 per cent increase to uplift contractor income and other staff expenses including general practice nurses. In a survey of its members in general practice, 50 per cent of respondents had not received any pay uplift for 2024-25 by October 2024.

4.122 Audit Scotland said that the Scottish Government did not have a full understanding about the current expenses of running a general practice or how much GPs earnt. It said that directly reimbursing expenses would support the long-term sustainability of general practices.[46] Without this, GPs were at risk of bearing the financial burden of increasing costs, which risked damaging trust with GPs and buy-in for future reforms or contractual changes.

4.123 The Welsh Government said that, despite the DDRB uplifts to cover staff pay for GPs, the rising minimum wage placed additional financial pressure on GP practices. It said that GPs were absorbing these increases without a fully matched uplift. While premises costs were partially mitigated through designated funding, practices faced significant inflationary pressures on operating costs, particularly energy expenses. It said that, unlike larger health boards, GP practices could not absorb these costs through economies of scale, and partners were personally liable for meeting these expenses. Their limited ability to adjust either income or expenses left them uniquely vulnerable to external cost pressures. Consequently, these financial strains posed serious challenges to both the recruitment and retention of GPs, potentially impacting practice sustainability and patient access in the longer term. In oral evidence, the Welsh Government said it was working on how to evidence increases in expenses.

4.124 The Welsh Government said it was working to consider amendments to the existing Premises Cost Directions to support investment in GMS facilities which could improve sustainability.

Motivation, morale and wellbeing

4.125 The General Medical Council's (GMC's) annual workplace experiences report found that, in 2023:[47]

- 48 per cent of GPs were struggling, compared to 33 per cent of all doctors.
- 42 per cent of GPs were satisfied with their day-to-day work, compared to 53 per cent of all doctors.
- 14 per cent of all GPs were 'doing well', compared with 27 per cent of all doctors.
- 21 per cent of GPs were at high risk of burnout, the same as for all doctors.
- 72 per cent of GPs agreed that they had enough autonomy in their role, compared to 60 per cent of all doctors.
- 31 per cent of GPs reported that they had to act in a way that conflicted with their personal values at least once a week, compared to 22 per cent of all doctors.

4.126 NHS England said that NHS staff survey was extended to general practice in 2023 on a voluntary basis. In total, 21 Integrated Care Boards (ICBs) participated, with a survey sample of more than 1,500 organisations and 45,000 individuals, 40 per cent of whom responded to survey. NHS England said that 34 ICBs committed to supporting the survey in 2024. Results for the GP staff survey have not been made publicly available.

[46] Audit Scotland, *General practice: Progress since the 2018 General Medical Services contract*. https://audit.scot/publications/general-practice-progress-since-the-2018-general-medical-services-contract

[47] General Medical Council, *Workplace experiences 2024*. https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk/workplace-report

GP trainers

4.127 NHS England said that one of the biggest challenges in meeting expansion targets for GP specialty training was the capacity of training placements, including the limitations imposed by estates. It said more placements were needed to deliver the GP specialty training reform agenda and meet current and future training targets.

4.128 NHS England also said that a shortage of educators and supervisors was hindering efforts to expand GP numbers. It said that the expansion of roles across primary care and the increase of GP specialty training places had increased the role of GP trainers and their workload. Feedback from all regions consistently highlighted the imbalance between workload and remuneration as the main reason practices and doctors decided not to join the training community. The GMC workplace experiences survey reported higher workload and poorer wellbeing among trainer GPs.

4.129 The BMA said that NHS England had confirmed the GP educator pay scale would be uplifted for 2024-25 in line with the DDRB's 6 per cent recommendation. The BMA said there was no published comprehensive evaluation of whether the GP trainers' grant was meeting the costs of GP registrar training in GP practices. It said that, with the growth required to the GP workforce in England, it should be possible for every practice to become a training practice and host GP registrars.

4.130 The Scottish Government said that all placements undertaken by GP trainees in primary care settings attracted a GP trainer grant of £10,492 (£12,685 with superannuation included). In 2023-24, 804 GP trainer grants were paid at a total cost of £10.2 million. Of these, 127 were directly related to the additional places created recent years in GP specialty training or the second year of foundation training. The Scottish Government said it would work with NHS Education for Scotland to fully understand the extent of costs incurred by GP practices through their hosting of these placements.

Our comments

The GP workforce and workforce planning

4.131 Across all nations, growth in GP numbers has been much slower than growth in the number of doctors directly employed by secondary care trusts and health boards over the last five years. This has constrained the number of GP appointments, and overall access to general practice. The more recent picture on the GP workforce is mixed, with strong growth in the number of salaried GPs in England, of over 2,000 in the last year, smaller increases in Wales and Northern Ireland, and a fall in GP numbers in Scotland.

4.132 Part-time working remains widespread among salaried GPs in particular and has constrained the size of the full-time equivalent GP workforce over the longer term. It would be useful to have a better understanding of the dynamics of choices around working hours, the implications for future planning of medical training and for the operation of the NHS, and whether there are actions that parties could take to support greater working hours and increase the full-time equivalent GP workforce.

4.133 While our evidence base on the GP labour market is not as strong as we would like, there is little indication of widespread recruitment or retention problems. There has been a fall in GP vacancies in Scotland, but this data is not available for other nations. The number of GP leavers has fallen in England but increased in Northern Ireland. There are some issues with attracting GPs to rural and remote locations in Scotland in particular.

4.134 Over all nations, there has been a shift from GP partners to salaried GPs. This is despite sustained average incomes for GP partners over the medium term. Ensuring the attraction of GP partnership is crucial to the stability of the current general practice model. There is a wide range in contractor GP earnings, and we would welcome evidence that would help us understand more about this to provide insight on the attractiveness of partnership, which may vary significantly by practice. This may enabled targeted support to the practices which are least sustainable.

4.135 Recent workforce changes have been made to support general practice, such as the extension of multi-disciplinary teams, the shift away from expensive locum use, and the expansion of GP training places. These initiatives have largely been successful. However, despite the strong growth in the number of salaried GPs, which is likely to be a result of the increased GP training cohort and the reduction in locum usage, there are reports of recently qualified GPs struggling to find work, or as much work as they would like. ARRS in England has recently been extended to GPs in recognition of this.

4.136 The forthcoming refreshed NHS workforce plan needs to have a specific focus on GPs. It should take into account the current and future workforce supply, as the expanded number of GP trainees become fully qualified; the recent reliance on international recruitment; the commitment to shift health services to the community and the implications of this for the general practice workforce; and the capacity for GP training, both in terms of trainers and infrastructure.

4.137 TERS incentive payments have been successful in attracting GP trainees to less popular and more remote areas. The cessation of TERS payments for GP training in England and Scotland is a pragmatic response to fill rates that are close to 100 per cent and demonstrates the flexibility of this incentive scheme. It will be important to keep this under review.

4.138 Increasing expenses, and the extent to which these are covered by contract uplifts, continue to be a significant issue for GPs. The recent funding increases in England aim to address this, as well as the non-consolidated payments to practices in Wales and Northern Ireland. Ongoing contract review and reform will be required to ensure the sustainability of general practice and to support health services moving to the community. Governments are already looking at this. The recent increase in GP funding is welcome and will help to support the increased costs and unmet demand the sector faces. There needs to be an effective mechanism to ensure that increased costs, including those from the recent rise in employer national insurance, do not undermine delivery of primary care. Our recommendation to develop an index of general practice costs to inform the expenses element of contract uplifts seeks to address this.

Earnings and pay comparability

4.139 Most secondary care medical and dental groups across the four nations received an additional pay award over the last 12 months, as well as our recommended uplift. This was not the case in primary care.

4.140 Contractor GPs saw significant falls in pre-tax incomes in 2022-23 in England and Northern Ireland and little change in Scotland and Wales. This is likely to be a combination of falling COVID-19 support and increasing expenses.

4.141 Compared to the pre-pandemic position in 2019-20, real pre-tax incomes for contractor GPs are higher in England, broadly unchanged in Scotland, and lower in Wales and Northern Ireland. Both salaried and contractor GPs have maintained, or improved, their position in the overall earnings distribution. Contractor GPs earnings were at similar levels to most of their

professional comparators. Salaried GPs earned less than comparator professions, but this position is affected by less-than-full-time working being common among GPs.

4.142 The DDRB sets the pay range for salaried GPs, with individual salaries and uplifts a decision for practices. Some parties have raised the issue of the minimum of the GP salary range with us. Market data from WTW indicate the GP salary band (£73,113 to £110,330) is above the market median equivalent for base pay, even at the minimum of the band. We note the recent contract change in England which increases the reimbursement rate for GPs recruited through ARRS to £82,418.

4.143 The evidence does not indicate that the GP salary minimum is out of line with comparator pay or causing a recruitment problem. Practices have the flexibility to pay higher than this salary when needed. We will continue to keep this under review.

4.144 Maximum pay for GPs in training, including the flexible pay premia in England, is at a similar level to the minimum of the salaried GP pay range, and the gap has closed as a result of higher pay uplifts for resident doctors than to the salary range for qualified GPs. We have recommended a review of flexible pay premia, to understand if these payments will be needed in future.

Workload and morale

4.145 The GMC workplace report indicates poorer morale and wellbeing in general practice than in secondary care. Unsustainable workloads driven by increased patient needs have been highlighted to us on our visits.

4.146 The extension of the NHS staff survey in England to GP practices is welcome and we expect the results to be shared soon. We would encourage all nations to find tools to monitor workload, morale and wellbeing among the GP workforce, as this will be crucial to ensuring the sustainability of the sector.

Chapter 5 Dentists

5.1 Our remit covers all general dental practitioners (GDPs) and salaried dentists providing NHS/HSC services including dentists working in the Community Dental Services (CDS) in England, Wales and Northern Ireland and the Public Dental Service (PDS) in Scotland.[48] Hospital dentists are covered in chapter 3.

5.2 This chapter looks at trends in the dental workforce, dental training, recruitment and retention, developments in dental contracts, earnings and pay comparisons, motivation and morale. Our comments on the data and evidence are at the end of the chapter.

Workforce

5.3 The latest data for England, Scotland and Wales all show fewer dentists providing NHS services than prior to COVID-19. The numbers in England show some pick up since 2021-22, but not by enough to recover the losses since 2019. Dental numbers in Scotland recovered in 2024 but remained 5 per cent below the level seen in September 2019. In Wales, dental numbers picked up in 2021-22 and 2022-23, but fell back again in 2023-24, to levels seen in 2020-21. Unlike in the other nations, dental numbers in Northern Ireland held up through COVID-19, increasing by 4.2 per cent between 2019-20 and 2023-24.

5.4 There were 24,335 dentists providing NHS services in England in the year to 31 March 2024, an increase of 108 (0.4 per cent), from 24,227 a year earlier. The number of dentists providing NHS services in the year to 31 March 2024 was 371 (1.5 per cent) lower than the peak recorded in the year to 31 March 2020. In 2023-24, 80 per cent of dentists providing NHS services in England were associates and 20 per cent were principals or providing-performers (down from 21 per cent in 2019-20).

Table 5.1: Number of dentists providing NHS services, 2023-24

	Number of dentists providing NHS services	One-year change	Five-year change
England	24,335	0.4%	-1.5%*
Scotland	3,173	4.0%	-5.2%
Wales	1,398	-2.6%	-7.2%
Northern Ireland	1,195	2.8%	4.9%

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

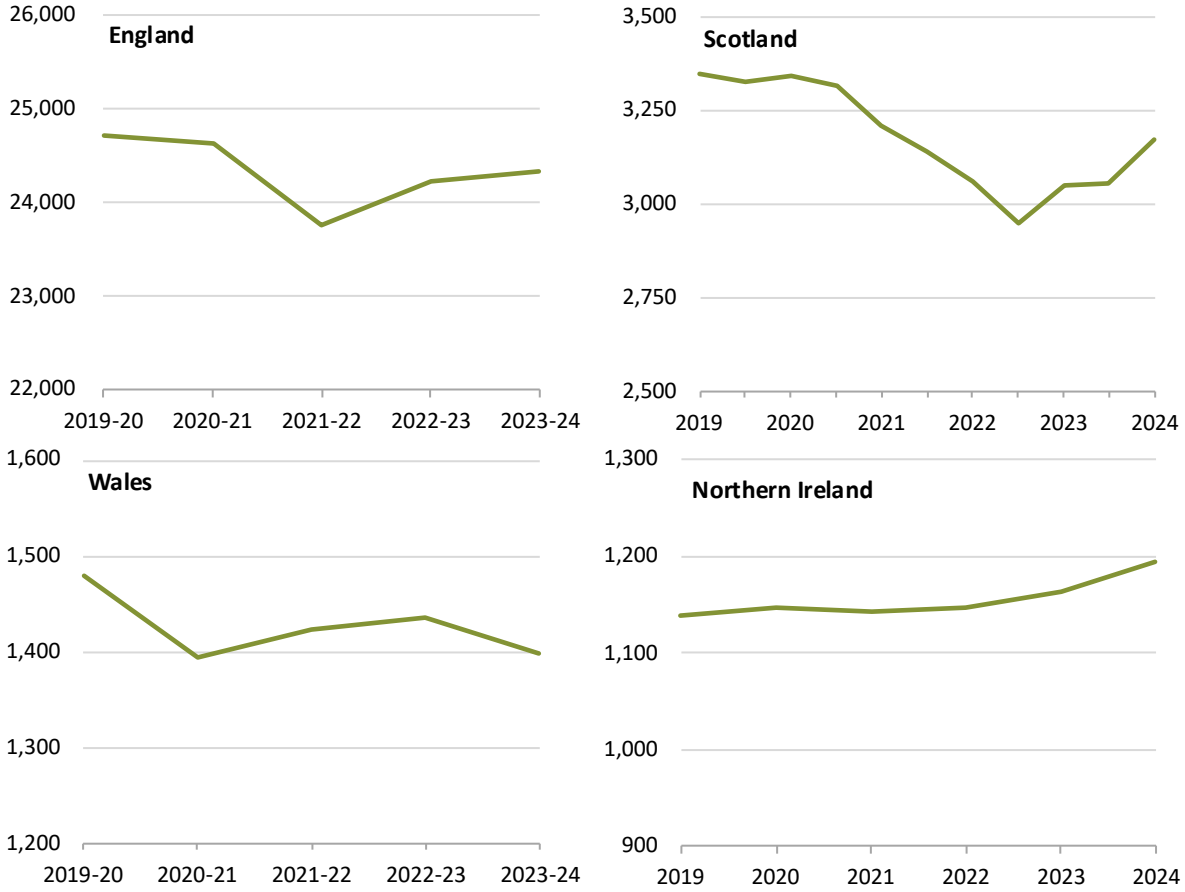
Note: England data from 31 March 2024; Scotland data from 30 September 2024; Wales and Northern Ireland data for 2023-24.

*Since March 2020.

5.5 There were 3,173 non-hospital dentists providing NHS services in Scotland at 30 September 2024, an increase of 123 (4.0 per cent) from 3,050 a year earlier, and a fall of 174 (5.2 per cent) since September 2019. The Scottish Government said the workforce position in Scotland was significantly better than the rest of the UK, with 57 dentists per 100,000 of the population, compared to 43 in England and 46 in Wales.

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

Figure 5.1: NHS dentists, 2019 to 2024



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

5.6 There were 1,398 dentists providing NHS services in Wales in 2023-24, a fall of 38 (2.6 per cent) from a year earlier, and 108 (7.2 per cent) below the peak recorded in 2018-19. The Welsh Government said that the number of dentists who performed any NHS work during the year had remained broadly similar for the previous ten years.

5.7 There were 1,195 dentists providing dental health services in Northern Ireland in 2023-24, an increase of 32 (2.8 per cent) from a year earlier. The number of dentists increased between 2015 and 2020, stabilised in 2021 and 2022, and increased again in both 2023 and 2024.

5.8 There were 42.6 dentists providing NHS services per 100,000 population in England in 2023-24, a small increase from 42.4 a year earlier but below the peak of 43.9 in 2019-20. There were 58.9 dentists providing NHS services per 100,000 population in Scotland in September 2024, an increase from 56.8 year earlier but below the peak of 63.4 in September 2019. There were 62.7 dentists per 100,000 population in Northern Ireland in 2024, up from 61.1 in 2023 and from 60.5 in 2019.

5.9 Data from the General Dental Council showed that there were 45,204 registered dentists in the UK at 31 December 2023, up 2.4 per cent over the year and 6.4 per cent since the end of 2019.[49] In December 2023, 69.7 per cent of dentists on the register were qualified in the UK, down from 70.6 per cent in December 2022, and 71.8 per cent in December 2019.

[49] General Dental Council, *Registration Statistical Report 2023*. https://www.gdc-uk.org/docs/default-source/registration/registration-reports/registration-statistical-report-2023---final-and-accessible-v2.pdf

Working hours

5.10 The dental working patterns survey for 2022-23 was published in April 2024 for the first time since 2019-20. This covered all dentists who had done some NHS work. The average weekly working hours (across NHS and private work) of principal dentists in 2022-23 were: 43.1 in Wales; 41.4 in Northern Ireland; 41.1 in England; and 39.9 in Scotland. Compared with 2019-20, the average working hours had declined in England, Scotland and Northern Ireland but had increased in Wales.

5.11 The average weekly working hours of associate dentists varied little between nations: 34.0 in Wales; 33.9 in Scotland; 33.7 in England: and 33.6 in Northern Ireland. Compared with 2019-20, the average number of hours worked fell in all countries: by 2.1 hours in Scotland; 1.1 hours in England; 1.0 hour in Wales; and 0.3 hours in Northern Ireland.

5.12 The proportion of time spent on NHS work by principal dentists in 2022-23 was: 61.2 per cent in England; 60.1 per cent in Scotland; 59.6 per cent in Wales; and 58.1 per cent in Northern Ireland. Compared with 2019-20, the proportion of time spent on NHS/health service work had declined in each of the four countries: by 4 percentage points in England; by 5 percentage points in Wales; by 8 percentage points in Northern Ireland; and by 12 percentage points in Scotland.

5.13 The proportion of time spent on NHS work by associate dentists in 2022-23 was: 73.3 per cent in Wales; 73.0 per cent in England; 72.4 per cent in Scotland; and 64.7 per cent in Northern Ireland. Compared with 2019-20, the proportion of time spent on NHS/health service work had declined in each of the four countries: by 3 percentage points in England; by 4 percentage points in Wales; by 9 percentage points in Scotland; and by 13 percentage points in Northern Ireland.

5.14 From the estimates of total average hours worked and the percentage of time spent on NHS/health service work, we can derive estimates of the average weekly hours worked on NHS/health service work. The average weekly hours spent on NHS/health service work by principal dentists in 2022-23 were: 25.7 in Wales; 25.2 in England; 24.1 in Northern Ireland; and 24.0 in Scotland. Compared with 2019-20, the average number of hours spent on NHS/health service work had declined in England, Scotland and Northern Ireland but had increased in Wales.

5.15 The average weekly hours spent on NHS/health service work by associate dentists in 2022-23 were: 24.9 in Wales; 24.6 in England; 24.5 in Scotland; and 21.7 in Northern Ireland. Compared with 2019-20, the average number of hours worked on NHS/health service work declined in all four nations.

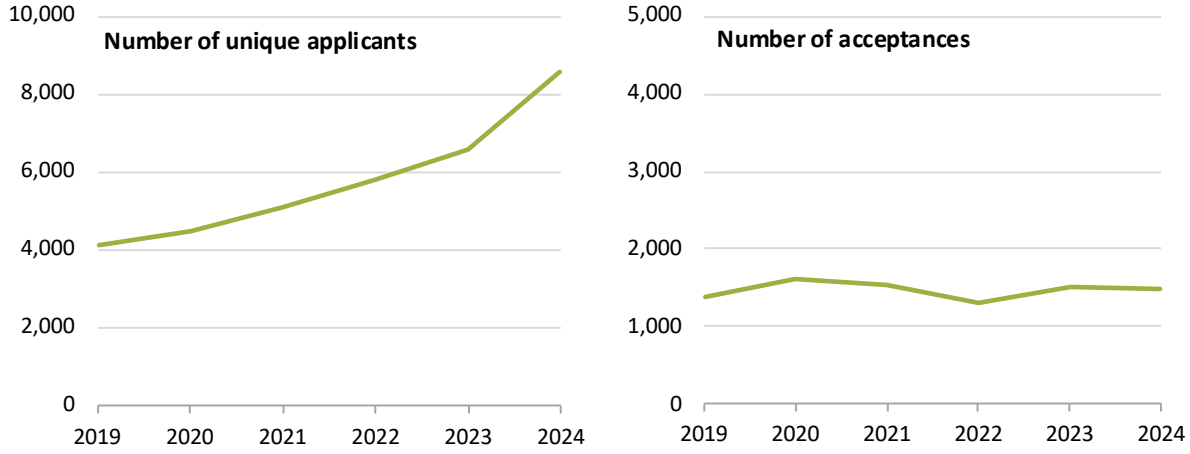
Dental training

Undergraduate admissions

5.16 There were 8,595 applicants to study undergraduate dentistry across the UK in 2024, an increase of 30.9 per cent from 2023. Following five years of consecutive growth, the number of applicants to study dentistry was 108.1 per cent higher than in 2019.

5.17 There were 1,485 acceptances to study dentistry in 2024, a fall of 1.3 per cent from 2023. In 2020 and 2021, the numbers accepted on to courses was higher than expected, because of the increase in A-Level grades that resulted from centre-assessed grading, but this was followed by a 15.2 per cent fall in the numbers accepted on to courses in 2022. The numbers accepted on to courses in 2024 to study dentistry were 7.6 per cent higher than in 2019.

Figure 5.2: Number of applicants and acceptances for dentistry degrees, UK, 2019 to 2024



Source: UCAS.

5.18 The undergraduate admission data do not show a marked change in the proportion of students coming from overseas to study dentistry. Between 2019 and 2024, the UK-domiciled share of applicants increased from 89 per cent to 92 per cent, and of acceptances increased from 93 per cent to 95 per cent.

5.19 The BDA expressed concern that the expansion in dental school places was not adequately funded. It said the Government had confirmed that there would not be additional funding to dental schools to support an expansion in the dental academic workforce. It said that incentivising more dentists to join academia was needed urgently to ensure there was sufficient capacity to support undergraduates studying dentistry.

Foundation training

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

5.21 The UK Committee of Postgraduate Dental Deans and Directors (COPDEND) said that all UK dental graduates who applied for dental foundation training were offered posts.[50] Of the 915 posts in national recruitment, 914 were accepted.

5.22 NHS England said that foundation training played a significant role in introducing graduate dentists to NHS general dental practice, and it was also the main route for UK dental graduates to be accepted on to the NHS performer list. It said that a loss of training sites within dental foundation training was a growing risk that impacted the placement of UK graduates. It said the decline was driven by factors including the workload on training practices and educational supervisors, as well as static payments for the service component of

[50] UK Committee of Postgraduate Dental Deans and Directors, *COPDEND Newsletter November 2024*. https://www.copdend.org/copdend-newsletter-november-2024/

training, which had not increased since 2013 despite rising inflationary costs. It said that the payment issue was a disincentive for practices and required urgent review.

5.23 The BDA highlighted that, in England, there was again no uplift to the dental foundation training service cost payment. It said this would impact the ability of NHS England to recruit and retain dental foundation training practices.

5.24 In January 2025, it was announced that the training fee paid to educational supervisors would increase in line with the expenses increase applied to contracts (1.68 per cent), rising from £64,164 to £65,244 a year.

5.25 The Welsh Government said that Health Education and Improvement Wales had put together an enhanced offer which aimed to encourage dental trainees to complete their foundation year in dental practices across rural Wales, rather than popular urban areas. September 2024 saw the second intake to this programme where the number of posts available was increased from 10 to 15 and the additional salary was increased from £5,000 to £7,000. Foundation dentists taking up the offer were provided with enhanced academic and wellbeing support for the duration of the programme. The Welsh Government said that this would help to increase access to NHS care for local people in rural Wales.

Core and specialty training

5.26 NHS England said there was a strong fill rate for dental core training in England, with a fill rate of 87.6 per cent for year 1, 74.9 per cent for year 2, and 94.7 per cent for year 3.

5.27 COPDEND said that recruitment for dental core training for 2024 was buoyant. It said that the application numbers were particularly high from overseas dentists, with an increase of over 1,000 overseas applications for year 1 posts. These applications came from many countries but particularly from the Sudan where numbers increased from eight in 2023 to 848 in 2024.

5.28 COPDEND said that most specialties saw an increase in applications in 2024 apart from dental public health, paediatric dentistry ST1, special care dentistry and orthodontics ST4.

5.29 NHS England said that most specialties had full recruitment in England at September 2024. It said that under recruitment in special care dentistry was concerning given the ageing population. It said there was also a shortage of consultant-level orthodontists and that many trusts had vacancies.

5.30 NHS England said the Dental Education Reform Programme had funded additional training posts in oral surgery, special care and paediatric dentistry.

5.31 The Department of Health said that there were 17 dental trainees in post in Northern Ireland in 2024-25, up from 14 in 2022-23 but down from 21 in 2020-21. A new allocations procedure had been introduced which had been effective in increasing the number of training practices in the west of Northern Ireland, where access to health service dentistry remained a concern.

Recruitment and retention

5.32 NHS England data from March 2024 showed a vacancy rate for dentists of 17 per cent within NHS dental practices.

5.33 In February 2024, the dental recovery plan announced a recruitment incentive scheme through which a golden hello payment of £20,000 would be offered to up to 240 dentists to deliver NHS work in areas that needed them most for three years. The scheme was expected

to deliver 284,000 more treatments a year. NHS England issued guidance to practices wishing to express an interest in the golden hello scheme and said that Integrated Care Boards (ICBs) had started to advertise posts.

5.34 A report from the National Audit Office concluded that, by October 2024, the golden hello payments had not delivered any additional courses of treatment.[51] In evidence to the Public Accounts Committee in February 2025, the Interim Permanent Secretary at the Department of Health and Social Care (DHSC) said that the golden hello scheme had not achieved its goals but that it was relatively early on.[52] In February 2025, 39 golden hello payments had been made, with 246 posts out to advert with a golden hello attached. The BDA was sceptical about the 240 golden hello payments, saying there was a clear risk that this simply moved the workforce around.

5.35 A consultation for a tie-in to NHS dentistry for graduate dentists closed on 18 July 2024 and the DHSC said it was considering the responses.

5.36 The BDA said that the NHS tie-in would involve dental graduates repaying up to £200,000 if they did not work in the NHS after graduation. It said this was an entirely disproportionate means of addressing the current workforce issues in NHS dentistry. It suggested it would be counter-productive if it put off potential students from applying to study dentistry.

5.37 In the BDA's survey of GDPs, 91 per cent of practice owners seeking to recruit an associate in 2023-24 had difficulty doing so. This compared to 93 per cent in 2023, 90 per cent in 2022 and 80 per cent in 2021. It found that 65 per cent of associate vacancies remained unfilled for at least six months, up from 55 per cent last year. Practice owners also reported difficulties recruiting dental hygienists, dental nurses, and dental therapists.

5.38 The Scottish Government said that golden hello payments were offered to dentists joining the national dental list for the first time or returning after a period of five years and wishing to practise in qualifying areas. It said the situation in rural areas was particularly challenging given Scotland's unique geography.

5.39 The Scottish Government said it had been instrumental in pursuing four-nation discussions between the respective governments where a broad consensus had emerged that provisional registration – with staff working in the NHS while awaiting qualification – would be beneficial for overall workforce numbers. However, this required UK legislation changes. The Scottish Government said this change was required to significantly alter the workforce position both in Scotland and the UK.

5.40 The Welsh Government said that 151 dentists joined the workforce in 2023-24, 10.8 per cent of the total NHS dental workforce in 2023-24. In 2022-23, 189 dentists left the workforce, 13.2 per cent of the total NHS dental workforce in 2022-23.

5.41 The Welsh Government said that recruitment and retention difficulties were being encountered by all health boards in Wales to varying degrees. Particular issues remained in the more rural and remote areas. It said that recruitment and retention of dentists was not a

[51] National Audit Office, *Investigation into the NHS dental recovery plan*. https://www.nao.org.uk/reports/investigation-into-the-nhs-dental-recovery-plan/?nab=1

[52] UK Parliament, *13 February 2025 - Fixing NHS Dentistry, oral evidence*. https://committees.parliament.uk/event/23201/formal-meeting-oral-evidence-session/

new challenge but seemed to have been exacerbated by the pandemic and was having a significant impact on the provision of NHS dental services in some areas.

5.42 Health boards in Wales had been successful in awarding several new contracts over the last year and distributing funding to existing NHS contract holders for additional activity. The Welsh Government said this suggested there was appetite from dentists wanting to become provider-performers and from existing practice owners to expand.

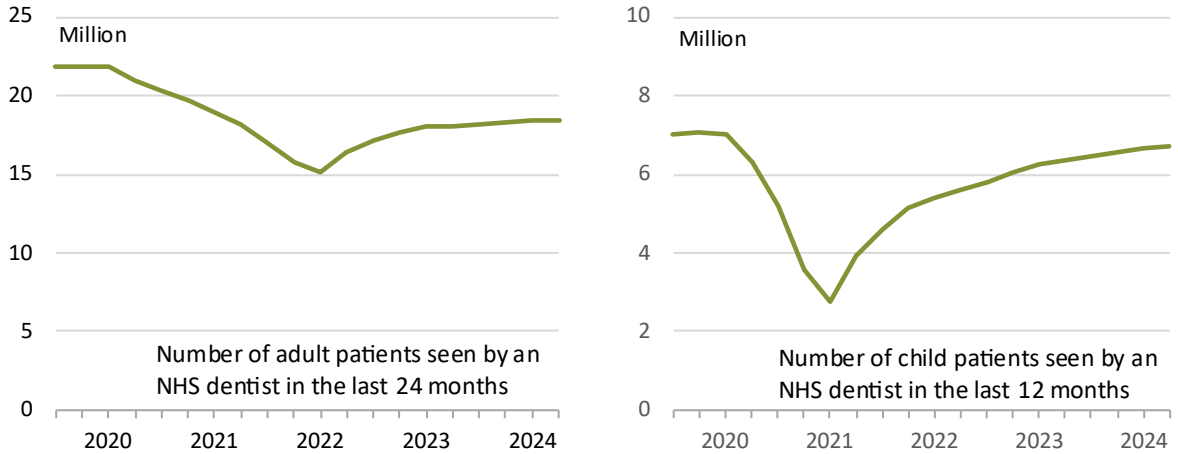
5.43 The Association of Dental Groups (ADG) said there continued to be significant workforce challenges in dentistry, and this was particularly acute in relation to dentists. It said there were crowded market forces competing for staff, especially dental nurses, and practices needed to be able to compete with commercial organisations to attract and retain staff, while remaining financially viable.

Provision of dental services

5.44 In the 24 months to September 2019, 21.9 million adults (aged 18+) were seen by an NHS dentist in England. As access to dental services was restricted by COVID-19, the number of adults seen by an NHS dentist fell by 31 per cent, to 15.2 million, in the 24 months to March 2022. Between the 24 months to March 2022 and the 24 months to June 2024, the number of adults seen by an NHS dentist increased by 22 per cent, to 18.4 million, but that remained 16 per cent below the September 2019 level.

5.45 In the 12 months to September 2019, 7.0 million children (aged 0-17) were seen by an NHS dentist in England. The number of children seen by an NHS dentist fell by 61 per cent, to 2.8 million, in the 12 months to March 2021. Between the 12 months to March 2021 and the 12 months to June 2024 the number of children seen by an NHS dentist increased by 144 per cent, to 6.7 million, but that remained 4 per cent below the September 2019 level.

Figure 5.3: Number of adults and children seen by an NHS dentist in the previous 24/12 months, England, 2019 to 2024



Source: NHS Dental Statistics 2023-24 – national overview.

5.46 The BDA said that the collapse of activity in NHS dentistry during the pandemic was more significant than other services, and it lagged well behind the recovery seen elsewhere in the NHS.

5.47 The DHSC said that the government's ambition was to make sure that everyone who needed dental treatment could access a dentist. It said there was a positive trend in the recovery of NHS dentistry following the pandemic and that 34.1 million courses of treatment were

delivered in 2023-24, an increase of 4.3 per cent from the previous year. In oral evidence, the DHSC said the government was committed to providing an additional 700,000 urgent care appointments a year for each year of the parliament.

5.48 The DHSC said it was reviewing the previous government's dental recovery plan, and which elements could be taken forward effectively and within NHS budgets. The dental recovery plan introduced a new patient premium, of £15 or £50 for each eligible new patient, to run from March 2024 to March 2025. However, the National Audit Office said that the period March to September 2024 saw a fall in the courses of treatment for new patients compared to the same period in 2023.

5.49 The BDA said that the £200 million funding for the dental recovery plan in England came from under-spend within the existing budget. It said the new patient premium was not additional funding but was earned against the existing contract i.e. the additional £15 (for a band one course of treatment) or £50 (for a band two or three course of treatment) had been converted into units of dental activity and were claimed against the contract's target. The BDA's view was that the premium had been set too low, but it supported extending and enhancing the scheme.

5.50 The view of the Scottish Government was that NHS service provision in Scotland remained far higher than in other parts of the UK. While the national Scotland picture was relatively stable, it noted there were localised challenges, particularly in rural areas (Dumfries and Galloway and parts of Highland and Argyll and Bute).

5.51 The Welsh Government said that each dentist completed an average of 1,000 courses of treatment in 2023-24. This was 5.8 per cent higher than in 2022-23, but markedly lower (39.4 per cent) than ten years ago.

5.52 The Welsh Government said that overall NHS dental activity remained below pre-pandemic levels, but urgent care was broadly in line with the pre-pandemic period. There was a 2 per cent increase in adults attending dental services in 2023-24 and a 1.1 per cent increase for children. The Welsh Government said that the treatment needs of patients were higher than pre-pandemic, with patients requiring more interventions as part of their treatment plan. There was a small reduction in the number of interventions per patient in 2023-24 compared to 2022-23.

5.53 The Welsh Government said it recognised that the continued higher treatment need, and the introduction of new patients, had a material effect on practices being able to recover activity to pre-pandemic levels in terms of unique patient attendances and courses of treatment delivered.

5.54 The Department of Health in Northern Ireland said that the number of patients seen in 2023-24 was up by 30 per cent compared to 2021-22 but this was still 24 per cent lower than pre-pandemic. The number of patients registered with a GDP in Northern Ireland grew from 1.213 million in 2019 to 1.341 million in 2023 but fell back to 1.294 million in 2024. The percentage of the population registered with a dentist remained stable at around 64 per cent between 2014 and 2021, increasing to 70 per cent by 2023, but falling to 68 per cent in 2024.

5.55 While the GDP headcount contracted to the Department had not diminished, payment data showed that the overall amount of health service work being undertaken by GDPs had reduced. General Dental Service (GDS) activity was plateauing at around 80 per cent of the pre-pandemic level, peaking at 84.2 per cent in January 2023. The Department said that the

impact for registered patients was longer waiting times and for unregistered patients it was a lack of access to health service dental care.

5.56 The Department of Health said that, with an expected underspend on the GDS budget for 2024-25, a reinvestment of £9.2 million was announced in March 2024. This was aimed at improving access for patients with oral health needs and further supporting practices. It included:

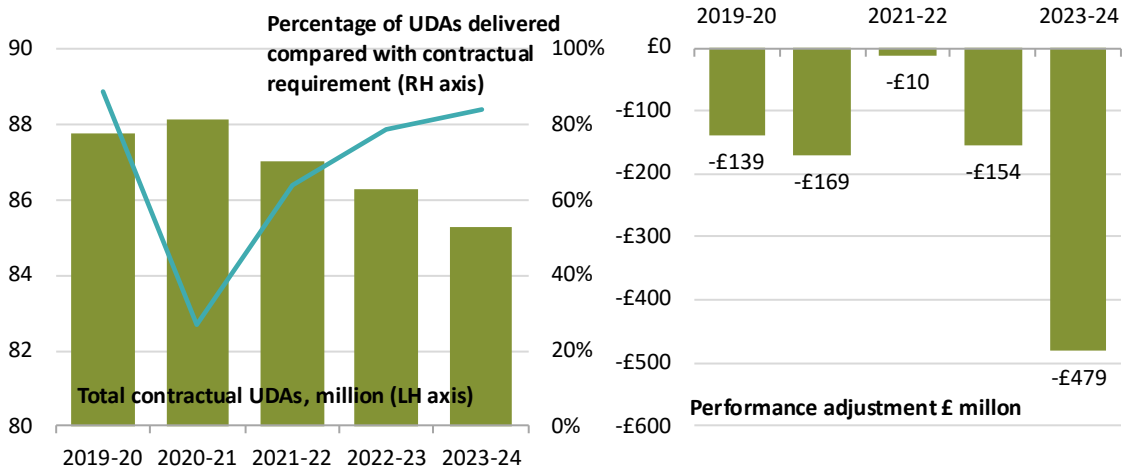
- £1 million for enhanced examinations for newly registered patients.
- £4.3 million for priority treatments for all patients via a 30 per cent enhancement to item of service fees for fillings, extractions and root canal treatment.
- £3.9 million for the treatment of high priority unregistered patients.

Dental contracts in England

5.57 NHS primary care dentistry in England is delivered through contracts structured around units of dental activity (UDAs) – each treatment is allocated a number of UDAs in proportion to the complexity/amount of work required. Commissioners negotiate contracts with practices to deliver a certain number of UDAs each year.

5.58 The number of contracted UDAs has fallen, from 87.8 million in 2019-20 to 85.3 million in 2023-24. The proportion of those UDAs actually delivered has varied significantly over the period. In 2019-20, almost 90 per cent of contracted UDAs were delivered, but this fell sharply, to 27 per cent in 2020-21, reflecting the impact of COVID-19. In each of the following years the percentage of UDAs delivered increased, but in 2023-24, at 84 per cent, was still 5 percentage points below pre-COVID-19 levels.

Figure 5.4: UDAs contracted and delivered, and performance adjustment, England, 2019-20 to 2023-24



Source: NHS England, NHS payments to dentists.

5.59 Where a contract holder has delivered less than 96 per cent of contract value, funding for the under-delivery is recovered in the following financial year. Despite just 27 per cent of contracted UDAs being delivered in 2020-21, the value of performance adjustments ('clawback') in 2021-22 was just £10 million, as special provisions were put in place to support dental contractors through COVID-19. Although some support remained in place in the following year, the value of performance adjustments increased to £154 million in 2022-23, similar to amounts seen prior to COVID-19, before tripling in value to £479 million in 2023-24, equivalent to 13.5 per cent of contract values. In 2023-24, 39 per cent of the 8,900 dental contracts experienced a performance adjustment.

5.60 In oral evidence, NHS England said it expected clawback to be less in 2024-25 as the system had recovered further, there was new patient funding, and ICBs were commissioning more, especially urgent dental care. In oral evidence, the BDA said that clawback happened because practices were struggling to recruit NHS dentists to deliver the work.

5.61 NHS England said it had made it easier for ICBs to free up funding for practices that could deliver more by addressing persistent contract under-performance. From April 2024, commissioners could permanently and unilaterally amend NHS dental contracts that failed to deliver their contracted amount of dental activity over three consecutive non-COVID-19 years.

5.62 NHS England said that NHS Business Services Authority data showed that, in 2023-24, more than 15 per cent of contracts received a payment equating to about £22 million for over-performance. NHS England said that it would collaborate with ICBs throughout 2024-25 to identify opportunities to support contractors to deliver additional capacity beyond their current contractual obligations (up to 110 per cent).

5.63 The DHSC said that differential UDA rates allowed providers to use differing pay rates to reflect the local market. It said that ICBs could also influence the UDA rate locally, which might help to support local interventions.

5.64 The dental recovery plan introduced an uplift to the minimum UDA value to £28 from 1 April 2024. In evidence to the Public Accounts Committee in February 2025, the Interim Permanent Secretary at the DHSC acknowledged that the minimum UDA was a long way from what a dentist would be able to make in the private sector and was fundamental to why many of the problems in NHS dentistry existed.[53] He said that, while the increase under the dental recovery plan only applied to a relatively small number of practices, it brought them closer to the market median.

5.65 The BDA said that the increase in the minimum UDA value from £25.33 to £28 was positive, but below the £35 that it believed was necessary. It said fewer than 900 contracts were affected. The BDA said that a number of ICBs had recognised that the national UDA value was too low and had implemented higher local rates. For example, Dorset ICB had introduced a UDA value of £35.

5.66 In oral evidence, NHS England acknowledged that the current NHS price was not commensurate with the effort required, and there was not enough paid, especially for high needs patients.

5.67 For 2024-25, dental contract values were uplifted by 4.64 per cent, composed of pay (6 per cent) and expenses (1.68 per cent) elements. The DHSC said there was a strong rationale for using GDP deflators for calculating expenses, to ensure increases to contract payments were affordable and equitable within the overall settlement, and that this was the measure more typically used across the NHS, including in general practice and ophthalmology.

[53] UK Parliament, *13 February 2025 - Fixing NHS Dentistry, oral evidence*. https://committees.parliament.uk/event/23201/formal-meeting-oral-evidence-session/

Table 5.2: Increase in annual contract value from 1 April 2024, England

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 deflator*	0.10%
Materials	6.60%	1.68%	GDP deflator*	0.11%
Other costs	18.80%	1.68%	GDP deflator*	0.32%
Total	100.00%	Not applicable	Not applicable	4.64%

Source: DHSC.

*2024-25 GDP deflator as forecast in October 2023. The latest OBR forecast (March 2025) for the GDP deflator in 2024-25 is 3.80 per cent.

5.68 The DHSC said that, to rebuild dentistry in the long term, the government had committed to reforming the dental contract, with a shift to focus on prevention and the retention of NHS dentists. It said there were no perfect payment models and careful consideration needed to be given to any potential changes to the complex dental system so that genuine improvements for patients and the profession were delivered.

5.69 NHS England said in oral evidence that there had been no decision on contract reform. It was looking at fundamental changes to the contract but acknowledged there was only funding to provide NHS services for around half the population.

5.70 The DHSC said in oral evidence that the dental contract would be reformed to focus on prevention and the retention of NHS dentists, and the comprehensive spending review would set the envelope for this. It said there needed to be a focus on using the full current budget at rates to make dentists want to do NHS work.

5.71 The BDA said there had been initial discussions on contract reform in England but no substantive progress. The ADG said that, in the absence of any immediate prospect of contract reform, the pay element of the DDRB process was critical in supporting retention of dentists within the NHS.

Dental contracts in Scotland

5.72 The Scottish Government said that the 2023 payment reform reflected significant reform of the care and treatment that could be provided on the NHS, and there was preliminary evidence that it was improving access for registered patients. It said the financial envelope had increased to reflect more closely the actual market prices of providing NHS care and treatment. It said that, on average, the overall value of item of service fees under the new system was around 20-25 per cent greater than before November 2023.

5.73 The Scottish Government implemented the DDRB pay recommendation of 6 per cent in 2024-25, which was applied to both gross item of service fees and capitation payments. It said that these improvements to the overall funding package of NHS dentistry would enable it to keep pace with expenses. The BDA said this was applied from 1 December 2024.

5.74 The Scottish Government noted that it did not have a mechanism to discuss expenses with BDA Scotland and said that Scottish Ministers were keen to seek resolution. The Scottish Government had committed to a working group on expenses with BDA Scotland.

Dental contracts in Wales

5.75 The Welsh Government said that, since April 2022, practices had been able to opt-in to a variation of their contract which reduced the reliance on UDAs. Practices could focus on providing preventive dental care for a set number of patients for their annual contract value instead of their previous UDA target. The Welsh Government said that this would also help open up access and practices were required to see a given number of new NHS patients. Around 83 per cent of the annual contract value operated under reformed contracts in 2023-24, which increased to around 90 per cent in 2024-25.

5.76 The Welsh Government said that, with the overwhelming majority of practices now working under these contract variation arrangements, it was difficult to compare current activity to the pre-pandemic period on a like-for-like basis. For 2024-25, the third year of contract reform variation, the metrics were changed to reflect the learning from the two previous years e.g., the number of new patients and new urgent patients was reduced with a commensurate increase to the number of historic patients for a given contract value. Further changes would be made for 2025-26.

5.77 In 2023-24, there was a significant change to the way the annual uplift was awarded for GDS contractors, with the uplift contingent on a wider package of reform and policy aims. In oral evidence, the Welsh Government said that pay and expenses were both uplifted by the DDRB recommendation of 6 per cent. For practices that opted to remain on the UDA contract, 100 per cent UDA targets were reinstated for the first time since the COVID-19 pandemic.

5.78 The BDA said that the Welsh Government remained entrenched in its policy position with all four contractor groups [dentists, GPs, pharmacies and opticians] that annual uplifts must be tied to conditions that promoted contract reform. It said that each year the Welsh Government formulated an offer to contract holders based on a series of volumetrics targets. The volumetrics had shifted towards greater provision for new patients including new urgent patients. Several options of conditions had been offered in exchange for the uplift, but agreement had not been reached.

5.79 The BDA's view was that the Welsh Government's use of the DDRB recommendation as an input into collective bargaining on pay fundamentally altered the DDRB's role in NHS GDPs pay in a way that undermined and sidelined the DDRB's role.

5.80 The Welsh Government said it remained conscious of the concerns expressed by dentists about workload, pay, operational aspects of the contract and perceived increases in administration all of which combined with inflation to place additional financial pressures on businesses. It believed that the reform of the dental contract was a key part of addressing the motivation and morale issues across dentistry. The aim was to implement a new GDS contract from April 2026.

5.81 A consultation was launched in March 2025 on proposals to reform the GDS contract in Wales. It said that the current contract, which was based on UDAs, resulted in practices being reluctant to accept patients with elevated levels of disease, that the system prioritised well patients over those with active disease, that the fees generated from similar private work often significantly exceeded NHS fees, and that health boards had difficulty reinvesting any financial underperformance. The consultation said that, while the contract variation introduced in 2022 had improved access for some patients, a new contract was needed for more substantial changes.

5.82 The proposed new contract aims to widen access and ensure there is always capacity for new patients to get access for both urgent and routine care. It proposes that 10 per cent of funding within the contract is allocated for urgent treatment for new patients and 10 per cent for new patient assessment. It proposes a care package model that provides payments for a range of common dental treatments based on complexity and time required. There are 19 proposed care packages with associated unit prices ranging from £45 for a 12-month recall to £329 for posterior root canal treatment. The consultation closes in June 2025.

5.83 The BDA said that government officials prematurely closed the negotiation process in September 2024, meaning that many elements of the contract remained indeterminate.

Dental contracts in Northern Ireland

5.84 The current GDS arrangements in Northern Ireland pay GDPs using a blended system of remuneration. Items of service payments account for approximately 60 per cent of GDP income, 20 per cent from capitation payments, and the remaining 20 per cent from allowances, reimbursements, initiatives, and other payments. The Statement of Dental Remuneration sets out the fees for more than four hundred items of service.

5.85 The net cost of primary care dental services in Northern Ireland in 2023-24 was £97.9 million with an additional £21.4 million in patient contributions for treatments. The net cost was down 2 per cent (from £100.0 million) from 2022-23, but the patient contribution had increased by 5 per cent (from £20.4 million). There was also an additional £2.3 million in COVID-19 support payments in 2023-24, down 82 per cent from 2022-23.

5.86 In oral evidence, the Department of Health in Northern Ireland confirmed the contract uplift for 2024-25 was 6.0 per cent for dentist and staff pay and 2.8 per cent for expenses. This gave an overall contract uplift of 4.85 per cent (and an increase to fees in the statement of dental remuneration).

5.87 The BDA said in oral evidence that the 2023-24 uplift was 6.47 per cent but only 4.92 per cent was carried on to future years. It said the viability of practices was impacted by [government] affordability.

5.88 The Department of Health said efforts were underway to model and cost the type of payment reform implemented in Scotland in the Northern Ireland context. In oral evidence, the Department acknowledged that there were issues with the contract, and that reform was needed, but progress had been delayed.

Earnings for providing-performer dentists

5.89 Earnings data for providing-performer and associate dentists comes from His Majesty's Revenue and Customs (HMRC) and the most recent data is for 2022-23. It combines all income from private and NHS work, so is not a measure of NHS earnings. From 2020-21 onwards, the average taxable incomes for providing-performer dentists have been particularly volatile, reflecting short-term COVID-19 related changes to the funding and delivery of dentistry. In 2022-23, mean pre-tax incomes of providing-performer dentists were highest in Scotland (£146,700), compared with England (£128,800), Northern Ireland (£124,600) and Wales (£122,600).

5.90 Earnings growth in the year to 2022-23 varied substantially by nation. Average pre-tax incomes for providing-performer dentists grew by 17.3 per cent in Scotland and by 1.5 per cent in Wales. Average pre-tax incomes for providing-performer dentists fell by 4.6 per cent in

England, while in Northern Ireland incomes fell by 10.2 per cent. Only the change in Scotland was statistically significant.

Table 5.3: Providing-performer dentists, pre-tax income, headcount, 2022-23

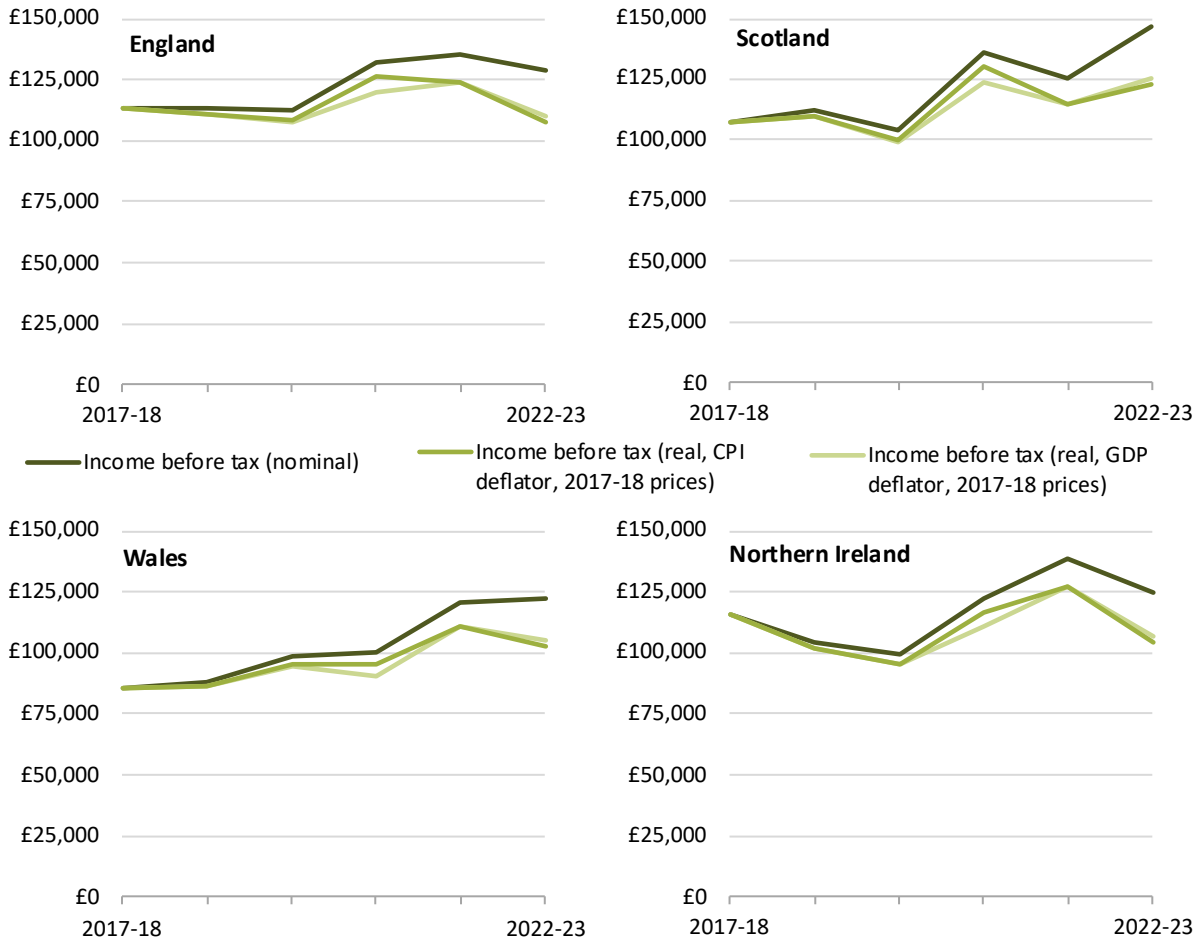
	England	Scotland	Wales	Northern Ireland
Mean (average)	£128,800	£146,700	£122,600	£124,600
Median	£99,200	£119,400	£107,000	£103,800
Lower quartile	£58,200	£83,100	£66,100	£71,000
Upper quartile	£165,600	£180,900	£147,400	£147,500

Source: NHS England.

5.91 In all four nations, average pre-tax incomes of providing-performer dentists increased between 2019-20 and 2022-23: by 41 per cent in Scotland; by 26 per cent in Northern Ireland; by 24 per cent in Wales; and by 14 per cent in England.

5.92 In nominal terms, average pre-tax incomes in 2022-23: in Scotland and Wales were at their highest levels since at least 2017-18; in England were lower than in 2020-21 and 2021-22 but higher than 2019-20 and the years before; and in Northern Ireland were lower than in 2021-22 but higher than in 2020-21 and the years before.

Figure 5.5: Providing-performer dentists, average pre-tax income, headcount, England, Scotland, Wales, Northern Ireland, 2017-18 to 2022-23, nominal and adjusted by CPI and the GDP deflator



Source: OPRB calculations using data from NHS England and ONS.

5.93 Adjusted by the GDP deflator, average pre-tax incomes: in Scotland were at their highest levels since at least 2017-18; in Wales were lower than in 2021-22, but higher than in 2020-21 and the preceding years; in England were lower than in 2020-21 and 2021-22, higher than in 2019-20, but lower than in both 2017-18 and 2018-19; and in Northern Ireland were lower than in 2020-21 and 2021-22, but higher than in 2019-20 and 2018-19.

5.94 Adjusted by the consumer prices index (CPI), average pre-tax incomes: in Scotland were higher than in every year since 2017-18, other than 2020-21; in Wales were lower than in 2021-22, but higher than in 2020-21 and the preceding years; in England were lower than in 2020-21 and 2021-22, little changed from 2019-20, but lower than in both 2017-18 and 2018-19; and in Northern Ireland were lower than in 2020-21 and 2021-22 but higher than in 2019-20 and 2018-19.

5.95 Between 2018-19 and 2022-23, average pre-tax incomes grew by more than the DDRB recommendation just under half of the time and by less than the DDRB recommendation just over half of the time. For the period as a whole, the increase in average pre-tax incomes in Scotland (36 per cent) and Wales (44 per cent) was greater than the value of the DDRB recommendations (16 per cent), but the increases in England (14 per cent) and Northern Ireland (7 per cent) were lower than the value of the DDRB recommendations.

Table 5.4: Changes to average pre-tax income for providing-performer dentists compared with DDRB recommendations, by nation, 2018-19 to 2022-23

	2018-19	2019-20	2020-21	2021-22	2022-23	Increase over the period
DDRB recommendation	2%	2.5%	2.8%	3%	4.5%	**16%**
England	-0.1%	-0.4%	17.4%	2.1%	-4.6%	**14%**
Scotland	4.3%	-7.6%	31.5%	-8.3%	17.3%	**36%**
Wales	3.6%	11.9%	1.3%	20.6%	1.5%	**44%**
Northern Ireland	-10.0%	-5.0%	23.0%	13.8%	-10.2%	**7%**

Note: Where the increase in average pre-tax income was below the DDRB recommendation the cell is shaded green.

5.96 The DHSC said that several factors made it difficult to compare the level of earnings and gross income from one year to another. These factors included 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 parts of corporates.

5.97 NHS England said that NHS dentistry remained profitable for both contractors and associates, although profits for 2022-23 decreased slightly compared to 2021-22. It said that the National Association of Specialist Dental Accountants and Lawyers benchmarking report for 2022-23 reported NHS practice profits of around £157,000 per provider.

5.98 The BDA said that the long-term trend since 2006-07 for both practice owners and associates remained a very significant erosion of take-home pay. It said that, for practice owners, taxable income was nearly flat or going backwards year on year, most significantly in Northern Ireland. It said that Scotland was an outlier, with the increase a consequence of COVID-19-related support payments.

5.99 In a BDA survey, 29 per cent of practice owners and 39 per cent of associates agreed or strongly agreed that they were fairly remunerated for their work. Where practice owners and associates worked at practices with a high NHS commitment, this fell to 12 per cent and 23 per cent respectively.

Earnings for associate dentists

5.100 In 2022-23, mean pre-tax incomes of associate dentists were highest in Scotland (£79,600), compared with Wales (£72,600), Northern Ireland (£67,300) and England (£64,300).

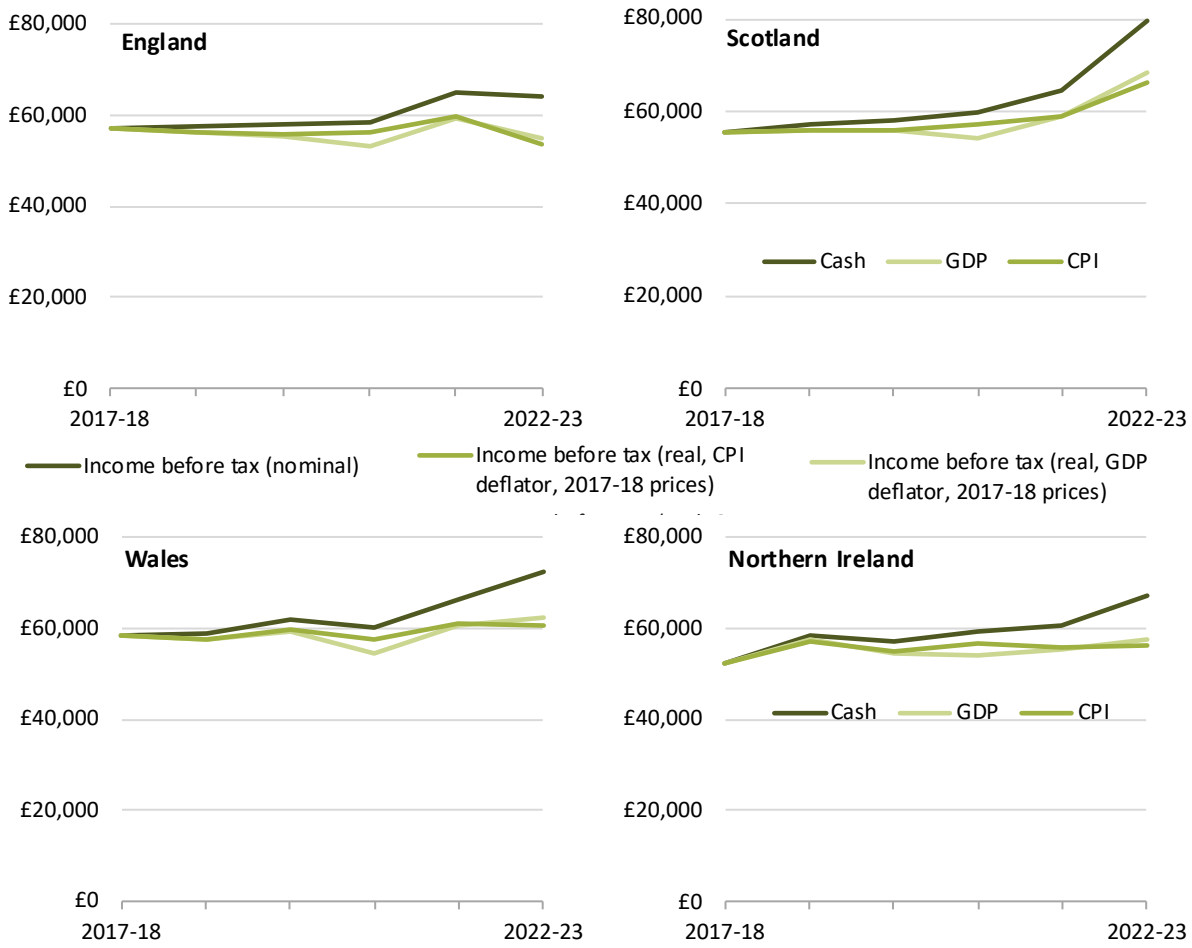
Table 5.5: Associate dentists, pre-tax income, headcount, 2022-23

	England	Scotland	Wales	Northern Ireland
Mean (average)	£64,300	£79,600	£72,600	£67,300
Median	£58,800	£73,000	£66,900	£58,500
Lower quartile	£37,200	£53,100	£44,300	£41,200
Upper quartile	£82,600	£96,300	£92,600	£80,500

Source: NHS England.

5.101 As with providing-performer dentists, earnings growth in the year to 2022-23 varied substantially by nation. In Scotland, average pre-tax incomes for associate dentists grew by 23.6 per cent, in Northern Ireland incomes grew by 10.9 per cent, and in Wales incomes grew by 9.5 per cent. All of these increases were statistically significant. In England, average pre-tax incomes for associate dentists fell by 0.9 per cent, which was not statistically significant.

Figure 5.6: Associate dentists, average pre-tax income, headcount, nominal and CPI-adjusted, England, Scotland, Wales, Northern Ireland, 2017-18 to 2022-23



Source: OPRB calculations using data from NHS England and ONS.

5.102 In nominal terms, average pre-tax incomes for associate dentists in 2022-23: in Scotland, Wales, and Northern Ireland were at their highest levels since at least 2017-18; and in England were lower than in 2021-22 but higher than all other years since 2017-18.

5.103 Adjusted by the GDP deflator, average pre-tax incomes in Scotland, Wales and Northern Ireland were at their highest levels since at least 2017-18, and in England fell back from 2021-22 and were lower than in 2017-18. Adjusted by the CPI, average pre-tax incomes: in Scotland were higher than in every year since 2017-18; in Wales were slightly lower than in 2021-22, but higher than in 2020-21 and the preceding years; in England were at their lowest level since 2017-18; and in Northern Ireland were higher than in 2021-22 but overall remain little changed since 2018-19.

5.104 Between 2018-19 and 2022-23, average pre-tax incomes for associate dentists grew by more than the DDRB recommendation half of the time and by less than the DDRB recommendation half of the time. Over the period as a whole, the increase in average pre-tax incomes in Scotland (44 per cent), Northern Ireland (29 per cent) and Wales (25 per cent) was greater than the value of the DDRB recommendations (16 per cent), while the increase in incomes in England (13 per cent) was lower than the value of the DDRB recommendations.

Table 5.6: Changes to average pre-tax income for associate dentists compared with DDRB recommendations, by nation, 2018-19 to 2022-23

	2018-19	2019-20	2020-21	2021-22	2022-23	Increase over the period
DDRB recommendation	2%	2.5%	2.8%	3%	4.5%	**16%**
England	1.1%	0.9%	1.0%	10.6%	-0.9%	**13%**
Scotland	3.6%	1.6%	2.6%	7.7%	23.6%	**44%**
Wales	0.9%	5.3%	-2.9%	10.3%	9.5%	**25%**
Northern Ireland	12.2%	-2.6%	4.0%	2.0%	10.9%	**29%**

Note: Where the increase in average pre-tax income was below the DDRB recommendation the cell is shaded green.

5.105 The DHSC said that while each year it strongly recommended that providing-performer dentists applied the recommended uplift to their associate dentists' salaries, it was unable to enforce practices to do so. As practices were private businesses, it fell to them to set employee pay and conditions.

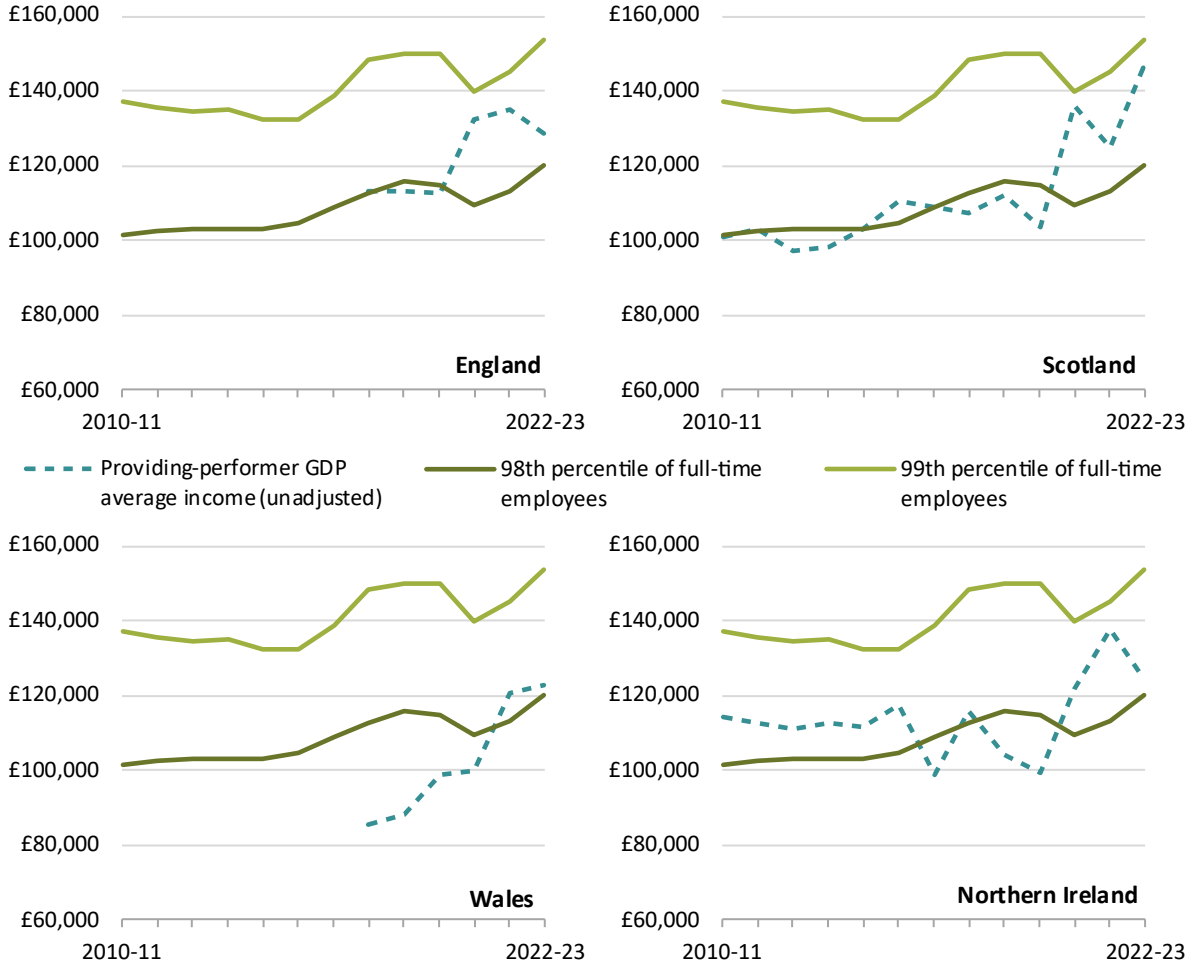
5.106 NHS England said there was no legal requirement for contract holders to pass DDRB uplifts or the minimum UDA value uplift on to performers and it remained concerned about the impact this might have on morale.

5.107 The BDA said that data on the fees associates were paid per UDA in England showed that they had remained largely static over the past three years. It concluded that the growth in associate earnings could not be attributed to a growth in their incomes from NHS sources.

Pay comparisons

5.108 In both Scotland and Northern Ireland, providing-performer GDP incomes were broadly in line with the 98th percentile of all full-time employees between 2010-11 and 2019-20 but increased above the 98th percentile in each year since. Data on GDP earnings for both England and Wales has only been available on a consistent basis since 2017-18. Providing-performer GDP incomes in England have been above the 98th percentile in each year, while providing-performer GDP earnings in Wales have increased from below to in line with the 98th percentile of all full-time employees since 2017-18.

Figure 5.7: Average pre-tax income of providing-performer GDPs, headcount, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2022-23



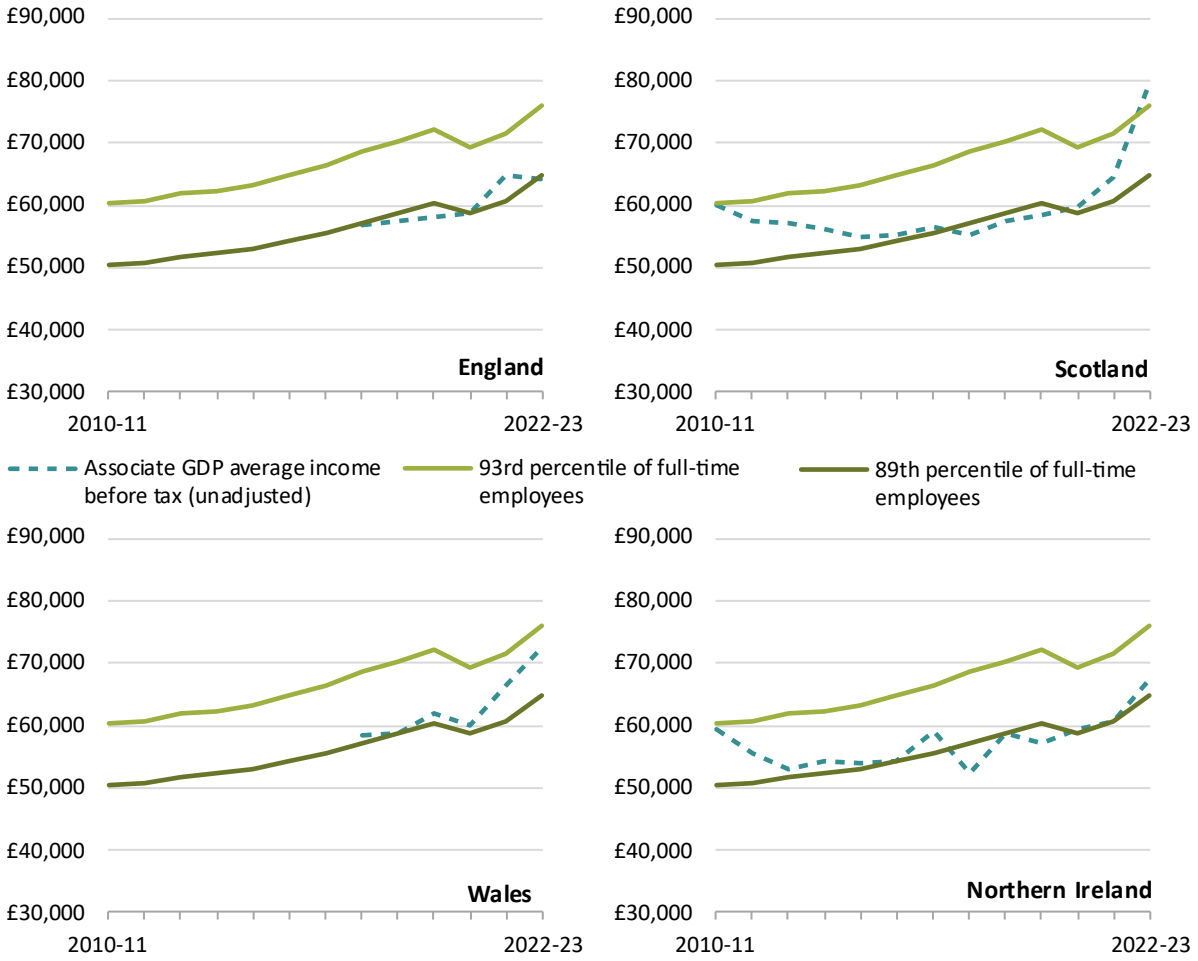
Source: OPRB calculations using data from NHS England and ONS.

Note: Dental earnings are not adjusted for working hours.

5.109 Average incomes for associate GDPs in Scotland and Northern Ireland fell back from the 93rd percentile to the 89th percentile of all full-time earnings between 2010-11 and 2021-22, but in 2021-22, in Scotland, average income for associate GDPs increased sharply, to a level above the 93rd percentile. Average incomes for associate GDPs in Wales increased relative to the 93rd percentile in both 2021-22 and 2022-23, while average incomes of associate GDPs in England increased relative to the 89th percentile in 2021-22, but fell back to the 89th percentile in 2022-23.

5.110 Median earnings for provider-performer GDPs were less than most comparators, with the exception of vets (see figure 5.9). Associate GDPs also earned less than their full-time professional comparators (see figure 5.10). It is important to note that pay for comparator professions is on a full-time equivalent (FTE) basis, whereas that for GDPs is on a headcount basis and is therefore lower than it would be on an FTE basis.

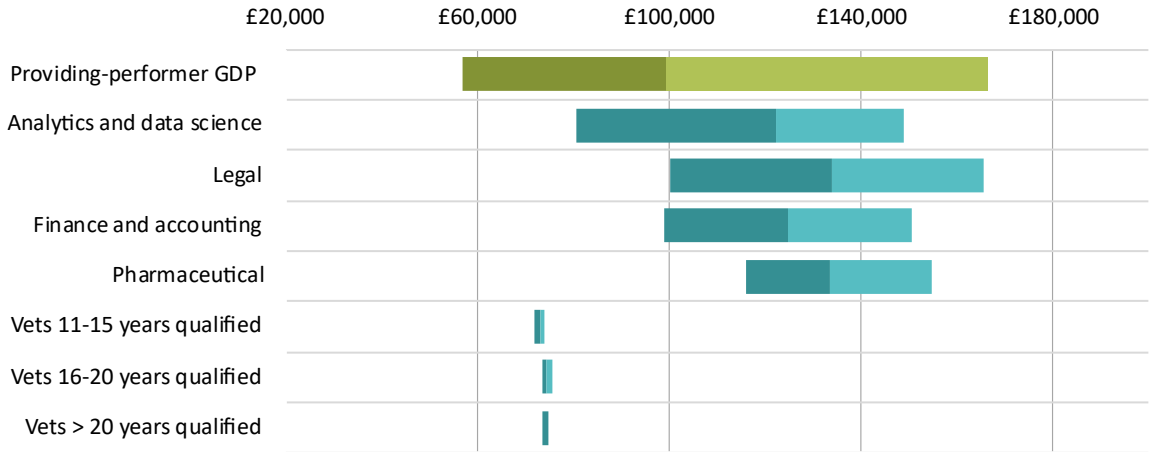
Figure 5.8: Average pre-tax income of associate GDPs, headcount, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2022-23



Source: OPRB calculations using data from NHS England and ONS.

Note: Dental earnings are not adjusted for working hours.

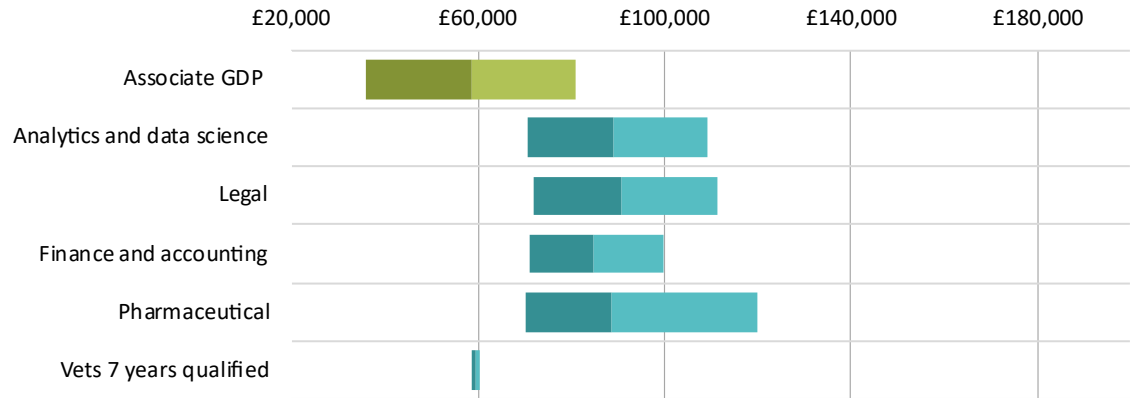
Figure 5.9: Interquartile range of total earnings of providing-performer GDPs, headcount, England, compared with professional groups, 2024



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

Notes: Pay for comparator professions is on an FTE basis, while GDP earnings are on a headcount basis and are therefore lower than they would be on an FTE basis. GDP earnings are also from 2022-23, while comparator earnings are from 2024. Individual dental roles are matched by job size to market data.

Figure 5.10: Interquartile range of total earnings of associate GDPs, headcount, England, compared with professional groups, 2024



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

Notes: Pay for comparator professions is on an FTE basis, while GDPs earnings are on a headcount basis and are therefore lower than they would be on an FTE basis. GDP earnings are also from 2022-23, while comparator earnings are from 2024. Individual dental roles are matched by job size to market data.

GDP earnings by gender

5.111 In England, Scotland and Northern Ireland, average pre-tax incomes of female providing-performer dentists were lower than those of male providing-performers in 2022-23, by 16 per cent, 14 per cent, and 22 per cent respectively. In Wales, in 2021-22 and 2022-23, average pre-tax incomes for female providing-performer dentists were 2 per cent and 4 per cent higher respectively than those for male providing-performers. The HMRC data does not adjust for working hours.

Table 5.7: Providing-performer dentists average pre-tax income, headcount, by gender and nation, 2017-18 to 2022-23

		2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
England	Male	£118,500	£119,200	£119,300	£137,000	£143,200	£135,300
	Female	£99,300	£97,500	£96,100	£120,400	£115,800	£114,100
	Difference	-16%	-18%	-19%	-12%	-19%	-16%
Scotland	Male	£115,000	£124,300	£110,300	£145,000	£132,200	£155,600
	Female	£91,500	£90,500	£91,500	£122,000	£113,300	£134,300
	Difference	-20%	-27%	-17%	-16%	-14%	-14%
Wales	Male	£88,500	£91,000	£99,600	£101,800	£120,000	£121,200
	Female	£77,200	£81,500	£96,700	£95,700	£123,000	£126,000
	Difference	-13%	-10%	-3%	-6%	2%	4%
Northern Ireland	Male	£125,900	£113,600	£108,300	£131,500	£147,300	£133,900
	Female	£91,800	£85,000	£80,600	£100,800	£118,800	£104,800
	Difference	-27%	-25%	-26%	-23%	-19%	-22%

Source: NHS England.

Note: Does not adjust for working hours.

5.112 Average pre-tax incomes of female associate dentists in 2022-23 were lower than those of male associates by: 33 per cent in Northern Ireland; 27 per cent in both Scotland and Wales; and 25 per cent in England. In Scotland and Wales, the gap between male and female average incomes increased between 2019-20 and 2022-23, while the gap narrowed in England and

Northern Ireland. Again, this data does not adjust for working hours, which may be driving much of the difference.

Table 5.8: Associate dentists average pre-tax income, headcount, by gender and nation, 2017-18 to 2022-23

		2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
England	Male	£67,500	£67,800	£69,100	£68,100	£76,900	£76,000
	Female	£49,000	£50,100	£50,300	£52,100	£56,900	£56,800
	Difference	*-27%*	*-26%*	*-27%*	*-23%*	*-26%*	*-25%*
Scotland	Male	£63,500	£66,400	£67,600	£68,000	£75,100	£95,000
	Female	£49,400	£50,700	£52,000	£54,100	£56,800	£68,900
	Difference	*-22%*	*-24%*	*-23%*	*-20%*	*-24%*	*-27%*
Wales	Male	£65,100	£64,200	£71,300	£69,300	£76,600	£86,600
	Female	£52,000	£54,100	£54,900	£53,600	£59,200	£63,400
	Difference	*-20%*	*-16%*	*-23%*	*-23%*	*-23%*	*-27%*
Northern Ireland	Male	£66,600	£77,100	£71,100	£74,300	£74,300	£86,400
	Female	£44,100	£47,900	£48,900	£51,300	£54,200	£58,000
	Difference	*-34%*	*-38%*	*-31%*	*-31%*	*-27%*	*-33%*

Source: NHS England.

Note: Does not adjust for working hours

Expenses

5.113 Pre-tax income figures are derived by deducting expenses from gross earnings. Expenses include the cost of associate dentists, as well as other staff costs, premises, laboratory and equipment costs, debt interest payments, etc. For example, for providing-performer dentists in England, the 2022-23 estimate of pre-tax income (£128,800) results from gross earnings (£440,800) less expenses (£312,000). Average gross earnings and expenses vary between nation, being highest for contractors in England. Expenses accounted for 71 per cent of gross earnings in England, 69 per cent in Wales, 67 per cent in Northern Ireland, and 66 per cent in Scotland.

Table 5.9: Providing-performer dentists, gross earnings, expenses and pre-tax income, 2022-23

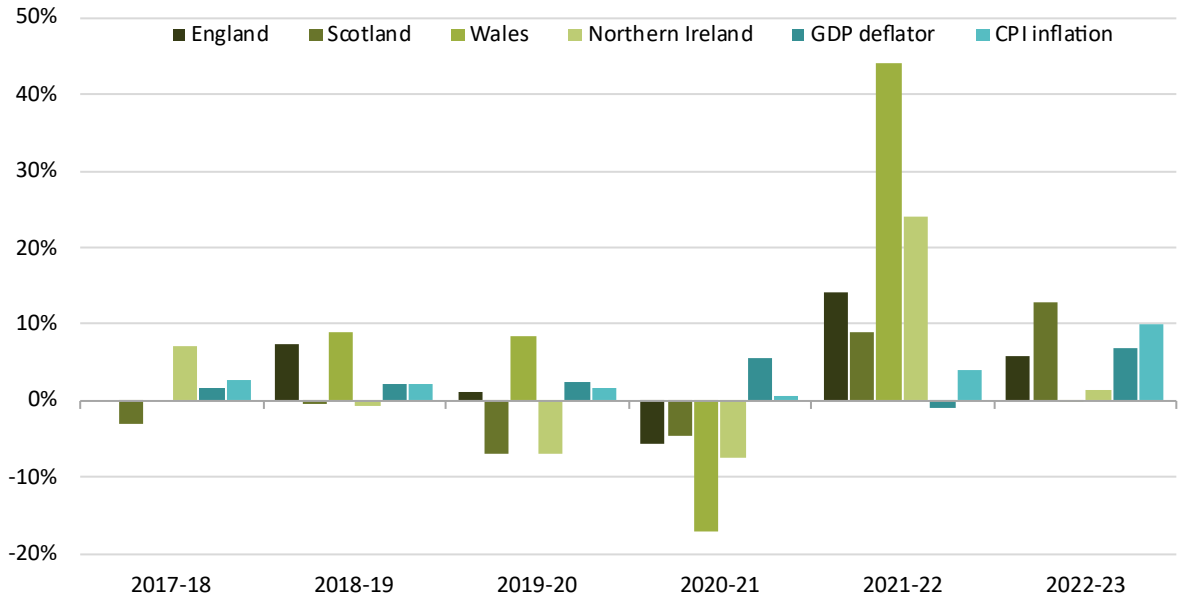
	England	Scotland	Wales	Northern Ireland
Gross earnings	£440,800	£429,300	£389,800	£373,300
Expenses	£312,000	£282,600	£267,300	£248,700
Income before tax (average)	£128,800	£146,700	£122,600	£124,600
Expenses as % of gross earnings	71%	66%	69%	67%

Source: NHS England.

5.114 Over time, the change in overall expenses each year shows a low correlation with both CPI inflation or the GDP deflator. The average expenses change also varies across nations. The change in expenses may result from: a change in the price of inputs (i.e. hourly wage rates, equipment or energy costs); the need to use more/fewer inputs (as demand/activity changes); a change in the composition of the expenses base (e.g. greater use of higher-paid staff relative to lower-paid staff, or vice versa). It is likely to be a combination of these factors. The weak correlation between price indices and expenses growth continues when only looking at non-

staff costs. Staff cost changes also show little correlation with changes in average earnings measures, such as the Annual Survey of Hours and Earnings, which was previously used for uprating the staff costs element of the contract.

Figure 5.11: Annual change in average dental practice expenses by nation, GDP deflator and CPI inflation, 2017-18 to 2022-23



Source: NHS England, ONS.

5.115 In oral evidence, the DHSC said the government's position was that the GDP deflator was the right figure for expenses because it covered the entire economy and questioning this figure would impact on its use across the wider public sector. It added that this would need to be part of longer-term contract negotiations.

5.116 The BDA said there were no agreed processes for agreeing uplifts to practice operating costs and that all four governments indicated that affordability was the main criterion. It said that, by restraining the uplifts on practice operating costs, governments could ensure that the DDRB uplift was not reflected in dentists' take-home pay. This meant dentists had to either accept lower pay, decrease their NHS work, or increase their private work. It said this had a real impact on the future sustainability of NHS dentistry.

5.117 The BDA said that, based on its assessment of the increase in practice operating costs, the uplift applied to contracts would have been 12.8 per cent for 2024-25. It said that material and laboratory costs increased by 18.0 per cent, other non-staff costs by 20.4 per cent, and staff costs by 17.7 per cent.

5.118 The BDA highlighted that there was no mechanism to address a variation in actual GDP deflator out-turn against the forecast used for uplifts. It said that, in 2022-23, the GDP deflator forecast applied was 5.3 per cent, but the outturn was 7.13 per cent. In 2023-24, a 3.23 per cent uplift was applied, but the out-turn GDP deflator was 6.14 per cent. It said these discrepancies had denied practices, and dentists, significant sums of funding.

5.119 The BDA said that the remuneration received by dentists was far below the true cost of NHS treatment borne by practice owners once the costs of delivering care were accounted for. It said it had conducted modelling which concluded that the cross subsidy of private income supporting NHS treatment could be as high as £300 million.

5.120 The BDA estimated that the national insurance and national living wage announcements in the October 2024 budget would add 9.5 per cent to non-dentist staffing costs for practices. It said that mostly private practices would be able to claim the employment allowance, but not those with more than 50 per cent of their revenue from the NHS. [54] It said that there had been indications from government that the impact of these changes on primary care providers including dentists would be dealt with through normal annual contract mechanisms.

5.121 The ADG said that the recent announcements on national insurance and the national living wage would significantly add to the financial pressure that dental providers faced. Without recognition of the impact of higher national insurance on providers, they would be faced with the choice of operating NHS dentistry at a potential loss, using private dentistry to further subsidise NHS operations, and/or reducing NHS commitments in favour of private care.

5.122 It said that the national insurance changes were not anticipated and would have a significant direct impact on employee costs. They were also expected to cause additional upward cost pressure from suppliers of consumables and materials.

5.123 The ADG had estimated the changes in key expenses:

- Impact of national insurance contributions, 1.9-5.0 per cent.
- Direct impact of the national living wage changes, 0.3-4.0 per cent.
- Indirect impact of the national living wage changes on other staff earnings, 0.7-5.0 per cent.
- Consumables and materials, 0.5-6.0 per cent.
- Dental labs, 0.6-10.0 per cent.
- Energy, 0.0-7.0 per cent.

5.124 The Department of Health in Northern Ireland said that a practice allowance paid 11 per cent (or 4 per cent) of the practice's gross health service earnings for those with a high HSC commitment. Practitioners with at least 85 per cent commitment to the health service were also able to claim reimbursement of non-domestic rates. Dentists could also receive payment towards the cost of removal of clinical waste from their practices.

5.125 In oral evidence, the Department said that the Minister of Health in Northern Ireland had committed to a cost-of-service review in 2025-26 to determine what it cost to provide dentistry. This would also look at funding and the future of dentistry.

Motivation, morale and wellbeing

5.126 The dental working patterns survey asked whether dentists felt good about their job. The proportion of positive responses from principal dentists for 2022-23 was: 44.3 per cent in England; 41.9 per cent in Scotland; 34.0 per cent in Wales; and 47.9 per cent in Northern Ireland. Compared with the 2019-20 survey, the results had worsened for England, Wales and Scotland, but improved for Northern Ireland.

5.127 Among associate dentists, the proportion of positive responses was: 45.5 per cent in England; 38.3 per cent in Scotland; 42.8 per cent in Wales; and 41.4 per cent in Northern Ireland. Compared with 2019-20, the results had worsened for England, Wales and Scotland, but slightly improved for Northern Ireland.

[54] Employment allowance allows businesses with national insurance liabilities of less than £100,000 in the previous tax year to reduce their national insurance liability by up to £5,000.

5.128 The dental working patterns survey asked dentists how they rated their morale. Among principal dentists, the proportion saying their morale was high or very high in 2022-23 was: 16.2 per cent in England; 9.4 per cent in Scotland; 13.1 per cent in Wales; and 16.1 per cent in Northern Ireland. Compared with 2019-20, the results had worsened for England, Wales and Scotland but improved for Northern Ireland. The most frequently cited cause of low morale among principal dentists was increasing expenses and/or declining income.

5.129 Among associate dentists, the percentage saying their morale was high or very high was: 18.1 per cent in England; 15.2 per cent in Scotland; 18.3 per cent in Wales; and 10.1 per cent in Northern Ireland. Compared with 2019-20, the results had worsened for all four nations. The most frequently cited cause of low morale among associate dentists was risk of litigation and the cost of indemnity fees.

5.130 The BDA said that high NHS commitment remained strongly correlated with poor motivation, morale and job satisfaction. Its survey found that 50 per cent of practice owners across the UK and 38 per cent of associates reported low or very low morale (an improvement from 60 per cent and 49 per cent in the previous year). Where the relevant dentists held a high NHS commitment, that figure increased to 65 per cent and 49 per cent respectively.

5.131 The BDA survey found that 66 per cent of practice owners and 45 per cent of associates felt that their level of stress had increased over the last 12 months. For practice owners and associates working in practices with a high NHS commitment, these figures were 74 per cent and 54 per cent respectively.

5.132 When asked to pick which factors were causing stress in their current role, 87 per cent of practice owners chose increased practice costs, and 78 per cent chose staffing, recruitment, and retention issues. For associates, the two factors most frequently identified as causing stress in their current role were patient complaints/legal issues, and staff shortages/high staff turnover, at 67 per cent and 54 per cent respectively. In addition, 62 per cent of practice owners and 45 per cent of associates also reported that financial pressures specifically arising from the increasing lack of viability of NHS dentistry were a factor in causing stress.

Community and Public Dental Services

5.133 The CDS in England, Wales and Northern Ireland and the PDS in Scotland provide general dental care to people who cannot be treated through practice-based GDPs. This includes those with particular dental needs, including vulnerable groups.

5.134 CDS/PDS dentists are salaried and are usually managed as NHS trust employees, with their own nationally agreed pay, terms and conditions. CDS and PDS dentists are often referred to as salaried dentists.

5.135 NHS England said it had 68 contracts with 296 locations for community dental services. Most of these (85 per cent) were with foundation, community and mental health trusts and the remainder with community interest companies.

5.136 Workforce data provided by governments improved for this year's report. However, there are still large evidence gaps in terms of understanding service delivery and workforce trends. A recent report from NHS England noted the lack of a consistent CDS data set and highlighted inconsistences in waiting list figures.[55] It said there were a myriad of CDS models, run by a

[55] NHS England, *Focus on Community Dental Services in new GIRFT supplementary report*. https://gettingitrightfirsttime.co.uk/focus-on-community-dental-services-in-new-girft-supplementary-report/

range of different types of organisations, delivered by different staff and skill mixes, and with a variety of approaches to governance.

Workforce

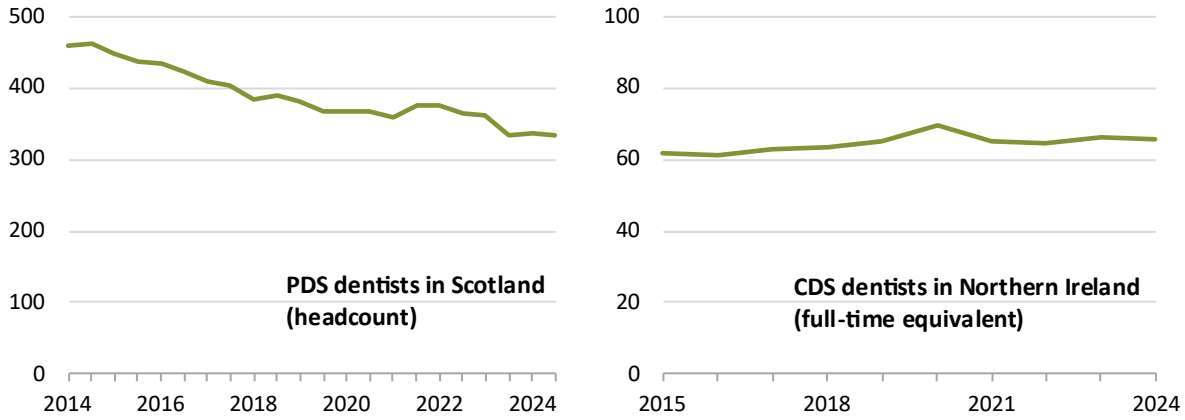
5.137 NHS England data showed that there were 621 dentists (headcount) working in community dentistry at 31 March 2024, unchanged over the previous six months. In oral evidence, NHS England said there had not been a drop in the CDS workforce.

5.138 There were 334 dentists working in the PDS in Scotland in September 2024, with the workforce showing steady decline over the last 10 years, from 462 in September 2014.

5.139 There were 136 (headcount) salaried dentists in NHS Wales in August 2024, compared to 141 in September 2023.

5.140 The CDS in Northern Ireland had 83 dentists in 2024, of whom 90 per cent were female. On an FTE basis, there were 37.2 community dentists, 24.2 senior community dentists, and 4.4 dental directors. The workforce has been broadly stable in size since 2015.

Figure 5.12: PDS dentists in Scotland and CDS dentists in Northern Ireland, 2014 to 2024



Source: Scottish Government; Department of Health, Northern Ireland.

Recruitment and retention

5.141 NHS England data from 54 CDS providers implied an annual leaver rate from the CDS of 12.2 per cent in the year to March 2024. There was a vacancy rate for CDS dentists of 13.4 per cent at March 2024. NHS England noted this was lower than the average 17 per cent vacancy rate for dentists across high street practices.

5.142 Based on freedom of information requests, BDA estimated a CDS/PDS vacancy rate of 18 per cent in England, 11 per cent in Scotland, and 16 per cent in Wales.

5.143 NHS Employers said there were reports of continued difficulties in recruiting entry-level salaried primary care dentists. It said salaries were no longer deemed competitive with wider remuneration levels across general dental practice or other areas of dentistry. Employers had described recruiting for band A roles as becoming increasingly more difficult, and vacancies remained unfilled for long periods. Although vacancies were advertised widely, employers often did not receive a single application.

5.144 The ADG included information from a community interest company providing community dental services. It had experienced severe recruitment difficulties, particularly in rural and

coastal areas. The company had secured golden hellos of up to £15,000 but it did not result in any interest or response. Over the previous 12 months, it had filled 18 out of 30 vacancies.

5.145 The Scottish Government said that each frontline NHS board had an appointed Director of Dentistry, and it maintained regular contact with the network to understand challenges and issues arising in both Public and General Dental Services. Since the pandemic, boards had been increasingly live to workforce supply issues, with recruitment of staff posing a particular challenge.

5.146 In oral evidence, the Welsh Government said that recruitment and retention were less of an issue in the CDS than in general dentistry. However, it noted that it often needed to recruit at band B and that it could take several rounds to recruit.

5.147 The Department of Health said that the CDS in Northern Ireland was continuing to face difficulty in recruitment. It said that the CDS workforce needed to be sufficiently large to meet the ever-increasing demand on the service. For this to be practicable, the CDS needed to be a rewarding and attractive place to work to encourage dentists to enter the service, progress and stay in it.

5.148 Some trusts in Northern Ireland reported finding CDS recruitment difficult, with it taking a significant time to fill posts. Trusts pointed to differences in pay with the rest of the UK, the lack of career progression and training pathways, and pay outside the NHS. The Department said there were fewer senior posts in Northern Ireland than in the rest of the UK and no specialist posts. The Department said there were very few, if any, opportunities for staff to access recognised training pathways within special care dentistry.

5.149 The Department of Health said that access to locum posts was very limited. There was no access to agency staff to fill gaps, which meant clinical teams were frequently running under capacity.

Pay

5.150 NHS England said that those employed in community interest companies might be subject to different rates of pay and wider terms and conditions although community interest companies tended to reference the NHS bands for salaried dentists when setting their pay scales.

5.151 The Department of Health in Northern Ireland said the recruitment salary was attractive to early career dentists along with the other benefits of being employed – annual leave, sick pay, a training allowance etc. It said that the ability to negotiate part-time working hours was also a significant benefit, as well as no requirement to provide on-call, or weekend cover.

5.152 Northern Ireland had a notably lower band A recruitment salary than the other nations (£46,363 compared to £50,512 to £52,035 in the other nations).

5.153 Job levelling and market data from Willis Towers Watson (WTW) indicate that base pay for CDS dentists in England is above the market median, especially for band B.

Motivation, morale and wellbeing

5.154 The 2024 NHS staff survey for England showed improvement for salaried dentists across most indicators, following significant declines in the engagement and job satisfaction scores for salaried primary care dentists in 2023. For example, 63.8 per cent of salaried primary care dentists said they were enthusiastic about their job in 2024, compared to 56.4 per cent in

2023, and 67.2 per cent in 2022. This was still lower than the 68.5 per cent for all medical and dental staff.

5.155 The proportion of salaried primary care dentists reporting that they were able to meet all the conflicting demands on their time at work was 38.1 per cent, up from 34.0 per cent in 2023 and slightly higher than the level for all medical and dental staff (36.5 per cent).

5.156 Just over half, 52.0 per cent, of salaried primary care dentists reported that they achieved a good balance between work and home life in 2024, up from 46.8 per cent in 2023 and higher than the 45.3 per cent seen for all medical and dental staff.

5.157 NHS Employers said that abuse and violence from patients remained a concern for salaried dentists. This was often due to frustrations around access to care and waiting times. This had significantly impacted salaried dentists' health and wellbeing, resulting in some requiring time off or leaving dental services altogether. The increased stress and burnout did not help to alleviate attraction, recruitment and retention pressures for this group.

5.158 Responses to the BDA's survey showed poor morale, motivation and wellbeing among CDS/PDS dentists. Factors that affected wellbeing included increasing workload, increasing pressure, long waiting times, and insufficient staff numbers. This had negatively impacted personal relationships, mental health, self-care and sleep, as well as leading to more serious consequences including suicide attempts. Many respondents described the working environment as toxic and relentless. Some had trouble switching off and felt run into the ground, tired, drained, overwhelmed, constantly worried, mentally exhausted, burnt out and unable to cope.

5.159 The BDA said it was unacceptable for health departments to simply refer to the existence of the CDS and provide no significant evidence on workforce trends, recruitment and retention. It said this system-wide lack of understanding, appreciation and recognition for the work of community dentists was one of the many contributing factors to their worsening morale and motivation.

5.160 The Department of Health in Northen Ireland said that challenges within GDS had resulted in reduced availability of NHS dentistry across the province and led to increasing pressures on the CDS. A substantial increase in referrals from GDS had had a knock-on effect and had put additional strain on staff with no corresponding increase in the workforce. There was also reduced access to theatre time, which had led to increased waiting lists and challenges in managing the vulnerable priority groups who rely on these services.

5.161 The Department said that a wide range of patient care issues were having a negative impact on the morale of CDS dentists. Many felt the over-stretched service was struggling to meet the needs of the increasingly complex patients it served. Lack of career progression, training opportunities and access to specialist posts was also having a detrimental impact.

5.162 Across all grades in Northern Ireland, staff were reporting an increase in workload challenges including waiting list pressures and the management of increasingly complex patients with a lack of efficient referral pathways and access to consultant-led services. Rising work stress and worsening work-life balance had resulted in some staff considering the possibility of an earlier retirement. Staff felt that they were firefighting with no opportunity to use their skills for prevention and patient-focused improvement regimes.

Our comments

The dental workforce and the delivery of NHS dentistry

5.163 In England, Scotland and Wales there are fewer dentists providing NHS services than prior to the COVID-19 pandemic. The proportion of time spent on NHS work by dentists has also declined in all four nations since 2019-20. Delivery of NHS dentistry in England, Wales and Northern Ireland has not recovered to pre-pandemic levels.

5.164 There has been a significant budget underspend in NHS dentistry in England, as dentists are not fulfilling their NHS contracts. Dentists tell us this is because the fees offered do not make the work viable, and they cannot recruit associate dentists to undertake NHS work. NHS England reports a 17 per cent vacancy rate for dentists in NHS practices. While there have been several recent initiatives to improve access to dentistry in England, they have not had a significant impact. The GDS contract in England needs urgent reform.

5.165 The Scottish Government has said the dental provision in Scotland is better than the other nations, in terms of dentists per population and overall delivery. However, recruitment and retention were particularly difficult in rural and remote areas of both Scotland and Wales, creating uneven delivery. While the data do not allow us to separate private and NHS earnings, dentists in Scotland have seen much stronger recent earnings growth, especially compared to dentists in England.

5.166 A number of parties have highlighted the lack of workforce planning for dentistry. This needs to start with an understanding of what NHS dentistry aims to provide, to establish how many NHS dentists are needed. Based on undergraduate applications, dentistry remains an attractive career. However, it cannot be assumed that qualified dentists will go into NHS dentistry, and it is uncertain that mandating recent graduates to perform NHS dentistry will be successful. Workforce growth has been constrained by the limited number of university places, while the number of internationally qualified dentists has increased.

5.167 Dentists have consistently highlighted that increases to contract prices do not reflect the increase in the costs of providing services. The expenses uplift in England was 1.68 per cent for 2024-25. Low uplifts to costs in the GDS contract in England are likely to be limiting the attractiveness of NHS work. We set out in chapter 1 how we recommend this be addressed by a targeted index of dental costs that can be used to inform the expenses uplift and should be integrated into contract reform.

5.168 Current contractual arrangements are not enabling NHS dentistry to be sustained or to grow, because dentists are increasingly choosing to work outside the NHS. We have repeatedly highlighted this as an area of concern. Some progress has been made on dental contract reform in Scotland which appears to be supporting NHS delivery. The Welsh Government has launched a public consultation on a new dental contract. Northern Ireland is looking to make similar reforms to those in Scotland. The UK Government has acknowledged the need for contract reform. This is an area where there is widespread public concern. We recommend that governments urgently prioritise contract reform, starting from the position of what they want the provision of NHS dentistry to be.

Community and Public Dental Services

5.169 It was helpful to have some workforce data on the size of the CDS and PDS workforces this year. There has been a decline in the PDS dentist workforce in Scotland over the last decade, and a broadly stable workforce in Northern Ireland. We were not provided with data over

time for Wales or England, although we were provided with an estimate of the overall number of dentists in the CDS for the first time.

5.170 CDS and PDS dentists face an extremely challenging work environment, high workloads and abuse from patients. This is damaging morale and wellbeing. During visits we have also heard that many CDS/PDS dentists are stuck at the top of pay band A with limited or no opportunity to progress.

5.171 A number of parties reported difficulty recruiting to band A, although some said the issues were not as significant as in general dentistry. The pay comparability evidence that we have shows CDS salaries in line with or above market rates. The evidence on the extent to which pay is a factor in recruitment and retention issues is mixed.

5.172 The Department of Health in Northern Ireland asked us to explore whether a higher uplift for salaried dentists in CDS might be appropriate to attract and retain dentists. Parties had mixed views on whether this was necessary. We note that Northern Ireland has a lower band A recruitment salary than the other nations. The late payment of the 2024 uplift would have exacerbated this difference. If the bottom pay point was removed, this would go some way to addressing the issue.

5.173 There are still significant areas where the evidence base on the CDS and PDS needs to be improved, especially in England. A recent report from NHS England has also highlighted the lack of a consistent CDS data set and inconsistencies in waiting list figures. This is key to understanding the effectiveness of the overall service. As well as trends in the workforce over time, and evidence on recruitment and retention, we would like to see the distribution of dentists across pay bands, and data on earnings and working hours. It is crucial for us to be able to track the size of the workforce, their workload, as well as recruitment and retention, to inform appropriate pay recommendations.

Chapter 6 Looking forward

6.1 In this chapter we look ahead to the next pay round, focusing on our data and evidence requirements.

Timing of the pay round and the evidence base

6.2 As set out in chapter 1, we have been able to move our report submission earlier this year. We expect this will result in the earlier receipt of the pay uplift by members of our remit group. Additional progress to move the pay round further ahead depends on us receiving written and oral evidence earlier in the autumn. For the next round, we hope to receive our remit letters from governments in summer 2025, and written evidence in early September, in order that oral evidence sessions can be completed before Christmas.

6.3 We address a great breadth of issues in our work and are committed to a full and detailed consideration of the evidence. This process takes time and needs to be built into a realistic schedule. We also undertake a valuable visit programme between pay rounds. Many of our parties spend considerable time and resource consulting with their members to provide us with high quality evidence and we do not wish to compromise this. We would again stress that the timetable needs to be agreed across all the parties to our process.

6.4 Moving the timing of our round forward, while a valuable development, means that there will be changes in the available evidence. This year, we have considered data published up to 31 March 2025. Next year, this cut-off date will be earlier. This means we will not be able to consider the 2025 NHS staff survey in England, or new OBR economic forecasts from spring 2026. We are also unlikely to have evidence on January pay settlements, which have been an important benchmark in recent years.

6.5 The Secretary of State for Health and Social Care announced in March that NHS England would be brought back into the Department of Health and Social Care. NHS England provides us with a valuable body of evidence and data; we hope the future arrangements will support an equivalent provision of information.

Workforce planning

6.6 A refreshed workforce plan for the NHS in England is expected in summer 2025, to reflect the priorities of the current government. Many of the issues and problems that have been raised with us can be addressed through workforce planning. We hope to see far more detailed planning on how doctors in training can be best matched to future healthcare needs, in terms of specialties and locality. There also needs to be work to align the expectations of doctors in the early parts of their career with the overall needs of the NHS in terms of where, and in which specialties, training places are needed.

6.7 A refreshed workforce plan will need to be costed, so that appropriate prioritisation can be given to the areas that will deliver the greatest improvements in healthcare outcomes. This will support improvements in productivity. Progress has already been made in reducing expensive agency and locum spend. Specific plans need to be prioritised for those specialties where there are most notable shortages, such as psychiatry, and where there has been a reliance on international recruitment to fill training places, such as general practice.

6.8 Specific concerns have been raised around capacity for general practice training. As we said last year, we would like to see a greater focus on whether appropriate reward and incentives

are in place for experienced members of the medical and dental professions to deliver the required increase in training.

6.9 We also hope a revised workforce plan will consider how a reward strategy can support delivery of the future medical and dental workforces. There are potential workforce gains to be made through restructuring of some contracts for the medical and dental workforce, which could also benefit productivity and long-term sustainability.

6.10 As we highlighted last year, the medical and dental labour markets across the four nations are interdependent. Workforce planning needs to be complementary and co-ordinated across the four nations and we would welcome updates on workforce planning from all four nations next year.

Medical training and resident doctors' working lives

6.11 NHS England announced a review of postgraduate medical training in February 2025, which is due to report this summer. This review needs to link to detailed workforce planning. We would expect this to look at whether there are the appropriate number of training places to address current and future service needs, how many UK graduate doctors are not getting a training place, and plans for the increased number of medical graduates coming through.

6.12 There are high levels of dissatisfaction among resident doctors with their working lives. It is positive that these concerns are being recognised by NHS Employers and NHS England and we expect the current review to examine the impact rotational training has on the work-life balance and wellbeing of doctors in training. Improving the working lives of resident doctors needs to be a priority for employers in the coming months. We would expect the current review to set clear and measurable objectives for progress. Investment in working facilities and arrangements for resident doctors is likely to be cost effective in terms of the improvement to motivation, morale and retention. We look forward to an update on this next round, alongside updates on the task and finish group and other initiatives in Wales focused on improving the working lives of resident doctors, and on the recommendations being developed to improve the experience of doctors in training in Northern Ireland.

Locally employed doctors

6.13 Data from the General Medical Council indicate that locally employed doctors are the fastest growing part of the medical workforce. This group has grown through local decision making, rather than through NHS-wide strategic direction. Locally employed doctors provide key support within trusts, and doctors are choosing to step out of training and work in these roles. We need an appropriate evidence base to understand how locally employed doctors contribute to service delivery, what their specific needs are, and their pay and career progression. This needs to start with locally employed doctors being clearly distinguished in the workforce data, separate from doctors in training.

6.14 The 2024 agreement for SAS doctors in England included a joint piece of work to determine how locally employed doctors can be better supported to progress in their careers. We look forward to seeing this.

6.15 We have recommended that parties consider the benefits of a separate pay framework for locally employed doctors. This will both require and facilitate a significant change in the evidence base for this group and enable a targeted workforce strategy.

Pay comparability

6.16 The changes to our terms of reference increase the importance of pay comparability and formalise the use of international comparisons. We set out our current approach to pay comparability in appendix E. We have commissioned Incomes Data Research to review our approach to pay comparability, which will inform our next round. A number of parties have already provided valuable input to this.

6.17 This review's aims are to:

- Identify good practice on undertaking pay comparability exercises and the strengths and weaknesses of the existing approach.
- Agree clearly identified roles/levels within medical and dental career paths for comparison, building on earlier work.
- Develop up-to-date descriptions of each role to enable benchmarking against comparators.
- Agree criteria for identifying comparators.
- Identify comparators for each role using the agreed criteria.
- Identify and source market pay data, highlighting strengths and weaknesses of the data sources.
- Identify a method for undertaking total reward comparisons.
- Undertake pay and reward comparisons.
- Develop an approach for updating the comparisons in future.

6.18 We are developing our body of evidence on international comparisons, which is set out in appendix F. This currently focuses on hospital doctors. We would like to build the evidence base for future rounds, in particular around:

- The criteria for identifying relevant countries for comparison.
- The comparability of roles and career structures.
- Better understanding of the data sources.
- Understanding the differences between countries, such as in income tax, and how these might be accounted for.
- Including other roles, in particular GPs and dentists.

NHS staff surveys

6.19 We continue to lack evidence on motivation, morale and wellbeing among hospital doctors and dentists in Wales and Northern Ireland. This is important in improving the effectiveness of the workforce and we hope it can be addressed. We understand there is a staff survey in Wales; we would like to see these results separately for medical and dental staff. We would also like the Department of Health in Northern Ireland to consider the viability of extending the NHS staff survey across HSC.

6.20 The extension of the NHS staff survey in England to GP practices is welcome and we expect the results to be shared soon. We would encourage all nations to find tools to monitor workload, morale and wellbeing among the GP workforce, as this will be crucial to ensuring the sustainability of the sector.

Workforce equalities

6.21 In chapter 2 we highlighted our concerns with the lack of demonstrable progress on gender and ethnicity pay gap reporting across our remit group. We would like all nations to consistently publish gender and ethnicity pay gaps for the secondary care workforce by pay grade. We expect to be updated on the progress of the Gender Pay Gap Review

Implementation Panel. We would also like to receive data on the ethnicity of the medical and dental workforce in Scotland and Northern Ireland.

6.22 We have previously asked for data on the socio-economic background of the medical and dental workforces, and how the expansion of training places can be used as an opportunity to increase social diversity. The report from the Sutton Trust on the socio-economic background of undergraduates studying medicine is very welcome and demonstrates that new medical schools have been an opportunity to enhance the diversity of the workforce. We would like to see policy engagement with this issue across all four governments and plans to further develop workforce diversity with any future expansion of medical school places.

GP workforce

6.23 Issues around GP unemployment and under-employment, especially in England, have been raised with us during evidence. We do not have data to assess the extent of this, but it occurs alongside a strong increase in the number of salaried GPs. It is likely to be a result of an increase in the number of GPs completing their training, following growth in the number of training places. The Additional Roles Reimbursement Scheme in England has been extended in recognition of this. It may take time for demand from practices and primary care networks to respond to this increase in supply and to reconfigure the workforce model.

6.24 NHS Scotland conducts an annual general practice workforce survey which provides valuable information on vacancies and GP locum use.[56] We suggest other nations look to this. It was helpful to be provided with data on joiners and leavers from the GP workforce in England for the first time this year.

6.25 The British Medical Association has highlighted to us that many salaried GPs undertake work in addition to their salaried employment. It would be useful to have a greater understanding of the overall employment picture for these GPs and, in particular, if there is an increase in private general practice.

6.26 The forthcoming refreshed NHS workforce plan needs to have a specific focus on GPs. It should take into account: the current and future workforce supply, as the expanded number of GP trainees become fully qualified; the recent reliance on international recruitment; the commitment to shift health services to the community and the implications of this for the general practice workforce; and the capacity for GP training, both in terms of trainers and infrastructure. It is important to monitor recruitment to GP specialty training in areas that have previously been harder to recruit to following the ending of targeted recruitment payments in England and Scotland.

6.27 It would be useful to have a better understanding of the dynamics of choices around GPs' working hours, the implications for future planning of medical training and for the operation of the NHS, and whether there are actions that parties could take to support greater working hours and increase the full-time equivalent GP workforce.

Dental workforce

6.28 Last year saw the publication of two valuable surveys on dentists from NHS England. The dental working patterns survey was published for the first time in four years. This provided useful information on how much time dentists spend on NHS work. NHS England also published information on the dental workforce for the first time in March 2024, providing

[56] NHS Education for Scotland, *General Practice Workforce Survey*. https://turasdata.nes.nhs.scot/data-and-reports/official-workforce-statistics/all-official-statistics-publications/general-practice-workforce-survey-2024

figures on vacancies across dental practice and the Community Dental Service (CDS). Given the significant issues in recruiting dentists to undertake NHS work, it is vital to continue to collect this information to inform policy making.

6.29 It was helpful to have some workforce data on the size of the CDS and Public Dental Service (PDS) workforces this year and more consideration of workforce requirements, especially from the Department of Health in Northern Ireland. There are still significant areas where the evidence base on the CDS and PDS can be improved, particularly in England. This is key to understanding the effectiveness of the overall service. As well as trends in the workforce over time, and evidence on recruitment and retention, we would like to see the distribution of dentists across pay bands, and data on earnings and working hours. We have recommended that the overall reward structure for CDS and PDS dentists is reviewed. This will require a significant expansion of the evidence base.

Future data and evidence requirements

6.30 In addition to the areas covered above, there are a number of specific areas where we would welcome data and evidence from the parties. This is in addition to what we normally receive.

Table 6.1: Further data requirements

Area	Data requests
Context	• Gender pay gaps for the secondary care workforce by pay grade. • Ethnicity pay gaps for the secondary care workforce by pay grade. • The ethnicity breakdown of the secondary care medical and dental workforce in Scotland and Northern Ireland.
Secondary care workforce	• Staff survey results in Wales that identify doctors and dentists separately from the rest of the NHS workforce. • Data on the motivation and morale of the HSC medical and dental workforce in Northern Ireland. • Uptake of the new SAS contracts. • The number of specialist posts created. • Average working hours for the main workforce groups. • The average number of programmed activities and supporting professional activities worked by consultants. • The number of doctors on local contracts.
Primary care workforces	• Leavers and joiners, turnover and vacancies in the GP and GDP workforces. • Number of GPs and GP appointments in the private sector. • Number of dentists, grades, working hours and earnings in CDS/PDS. • Leavers and joiners, turnover and vacancies in the CDS/PDS. • NHS staff survey results for GP practices.

Appendix A Remit letters

Department of Health & Social Care

From the Rt Hon Wes Streeting MP
Secretary of State for Health and Social Care

39 Victoria Street
London
SW1H 0EU

020 7210 4850

Mr Christopher Pilgrim
Chair, Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
First floor
10 Victoria Street
London
SW1H 0NB

30 September 2024

Dear Mr Pilgrim,

I would firstly like to offer my thanks for the Review Body on Doctors' and Dentists' Remuneration's (DDRB's) work over the past year on the 2024 to 2025 report. The government appreciates the independent, expert advice and valuable contribution that DDRB makes.

I write to you now to formally commence the 2025 to 2026 pay round.

My department's evidence will, as usual, cover the recruitment and retention context alongside pay and earnings data, as well as our workforce strategy, and the expected position following the implementation of the 2024 to 2025 pay award. It will also set out the funds available to the Department of Health and Social Care for 2025 to 2026, which will be finalised through the Spending Review and announced at the Autumn Budget on 30 October 2024. That comes against the backdrop of the challenging financial position this government has inherited, including a £22 billion pressure against the spending plans set out for departments at Spring Budget 2024. My department will continue to strive to deliver on our manifesto commitment to build an NHS fit for the future to ensure it is equipped to efficiently deliver the vital, high quality public service we rely on, while ensuring value for money for taxpayers.

We know that public sector workers delivering our vital public services deserve timely pay awards, so, as the Chancellor said in her July Statement, the government's intention is to announce pay awards as close to the start of the pay year of 1 April as possible for 2025 to 2026. It is unfortunate that, given the knock-on effects from the previous government's delays to the 2024 to 2025 round, it is unlikely that workforces will receive pay increases by April, but by bringing the pay round forwards this year, we can more fully reset the timeline in 2026 to 2027.

To this end, where possible I would be grateful if you can deliver recommendations to the government on the 2025 to 2026 pay award for doctors and dentists at the earliest point that allows you to give due consideration to the relevant evidence. To support with this, the government will publish its written evidence as soon as possible after the Spending Review is finalised and 2025 to 2026 budgets are set on 30 October 2024, including budgets relating to pay. I recognise that changing the timeline from recent years will present challenges for DDRB, but I am sure you also

share the government's belief in the importance of returning to more timely annual pay processes, so I hope you will understand the necessity of doing so.

As always, while your remit covers the whole of the United Kingdom, it is for each administration to make its own decisions on its approach to this year's pay round and to communicate this to you directly.

I also note that this year DDRB's terms of reference have changed. The new terms are annexed to this letter and, as per the wording of the consultant deal, I request that you use them for this and future rounds.

As laid out in the resident doctors' deal agreed on 16 September 2024, I would like you to consider, as part of your 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.

I would like to thank you again for your and the review body's invaluable contribution to the pay round and look forward to receiving your report for 2025 to 2026 in due course.

Yours ever,

Wes Streeting

RT. HON. WES STREETING MP

SECRETARY OF STATE FOR HEALTH & SOCIAL CARE

Annex – DDRB Amended Terms of Reference

The Review Body on Doctors' and Dentists' Remuneration was appointed in its current form in July 1971. Its terms of reference were introduced in 1998, and amended in 2003, 2007 and 2024 and are reproduced below.

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

In reaching its recommendations, the Review Body is to have regard to the following considerations, evaluating the weight of each independently, in parallel and non-contingently:

- The need to attract, recruit, retain and motivate doctors and dentists, including consideration of local and regional labour market factors, in view of their contribution to the health of the nation;
- Developments in doctors' and dentists' earnings in the context of long-term trends in the wider labour market, alongside comparator professions, including relevant international comparators;
- Economic and other evidence submitted by the Government, and the funds available to the Government Health Departments;
- Economic and other evidence submitted by staff and professional representatives, and others;
- Wider macroeconomic factors;
- The overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved; and
- The legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief and disability.

The Review Body may also be asked to consider other specific issues, where agreed by relevant unions and the Government.

These Terms of Reference are intended to give all parties, including the remit groups, confidence that the Review Body's recommendations have been independently, properly and fairly determined.

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

Jeremy Miles AS/MS
Ysgrifennydd y Cabinet dros Iechyd a Gofal Cymdeithasol
Cabinet Secretary for Health and Social Care

Llywodraeth Cymru
Welsh Government

Our ref: MA/JMHSC/10446/24

Mr Christopher Pilgrim
Chair of Review Body on Doctors' and Dentists' Remuneration
Dentists Remuneration
1st Floor, 10 Victoria Street
London
SW1H 0NB

ddrb@businessandtrade.gov.uk

30 October 2024

Dear Christopher,

I would like to thank you for the DDRBs hard work and independent observations in the 2024-25 round which have been invaluable.

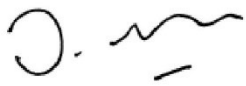
I am now writing to formally commence the 2025-26 pay round for Medical and Dental staff in Wales.

In order to support your work, I will provide written evidence, and I also plan to attend the oral evidence session when arranged.

I would like to take this opportunity to say I truly value the hard work and commitment of all our dedicated healthcare workers in Wales and recognise the pressures on our workforce.

Therefore, I would like to receive your advice and recommendations as soon as possible to ensure that payment of any award to our dedicated NHS workforce is not unduly delayed past April 2025.

Yours sincerely,



Jeremy Miles AS/MS
Ysgrifennydd y Cabinet dros Iechyd a Gofal Cymdeithasol
Cabinet Secretary for Health and Social Care

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1SN

Canolfan Cyswllt Cyntaf / First Point of Contact Centre:
0300 0604400
Gohebiaeth.Jeremy.Miles@llyw.cymru
Correspondence.Jeremy.Miles@gov.wales

FROM THE MINISTER OF HEALTH

Mr Christopher Pilgrim
Chair of the Review Body for
Doctors' and Dentists' Remuneration
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8JX

Via email:

Department of
Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Castle Buildings
Stormont Estate
BELFAST, BT4 3SQ
Tel: 028 9052 2556
Email:

Our Ref: SUB-1775-2024

Date 25 November 2024

Dear Christopher,

DDRB 2024/25 PAY ROUND

I am writing to you now to formally commence the 2025/26 pay round for doctors and dentists in Northern Ireland and provide you with an update on the implementation of the 2024/25 pay award in Northern Ireland. I would firstly like to begin by thanking the Review Body for Doctors' and Dentists' Remuneration (DDRB) for its invaluable work on the 2024/25 pay round and the recommendations contained therein.

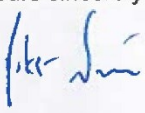
We have met with representatives from BMA and BDA to put a firm proposal on 2024/25 pay to them. This would involve full implementation of your recommendations, initially for part of the financial year. It is important to recognise that further work still needs to be undertaken in order to reach a resolution to the issue of health service pay. It is also important to recognise that the challenges facing public sector pay in general will only be resolved through an all-Executive approach.

It is recognised that this is not the position we would want to be in; appropriate reward and recognition for our staff is clearly an important part of demonstrating that we value the work that they undertake. I will continue to make the case to Executive colleagues, for additional financial allocations that would allow me to implement a pay award in line with the recommendations from DDRB for 24/25.

I do, however, want to emphasise that the work of the Review Body in providing recommendations will be of great value to the Department.

I would therefore welcome your pay recommendations for health and social care staff in Northern Ireland for 2025/26. The Department will, of course, keep you updated in regard to any progress made in respect of 2024/25 awards.

Yours sincerely



Mike Nesbitt MLA
Minister of Health

Cabinet Secretary Health and Social Care
Neil Gray MSP

T: 0300 244 4000
E: scottish.ministers@gov.scot

Mr Christopher Pilgrim
(Chair)
Review Body on Doctors' and Dentists'
Remuneration
Office of the Pay Review Bodies
London,
SW1H 0NB

By email:

11 December 2024

Dear Mr Pilgrim,

I am writing to formally commence the 2025-26 pay round for Doctors and Dentists in Scotland.

The Scottish Government continues to value the independent review process, and I would like to take this opportunity to thank you for the significant work that took place in producing the 2024-25 report and recommendations.

I wish to acknowlege that I am submitting this letter in full support of the elements of reform to the DDRB process that were agreed as part of the DHSC offer to Consultants in England in 2024-25.

In Scotland in 2023, we agreed a separate pay deal with Resident Doctors, and that deal includes a commitment to develop a pay bargaining system for Resident Doctors in Scotland, as well as a commitment to enter discussions to reform the Resident Doctors Contract. We remain committed to this agreement and will therefore not be seeking a recommendation for Resident Doctors.

Accordingly, the Scottish Government will provide a written evidence document, and we would be pleased to receive the DDRB views regarding a recommendation for 2025-26. This will be for all medical and dental staff in NHS Scotland, for medical and dental contractors in primary care, but not for Resident Doctors.

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot

Copies of this letter will be sent to the Secretary of State for Health and Social Care and the respective Ministers in the devolved governments as well as representatives of the Staff Side and NHS Employers.

NEIL GRAY

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot

Appendix B Detailed recommendations on remuneration

Recommendations on remuneration in England from 1 April 2025

	2024	2025
Doctors and dentists in training (2016 contract)	**£**	**£**
Foundation doctors – year 1	36,616	38,831
Foundation doctors – year 2	42,008	44,439
Core/run-through training – years 1-2	49,909	52,656
Core/run-through/higher training – years 3-5	61,825	65,048
Core/run-through/higher training – years 6+	70,425	73,992
Flexible pay premia (2016 contract)		
General practice	10,690	11,118
Psychiatry core training	4,347	4,520
Psychiatry higher training (3 year)	4,347	4,520
Psychiatry higher training (4 year)	3,260	3,390
Academia	5,216	5,424
Histopathology	5,216	5,424
Emergency medicine/oral & maxillofacial surgery:		
3 years	8,693	9,040
4 years	6,520	6,780
5 years	5,216	5,424
6 years	4,347	4,520
7 years	3,726	3,875
8 years	3,260	3,390
Dental foundation training	40,776	42,408
Specialty doctor (2021 contract)	59,175	61,542
	68,174	70,901
	75,998	79,038
	84,121	87,486
	95,400	99,216
Specialty doctor (2008 contract)	51,259	53,310
	55,515	57,736
	61,048	63,491
	64,014	66,575
	68,286	71,018
	72,542	75,445
	76,894	79,970
	81,247	84,498
	85,600	89,025
	89,952	93,551
	94,305	98,078

	2024 £	2025 £
Specialist (2021 contract)	96,990	100,870
	100,784	104,816
	107,154	111,441
Associate specialist (2008 contract)	71,271	74,123
	76,882	79,957
	82,489	85,790
	89,897	93,493
	96,317	100,170
	98,980	102,940
	102,456	106,554
	105,931	110,169
	109,407	113,783
	112,882	117,398
	116,361	121,016
Staff grade practitioner (1997 contract)	47,598	49,502
	51,259	53,310
	54,919	57,116
	58,580	60,924
	62,241	64,731
	66,551	69,214
	69,562	72,345
	73,222	76,151
	76,883	79,959
	80,544	83,766
	84,204	87,572
	87,866	91,381
Consultant (2003 contract)	105,504	109,725
	111,714	116,182
	114,894	119,490
	126,018	131,058
	139,882	145,478
National clinical impact awards		
Level 1	20,000	21,000
Level 2	30,000	31,500
Level 3	40,000	42,000

	2024 £	2025 £
Salaried general medical practitioner range		
Minimum	73,113	76,038
Maximum	110,330	114,743
Salaried primary care dental staff (2008 contract)		
Band A: Salaried dentist	50,511	52,532
	56,124	58,369
	64,542	67,124
	68,751	71,502
	72,961	75,879
	75,767	78,798
Band B: Salaried dentist[57]	78,573	81,716
	81,379	84,635
	85,588	89,012
	87,693	91,201
	89,798	93,390
	91,902	95,579
Band C: Salaried dentist[58,59]	94,007	97,768
	96,813	100,686
	99,619	103,604
	102,425	106,523
	105,232	109,441
	108,038	112,360
London weighting		
Resident staff	602	602
Non-resident staff	2,162	2,162

[57] The first salary point of band B is also the extended competency point at the top of band A.
[58] The first salary point of band C is also the extended competency point at the top of band B.
[59] The first three points on the band C range represent those available to assistant clinical directors.

Recommendations on remuneration in Scotland from 1 April 2025[60]

	2024 £	2025 £
Foundation house officer 1	34,500	
	36,657	
	38,809	
Foundation house officer 2	42,794	
	45,593	
	48,391	
Specialty registrar (full)	45,504	
	48,288	
	52,177	
	54,528	
	57,363	
	60,199	
	63,039	
	65,875	
	68,710	
	71,550	
Dental core training[61]	50,538	
Dental senior house officer/senior house officer	42,794	
	45,593	
	48,391	
	51,188	
	53,987	
	56,784	
	59,582	
Specialty doctor (2022 contract)	61,690	64,158
	73,593	76,537
	78,099	81,223
	87,115	90,600
	96,129	99,974

[60] The DDRB is not making recommendations for resident doctors and dentists in Scotland for 2025. The 2024 rates for these groups are as at 1 October 2024

[61] On completion of core training, employees move to the nearest point on or above their existing salary on the dental senior house officer scale.

	2024 £	2025 £
Specialty doctor (2008 contract)	50,780	52,811
	55,122	57,327
	60,765	63,196
	63,790	66,342
	68,149	70,875
	72,491	75,391
	76,929	80,006
	81,370	84,625
	85,811	89,243
	90,250	93,860
	94,689	98,477
Specialist (2022 contract)	96,990	100,870
	100,784	104,815
	107,154	111,440
Associate specialist (2008 contract)	71,193	74,041
	76,916	79,993
	82,637	85,942
	90,194	93,802
	96,741	100,611
	99,459	103,437
	103,005	107,125
	105,484	109,703
	108,928	113,285
	112,370	116,865
	115,815	120,448
Consultant (2004 contract)	107,144	111,430
	109,407	113,783
	112,662	117,168
	115,921	120,558
	119,170	123,937
	126,905	131,981
	134,640	140,026
	142,369	148,064

Salaried general medical practitioner range	2024 £	2025 £
Minimum	74,192	77,160
Maximum	110,737	115,166
Salaried primary care dental staff (2008 contract)		
Band A: Dental officer	52,035	54,116
	57,818	60,131
	66,490	69,150
	70,824	73,657
	75,161	78,167
	78,051	81,173
Band B: Senior dental officer	80,942	84,180
	83,832	87,185
	88,169	91,696
	90,337	93,950
	92,506	96,206
	94,673	98,460
Band C: Assistant clinical director	96,841	100,715
	99,732	103,721
	102,621	106,726
Band C: Specialist dental officer	96,841	100,715
	99,732	103,721
	102,621	106,726
	104,479	108,658
Band C: Clinical director/chief administrative dental officer	96,841	100,715
	99,732	103,721
	102,621	106,726
	104,479	108,658
	107,285	111,576
	110,092	114,496

Recommendations on remuneration in Wales from 1 April 2025

	2024 £	2025 £
Foundation house officer 1 (2015 contract)	33,307	35,390
	35,324	37,487
	37,343	39,587
Foundation house officer 2 (2015 contract)	41,073	43,466
	43,694	46,192
	46,312	48,915
Specialty registrar (full)	43,821	46,324
	46,438	49,046
	50,099	52,853
	52,314	55,157
	54,979	57,929
	57,650	60,706
	60,319	63,482
	62,989	66,259
	65,657	69,034
	68,330	71,814
Dental foundation training	44,448	46,226
Dental core training	41,269	43,670
	43,904	46,411
	46,536	49,148
	49,170	51,887
	51,802	54,625
	54,436	57,364
	57,069	60,102
Specialty doctor (2021 contract)	59,727	62,117
	68,810	71,563
	76,708	79,777
	84,905	88,302
	95,400	99,216

	2024	2025
Specialty doctor (2008 contract)	**£**	**£**
	50,294	52,306
	54,593	56,777
	60,185	62,593
	63,180	65,708
	67,495	70,195
	71,796	74,668
	76,191	79,239
	80,590	83,814
	84,989	88,389
	89,386	92,962
	93,784	97,536
Specialist (2021 contract)	96,990	100,870
	100,784	104,816
	107,155	111,442
Associate specialist (2008 contract)	73,198	76,126
	79,081	82,245
	84,963	88,362
	92,730	96,440
	99,442	103,420
	102,256	106,347
	105,903	110,140
	109,549	113,931
	113,193	117,721
	116,840	121,514
	120,488	125,308
Staff grade practitioner (1997 contract)	49,880	51,876
	53,839	55,993
	57,798	60,110
	61,755	64,226
	65,716	68,345
	69,672	72,459
	73,633	76,579
	77,591	80,695
	81,551	84,814
	85,510	88,931
	89,467	93,046
	93,427	97,165

	2024 £	2025 £
Consultant (2003 contract)	106,000	110,240
	111,300	115,752
	116,600	121,264
	121,900	126,776
	130,380	135,596
	137,800	143,312
	146,280	152,132
	154,760	160,951
National clinical impact awards		
Level 0	10,000	10,500
Level 1	20,000	21,000
Level 2	30,000	31,500
Level 3	40,000	42,000
Salaried general medical practitioner range		
Minimum	76,079	79,123
Maximum	114,801	119,394
Salaried primary care dental staff (2008 contract)		
Band A: Salaried dentist	50,789	52,821
	56,435	58,693
	64,898	67,494
	69,129	71,895
	73,362	76,297
	76,184	79,232
Band B: Salaried dentist[62]	79,003	82,164
	81,825	85,098
	86,057	89,500
	88,172	91,699
	90,290	93,902
	92,406	96,103
Band C: Salaried dentist[63,64]	94,525	98,306
	97,343	101,237
	100,164	104,171
	102,987	107,107
	105,808	110,041
	108,628	112,974

[62] The first salary point of Band B is also the extended competency point at the top of Band A.
[63] The first salary point of Band C is also the extended competency point at the top of Band B.
[64] The first three points on the Band C range represent those available to assistant clinical directors.

Recommendations on remuneration in Northern Ireland from 1 April 2025

	2024 £	2025 £
Foundation house officer 1	33,609	35,704
	35,560	37,733
	37,507	39,758
Foundation house officer 2	41,115	43,510
	43,646	46,142
	46,181	48,779
Specialty registrar (full)	43,773	46,274
	46,307	48,910
	49,841	52,585
	51,982	54,812
	54,562	57,495
	57,143	60,179
	59,723	62,862
	62,303	65,546
	64,884	68,230
	67,465	70,914
Specialty doctor (2021 contract)	59,175	61,542
	68,174	70,901
	75,998	79,038
	84,121	87,486
	95,400	99,216
Specialty doctor (2008 contract)	51,502	53,563
	55,781	58,013
	61,340	63,794
	64,319	66,892
	68,613	71,358
	72,891	75,807
	77,263	80,354
	81,637	84,903
	86,010	89,451
	90,385	94,001
	94,758	98,549
Specialist (2021 contract)	96,990	100,870
	100,784	104,816
	107,155	111,442

	2024 £	2025 £
Associate specialist (2008 contract)	71,612	74,477
	77,250	80,340
	82,885	86,201
	90,328	93,942
	96,777	100,649
	99,455	103,434
	102,949	107,067
	106,440	110,698
	109,933	114,331
	113,424	117,961
	116,922	121,599
Staff grade practitioner (1997 contract)	47,825	49,738
	51,501	53,562
	55,180	57,388
	58,860	61,215
	62,538	65,040
	66,870	69,545
	69,895	72,691
	73,572	76,515
	77,251	80,342
	80,929	84,167
	84,608	87,993
	88,289	91,821
Consultant (2004 contract)	106,424	110,681
	111,724	116,193
	114,904	119,501
	126,034	131,076
	139,920	145,517
Salaried general medical practitioner range		
Minimum	74,173	77,140
Maximum	111,928	116,406

Salaried primary care dental staff	2024 £	2025 £
Band 1: Salaried dentist	46,363	48,218
	50,113	52,118
	53,862	56,017
	57,615	59,920
	61,365	63,820
	65,113	67,718
	68,867	71,622
	72,617	75,522
Band 2: Senior salaried dentist	66,250	68,900
	71,494	74,354
	76,736	79,806
	81,978	85,258
	87,222	90,711
	88,379	91,915
	89,532	93,114
Band 3: Assistant clinical director salaried dentist	88,035	91,557
	89,397	92,973
	90,757	94,388
	92,122	95,807
	93,482	97,222
	94,845	98,639
Band 4: Clinical director salaried dentist	88,035	91,557
	89,397	92,973
	90,757	94,388
	92,122	95,807
	93,482	97,222
	94,845	98,639
	96,208	100,057
	97,595	101,499
	98,958	102,917
	100,319	104,332

Appendix C The number of doctors and dentists in the NHS/HSC in the UK[65]

England[66]	2023		2024		Percentage change 2023-2024	
Hospital and Community Health Services medical staff	**Full-time equivalent**	**Headcount**	**Full-time equivalent**	**Headcount**	**Full-time equivalent**	**Headcount**
Consultants	55,722	60,040	57,851	62,607	3.8%	4.3%
Associate specialists/specialists	2,311	2,592	2,591	2,932	12.1%	13.1%
Specialty doctors	8,702	9,808	9,205	10,342	5.8%	5.4%
Staff grades	341	373	351	381	2.9%	2.1%
Specialty registrars	34,556	36,182	35,888	37,685	3.9%	4.2%
Core training	20,741	21,239	23,145	23,749	11.6%	11.8%
Foundation doctors year 2	7,093	7,159	7,482	7,567	5.5%	5.7%
Foundation doctors year 1	7,695	7,738	8,354	8,409	8.6%	8.7%
Hospital practitioners/ clinical assistants	605	1,705	686	1,914	13.3%	12.3%
Other staff	839	1,298	834	1,324	-0.6%	2.0%
Total	**138,604**	**147,622**	**146,387**	**156,368**	**5.6%**	**5.9%**
General medical practitioners[67]	**36,795**	**45,591**	**37,818**	**47,562**	**2.8%**	**4.3%**
GP partners	16,342	19,073	15,897	18,640	-2.7%	-2.3%
GPs in training	10,116	10,353	10,455	10,823	3.3%	4.5%
GP retainers	272	655	287	688	5.6%	5.0%
Salaried GPs	10,065	15,914	11,179	17,834	11.1%	12.1%
General dental practitioners[68, 69]		**24,227**		**24,335**		**0.4%**
Providing-performers		4,476		4,353		-2.7%
Associates		16,856		17,377		3.1%
Unknown		2,895		2,605		-10.0%
Total general practitioners		**69,818**		**71,897**		**3.0%**
Total – NHS doctors and dentists		**217,440**		**228,265**		**5.0%**

[65] An employee can work in more than one organisation, location, specialty or grade and their headcount is presented under each group but counted once in the headcount total.
[66] Data as 30 September unless otherwise indicated.
[67] Excludes locums.
[68] This is the number of dental performers who have any NHS activity recorded against them via FP17 claim forms.
[69] Data for 1 April 2022 to 31 March 2023 and 1 April 2023 to 31 March 2024.

Scotland[70]	2023		2024		Percentage change 2023-2024	
Hospital and Community Health Services medical staff	**Full-time equivalent**	**Headcount**	**Full-time equivalent**	**Headcount**	**Full-time equivalent**	**Headcount**
Consultants	6,096	6,708	6,181	6,819	1.4%	1.7%
Staff and associate specialist grades	1,237	1,554	1,266	1,584	2.3%	1.9%
Resident doctors	6,888	7,245	7,009	7,421	1.8%	2.4%
Other staff	1,562	2,303	1,660	2,416	6.3%	4.9%
Total	**15,782**	**17,612**	**16,116**	**18,062**	**2.1%**	**2.6%**
General medical practitioners	**3,478**	**4,474**	**3,453**	**4,438**	**-0.7%**	**-0.8%**
Performers (partners)	2,624	3,196	2,554	3,105	-2.7%	-2.8%
Performers (salaried)	828	1,249	875	1,299	5.6%	4.0%
Retainers	26	51	25	53	-5.3%	3.9%
General dental practitioners (non-hospital)[71]		**3,134**		**3,258**		**4.0%**
General Dental Service		2,800		2,924		4.4%
Public Dental Service		334		334		0.0%
Total general practitioners		**7,608**		**7,696**		**1.2%**
Total – NHS doctors and dentists		**25,220**		**25,758**		**2.1%**

[70] Data as 30 September of each year.

[71] Includes general dental services and public dental service dentists.

Wales[72]	2023		2024		Percentage change 2023-2024	
Hospital and Community Health Services medical staff	**Full-time equivalent**	**Headcount**	**Full-time equivalent**	**Headcount**	**Full-time equivalent**	**Headcount**
Consultants	2,944	3,214	3,031	3,317	2.9%	3.2%
Associate specialists	137	156	129	149	-6.4%	-4.5%
Specialty doctors	816	914	859	963	5.3%	5.4%
Staff grades	2	2	2	2	0.0%	0.0%
Specialist registrars	2,918	3,197	3,211	3,468	10.0%	8.5%
Foundation house officers 2	690	712	661	683	-4.1%	-4.1%
Foundation house officers 1	533	565	601	638	12.8%	12.9%
Other staff[73]	63	169	75	183	19.4%	8.3%
Total	8,103	8,929	8,569	9,403	5.8%	5.3%
General medical practitioners	**1,880**	**2,521**	**1,937**	**2,666**	**3.0%**	**5.8%**
GP partners	1,061	1,381	1,024	1,365	-3.6%	-1.2%
GP salaried	380	628	438	739	15.3%	17.7%
GP specialty registrars	428	485	463	534	8.1%	10.1%
GP retainers	11	28	13	32	13.3%	14.3%
General dental practitioners[74]		**1,436**		**1,398**		**-2.6%**
Performers		1,136		1,105		-2.7%
Providing performers		292		283		-3.1%
Total general practitioners		**3,957**		**4,064**		**2.7%**
Total – NHS doctors and dentists		**12,886**		**13,467**		**4.5%**

[72] Data at 30 September of each year.
[73] Some hospital practitioners and clinical assistants also appear as general practitioners, general dental practitioners or ophthalmic practitioners.
[74] Data at 31 March each year.

Northern Ireland[75]	2023		2024		Percentage change 2023-2024	
Hospital and Community Health Services medical staff	**Full-time equivalent**	**Headcount**	**Full-time equivalent**	**Headcount**	**Full-time equivalent**	**Headcount**
Consultant	1,972	2,107	2,103	2,150	2.1%	2.0%
Associate specialist/specialist/specialty doctor/staff grade	564	644	619	701	9.8%	8.9%
Specialty/specialist registrar	1,522	1,605	1,613	1,722	6.0%	7.3%
Foundation doctor	534	539	549	555	2.7%	3.0%
Other	242	385	193	334	-13.5%	-8.5%
Total	**4,833**	**5,280**	**4,986**	**5,462**	**3.2%**	**3.4%**
General medical practitioners		**1,448**		**1,454**		**0.4%**
GP principals		1,175		1,129		-3.9%
GP salaried		261		314		20.3%
GP retainers		12		11		-8.3%
General dental practitioners		**1,163**		**1,195**		**2.8%**
Total general practitioners		**2,611**		**2,649**		**1.5%**
Total – NHS doctors and dentists		**7,891**		**8,111**		**2.8%**

[75] As at 31 March unless otherwise specified.

Appendix D Previous DDRB recommendations and the governments' responses

The main DDRB recommendations since 1990 for the general pay uplift are shown in the table below, together with the November or quarter 4 RPI and CPI inflation figures which were usually the latest figures available at the time of publishing the DDRB's report and the governments' responses to the main recommendations.

Report year	Main uplift	RPI %[76]	CPI %[77]	Government responses
1990	9.5%	7.3	5.5	Not accepted. Rejected increases at top of consultants' scale and in the size of the A+ distinction award; staged implementation
1991	9.5% to 11%	10.9	7.8	Accepted, but staged implementation
1992	5.5% to 8.5%	3.7	7.1	Accepted
1993		3.6	2.6	No report following Government's decision to impose a 1.5% pay limit on the public sector
1994	3%	1.4	2.3	Accepted
1995	2.5% to 3%	2.4	1.8	Accepted
1996	3.8% to 6.8%	3.2	2.8	Accepted, but staged implementation
1997	3.7% to 4.1%	2.7	2.6	Accepted, but staged implementation
1998	4.2% to 5.2%	3.7	1.9	Accepted, but staged implementation
1999	3.5%	3.1	1.4	Accepted
2000	3.3%	1.2	1.2	Accepted
2001	3.9%	3.1	1.1	Accepted, but Government suspended the operation of the balancing mechanism (which recovers GPs 'debt')
2002	3.6% to 4.6%	0.9	0.8	Accepted
2003	3.225%	2.6*	1.5	Accepted
2004	2.5% to 2.9%	2.5	1.3	Accepted
2005	3.0% to 3.4%	3.4**	1.5	Accepted
2006	2.2% to 3.0%	2.2**	2.1	Accepted, although consultants' pay award of 2.2 % was staged – 1.0 % paid from 1 April 2006 and the remaining 1.2 % paid from 1 November 2006
2007	£1,000 on all pay points***	3.9	2.7	Accepted, although Scottish Executive did not implement one of the smaller recommendations relating to the pot of money for distinction awards to cover newly eligible senior academic GPs. England and Wales chose to stage awards in excess of 1.5 % – 1.5 % from 1 April 2007, the balance from 1 November 2007
2008	2.2% to 3.4%	4.3	2.1	Accepted
2009	1.5%	3.0****	4.1	Accepted

[76] At November in the previous year unless otherwise indicated, series CZBH.
[77] At November in the previous year unless otherwise indicated, series D7G7.

Report year	Main uplift	RPI %[76]	CPI %[77]	Government responses
2010	0% to 1.5%	0.3	1.9	Mostly accepted: DDRB recommended: 0% for consultants and independent contractor GPs and GDPs; 1% for registrars, SAS grades, salaried GPs and salaried dentists; and 1.5% for foundation house officers. England and Northern Ireland both restricted the foundation house officer recommendation to 1%.
2011	No recommendation due to public sector pay freeze	4.7	3.3	
2012	No recommendation due to public sector pay freeze	5.2	4.8	
2013	1%	3	2.7	Accepted
2014	1%	2.6 (Q4 figure)	2.1 Q4	Accepted in Scotland. Partially accepted in England and Wales: no uplift to incremental points. 1% non-consolidated to staff at the top of pay scales. Northern Ireland – no uplift to incremental points. 1% non-consolidated to staff at the top of pay scales
2015	1%	1.9 Q4	0.9 Q4	Recommendation only applied to independent contractor GPs and GDPs in the UK and for salaried hospital staff in Scotland. Accepted
2016	1%	1.0 Q4	0.1 Q4	Accepted
2017	1%	2.2 Q4	1.2 Q4	Accepted with the exception of uplifts to CEAs, discretionary points and distinction awards in Scotland and Northern Ireland
2018	2%	3.7 Q1	2.7 Q1	Staged and abated in England. Accepted in Wales and Northern Ireland. Accepted in Scotland, except for staff earning at least £80,000 who received £1,600
2019	2.5%	2.5 Q1	1.9 Q1	Accepted with the exception of uplifts to CEAs, discretionary points and distinction awards. Additional 1% for SAS not implemented anywhere
2020	2.8%	2.6 Q1	1.7 Q1	Accepted
2021	3%	1.4 Q1	0.6 Q1	Accepted
2022	4.5%	8.4 Q1	6.2 Q1	Accepted with the exception of SAS doctors and dentists at the top of the 2008 specialty doctor pay scale in Wales, where a 4.5% non-consolidated payment was made instead. Subsequent to implementing most of the recommendations, the Welsh Government also implemented an additional 1.5% consolidated uplift and made a 1.5% non-consolidated payment to HCHS doctors and dentists and uplifted the salaried GP pay range by 1.5%.

Report year	Main uplift	RPI %[76]	CPI %[77]	Government responses
2023	6% (6%+£1,250 consolidated uplift for doctors and dentists in training) (3% above the uplift in the SAS 2021 contract multi-year deal in England, Wales, and Northern Ireland)	13.6 Q1	10.2 Q1	Accepted in England. Partially accepted in Scotland except for doctors and dentists in training who were awarded 12.4%. Not accepted in Wales where a 5% increase was implemented except for SAS on the 2021 contract who received a 1.5% uplift above that in the multi-year deal. Accepted in Northern Ireland
2024	6% (6%+£1,000 consolidated uplift for doctors and dentists in training)	4.3 (Mar)	3.2 (Mar)	Accepted in England, Wales and Northern Ireland. No formal response from Scotland. Additional deals for resident doctors, SAS, and consultants were agreed in England, Wales and Northern Ireland. Separate agreements were reached in Scotland.
2025	4% (4%+£750 consolidated uplift for resident doctors)	3.4 (Feb)	2.8 (Feb)	

* Due to the late running of the round, the DDRB was also able to take account of the March figures for RPI (3.1%).
** Due to a later round, the DDRB was also able to take into account the December RPI figure.
*** £650 on the pay points for doctors and dentists in training. The average banding multiplier for juniors meant that this would also deliver approximately £1,000.
**** DDRB also took into account the December RPI figure (0.9%).

Appendix E Our approach to pay comparability

Our terms of reference

1. Our previous terms of reference asked us to consider regional/local variations in labour markets and their effects on the recruitment and retention of doctors and dentists. Our revised terms of reference ask us to take into consideration:
   - 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.

2. Reflecting our revised terms of reference, it is an appropriate time to review our overall approach to pay comparability, including a review of the methodology used to make comparisons with other professions. The methodology was last reviewed in 2017 by the Institute of Employment Studies.

Pay comparability

3. The purpose of pay comparisons for any workforce are to help ensure that remuneration is fair and appropriate. Reward levels that are not in line with the broader market will create recruitment and retention problems over the medium and longer term. In our consideration of doctors' and dentists' remuneration, we do not try to track or align with any specific measure of market pay but consider a range of indicators alongside other evidence.

4. There are a number of parameters to consider in benchmarking pay for our remit group:
   - The medical and dental roles under consideration.
   - The UK nations in scope.
   - The measures of pay to be used i.e., base pay, total earnings, pensions, hourly/annual pay.
   - The time period to be considered.
   - The comparators to be used, such as roles matched by job size, international equivalents, or broader economic indicators such as inflation or whole economy earnings.
   - The sectors to be considered for comparisons, such as public/private healthcare, broader professions, or the whole economy.

Our approach to pay comparability

5. In recent reports, we have examined trends in pay for doctors and dentists in three main ways.

6. Firstly, we look at how earnings have evolved relative to the pay distribution across the UK economy. This uses the Annual Survey of Hours and Earnings.[78] We do this separately for 11 different medical and dental roles.

7. Secondly, we look at how real terms pay has changed over time. This uses CPI as the benchmark.[79] This can either be expressed by comparing growth e.g., prices have risen by 51

[78] The Annual Survey of Hours and Earnings (ASHE) is a 1 per cent sample of all UK employees. It is published at the end of October each year by the ONS.

[79] We also look at CPIH, which includes a measure of housing costs. This has not shown significantly different results from CPI over the longer term, but we will keep this under review. The ONS has said that the retail prices index (RPI) is not a good

per cent and earnings by 32 per cent since 2010, or by adjusting the level of earnings to express it in real terms, using prices from one year. We do this separately for 11 different medical and dental roles. Trends over time are sensitive to the start point chosen. We currently go back to when the data series starts (2010 for most groups, later for GDPs) and also look at growth since 2015. This does not take into account changes in working hours.

8. Thirdly, we look at how pay compares to equivalent roles in other professions. This is based on job evaluation from the 2017 review of our pay comparability methodology which matched medical and dental roles to analytics/data science, legal, finance/accounting, pharmaceutical, academic and veterinary roles. Data comes from a number of sources, including Kornferry. This is done separately for 10 different medical and dental roles.

9. Most of these approaches use England as the source for doctors and dentists pay, as we have not had access to earnings data for the other nations. They also use total earnings for medical and dental roles and adjust for working hours where possible. The adjustment for working hours can be done for average earnings, but not for median/interquartile earnings.

10. We also look at Longitudinal Education Outcomes (LEO) data, which tracks the employment and earnings outcomes of UK graduates, broken down by subject studied, one, three, five and 10 years after graduation.

Developments this round

11. Reflecting our revised terms of reference, we have made a number of developments to our pay comparability approach this round.
    - Average weekly earnings have been included in our tracking of earnings over time. While this provides a broad measure of earnings growth across the whole economy, it is not a good benchmark comparator, as it is affected by factors such as changes in workforce structure and working hours.
    - We have included earnings comparisons for salaried GPs using earnings from salaried employment only, as well as total earnings, which has been our previous focus. This was brought to our attention by the BMA's England General Practice Committee.
    - We commissioned Willis Towers Watson (WTW) to undertake a job levelling evaluation of 10 key medical and dental roles to enable us to benchmark the roles against market data. This was to provide supplementary market data to support this year's round, in advance of a full review of our pay comparability methodology for the next round. Further details are set out below.

WTW job levelling and market data

12. WTW used its global grading system (its proprietary job evaluation system) to evaluate 10 medical and dental roles. Under this system, a chief executive officer in a large organisation is typically at level 20, and other roles are assigned a level below this based on: job functional knowledge; business expertise; leadership; problem-solving; nature of impact; area of impact; and interpersonal skills. The assessment of medical/dental roles was based on a sample of job descriptions and background information provided by the DDRB secretariat. This means that there may be variation within roles that is not accounted for. Self-employed roles (partner GPs

measure of inflation. The methods used to produce it are not consistent with internationally recognised best practice. It also has other significant weaknesses, including how it measures housing costs, and its population coverage, which excludes certain households. ONS, *Measuring changing prices and costs for consumers and households: December 2023*. https://www.ons.gov.uk/economy/inflationandpriceindices/articles/measuringchangingpricesandcostsforconsumersandhouseholds/december2023

and general dental practitioners) were not included as this type of methodology was not thought appropriate for these roles.

Table E.1: Results of the WTW job levelling

Global grading system	Roles
16	Senior consultant[1]
15	Consultant
14	Specialist doctor[2]
13	Salaried dentist band B, salaried GP
12	Specialty doctor, salaried dentist band A, registrar (ST3+)[3]
11	Core training (CT1)
10	Foundation year 2
9	Foundation year 1

Source: WTW.

Notes:

[1] The senior consultant role has been slotted into the structure and has not been evaluated using the global grading system methodology. This is because we do not have a separate job description for experienced consultants.

[2] Possibly level 15 (around 12 years' experience) if i) this role is an externally recognised expert ii) is a thought leader and iii) develops groundbreaking solutions.

[3] Depends on the year in specialty training. If ST6, then this could be a global grading 13+ role.

13. The market data used is the WTW 2024 Manufacturing, Distribution and Services Total Rewards Survey (UK), with data effective from 1 July 2024. This is a leading database for pay comparisons covering a wide variety of professional and services employers. Overall, the database includes 1,259 organisations and over 175,000 job roles. It gives 10th, 25th, 50th, 75th and 90th percentiles at each job level for various measures of remuneration. The analysis here uses base salary (see table E.2) and total annual compensation (see table E.3).

Table E.2: Base pay comparisons using WTW data

Level	Role	Pay point	England basic salary	WTW market base pay			Compa-ratio
				25th	50th	75th	
9	Foundation year 1		£36,616	£31,547	£36,620	£42,965	100%
10	Foundation year 2		£42,008	£34,511	£40,320	£47,094	104%
11	Core training (CT1)	CT1	£49,909	£43,255	£49,977	£58,447	100%
12	Registrar (ST3)	ST3	£61,825	£50,683	£58,592	£68,070	106%
12	Specialty doctor	Midpoint	£77,288	£50,683	£58,592	£68,070	132%
12	Salaried dentist band A	Midpoint	£63,140	£50,683	£58,592	£68,070	108%
13	Salaried dentist band B	Midpoint	£85,238	£60,469	£69,874	£80,575	122%
13	Salaried GP pay range	Midpoint	£91,722	£60,469	£69,874	£80,575	131%
14	Specialist	Midpoint	£102,073	£72,774	£83,476	£96,862	122%
15	Consultant	3 years	£111,714	£87,780	£100,179	£117,323	112%
16	Senior consultant	8-13 years	£126,018	£111,695	£130,561	£153,232	97%

Source: OPRB analysis of WTW data.

Note: Base pay is at 1 April 2024. WTW data is at 1 July 2024.

14. The compa-ratios of base salary for medical and dental roles to the market median are shown in table E.2. It uses the mid-point of the pay range (and two different pay points for consultant,

to reflect this job being across two job levels). Salaries are generally considered to be in line with the market if they are within 10 per cent of the market median.

15. Base pay for training roles (foundation, core training and specialty registrar) is very close to the market median. Base pay for SAS roles (specialty doctor and specialist) is significantly above the market median. Base pay for community dentistry roles is also above the market median. Base pay for consultants is broadly in line with the market. The salaried GP pay range is above market pay.

16. When looking at total remuneration, because of the ability for most hospital roles to earn significant additional earnings (of 20 to 30 per cent), the relative market position of these roles improves. Foundation year 1 and consultant average earnings are in line with the market; all other roles are above (see table E.3).

17. Comparisons for salaried GPs are sensitive to the assumption made about the measure of earnings and whether adjustment is made for full-time equivalence. The table below uses earnings from direct employment only, adjusted by an FTE factor of 0.639.

Table E.3: Total pay comparisons using WTW data

			WTW total compensation			Compa-
Level	Role	Average total earnings	25th	50th	75th	ratio
9	Foundation year 1	£39,802	£32,429	£38,000	£45,000	105%
10	Foundation year 2	£47,478	£35,291	£42,190	£49,869	113%
11	Core training	£61,054	£44,659	£52,159	£62,005	117%
12	Registrar	£70,420	£54,000	£63,082	£74,934	112%
12	Specialty doctor	£91,462	£54,000	£63,082	£74,934	145%
13	Salaried GP	£89,984	£64,921	£76,042	£90,000	118%
14	Specialist	£120,351	£79,455	£93,600	£112,183	129%
15/16	Consultant	£148,447	£97,812	137,600	£195,817	108%

Source: OPRB analysis of WTW data.

Note: We do not have total earnings data for salaried dentists.

The average earnings data is for consultants as a whole, so the market data spans two job levels. Just using the lower (evaluated) job level would give a compa-ratio of 127 per cent.

GP earnings are 2022-23 earnings from direct employment only, adjusted by an FTE factor of 0.639. Average earnings for the other roles are for the year to September 2024. WTW data is at 1 July 2024.

Total compensation covers base pay, allowances and incentive payments. It does not include pension or other benefits.

18. The evidence on pay comparability is set out for the different parts of our remit group in chapters 3, 4 and 5. The evidence we have on international pay comparisons is set out in appendix F.

Review of our pay comparability methodology

19. We have commissioned Incomes Data Research to review our approach to pay comparability, which will inform our next round. The aims of the current review are to:
    - Identify good practice on undertaking pay comparability exercises and the strengths and weaknesses of the existing approach.
    - Agree clearly identified roles/levels within medical and dental career paths for comparison, building on earlier work.

- Develop up-to-date descriptions of each role to enable benchmarking against comparators.
- Agree criteria for identifying comparators.
- Identify comparators for each role using the agreed criteria.
- Identify and source market pay data, highlighting strengths and weaknesses of the data sources.
- Identify a method for undertaking total reward comparisons.
- Undertake pay and reward comparisons.
- Develop an approach for updating the comparisons in future.

20. This review will be published during the next round.

Appendix F International comparisons of doctors' pay

Our terms of reference

1. Our revised terms of reference ask us to have regard to relevant international comparisons. The rationale for looking at international comparisons is that there is an international labour market for doctors and dentists.

2. We are developing our body of evidence in this area. In this appendix we consider the international medical workforce, which countries might be a priority for pay comparisons, the issues with making international comparisons, and look at the data we have on international earnings. This focuses on hospital doctors. We would like to build the evidence base for future rounds, in particular around:
   - The criteria for identifying relevant countries for comparison.
   - The comparability of roles and career structures.
   - Better understanding of the data sources and measures of pay.
   - Understanding the differences between countries, such as in income tax, and how these might be accounted for.
   - Including other roles, in particular GPs and dentists.

Summary of the evidence

3. The main findings from this review of the evidence on international comparisons are that:
   - The number of doctors leaving to work overseas increased from 1,629 in 2021 to 2,494 in 2022 and 2,801 in 2023.
   - The numbers leaving are not unduly large each year (0.9 per cent of all doctors on the General Medical Council (GMC) register in 2023), but may accumulate over time to a significant loss, especially for doctors in training.
   - This will depend on whether doctors return to practice in the UK following time abroad. The GMC have reported that 43 per cent of UK graduates under 35 who left between 2012 and 2017 later returned, with their time away from UK practice rarely exceeding three years.
   - The numbers leaving the UK are dwarfed by the number of internationally qualified doctors joining the GMC register each year (nearly 20,000 in 2023) and needs to be seen in the context of overall strong growth in the medical workforce.
   - Over half (54 per cent) of those leaving because they wanted to practice abroad in 2023 were non-UK nationals.
   - The key destination countries (for UK nationals in particular) are Australia and New Zealand.
   - Doctors move to work overseas for many other reasons beyond seeking higher salaries.
   - Comparisons of international pay are necessarily complex, and it is often not possible to compare similar roles. Career structures are likely to be different between countries, as well as differences in payment mechanisms, tax, social insurance, pensions and other benefits.
   - Available comparable pay data is limited especially when looking beyond consultants.
   - The data we have on comparative earnings for specialists/consultants indicates that UK salaries are ahead of New Zealand but behind Australia, Canada and Ireland.

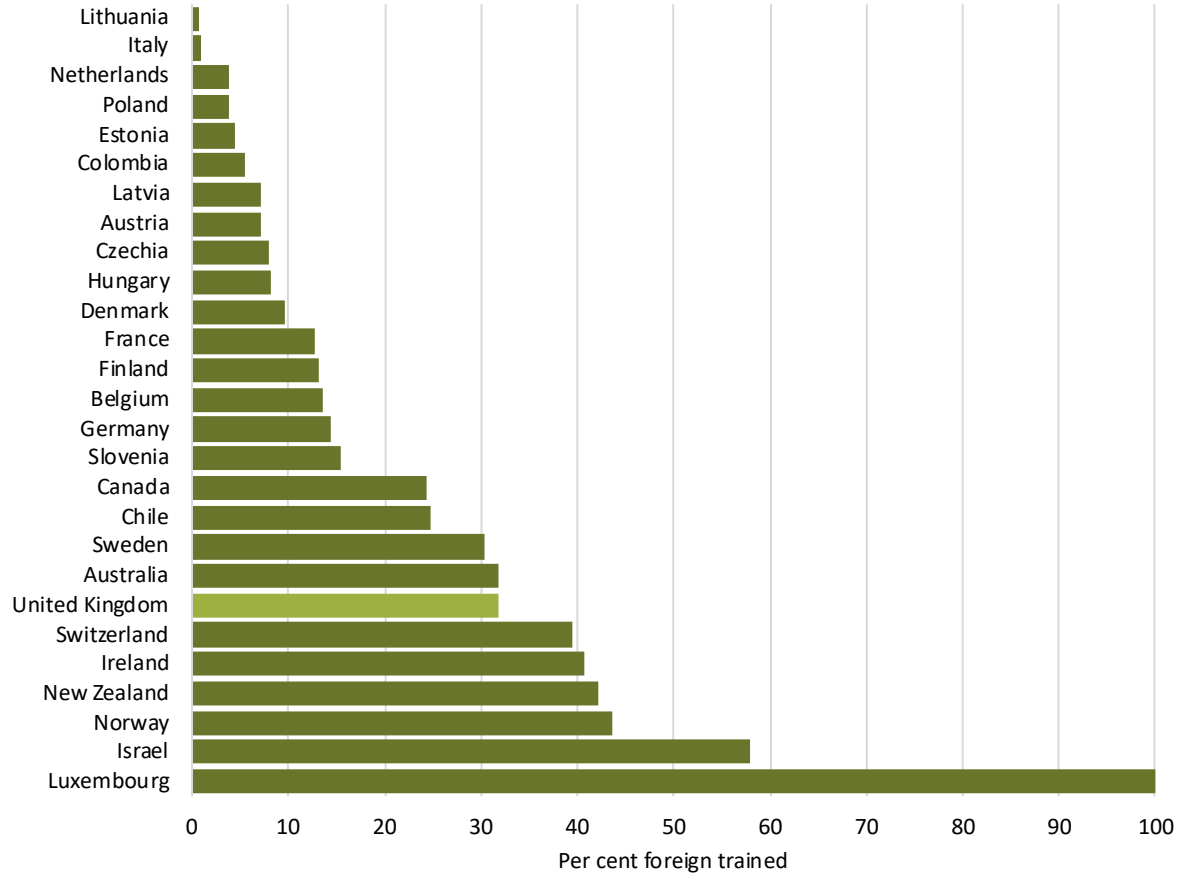
The international medical workforce

4. Different countries have a different reliance on internationally qualified doctors. The fact that some countries recruit large numbers of their doctors from overseas means they will need to pay a higher salary to attract doctors, and there will always be international movement.

5. The appropriate balance of UK and internationally qualified doctors in the NHS workforce is a policy decision for the governments. Our objective is to set pay so that the NHS can recruit and retain the doctors and dentists it needs. It has long been the case that UK-trained doctors have moved to work overseas, either temporarily or permanently, especially to other English-speaking countries. The ability to do this is one part of the attraction of the medical profession.

6. The Organisation for Economic Co-operation and Development (OECD) data sets out the proportion of doctors in each country in 2022 that were foreign trained (see figure F.1). Almost 32 per cent of UK doctors were foreign trained. The percentage for the UK is much larger than that for other large European countries, but similar to Australia and notably lower than Ireland or New Zealand. Luxembourg is entirely reliant on foreign trained doctors.

Figure F.1: Percentage of doctors that are foreign trained, OECD, 2022



Source: OECD.

Note: 2022 data except for UK, Sweden, Finland, Colombia (all 2021), and Denmark (2020).

OECD data is not available for the countries not included in the chart.

International joiners and leavers

7. One of the first points to consider when making international comparisons is which countries are relevant. This includes considering not only the countries UK doctors leave to work in but also the countries the UK recruits doctors from. The data on this is set out below. The numbers of doctors moving to the UK far outweighs those leaving, indicating that the UK remains a highly attractive destination for international doctors.

8. It makes sense to focus on countries which have broadly comparable healthcare systems. The overall scope and funding of healthcare varies substantially across countries, including the balance between public and private provision. Some countries do not have a national system, with many operating healthcare at a state level, and there can be significant variation within a country.[80]

International recruitment

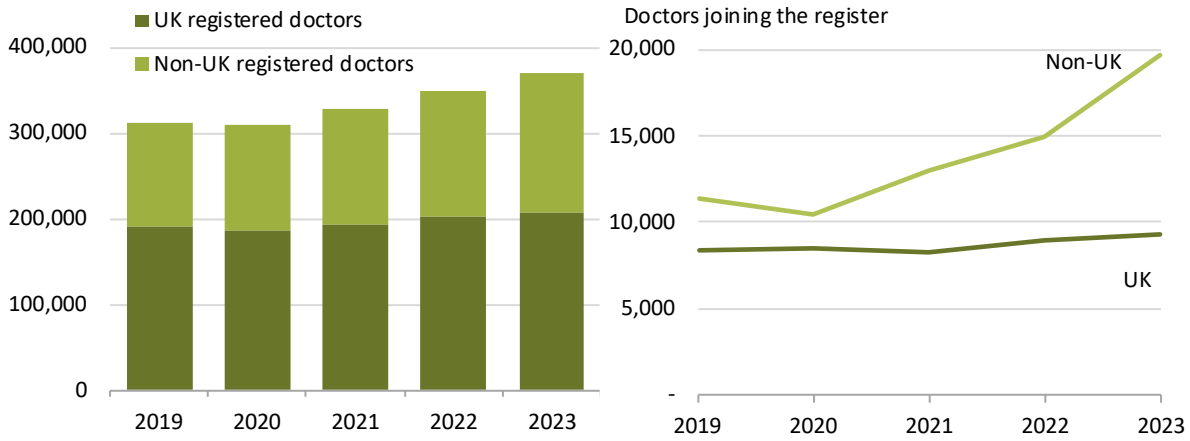
9. In 2023, over two-thirds of joiners to the GMC register (68 per cent) were non-UK graduates. This was an increase from 47 per cent in 2017. The number of UK graduate joiners increased by 5 per cent from 2022 to 2023, while the number of non-UK joiners increased by 32 per cent. Non-UK graduates made up 41 per cent of the medical workforce in 2023, up from 33 per cent in 2017.

10. The GMC said that non-UK graduate joiners were from 137 different countries and 155 different nationalities. Over half (52 per cent) of the non-UK graduates who joined the UK doctor workforce in 2023 qualified in India, Pakistan, Nigeria, Egypt, or Bangladesh. Bangladesh and Pakistan were among the ten fastest-growing primary medical qualification (PMQ) countries supplying UK joiners.

11. Bulgaria was the fastest growing country, in terms of the supply of non-UK graduates into the UK workforce, in 2023. This was driven by UK nationals travelling there to obtain their PMQ and then returning to start their career as a qualified doctor in the UK. In 2023, 435 of the 622 doctors (70 per cent) who joined the UK workforce with a Bulgarian PMQ were British nationals.

12. Health and care worker visa data for doctors showed significant growth in visa grants for doctors between 2021 and 2022, rising from 5,773 visas in 2021 to 8,487 in 2022 and 8,805 in 2023, but with a fall to 7,395 in 2024. The DHSC suggested that the fall in visa grants might be due to changes in demand for international staff. It said that doctors were most likely to come from India, Pakistan, Egypt and Nigeria.

Figure F.2: Registered doctors and joiners to the GMC register by region of primary medical qualification, 2019 to 2023



Source: GMC.

[80] Previous work for the DDRB in 2011 looked at: Australia, New Zealand, the Republic of Ireland, Canada, USA, and other European countries including Germany, France, Switzerland, Italy, Spain, Netherlands, Belgium, Sweden, Norway, and Denmark.

13. In England, the proportion of the secondary care medical and dental workforce with a UK nationality fell from 69.0 in December 2019 to 63.2 per cent in December 2024. The proportion of staff with a non-UK nationality varied by grade: 22.6 per cent of foundation year 1; 33.1 per cent of foundation year 2; 58.0 per cent of core trainees; 43.5 per cent of registrars; 57.2 per cent of specialty doctors; 40.0 per cent of specialists/associate specialists; and 21.6 per cent of consultants.

International leavers

14. Doctors who qualified outside the UK are the most likely to make international moves, often back to their home countries. So the increasing internationalisation of the UK workforce will, in turn, increase the number of international leavers. This needs to be considered when looking at the data on trends of those leaving the UK.

15. We do not have NHS data on international leavers so rely on the data published by the GMC. This will include doctors who are not employed in the NHS (which could be part of the reason for leaving).[81]

16. The GMC reports that 2,801 doctors who left the UK medical register in 2023 gave "want to practise abroad" as their main reason for leaving.[82] This was up from 2,494 in 2022 and 1,629 in 2021.[83] This represents 0.89 per cent of the 313,829 doctors on the register in 2023 (up from 0.84 in 2022 and 0.57 per cent in 2021). This compares to over 19,629 internationally qualified doctors joining the GMC register in 2023.

17. Of the 2,801: 482 (17 per cent) were specialists/consultants; 437 (16 per cent) were doctors in training; 187 (7 per cent) were general medical practitioners (GPs) and 1,688 (6 per cent) were other doctors, including specialty, associate specialist and specialist (SAS) and locally employed doctors. This represented 0.46 per cent of all specialists/consultants on the register in 2023, and 0.58 per cent of all doctors in training.

Table F.1: Doctors leaving the medical register because they want to practice abroad

Group	2021	2022	2023
GP	97	175	187
Specialist	392	474	482
GP and specialist	9	4	7
Neither register and in training	267	324	437
Neither register and not in training (includes SAS and locally employed doctors)	864	1,517	1,688
PMQ region			
UK	772	1,050	1,299
Non-UK	857	1,444	1,502
Total	1,629	2,494	2,801

Source: GMC.

[81] This uses data published in, or accompanying the GMC's 2024 workforce report: https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk/workforce-report
The detailed destination data has been helpfully supplied to us by the GMC.

[82] A further 857 doctors gave "want to live abroad" as their main reason for leaving in 2023, up from 819 in 2022 and 601 in 2021. The GMC has pointed out that doctors can choose not to answer the question why they are leaving or where they are planning to go to.

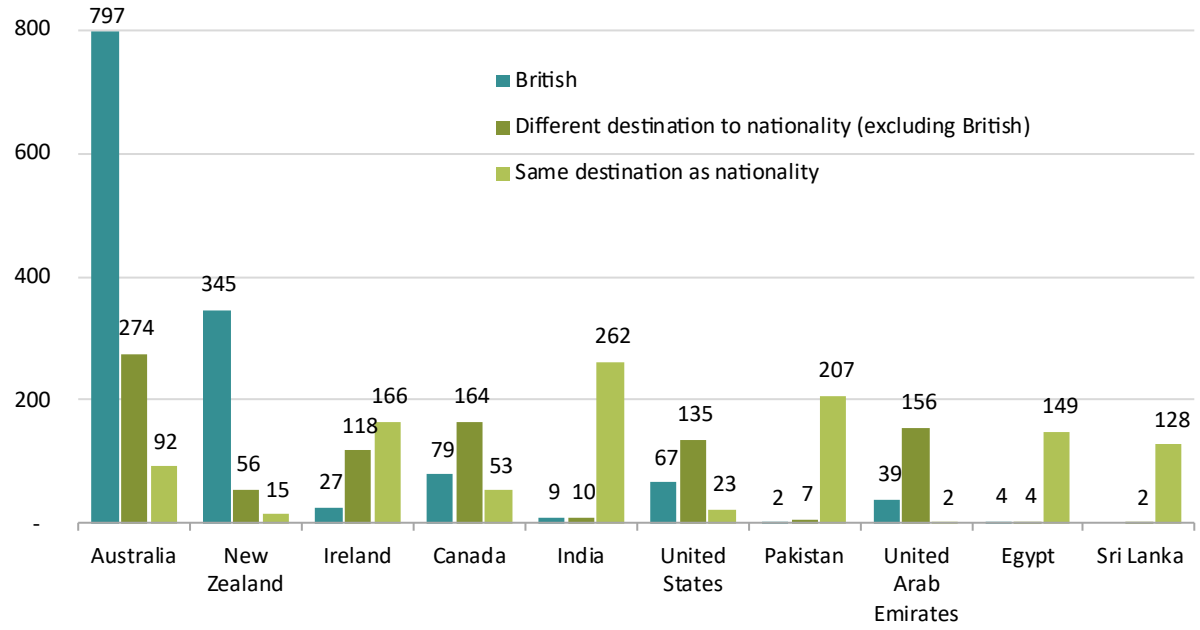
[83] 2021 data may be affected by COVID-19. Data is not collected on a consistent basis before 2021.

18. Less than half (46 per cent) of those leaving because they wanted to practice abroad had a UK primary medical qualification. The number increased by 68 per cent between 2021 and 2023, compared to 75 per cent for those with a non-UK primary medical qualification.

19. In 2023, 5,104 leavers disclosed a country to which they intended to move (this includes those for whom wanting to practise abroad was not the primary reason for leaving). Of these leavers, 31 per cent were British, 26 per cent were not British and were a different nationality to their intended destination country, and 43 per cent were the same nationality as their intended destination country.

20. Australia remained the main intended destination for doctors who left the UK medical workforce in 2023, followed by New Zealand, Canada and Ireland. In 2023:
    - 797 British doctors reported they were moving to Australia, up from 656 in 2022.
    - 345 British doctors reported they were moving to New Zealand, up from 271 in 2022.
    - 79 British doctors reported they were moving to Canada, up from 51 in 2022.
    - 27 British doctors reported they were moving to Ireland, largely unchanged on 26 in 2022.

Figure F.3: Top ten destinations of doctors who left the GMC register in 2023 and moved to another country



Source: GMC.

Note: Doctors can have multiple nationalities. The GMC uses the nationality the doctor states as their first preference.

21. The GMC reported that nearly two-thirds (64 per cent) of the 797 British nationals who intended to move to Australia in 2023 had completed foundation year 2 in the last three years. Similarly, 68 per cent of the 345 British nationals who intended to move to New Zealand had completed foundation year 2 in the last three years.

22. Most of the 2023 leavers who intended to move to India, Pakistan, Egypt, or Sri Lanka had the same nationality as their destination country. Very few doctors of any other nationality intended to move to these countries. The largest group of doctors leaving in 2023 who intended to move to Canada, the United Arab Emirates, or the United States were doctors who were neither British nor the same nationality as their destination country.

23. While these nationality types made up 24 per cent of leavers moving to Australia, they represented 55 per cent of leavers moving to Canada, 79 per cent moving to the United Arab Emirates, and 60 per cent moving to the United States.

24. The GMC reported that, of the 9,679 UK graduates under 35 who left between 2012 and 2017, 4,163 (43 per cent) later returned, with their time away from UK practice rarely exceeding three years.

25. Separate research by the GMC identified the many different reasons doctors migrate from the UK. These were: burnout; career opportunities; being disheartened/disillusioned; and looking for new experiences and challenges; as well as seeking higher salaries.[84]

Issues with making international pay comparisons

26. There are a large number of issues to consider when making international earnings comparisons. There are issues with the comparability of medical roles:
    - It is hard to establish if roles are similar across countries, and often they are not. International comparisons do not tend to encompass any of the factors we would like to see in a pay comparability exercise, such as matching on specialty, experience or responsibility.
    - There are differences across countries in regard to workforce definitions, qualification requirements, grade hierarchies and the distribution of responsibilities among specialists.
    - The career and training structures are likely to differ significantly across countries.
    - The available data typically provide an average for all doctors in a country, which might represent very different workforces.
    - There is often a large variation across medical roles within a country, and specialty has an important influence on earnings in some countries. Previous work found that earnings variations between specialties were most pronounced in the USA, where, for example, surgical specialties had incomes up to three times greater than those in family medicine.[85] Even within the UK, there is significant variation in pay across nations and within grades.
    - There are often different employment models, such as self-employment/employee status which make the roles less comparable.
    - Comparisons are unlikely to be able to take into account working hours.

27. There are also issues when making comparisons in earnings across countries.
    - Earnings come from different sources and are based on different payment mechanisms such as capitation, fee-for-service payments, or bonuses, as well as salary. Previous work on international comparisons did not find any schemes similar to clinical excellence awards in the UK, for example.
    - Earnings need to be adjusted for exchange rates or, preferably, purchasing power i.e. the amount that can be bought in each country with the same money.
    - Even adjusting for purchasing power may not make up for all the cost-of-living differences in a country such as housing, education or healthcare costs.
    - There will be significant tax and social insurance differences across countries that affect take-home pay.

[84] General Medical Council, *Understanding doctors' decisions to migrate from the UK*. https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/understanding-doctors-decisions-to-migrate-from-the-uk

[85] Capita, *Compensation Levels and Incentive Systems for Medical and Dental Consultants: International Experience*, March 2011. https://webarchive.nationalarchives.gov.uk/ukgwa/20130705000835/http://www.ome.uk.com/DDRB_Research.aspx

- Student loan repayments and training costs, such as exam fees, will also vary between countries.
- There will be differences in the broader reward package, such as pensions and other additional benefits.
- The data only relate to public sector employees in some countries.

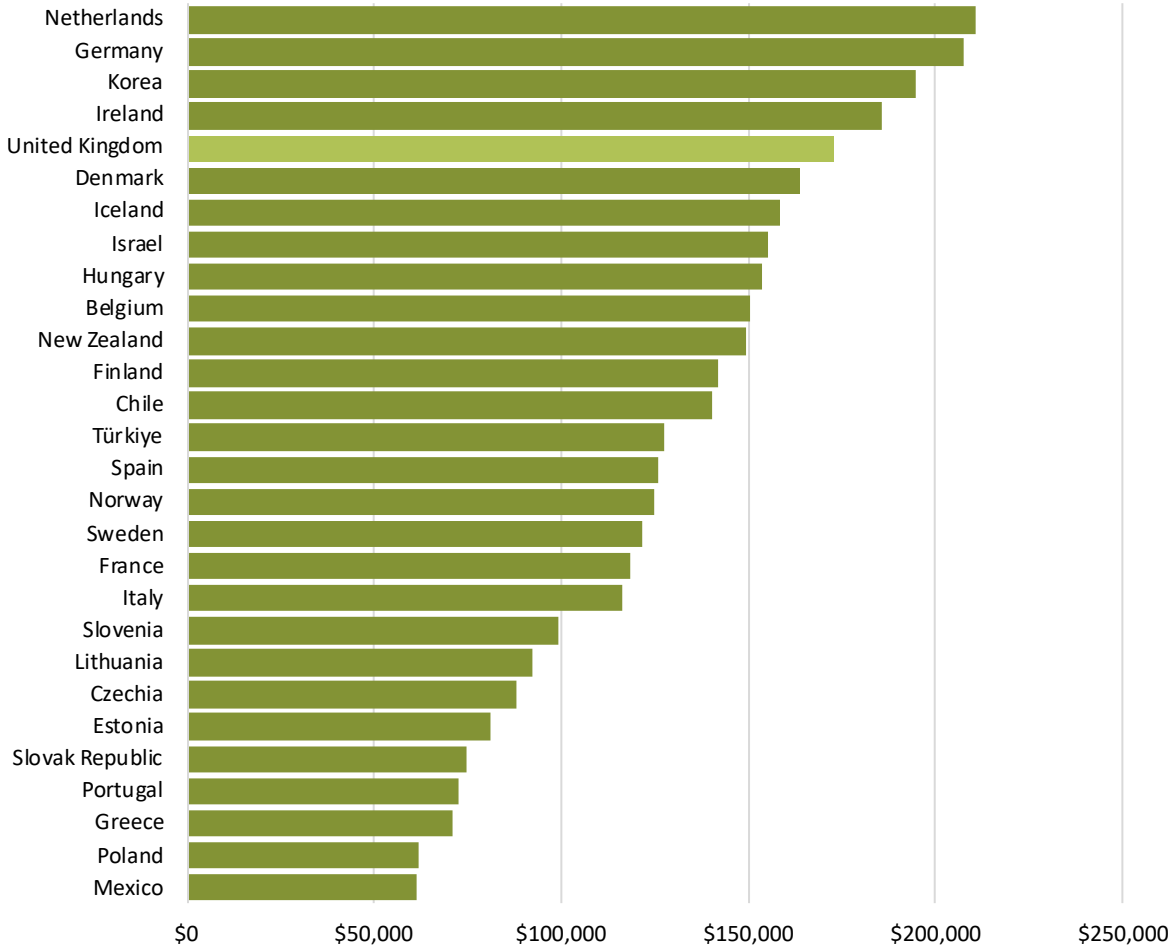
28. There are also significant data issues. The selection of comparator countries will be limited by data availability, and data can be some years out of date. It often does not come from official sources, such as national statistics bodies, and it is hard to assess data reliability.

Evidence on pay in other countries

29. Notwithstanding the significant challenges with making international comparisons set out above, we have gathered and analysed some key evidence as we develop our approach to international comparators in line with our new terms of reference.

30. The top destinations for doctors leaving the UK are: Australia, New Zealand, Ireland and Canada. Australia and New Zealand dominate, while other European countries do not feature. We focus our pay comparisons on these countries.

Figure F.4: Remuneration of specialists, OECD, 2022



Source: OECD, OPRB calculations based on NHS England data.

Data for the UK is based on consultant earnings in England. The chart includes the latest available data for France, Belgium and Iceland (all for 2021) and Korea (to 2020).

OECD data is not available for the countries not included in the chart.

31. The OECD publishes data on international pay comparisons for medical specialists, which equate to consultants in the UK (see figure F.4). It has been converted to a common currency (US$) using purchasing power parities. The OECD data for the UK only runs to 2020. To make a more recent comparison we have used NHS England data for consultants' earnings to 2022 and converted to $US. For all other countries the data is for 2022, except for France, Belgium, Ireland (all 2021) and Korea (2020).

32. This shows that remuneration for consultants in England is towards the top of the range within the OECD, 8 per cent below Ireland and 13 per cent above New Zealand. OECD data is not available for Australia, Canada or the US. It also does not include any of the countries the UK is most commonly recruiting doctors from.

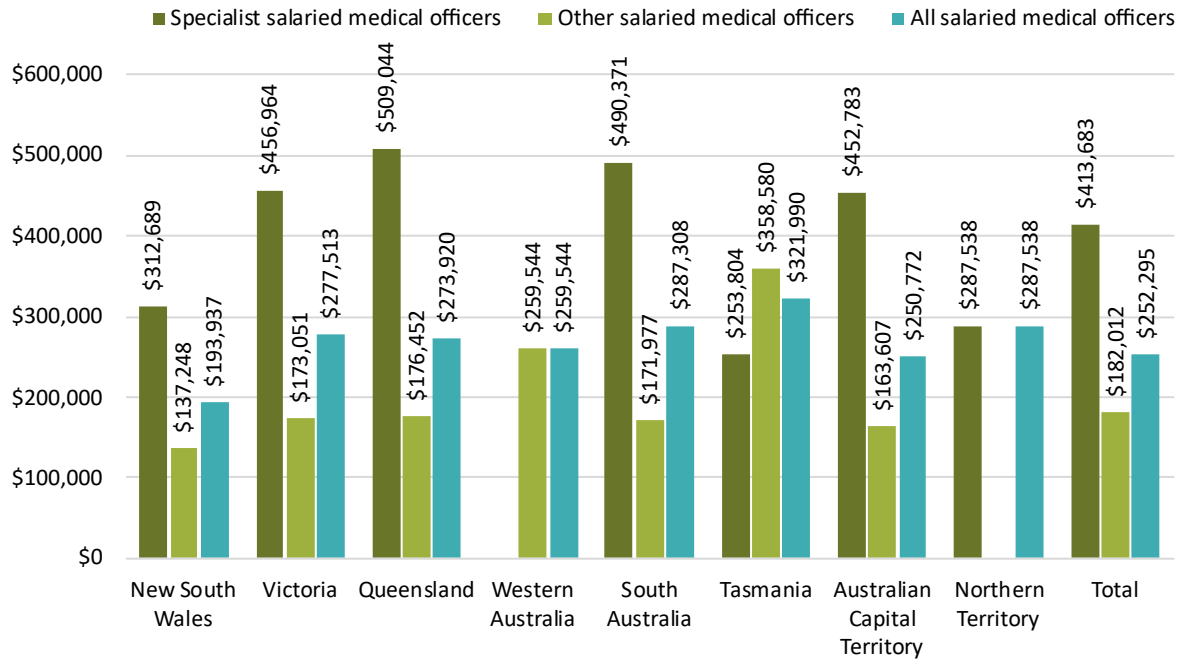
33. Our other evidence on international earnings have been sourced through desk research. They are particularly subject to the caveats and limitations set out in paragraphs 26 to 28.

Australia

34. Medical pay in Australia is set at a state level and the specialist/senior specialist role is broadly equivalent to consultants in the UK. The Australian Institute of Health and Welfare publishes average salaries for salaried medical officers employed in providing public hospital services.[86]

35. This indicates average salaries for specialists (consultants) at $413,683 and for other doctors at $182,012 (which we infer are equivalent to SAS doctors and resident doctors in the UK). There is a very wide range across states, from $312,689 to $509,044 for specialists (excluding Northern Territory, where the data do not differentiate by type of doctor).

Figure F.5: Average salaries for salaried medical officers employed in providing public hospital services, Australia, FTE, 2022-23



Source: Australian Institute of Health and Welfare.

[86] https://www.aihw.gov.au/reports-data/myhospitals/themes/hospital-workforce

36. Adjusting for purchasing power parity,[87] this implies average Australian salaries of around £213,000 for consultants and £94,000 for other doctors. This compares to average earnings per head in England of £127,228 for consultants in 2022-23 (putting Australia 68 per cent higher); £76,112 for specialty doctors (Australia 23 per cent higher); and £63,350 for registrars (Australia 48 per cent higher).

New Zealand

37. Te Whatu Ora is the publicly funded healthcare system of New Zealand. It was established by the New Zealand Government in 2022 to replace the country's 20 district health boards. Collective agreements have been made since then for medical and dental officers.[88]

38. OECD data indicates that remuneration for specialists/consultants is 16 per cent higher in England than in New Zealand. Base salaries are 7 to 17 per cent higher in England than in New Zealand for specialists/consultants. At resident doctor level, England salaries are up to 26 per cent higher than in New Zealand. There is also a maximum employer pension contribution of 6 per cent in New Zealand, significantly below the England level.

Table F.2: Pay ranges in New Zealand, 2024

Role	New Zealand pay range	Converted to £ using purchasing power parity	England equivalent	England/ New Zealand
House officer year 1	$76,000	£36,994	£36,616	99%
House officer year 2	$79,981	£38,931	£42,008	108%
Registrar years 1 to 2	$91,911 to $96,921	£44,738 to £47,177	£49,909	112% to 106%
Registrar years 3 to 6	$100,633 to $129,266	£48,984 to £62,921	£61,825 to £70,425	126% to 112%
Medical and dental specialist	$185,380 to $267,980	£90,235 to £130,442	£105,504 to £139,882	117% to 107%

Source: https://www.tewhatuora.govt.nz/for-health-professionals/employment-relations/employment-agreements

Note: Resident doctors pay in New Zealand is from 20 June 2024 and specialist pay is from 1 January 2024.

Matches are assumed and not based on an analysis of roles.

Uses OECD data for household consumption purchasing power parity for 2023: 0.748 £/US$, 1.536 NZ$/US$.

Canada

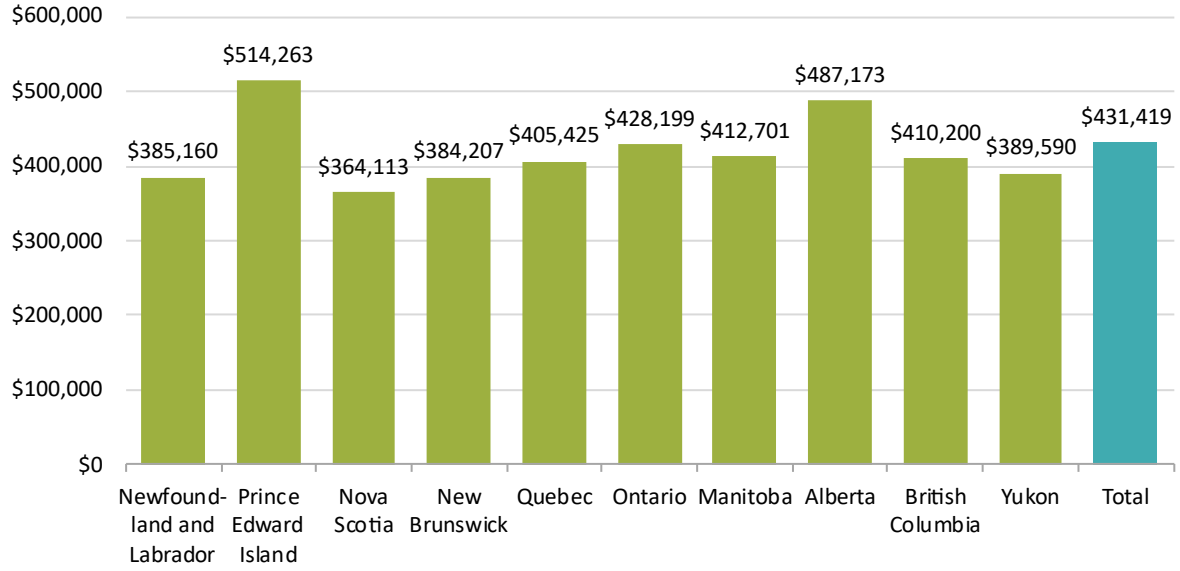
39. Canada has a comprehensive publicly funded healthcare service, delivered at a provincial/territorial level. The Canadian Institute for Health Information publishes average payments made to physicians, by province and by medical specialty, with the latest data for 2022-23. By specialty, average payments ranged from $302,208 for psychiatrists to $910,192 for ophthalmologists. The average was $431,410. The average payment for a family doctor (similar to a GP) was $307,700. The data does not differentiate by grade of doctor.

40. Adjusting for purchasing power parity,[89] implies an average Canadian salary of around £263,500 for hospital physicians and £187,900 for family doctors. This is 182 per cent higher

[87] Using OECD data for household consumption purchasing power parity for 2023: 0.748 £/US$, 1.450 Aus$/US$. OECD, *Purchasing Power Parities*. https://www.oecd.org/en/data/datasets/purchasing-power-parities.html
[88] Health New Zealand, *Employment agreements*. https://www.tewhatuora.govt.nz/for-health-professionals/employment-relations/employment-agreements
[89] Using OECD data for household consumption purchasing power parity for 2023: 0.748 £/US$, 1.224 Can$/US$.

than average earnings per head in England of £93,417 for all hospital doctors, and 70 per cent higher than average earnings for GPs in England of £110,200 (£140,200 for contractors, £69,200 for salaried GPs) in 2022-23.

Figure F.6: Average gross clinical payment per physician by province/territory, Canada, 2022-2023



Source: Canadian Institute for Health Information, National Physician Database – Payments Data 2022-23.

Note: The average payment is the sum of each province's expenditure for clinical payments to physicians (medical and surgical specialties) divided by the total number of physicians reported by each province in the given specialty. It does not include family doctors.

Ireland

41. A new contract was introduced for consultants in the Republic of Ireland in 2023 under the Sláintecare programme. It prohibits private work in public hospitals, extends the hours during which consultants are available to be rostered, and increases basic remuneration.

Table F.3: Pay ranges in the Republic of Ireland from 1 June 2024

Grade	Ireland pay range	Converted to £ using purchasing power parity	England equivalent	Northern Ireland equivalent	England/ Ireland	Northern Ireland/ Ireland
Foundation year/intern	€44,203	£34,772	£36,616	£33,609 to £37,506	105%	97% to 108%
Senior house officer	€52,093 to €71,248	£40,979 to £56,047	£49,909	£43,773 to £49,841	122% to 89%	107% to 89%
Registrar	€66,210 to €77,968	£52,084 to £61,333	£61,825 to £70,425	£49,841 to £67,465	119% to 115%	96% to 110%
Consultant	€224,437 to €269,594	£176,553 to £212,076	£105,504 to £139,998	£106,424 to £139,920	60% to 66%	60% to 66%

Source: https://healthservice.hse.ie/staff/pay/pay-scales/

Note: Increases of 1 per cent (or €500) from 1 October 2024 and 2 per cent (or €1,000) from 1 March 2025 were paid to HSE staff in Ireland.

Matches are assumed and not based on an analysis of roles.

Uses OECD data for household consumption purchasing power parity for 2023: 0.748 £/US$, 0.950 Ire€/US$.

42. We have information on basic pay scales for doctors in Ireland, rather than earnings. Doctors will receive payment for overtime, on call and shifts in addition to this. Basic salaries are close to the UK at resident doctor level, but consultants have substantially higher base pay in the Republic of Ireland.

43. The Department of Health in Northern Ireland has commissioned the Government Actuary's Department to produce a comparison of employment and pension benefits and relevant tax treatment for consultants in Northern Ireland and the Republic of Ireland.

Appendix G The data historically used in our formulae-based decisions for independent contractor GPs and GDPs

1. This appendix gives the latest data that would have populated the formulae for both general medical practitioners (GPs) and general dental practitioners (GDPs), had we used the previous formulae-based approach.

2. While we are not making formula-based recommendations for independent contractor GPs and GDPs, we set out below the data that would have populated the formulae as they existed in 2015. Given our ongoing concerns with the reliability of the formulae, we do not consider it appropriate to adjust the weightings of the coefficients. When we last considered this issue, the coefficients and their weightings for dentists were based on data that covered all dentists, regardless of the time devoted to NHS work. As noted in our 2012 report, average earnings and expenses for dentists reporting a high NHS share were similar to the total dental population. If we were using the formula this year, then we would wish to examine whether that case remained sound.

Table G.1: Data historically used in our formulae-based decisions for independent contractor GPs and GDPs

Coefficient	**Value**
Income (contractor GPs, salaried GPs across the UK) *DDRB recommendation*	4.0%
Staff costs (GPs) *Annual Survey of Hours and Earnings (ASHE) 2024 (general medical practice activities)*	5.6%
Other costs (GPs) *Retail Prices Index excluding mortgage interest payments (RPIX) for Q4 2024*	2.9%
Income (GDPs) *DDRB recommendation*	4.0%
Staff costs (GDPs) England, Scotland, Wales, Northern Ireland *ASHE 2024 (dental practice activities)*	8.9%
Laboratory costs (GDPs) England, Scotland, Wales, Northern Ireland *RPIX for Q4 2024*	2.9%
Materials (GDPs) England, Scotland, Wales, Northern Ireland *RPIX for Q4 2024*	2.9%
Other costs (GDPs) England, Wales, Northern Ireland *Retail Prices Index (RPI) for Q4 2024*	3.5%
Other costs (GDPs) Scotland *RPIX for Q4 2024*	2.9%

Source: Annual Survey of Hours and Earnings (Table 16.5a, all, median), Consumer Price Inflation (CDKQ, CZBH).

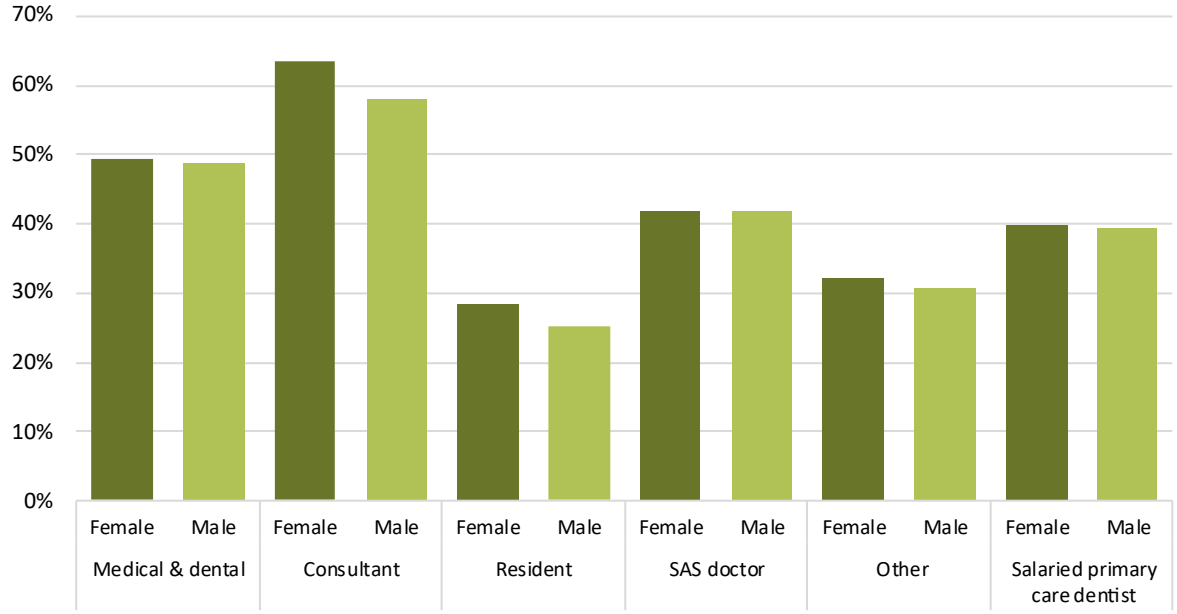
Appendix H NHS staff survey, gender and ethnicity data

1. In this appendix we look at NHS staff survey data from 2024, for England, broken down by gender and ethnicity.

Hospital and Community Health Services

2. Figure H.1 shows satisfaction with pay broken down by staff group and gender in 2024 across all Hospital and Community Health Services (HCHS) medical and dental staff. When looking across all medical and dental staff, 49 per cent of female staff and 49 per cent of male staff expressed satisfaction with pay. Female consultants, resident doctors and dentists, primary care dental staff and 'other' medical and dental staff were all more likely than their male counterparts to express satisfaction with pay.

Figure H.1: HCHS, percentage of staff satisfied or very satisfied with their pay, by grade and gender, England, 2024



Source: NHS Staff Survey.

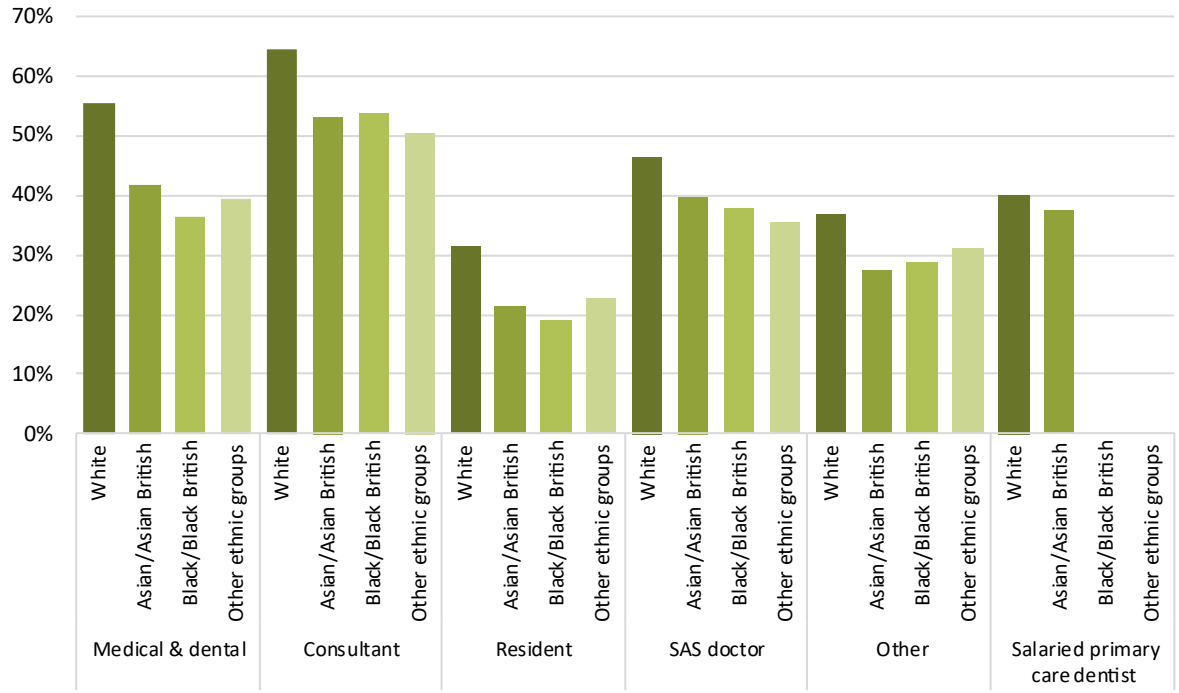
Note: Percentage of staff saying they were 'very satisfied' or 'satisfied' with their pay.

3. Figure H.2 shows satisfaction with pay broken down by staff group and ethnic group in 2024.[90] When looking across all medical and dental staff, 55 per cent of White staff expressed satisfaction with their pay, compared with 42 per cent of Asian/Asian British staff, 36 per cent of Black/Black British staff and 39 per cent of staff from other ethnic groups.
   - White consultants (65 per cent) were more likely to express satisfaction with their pay than Black/Black British consultants (54 per cent), Asian/Asian British consultants (53 per cent) and consultants from other ethnic groups (50 per cent).

[90] In this appendix, the data for Asian/Asian British is a weighted average of the data for Asian/Asian British – Indian, Asian/Asian British – Pakistani, Asian/Asian British – Bangladeshi, Asian/Asian British – Chinese, Asian/Asian British – any other Asian background. The data for Black/Black British is a weighted average of the data for Black/Black British – African, Black/Black British – Caribbean, Black/Black British – any other Black/African/Caribbean background. The data for Other ethnic groups is a weighted average of the data for Mixed/multiple ethnic background: White and Black Caribbean; White and Black African; White and Asian; any other Mixed/multiple ethnic background and Other Ethnic group: Arab; any other ethnic background.

- White resident doctors and dentists (32 per cent) were more likely to express satisfaction with their pay than Asian/Asian British resident doctors and dentists (21 per cent), Black/Black British resident doctors and dentists (19 per cent) and resident doctors and dentists from other ethnic groups (23 per cent).
- White SAS doctors and dentists (47 per cent) were more likely to express satisfaction with their pay than Asian/Asian British SAS doctors and dentists (40 per cent), Black/Black British SAS doctors and dentists (38 per cent) and SAS doctors and dentists from other ethnic groups (36 per cent).
- White salaried primary care dentists (40 per cent) were more likely to express satisfaction with their pay than Asian/Asian British salaried primary care dentists (37 per cent). Data was not available for Black/Black British salaried primary care dentists and salaried primary care dentists from other ethnic groups.
- White 'other' staff (37 per cent) were more likely to express satisfaction with their pay than Black/Black British 'other' staff (29 per cent), Asian/Asian British 'other' staff (27 per cent), and 'other' staff from other ethnic groups (31 per cent).

Figure H.2: HCHS, percentage of staff satisfied or very satisfied with their pay, by grade and ethnic group, England, 2024



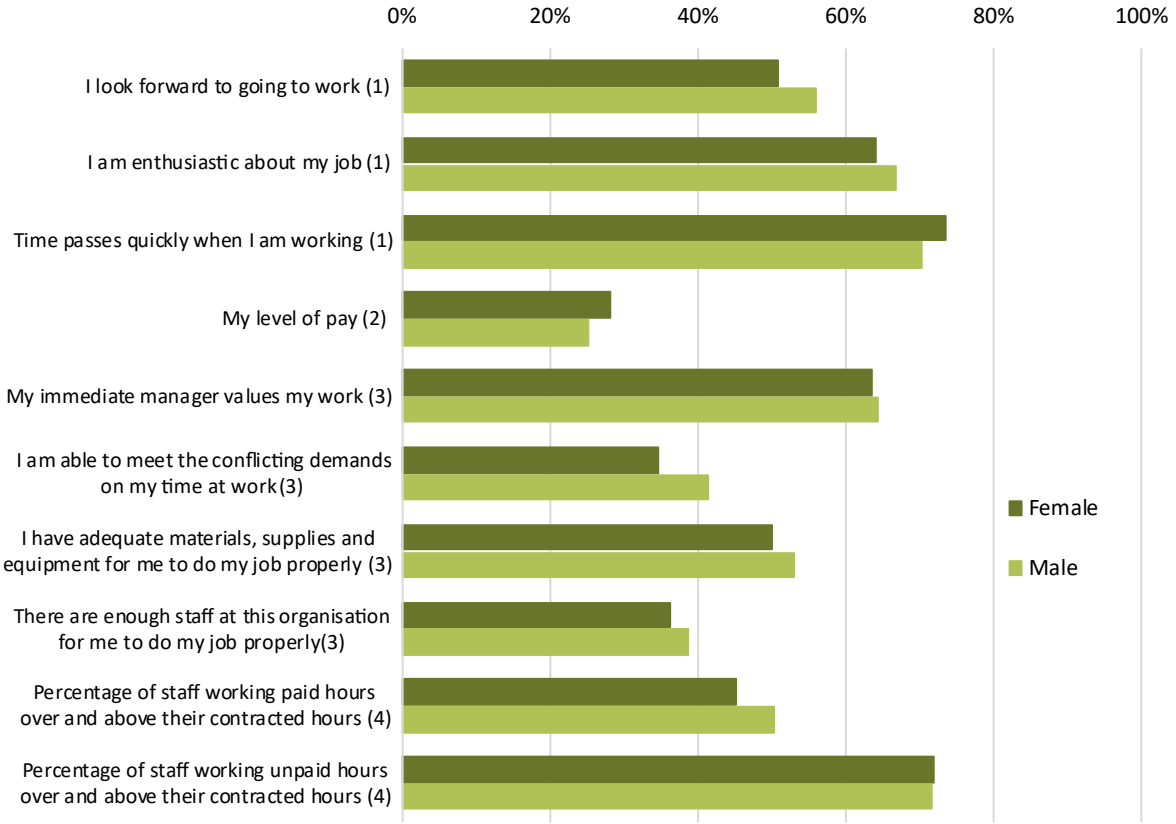
Source: OPRB calculations, using data from the NHS Staff Survey.

Note: Percentage of staff saying they were 'very satisfied' or 'satisfied' with their pay. The sample was too small to generate data for salaried primary care dentists: Black/Black British and Other ethnic groups.

Resident doctors and dentists

4. Figure H.3 shows that in 2024 female resident doctors and dentists were more satisfied with their pay than their male colleagues. However, compared with female colleagues, male resident doctors and dentists were more likely to say that they looked forward to going to work, were able to meet the conflicting demands on their time, and had adequate materials and enough staff to do their job. Male resident doctors and dentists were more likely to work paid hours over and above their contracted hours, and equally likely to work extra unpaid hours than their female colleagues.

Figure H.3: HCHS resident doctors and dentists, satisfaction with aspects of the job and work pressures by gender, England, 2024



Source: NHS Staff Survey, England, 2024.

Notes:

(1) Staff responding “often” or “always”.

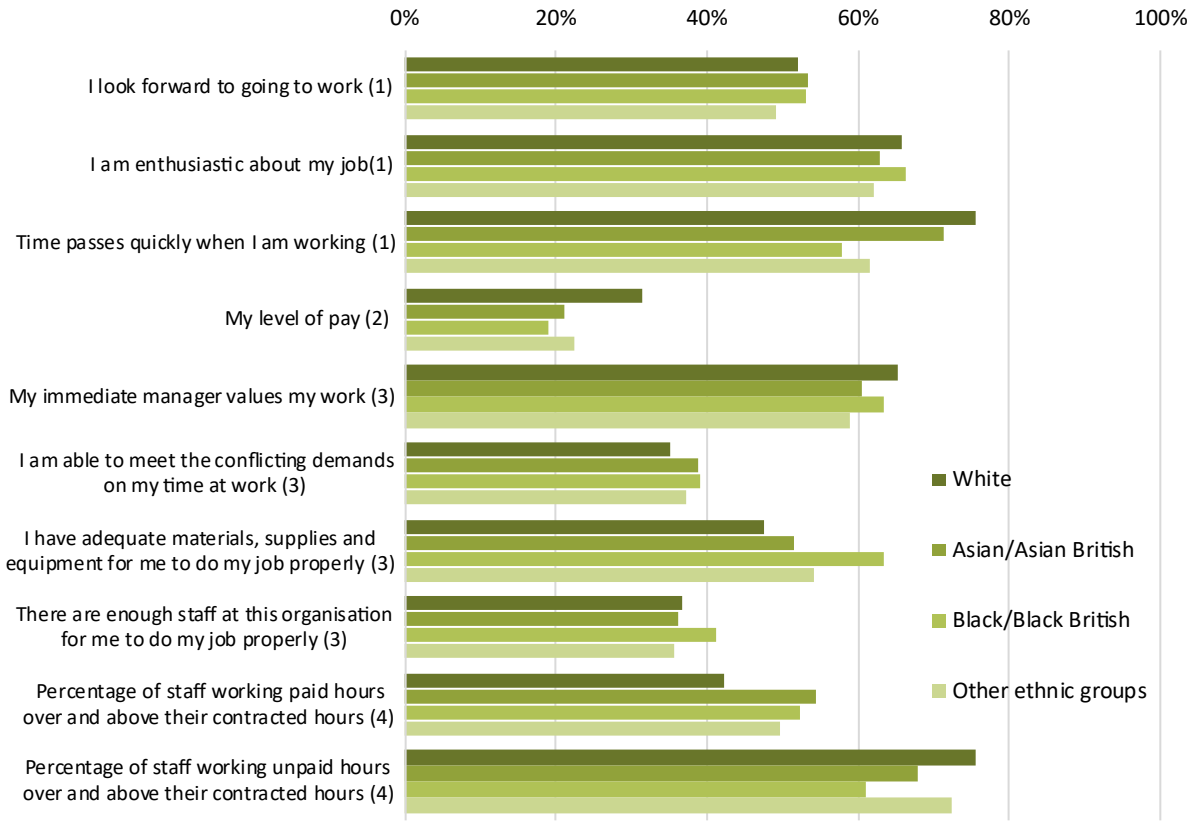
(2) Staff responding “satisfied” or “very satisfied”.

(3) Staff responding “agree” or “strongly agree”.

(4) Staff indicating one or more additional hours.

5. Figure H.4 shows satisfaction with aspects of the job and work pressures, by ethnic group. Asian/Asian British and Black/Black British resident doctors and dentists were more likely to say that they were able to meet the conflicting demands on their time, and had adequate materials and equipment to do their job properly, than White resident doctors and dentists and those from other ethnic groups. White resident doctors and dentists were less likely to say that they worked paid hours in addition to their contracted hours than colleagues from other ethnic groups, while White resident doctors and dentists were more likely to say that they worked unpaid hours in addition to their contracted hours.

Figure H.4: HCHS resident doctors and dentists, satisfaction with aspects of the job and work pressures by ethnic group, England, 2024



Source: NHS Staff Survey, England, 2024.

Notes:

(1) Staff responding “often” or “always”.

(2) Staff responding “satisfied” or “very satisfied”.

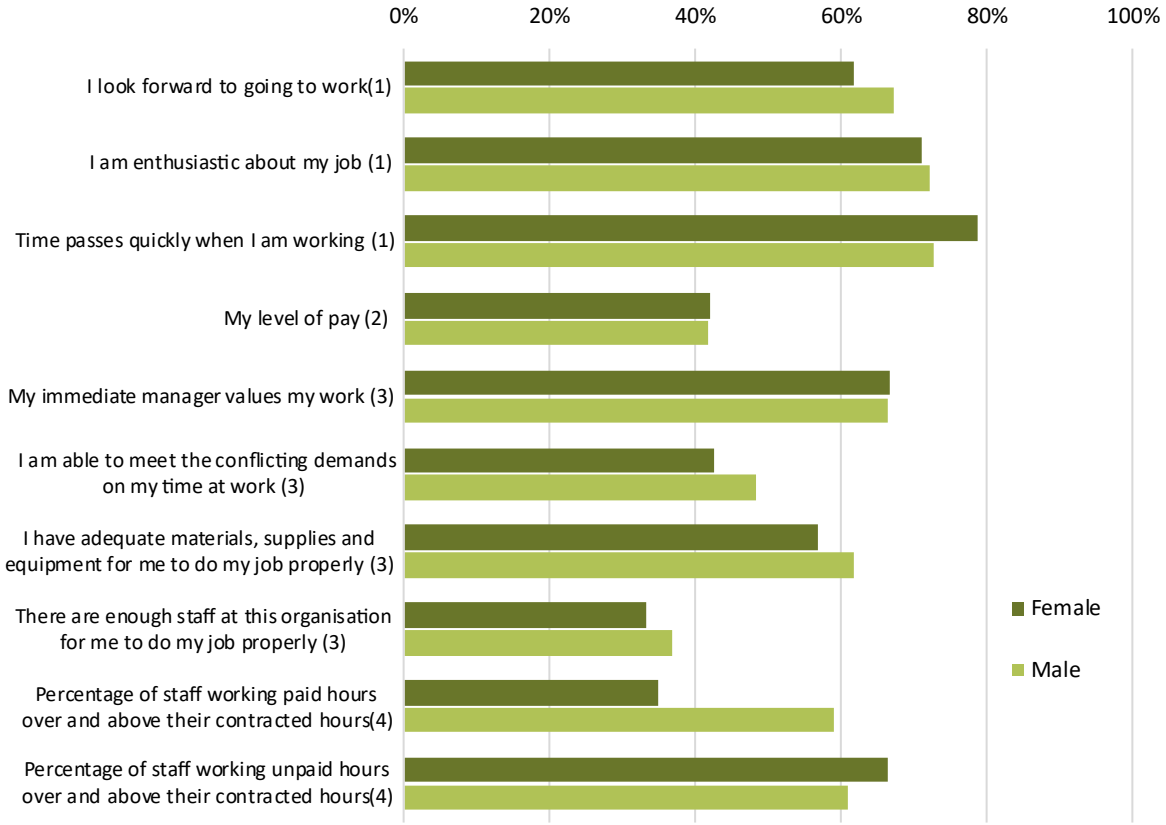
(3) Staff responding “agree” or “strongly agree”.

(4) Staff indicating one or more additional hours.

SAS doctors and dentists

6. Figure H.5 shows that in 2024 female and male SAS doctors and dentists were equally satisfied with their pay. Compared with female colleagues, male SAS doctors and dentists were more likely to say that they looked forward to going to work, were able to meet the conflicting demands on their time, and had adequate materials and enough staff to do their job. Male SAS doctors and dentists were more likely to work paid hours over and above their contracted hours, and less likely to work extra unpaid hours.

Figure H.5: HCHS SAS doctors and dentists, satisfaction with aspects of the job and work pressures by gender, England, 2024



Source: NHS Staff Survey, England, 2024.

Notes:

(1) Staff responding “often” or “always”.

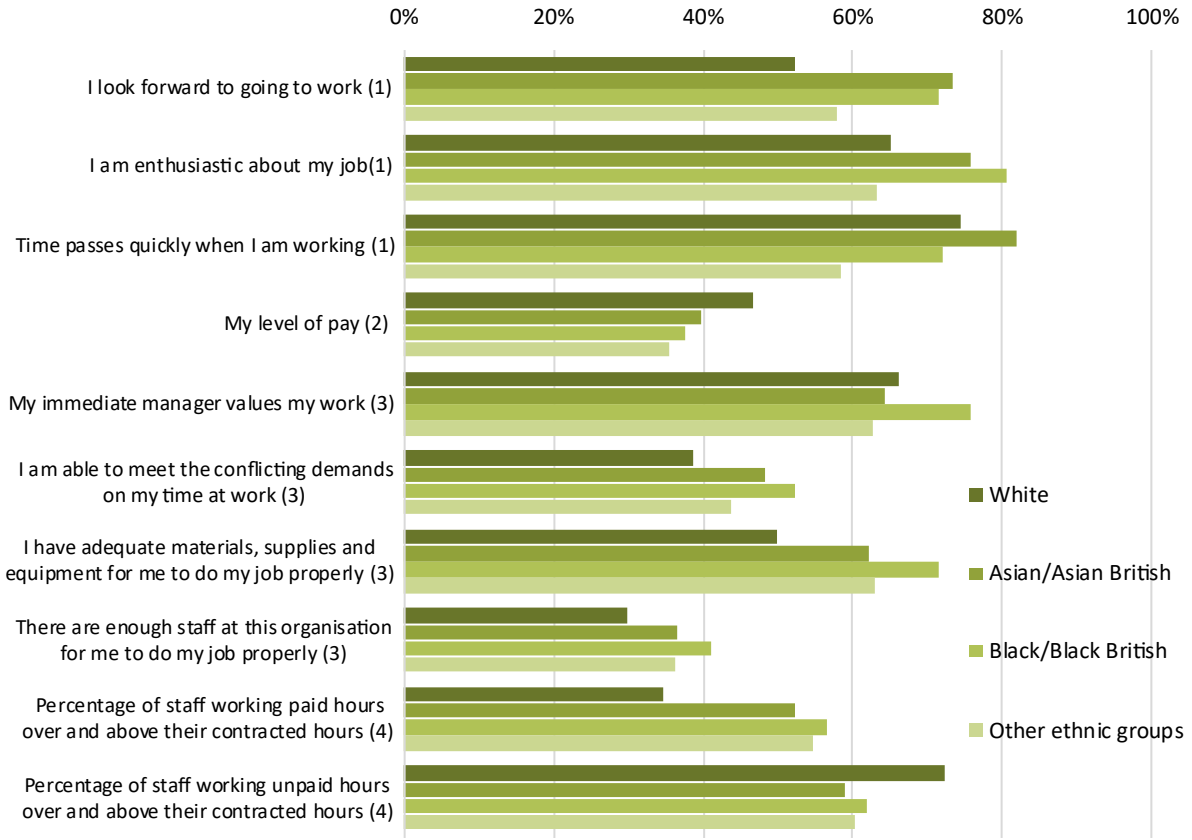
(2) Staff responding “satisfied” or “very satisfied”.

(3) Staff responding “agree” or “strongly agree”.

(4) Staff indicating one or more additional hours.

7. Figure H.6 shows satisfaction with aspects of the job and work pressures, by ethnic group. Asian/Asian British SAS doctors, compared with those from other ethnic groups, were more likely to say that they looked forward to going to work, and say that time passed quickly when they were working. Black/Black British SAS doctors, compared with those from other ethnic groups, were more likely to say that: they were enthusiastic about their job; their immediate line manager values their work; they were able to meet conflicting demands on their time at work; they had adequate materials and equipment to do their job properly; and there were enough staff at their organisation to do their job properly. White SAS doctors, compared with those from other ethnic groups, were the least likely to work extra paid hours but the most likely to work extra unpaid hours.

Figure H.6: HCHS SAS doctors and dentists, satisfaction with aspects of the job and work pressures by ethnic group, England, 2024



Source: NHS Staff Survey, England, 2024.

Notes:

(1) Staff responding “often” or “always”.

(2) Staff responding “satisfied” or “very satisfied”.

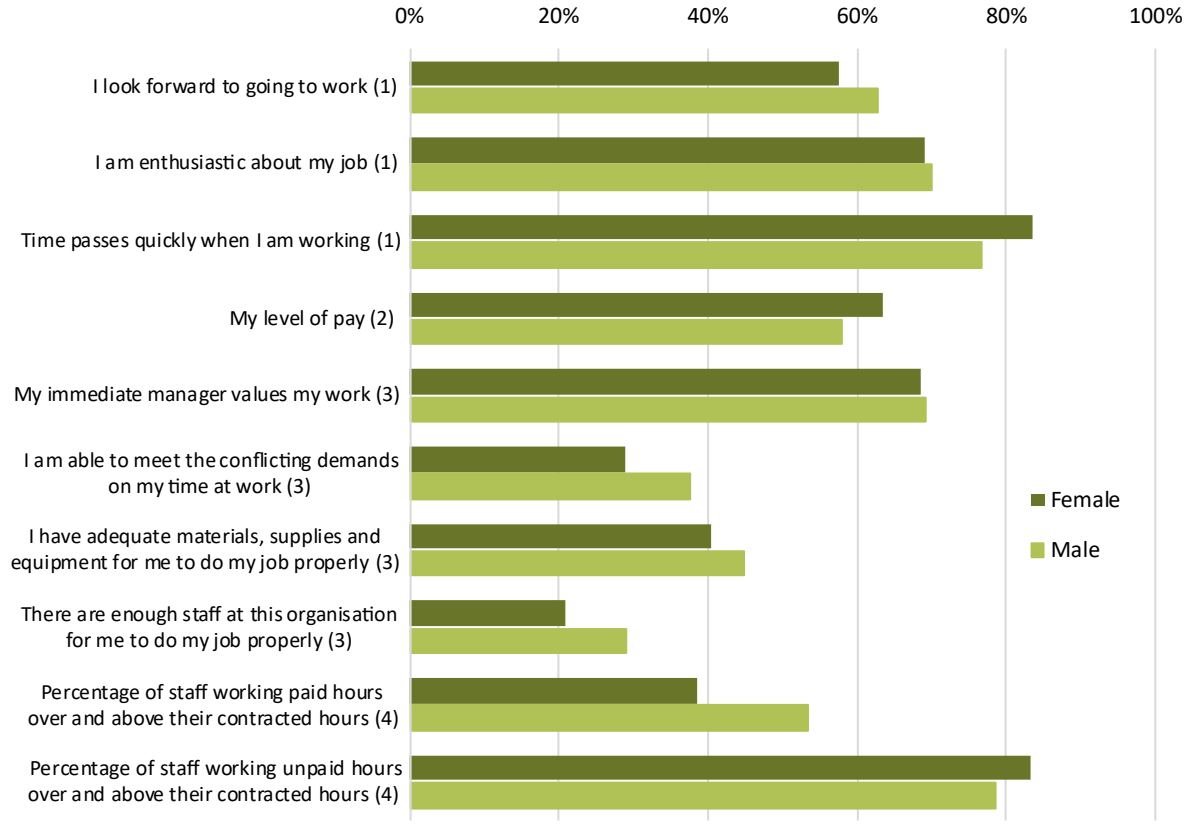
(3) Staff responding “agree” or “strongly agree”.

(4) Staff indicating one or more additional hours.

Consultants

8. Figure H.7 shows that in 2024 female consultants were more satisfied with their pay than their male colleagues. However, compared with female colleagues, male consultants were more likely to say that they looked forward to going to work, were able to meet the conflicting demands on their time, and had adequate materials and enough staff to do their job. Male consultants were more likely to work paid hours over and above their contracted hours, and less likely to work extra unpaid hours.

Figure H.7: HCHS consultants, satisfaction with aspects of the job and work pressures by gender, England, 2024



Source: NHS Staff Survey, England, 2024.

Notes:

(1) Staff responding “often” or “always”.

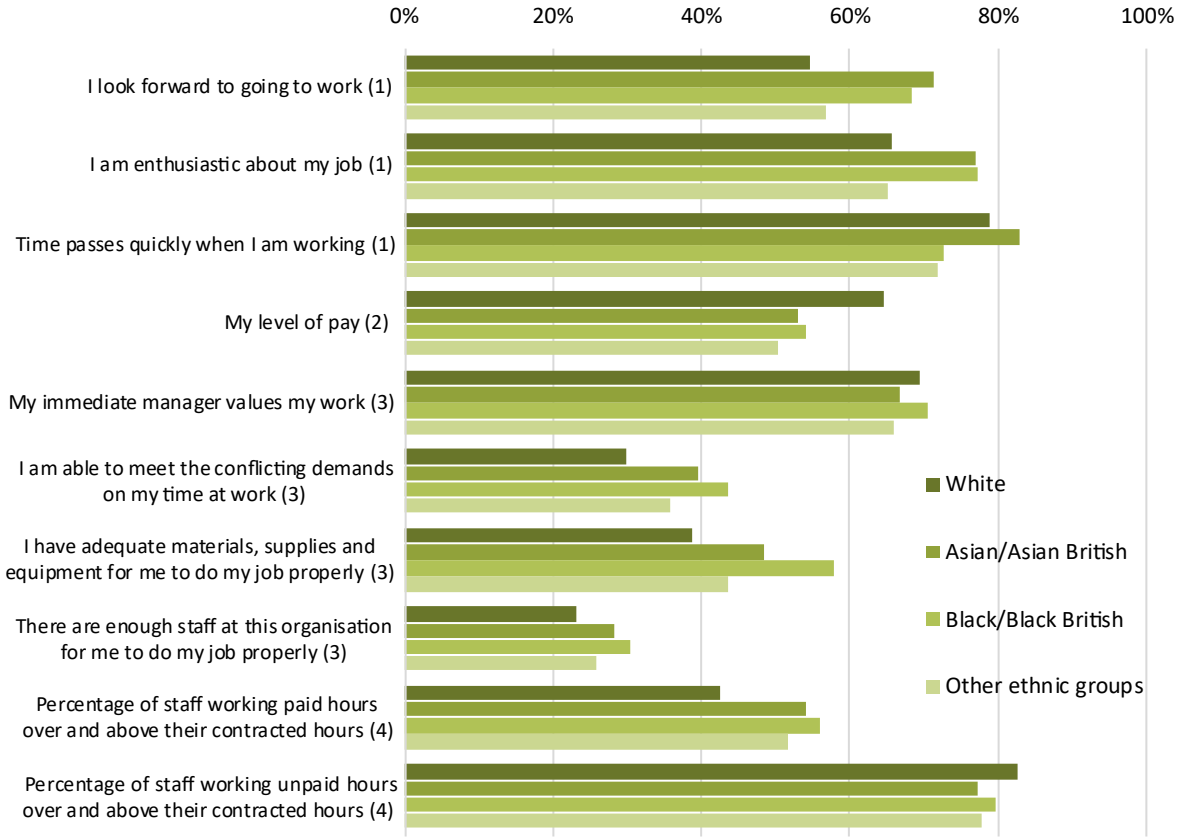
(2) Staff responding “satisfied” or “very satisfied”.

(3) Staff responding “agree” or “strongly agree”.

(4) Staff indicating one or more additional hours.

9. Figure H.8 shows satisfaction with aspects of the job and work pressures, by ethnic group. Black/Black British consultants, compared with those from other ethnic groups, were more likely to say that: they were able to meet conflicting demands on their time at work; they had adequate materials and equipment to do their job properly; and there were enough staff at their organisation to do their job properly. White consultants, compared with those from other ethnic groups, were the least likely to work extra paid hours but the most likely to work extra unpaid hours.

Figure H.8: HCHS doctors and dentists, consultants, satisfaction with aspects of the job and work pressures by ethnic group, England, 2024



Source: NHS Staff Survey, England, 2024.

Notes:

(1) Staff responding “often” or “always”.

(2) Staff responding “satisfied” or “very satisfied”.

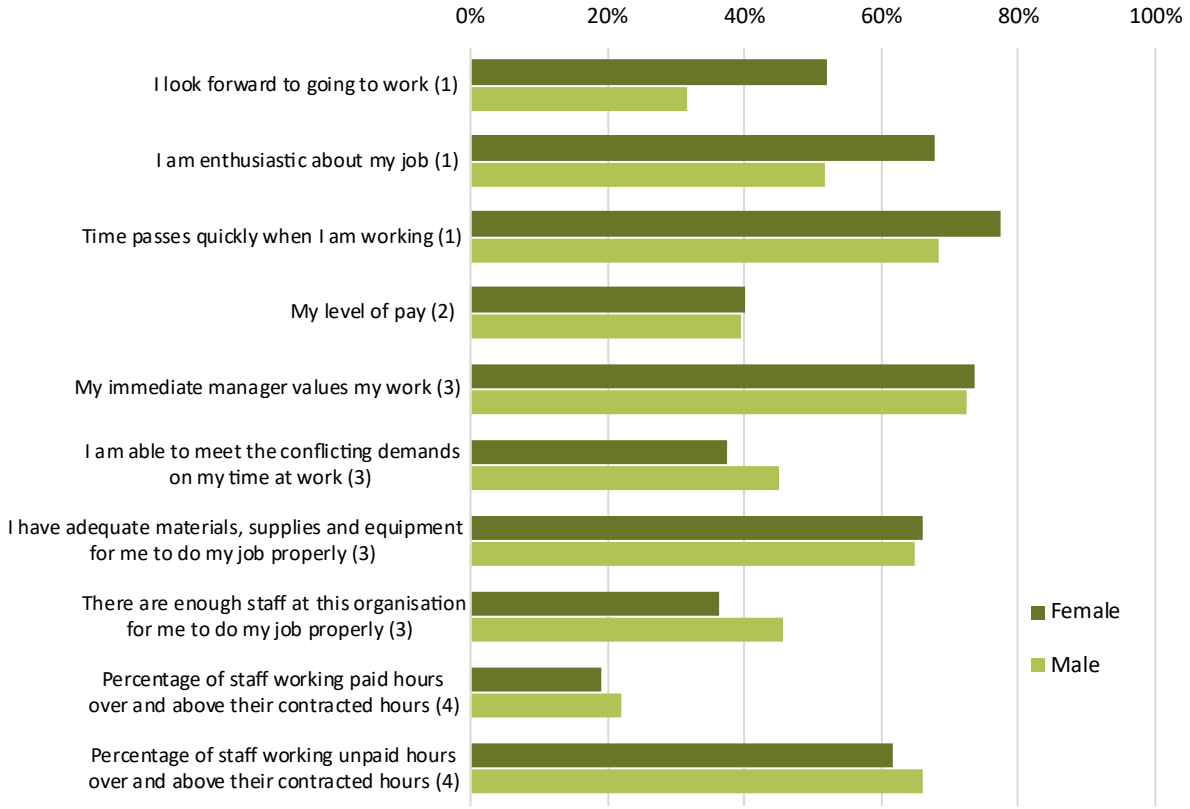
(3) Staff responding “agree” or “strongly agree”.

(4) Staff indicating one or more additional hours.

Salaried primary care dental staff

10. Figure H.9 shows that in 2024 female salaried primary care dental staff were slightly more satisfied with their pay than their male colleagues. Compared with male colleagues, female salaried primary care dental staff were more likely to say that they looked forward to going to work and were enthusiastic about their job, but were less likely to say that they were able to meet the conflicting demands on their time at work, and that there were enough staff at their organisation for them to do their job properly. Female salaried primary care dental staff were less likely to work paid hours over and above their contracted hours, and less likely to work extra unpaid hours, than their male colleagues.

Figure H.9: HCHS, salaried primary care dental staff, satisfaction with aspects of the job and work pressures by gender, England, 2024



Source: NHS Staff Survey, England, 2024.

Notes:

(1) Staff responding “often” or “always”.

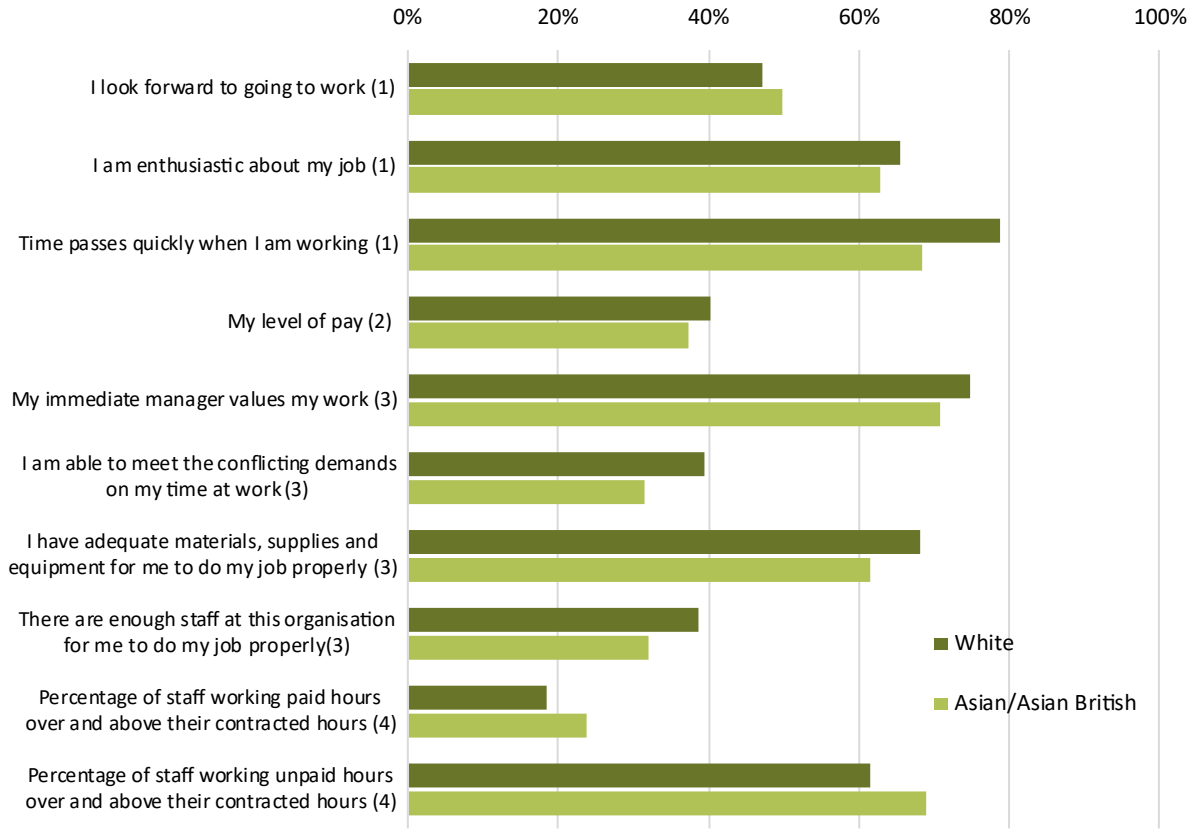
(2) Staff responding “satisfied” or “very satisfied”.

(3) Staff responding “agree” or “strongly agree”.

(4) Staff indicating one or more additional hours.

11. Figure H.10 shows satisfaction with aspects of the job and work pressures, by ethnic group. The sample was too small to generate data for Black/Black British salaried primary care dentists and those from other ethnic groups. Asian/Asian British salaried primary care dentists were more likely than their White colleagues to say that they looked forward to going to work, but were less likely to say that: they were enthusiastic about their job; their line manager valued their work; they were able to meet the conflicting demands on their time at work; they had adequate materials and equipment to do their job properly; and there were enough staff at their organisation for them to do their job properly. Asian/Asian British salaried primary care dentists were more likely to do both paid and unpaid additional hours than their white colleagues.

Figure H.10: HCHS doctors and dentists, salaried primary care dental staff, satisfaction with aspects of the job and work pressures by ethnic group, England, 2024



Source: NHS Staff Survey, England, 2024.

Notes:

(1) Staff responding “often” or “always”

(2) Staff responding “satisfied” or “very satisfied”

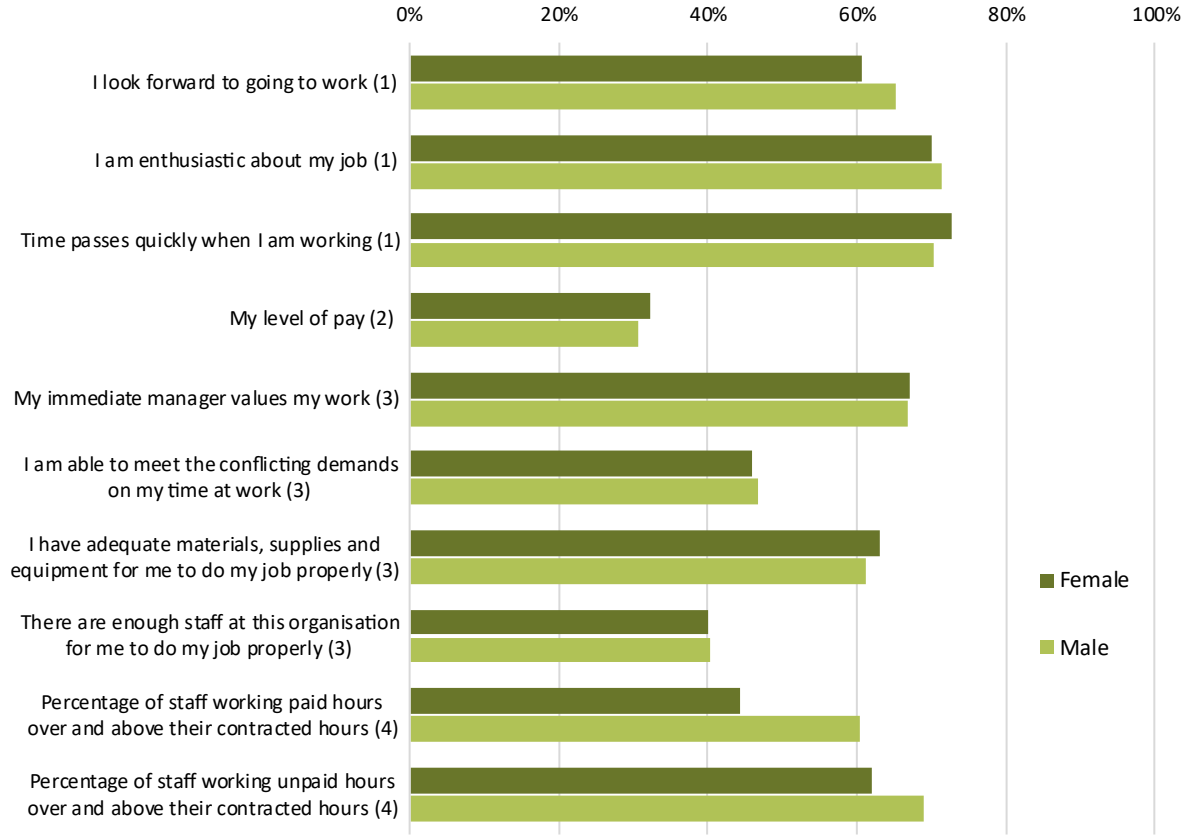
(3) Staff responding “agree” or “strongly agree”

(4) Staff indicating one or more additional hours

Other staff

12. Figure H.11 shows that in 2024 female 'other' staff were more satisfied with their pay than their male colleagues. However, compared with female colleagues, male 'other' staff were more likely to say that: they looked forward to going to work; were enthusiastic about their job; and they were able to meet the conflicting demands on their time. Male 'other' staff were more likely to work both paid and unpaid hours over and above their contracted hours, than their female colleagues.

Figure H.11: HCHS, 'other' staff, satisfaction with aspects of the job and work pressures by gender, England, 2024



Source: NHS Staff Survey, England, 2024.

Notes:

(1) Staff responding "often" or "always".

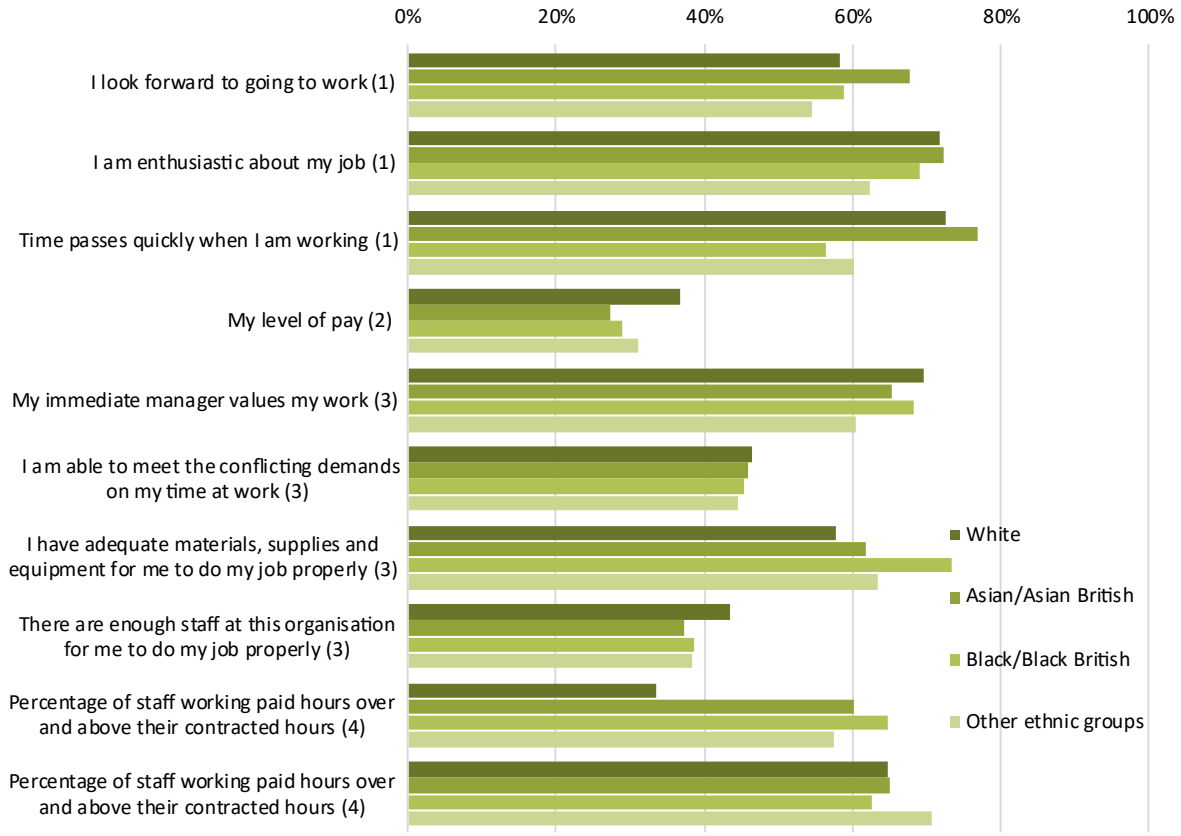
(2) Staff responding "satisfied" or "very satisfied".

(3) Staff responding "agree" or "strongly agree".

(4) Staff indicating one or more additional hours.

13. Figure H.12 shows satisfaction with aspects of the job and work pressures, by ethnic group. Asian/Asian British 'other' staff were more likely than those from other ethnic groups to say that: they looked forward to going to work, and that time passed quickly when they were working. White 'other' staff were more likely than those from other groups to say their immediate line manager values their work, and that there are enough staff at their organisation for them to do their job properly. Black/Black British 'other' staff were more likely to work extra paid hours and less likely to work extra unpaid hours, than colleagues from other ethnic groups.

Figure H.12: HCHS doctors and dentists, 'other' staff, satisfaction with aspects of the job and work pressures by ethnic group, England, 2024



Source: NHS Staff Survey, England, 2024.

Notes:

(1) Staff responding "often" or "always".

(2) Staff responding "satisfied" or "very satisfied".

(3) Staff responding "agree" or "strongly agree".

(4) Staff indicating one or more additional hours.

Appendix I Glossary and abbreviations

ACCIA	Advisory Committee on Clinical Impact Awards
ADG	Association of Dental Groups
ARRS	Additional Roles Reimbursement Scheme
ASHE	Annual Survey of Hours and Earnings
AWE	Average Weekly Earnings
A&E	Accident and emergency
BDA	British Dental Association
BMA	British Medical Association
CCT	Certificate of Completion of Training
CDS	Community Dental Services
CEA	Clinical excellence award
CIA	Clinical impact award
CPI	Consumer prices index
CPIH	Consumer prices index including owner occupiers' housing costs
COPDEND	Committee of Postgraduate Dental Deans and Directors
COVID/COVID-19	Coronavirus disease 2019
CT	Core training
DDRB	Review Body on Doctors' and Dentists' Remuneration
DHSC	Department of Health and Social Care
EU	European Union
FY1, FY2	Foundation year 1, foundation year 2
FTE	Full-time equivalent
GDP	General dental practitioner
GDP	Gross Domestic Product
GDP deflator	Gross Domestic Product deflator
GDS	General Dental Services
GMC	General Medical Council
GMS	General Medical Services
GMP	General medical practitioner
GP	General practitioner
HCHS	Hospital and Community Health Services
HCSA	Hospital Consultants and Specialists Association
HMRC	His Majesty's Revenue and Customs
HM Treasury	His Majesty's Treasury
HSC	Health and Social Care
ICB	Integrated Care Board
IFS	Institute for Fiscal Studies

IMD	Index of multiple deprivation
IMG	International medical graduate
LEO	Longitudinal Education Outcomes
MRCPsych	Member of the Royal College of Psychiatrists
NHS	National Health Service
NS-SEC	National Statistics Socio-economic Classification
OB	Office for Budget Responsibility
OECD	Organisation for Economic Co-operation and Development
ONS	Office for National Statistics
OPRB	Office for the Pay Review Bodies
PA	Programmed activity
PAYE	Pay as you earn
PDS	Public Dental Service
PMQ	Primary medical qualification
QOF	Quality and Outcomes Framework
RDEL	Resource Departmental Expenditure Limits
RPI	Retail prices index
SAS	Specialty, associate specialist and specialist
ST1-9	Specialty training, years 1-9
TERS	Targeted Enhanced Recruitment Scheme
UCAS	Universities and Colleges Admissions Service
UDA	Unit of dental activity
UK	United Kingdom
WTW	Willis Towers Watson

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