Department of Health & Social Care

The Department of Health and Social Care's written evidence to the Doctors' and Dentists' Remuneration Body for the pay round 2026 to 2027

Published 30 October 2025

Contents

1. Introduction

This document is the governments written evidence to the Doctors and Dentists Renumeration Body (DDRB) in response to DDRB call for evidence.

In July, the government remitted DDRB to commence the 2026 to 2027 pay round to provide recommendations for the 2026 to 2027 pay award for medical and dental workforces. The remit letter to DDRB sets out the terms for its annual pay recommendations. The remit letter was sent over 2 months earlier than the previous year in order to return to a more timely annual pay process. DDRB responded and asked us to provide evidence on all aspects of its terms of reference as well as a number of additional points of interest that were annexed to their 2025 report, this document is the written part of the governments evidence. Once it has finished collecting evidence for this pay round DDRB will write a report as usual, including recommendations for doctors and dentists pay uplifts for the 2026 to 2027 financial year.

For the 2025 to 2026 pay round, DDRB made headline pay recommendations for all doctors and dentists in its remit, additionally they separated out the resident doctor workforce for an enhanced award and made 5 further non-pay recommendations. We responded, by accepting the headline pay recommendations and will respond to those further 5 recommendations in due course.

This chapter provides the context for the department's evidence to DDRB for the 2026 to 2027 pay round, as well as a brief overview of the evidence itself.

This year's evidence follows a similar structure to previous years, summarised below. The accelerated timeline means certain datasets have not been updated so some of the data and evidence is the same, however we have still provided it for completeness.

Chapter 2 provides an overview of the economic context and government finances. In 2026 to 2027, as confirmed through the Spending Review (SR), all pay must be funded from departmental budgets and there will be no additional funding above this available for pay settlements. Pay awards above what is considered affordable in the SR settlement will require further tough national and local re-prioritisation of the decisions already made which would impact and challenge the speed and delivery of front-line services and the 10Year Health Plan (10YHP).

Chapter 3 outlines the work being undertaken to implement workforce strategy and planning, as well as detailing programmes relating to training, education, and international recruitment. It also details our aims of reducing international recruitment while improving opportunities for domestically trained staff. Additionally, the chapter covers the government and NHS England’s approach to temporary staffing, and the 10YHP recommendations on leadership.

Chapter 4 of our evidence sets out the important context of staff experience, covering morale and motivation, as well as the work being done to improve doctors and dentists working lives. Taken with the evidence to the NHS Pay Review Body (NHSPRB) it highlights the importance of considering the workforce as a single joined up whole across Agenda for Change staff as well as their medical and dental colleagues, reflecting the reality of team working in the NHS. Ensuring each member of that team is treated equally and fairly, especially those in lower-paid roles, is important to this government.

In chapter 5, the workforce is broken down into its constituent parts with the context of recruitment, retention, motivation, and morale for each part of the remit group.

Chapter 6 contains earnings and expenses data, and the labour market context for the workforce.

Finally, chapter 7 reflects the total reward package that NHS staff receive which is above the statutory minimum and exceeds that offered in other sectors. This includes access to a defined benefit pension scheme, as well as a generous holiday allowance, enhanced parental leave, and support for learning, development, and career progression.

The NHS workforce and the 10 Year Health Plan (10YHP)

An engaged workforce is central to delivering government's objectives for the NHS. The 10YHP has set out the vision for how this government will make an NHS 'fit for the future'.

When the Prime Minister and Secretary of State for Health and Social Care published the plan on 3 July 2025, they made it very clear that the NHS faces a choice; reform or die, and that the only answer was to choose reform. Making that choice and delivering on the ambitions set out in the plan is not possible without an engaged workforce that has been empowered to deliver the 3 big shifts in care: from hospital to community, from analogue to digital, and from sickness to prevention.

The 10YHP set out our vision for the models of care staff will deliver and the tools they should have to do it, as well as how the department will improve the NHS as an employer. The 10 Year Workforce Plan will be published later this year and will detail how the department will ensure it has the right people in the right places with the right skills to deliver on our plan.

Evidence approach

On 13 March 2025 it was announced that the Department of Health and Social Care (DHSC) and NHS England will merge into a single organisation under the mantle of DHSC. This means that the evidence contained in this document will cover what has

previously been covered across DHSC and NHS England evidence. This should reduce duplication and further streamline government evidence. As with last year, rather than including all the data in the text, we will reference certain data in the 'data pack'. As always, we will provide our own narrative and interpretation, signalling clearly where data pack figures, or publicly available data sources, are being referenced. Any feedback on this approach would be appreciated.

Note, where we use the date format '2026 to 2027' we are referencing the financial year, unless otherwise stated.

2. NHS finances

This chapter will outline the financial context including assumptions on efficiency and productivity within which NHS pay awards are being determined. The government's position is that pay awards must be funded from departmental budgets and there is no additional funding available for pay settlements above what has been allocated through the SR.

To set a balanced budget post SR, we have made significant prioritisation decisions across both DHSC and NHS England, and health systems will be asked through a forthcoming multi-year planning process to set out their plans over the next 3 years. The productivity and efficiency section sets out the significant ask on both integrated care boards (ICBs) and NHS trusts in relation to productivity and efficiency in 2025 to 2026, to permit delivery of planned activity across the NHS, with pay and non-pay pressures, alongside unplanned event such as industrial action, directly impacting the scale of the challenge.

Pay awards above what is considered affordable in the SR settlement will require further tough national and local re-prioritisation of the decisions and would impact and challenge the speed and delivery of front-line services and the 10 Year Health Plan. For the 2025 to 2026 pay uplift, funding was met from within DHSC budgets through decisions on reprioritisation, the dissolution of NHS England, and reshaping and reducing ICB costs. Further pay awards above what is considered affordable will require difficult government trade-offs from within existing DHSC budgets, including a reduction in ambitions for service or performance improvement.

Under the 2025 SR, NHS funding will rise by an average of 3% in real terms annually and expected to deliver ambitious productivity targets of 2% per year equating to £17 billion in savings. In setting the departmental financial plan for 2026 to 2027, this is predicated on the successful delivery of the 2% productivity target, alongside managing a wide range of material financial risks through 2025 to 2026.

Economic context

Low and stable inflation is a key component of a stable macroeconomic environment and a prerequisite for sustainable economic growth and improved living standards. Headline Consumer Prices Index (CPI) inflation has risen over the past year to 3.8% in August – above the 2% target. Services inflation, an indicator of underlying inflationary pressure, has fallen by 1.0 ppts since the start of Q1 2024 2025. Overall, risks to inflation remain 2-sided, reflecting domestic cost pressure from wage growth which has been a major factor

in services inflation persistence, and prices as well as external pressures from energy markets and trade policy.

The unemployment rate has risen over the last year, reaching 4.7% in the 3 months to July 2025. Wider sources also suggest that the labour market has continued to loosen. Vacancy levels in the economy have fallen over the past 3 years, and RTI data on payrolled employees shows a gradual fall over the last 7 months.

Measures of average wage growth have historically been higher than median pay settlements, as they are affected by compositional changes in the labour force and factors such as changes to working hours. Settlement data are the most comparable data to PRB decisions, as they are a direct measure of consolidated pay awards, and are not directly affected by other factors such as changes to working hours or changes in the composition of employment. According to Brightmine, median settlements across the economy were 3% in Q1 and Q2 2025. Average earnings growth is forecast to slow further over the coming months, with the OBR expecting earnings growth to fall to 2.2% in 2026 to 2027. The government has brought forward the pay round again even further this year, which makes it particularly important that PRBs consider forecasts for wage growth

Low and stable inflation is a key component of a stable macroeconomic environment and a prerequisite for sustainable economic growth and improved living standards. Headline Consumer Prices Index (CPI) inflation has risen over the past year to 3.8% in July while forecast inflation is above the 2% target. Services inflation, an indicator of underlying inflationary pressure, has fallen by (0.9 percentage points) since the start of Q1 2024 to 2025. Risks to inflation remain 2-sided, reflecting domestic cost pressure from wage growth which has been a major factor in services inflation persistence, and prices as well as external pressures from energy markets and trade policy.

The unemployment rate has risen over the last year, reaching (4.7% in Q2 2025). Wider sources also suggest that the labour market has continued to loosen. Vacancy levels in the economy have been falling over the past 3 years, and Real Time Information RTI data on payrolled employees shows a gradual fall over the last 6 months.

Measures of average wage growth have historically been higher than median pay settlements, as they are affected by compositional changes in the labour force and factors such as changes to working hours. Settlement data are the most comparable data to PRB decisions, as they are a direct measure of consolidated pay awards, and are not directly affected by other factors such as changes to working hours or changes in the composition of employment. According to Brightmine, median settlements across the economy were 3% in Q1 and Q2 2025, and the OBR forecast for earnings growth in 2026 to 2027 is 2.2%.

Funding growth

Table 1: mandate funding for NHS England

NHS England	NHS England revenue departmental expenditure limits (RDEL) excluding ringfence (RF) (cash) £ billion	NHS England capital departmental expenditure limits (CDEL) excluding ringfence (RF) (cash) £ billion
2023 to 2024	171.036	0.439
2024 to 2025	186.838	0.431
2025 to 2026	195.593	0.394

Source: 2024 to 2025 and 2025 to 2026 financial directions to NHS England

Table 1 above shows the closing mandates for NHS England up to 2025 to 2026 and the opening mandate in 2026 to 2027. This outlines the funding for NHS England over the last few years and the subsequent growth. The figures are adjusted annually to account for reallocation of resource, additional funding, and changes of responsibility between government bodies. Figures exclude depreciation, annually managed expenditure (AME) and the technical accounting budget, namely capital grants or Private Finance Initiative.

The 2025 to 2026 totals will be updated with closing financial directions in April 2026, to reflect any changes to NHS budgets agreed, including NHS for funding for the pay awards announced in May.

Financial position of the NHS

The Autumn Budget 2024 set out that NHS England RDEL budgets will rise to £181.4 billion in 2024 to 2025 and £192 billion in 2025 to 2026. The latest Financial Performance Report for 2025 to 2026 shows that with planning completed, all 42 systems have balanced plans for the year, after receiving £2.2 billion in deficit support funding. The year-to-date (YTD) position at Month 2 points to an overspend of £51 million which is largely driven by a shortfall in performance against efficiency plans. It is expected that YTD system overspends will be recovered in the latter part of the year resulting in a forecast position in line with plan. However, material risks remain from the cost of managing industrial action, implementing planned restructuring and headcount reductions and delivery of efficiency plans over the remainder of the year.

Table 2 shows the breakdown of funding provided to NHS providers since the 2017 to 2018 financial year, including preliminary outturn data for 2024 to 2025.

Table 2: NHS providers RDEL breakdown

NHS Providers RDEL breakdown (£ million)	2019 to 2020	2020 to 2021	2021 to 2022	2022 to 2023	2023 to 2024	2024 to 2025
Gross deficit	1,560	158	126	1,001	1,606	1,094
Gross surplus	-567	-363	-442	-299	-305	-318
Reporting adjustment	-323	-450	-240	-252	12	0
NHS providers SRP (sector reported performance)	670	-655	-556	450	1,312	776
Plus additional RDEL adjustment	338	-77	-39	528	69	293
Net NHS providers RDEL NRF (Non-Ringfenced RDEL)	1,008	-732	-595	978	1,382	1,070

Share of resources going to pay

The growth rate in the NHS trust and foundation trust provider sector (NHS trusts and NHS foundation trusts only and so does not include other providers of NHS services such as primary care and some community services) permanent and bank staff spend has exceeded the growth rate in overall NHS England funding in each of the past 3 financial years.

Table 3 shows the proportion of funding consumed by NHS trust and foundation trust permanent and bank staff spend since the 2022 to 2023 financial year. This only covers staff working within hospital and community health settings and excludes agency spend by these organisations. Further information is set out in the 'Productivity in the NHS' section on the elimination of agency expenditure.

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

Year	NHS England RDEL (£ billion)	NHS provider permanent and bank staff spend (£ billion)	% of spend on staff	increase in total spend	increase in provider permanent and bank staff spend
2022 to 2023	152.553	73.942	48.47%	3.98%	7.37%
2023 to 2024	165.926	82.004	49.42%	8.77%	10.90%
2024 to 2025	179.570	89.910	50.07%	8.22%	9.64%

Notes:

- 2022 to 2023: NHS England RDEL figure excludes non-recurrent funding for a non-consolidated pay award compared with the corresponding figure in Table 1. NHS trust and foundation trust permanent and bank staff spend excludes a corresponding amount

- 2023 to 2024: NHS England RDEL figure excludes Health Education England (HEE) funding compared with the corresponding figure in table 1

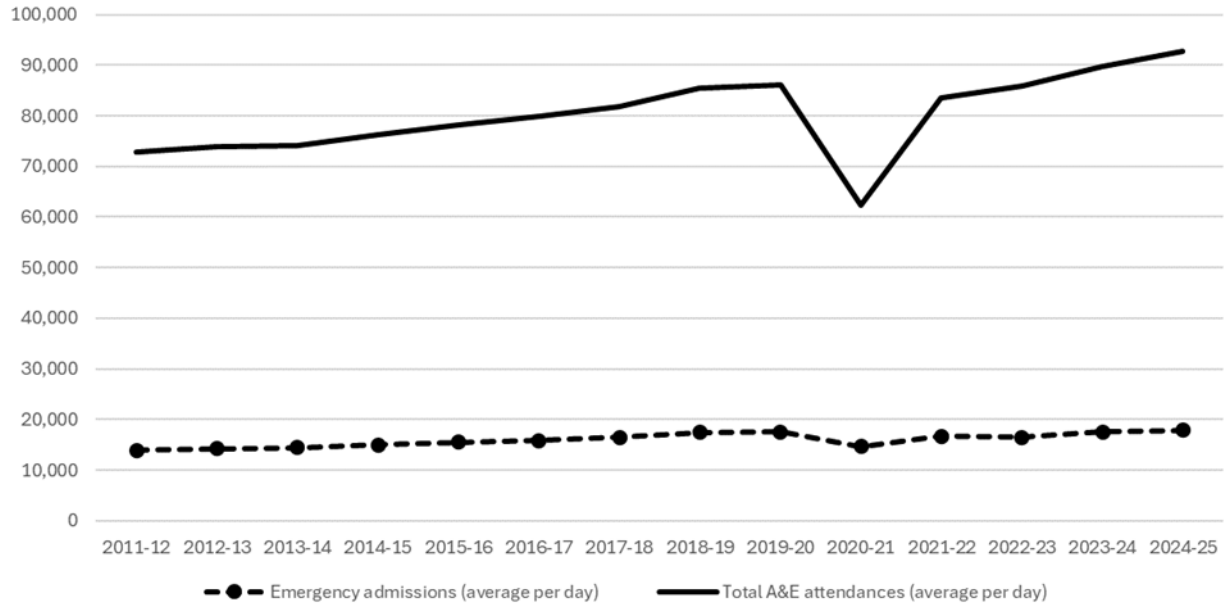
- 2024 to 2025: NHS England RDEL figure excludes HEE funding and additional pensions funding compared with the corresponding figure in table 1. NHS trust and foundation trust permanent and bank staff spend excludes a corresponding amount for additional pensions spend

- figures in the table are correct to the specified level of significance. Percentage increases may not match increases calculated from budget or spend figures as given in the table due to rounding

Demand pressures

Demand for emergency care is now above levels seen before the COVID-19 demand spike, with more accident and emergency (A&E) attendances.

Figure 1: total and emergency admissions per calendar day



Source: Statistics A&E Attendances and Emergency Admissions

Figure 1 shows the total attendances and emergency admissions to NHS England per calendar day between 2011 to 2012 and 2024 to 2025.

In 2019 to 2020, there were an average of 68,540 A&E attendances and 17,551 emergency admissions per day. In 2024 to 2025, there were 74,941 A&E attendances and 17,873 emergency admissions per day. This equates to a 9% increase in A&E attendances, while emergency admissions grew more slowly demonstrating an increase of 2% between 2019 to 2020 and 2023 to 2024.

Table 4 shows the total patient referral to treatment (RTT) pathways completed per working day

Year	RTT estimated clock starts per working day	RTT total completed pathways and unreported removals per working day	Waiting list
2018 to 2019	82,231	81,272	4,345,467
2019 to 2020	79,712	79,552	4,386,297
2020 to 2021	55,824	53,595	4,950,297
2021 to 2022	74,916	69,322	6,365,772
2022 to 2023	79,511	75,665	7,331,186
2023 to 2024	82,163	81,332	7,538,830
2024 to 2025	82,440	82,878	7,418,598

Source: NHS England consultant led referral to treatment statistics.

Elective reform is a key focus for the NHS, with the government supporting the NHS to deliver on the commitment that 92% of patients will wait no longer than 18 weeks from referral to consultant-led treatment – in line with the NHS constitutional standard – by March 2029. The size of the challenge remains significant. The waiting list currently stands at 7.4 million (as of May 2025). This is down from 7.6 million in May 2024, but up from 4.5 million in May 2019 before the pandemic. As of July 2024, the start of the current parliament, only 58.9% of waits are within the 18-week standard with nearly 200,000 patients waiting more than 52 weeks for elective treatment. Currently, in May 2025, the data has shown some improvement with 60.9% of waits now within the 18-week standard, but this is still way below the constitutional commitment of 92%.

The Elective Reform Plan; published in January 2025, outlines an ambitious package of reforms that the NHS is expected to deliver with national funding and support. It includes

action to manage demand and transform outpatient services, provide faster and more local diagnostics, implement more productive surgical pathways and improve patient experience.

The DHSC 2025 SR settlement includes £1.8 billion of additional funding, announced at the Autumn Budget 2024, to support the delivery of 2 million extra operations, scans and appointments (equivalent to 40,000 per week) during this government's first year. The government has reached and surpassed this target.

This is supported by £6 billion additional capital investment over 5 years for diagnostic, elective, urgent and emergency capacity in the NHS to March 2030. This includes £1.65 billion capital funding in 2025 to 2026 to deliver new surgical hubs, diagnostic scanners and beds to increase capacity for elective and emergency care.

Monthly per working day RTT activity across 2024 to 2025 was above pre-pandemic levels, 16% higher than activity seen in 2019 to 2020. However, activity levels are still lower than originally planned; the 2022 Elective Recovery Plan envisaged they would be 30% higher by 2024 to 2025. This has been due to slower productivity recovery, in part due to industrial action. NHS analysis estimates that the waiting list could have fallen by an extra 430,000 from December 2022 to March 2024 without strikes.

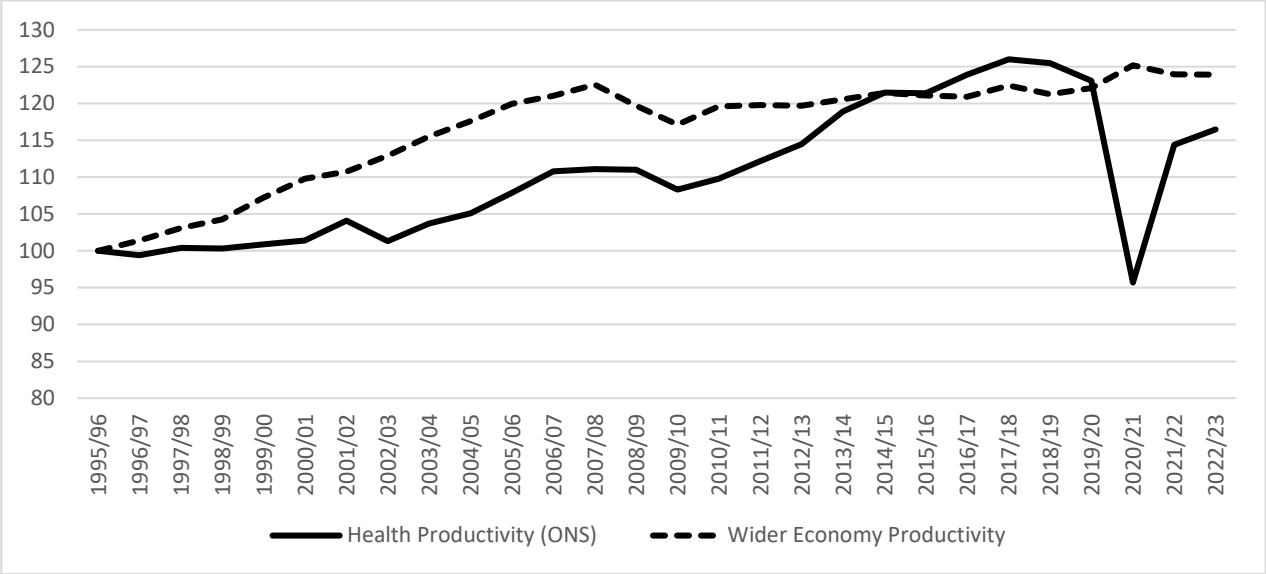
Average elective demand growth pre-pandemic (between October 2016 and February 2020) was 2.1%. Demand returned to pre-pandemic levels in January 2023 and rebounded at a rate of 6.1% across 2022 to 2023. The rate of demand growth has fallen since then, at just 0.3% across 2024 to 2025 (although changes in the reporting of community pathways in February 2024 explain some of this decrease). Demand growth is expected to return to the long-term trend seen before the pandemic at around 2% without mitigations from advice and guidance interventions.

Calculating productivity in the NHS

In England, quality adjusted public service healthcare productivity increased on average by 0.9% per annum from 1995 to 1996 until 2019 to 2020 – a similar rate to the wider economy.

Office for National Statistics (ONS) figures showed a 22.2% reduction in productivity in 2020 to 2021. ONS has since reported a significant bounce back with productivity back to 5.3% below the 2019 to 2020 level by 2022 to 2023, but some of this recovery is due to the inclusion of Test and Trace and COVID vaccinations. A more modest recovery of 10.2% below the 2019 to 2020 was reported by York University in 2022 to 2023 who published a similar measure that excluded Test and Trace and most COVID vaccinations.

Figure 2: ONS England Health versus Wider Economy Multi Factor Productivity (index 1995 to 1996 equals 100)



These formal estimates are only published up to 2022 to 2023. However, NHS England has published an in-year measurement of productivity for the acute sector, aligned to the ONS annual approach. The measure was published in February 2025 and March 2025 and estimated acute productivity growth has averaged 2% over the last 3 years (2022 to 2023, 2023 to 2024, and YTD 2024 to 2025) but is still 7 to 8% below the 2019 to 2020 level.

The measure will become an official statistic in development since September 2025. It is broken down by provider so organisations can understand their own productivity and opportunities for improvement.

ONS publish an in-year quarterly measure, however this is experimental and has large confidence intervals around its findings. The quarterly public service productivity published in July 2025 found public service healthcare in the United Kingdom was 2.7% more productive in January to March 2025 than in January to March 2024, with 2.9% more output and 0.2% more input. As an experimental measure, it should be viewed with caution.

Sources:
ONS Public service productivity estimates healthcare England FYE 2023;

Latest CHE Research Paper on NHS Productivity 2022 to2023 update

NHS productivity update Board Meeting February 2025

NHS England public board meeting agenda and papers 27 March 2025

ONS Public service productivity quarterly UK: January to March 2025

NHS England has developed the Model Health System (MHS) which is a data driven improvement tool designed to help systems and trusts improve their productivity and efficiency. The MHS gives trust-level benchmarking allowing systems and trusts to compare productivity, quality and responsiveness data to their peers to identify opportunities to improve. Data within the MHS relating to workforce productivity include:

- non-elective admissions per clinical whole time equivalent (WTE)
- elective admissions per clinical WTE
- A&E attendances (Type 1 and Type 2) per Emergency Medicine consultant

Productivity and efficiency in the NHS

The SR 2025 announcement included a commitment that the NHS would deliver 2% annual productivity growth over the 3 years of the SR (from 2025 to 2026 to 2028 to 2029), driven by significant technology and digital infrastructure investments. This includes up to £10 billion investment to advance NHS technology, supporting the move towards a single patient record, expanding and enhancing the NHS App, and harnessing AI and other digital tools. These investments will free up staff time, improve patient experience, and ensure the NHS is better equipped to meet future demand. The 2% annual productivity target is an integral part of the settlement and does not represent further savings beyond what has already been agreed.

Increasing NHS productivity and efficiency remain essential to meet the growing demand for health services to support enduring improvements in performance and ensure financial sustainability. In recent years, funding and workforce levels within the NHS have gradually increased. However, though there has been some sustained progress since the COVID-19 pandemic, this has not yet translated into significant corresponding improvements in productivity. The 2% productivity growth aims to address this gap, to ensure that increased resources translate into measurable improvements in the quality of services patients receive.

The 10YHP emphasises the need for reform within the NHS, and the critical role that improving productivity must play in this. This includes focusing on system reform, leveraging technology, and investing in workforce development. Lord Darzi's recommendations also stressed that any financial increase, including pay, should be tied to productivity gains and wider systemic improvements. Following the SR announcement in June, future pay decisions should be considered alongside these broader reforms to ensure sustainable investment that enhances both workforce well-being and service delivery.

To deliver the 2% productivity target, NHS England is focusing on 5 key areas:

1. Operational and clinical excellence: improving patient flow, reducing discharge delays, adopting best practices to minimise clinical variation, and delivering care in the right place at the right time through new models of care.

2. Workforce - optimising workforce capacity through best practice standards of planning and deployment, improving retention and culture and upskilling staff, including reducing the volume of temporary staffing, which will reduce bank and agency spend.

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

4. Technology and transformation: modernising technology through the 'One Digital' estate, modernising data infrastructure, transforming the NHS App and digitally enabled services and releasing time for workforce through digital tools and services.

5. Reducing waste: achieving efficiencies in medicines, enhancing commercial processes, and improving corporate services by exploring large-scale automation.

Affordability

SR25 set departmental budgets for day-to-day spending until 2028/29. The Government has been clear in the SR that pay awards need to be funded in full from within these budgets and there will be no access to the reserve.

The Government has allocated its SR funding in order to deliver on its commitments in the Plan for Change and the 10 Year Health Plan. These require increased activity particularly in electives and to deliver other service and performance expectations, as well as meeting inflation and other cost increases.

DHSC is balancing these spending commitments across NHS England, its other ALBs and the core department, with an ambitious productivity assumption of 2% each year in the NHS which will be required to deliver to balance the settlement. DHSC have developed financial and delivery plans which currently allow for a pay uplift of 2.5% without having to make trade-offs against headline government health commitments. Should the independent pay review bodies recommend an award above this level, we would need to consider whether and how this could be made affordable from within existing DHSC budgets. Accepting such an award would inevitably have an impact on healthcare delivery.

DHSC, along with NHS, is already managing a wide set of material financial risks including industrial action costs and other demand pressures on the NHS. NHS pay is a significant material pressure where every 0.5% increase to pay costs c. £750m, so anything above the pay plan outlined above will require difficult trade-offs for the Government.

These trade-offs could include reduction in ambitions for service or performance improvement (for example, additional investment in digital and technology to support productivity improvements in future years). As staffing costs are the largest single area of NHS expenditure, it is likely that higher pay awards will affect the ability for the NHS to afford to maintain or expand staffing levels.

As you saw last year, the government has showed its willingness to make the difficult decisions needed to improve outcomes for the public from the health system. Including through identifying how extra funds will be freed up by cutting duplication and waste, and through abolishing NHS England, and reshaping and reducing ICB costs by 50% to empower NHS staff and deliver better care for patients.

GP finances

Investment in general practice

The latest NHS England published information is for 2018 to 2019, to 2022 to 2023 and showed that £14.8 billion was invested in general practice in 2022 to 2023, which represented a year-on-year cash increase of 4.1%. Although it was a real terms reduction of 2.5% due to exceptional GDP deflator figures, it represented 15.1% cumulative real terms growth in expenditure since 2018 to 2019.

GP contract funding and reform

There has been a 3% real terms growth in funding for the NHS over 3 years which has been directed to train more GPs and deliver more appointments.

In 2025 to 2026 we announced an additional investment of £889 million across the core practice contract and the Network Contract Directed Enhanced Service (DES) representing a 4.8% real terms growth and included an assumed pay growth of 2.8% compared with the previous year. This is the largest uplift to GP contract funding in over a decade and was supported by the General Practitioners Committee England (GPCE). Following DDRB and NHS Pay Review Body recommendations for 2025 to 2026; the contract has been further uplifted by an additional £122 million to cover pay uplifts for practice staff and staff employed through the Additional Roles Reimbursement Scheme (ARRS) staff in line with the recommendations.

In 2024 to 2025, £82 million of additional funding was invested into the ARRS to enable the recruitment of 1,000 recently qualified GPs (up to 2 years post certificate of completion of training (CCT)). This has continued in 2025 to 2026, with £190 million being invested (reflecting full year costs of employing that GP cohort). Over 2,000 GPs have now been recruited through the scheme. Overall, total funding for the ARRS was uplifted by £188 million for 2025 to 2026. From April 2025, the ARRS has also become more flexible to allow primary care networks (PCNs) to respond better to local workforce needs, with fewer

restrictions on the number or type of staff covered and the inclusion of practice nurses in the scheme. The 2 funding pots - one for recently qualified GPs and one for other direct patient care staff - have been combined into one to enable PCNs to utilise the entire pot as flexibly as possible.

In 2025 to 2026, practices also have the opportunity to take part in a new enhanced service for advice and guidance to improve the interface between primary and secondary care, which is worth up to £80 million. The overall increase to GP contract funding for 2025 to 2026 is now £1,092 million. The contract uplift that was initially announced as part of 2025 to 2026 GP contract announcement was £889 million. In addition to this, an additional £80 million has been made available as part of the introduction of the Advice and Guidance enhanced service. Finally, the acceptance of the pay review body recommendations has resulted in a further uplift of £122 million, creating the £1,092 million figure.

The government has committed to working with the GPCE on reform of the GMS contract within this parliamentary cycle.

Dental finances

NHS dentistry in England is funded by a combination of delegated funding from NHS England and Patient Charge Revenue (PCR). From 1 April 2023, all integrated care boards (ICBs) took on delegated responsibility from NHS England for commissioning primary care dental services At this point the funding delegated to ICBs was ringfenced.

The government is committed to ensuring that every penny committed to dentistry is spent on dentistry, and dental budgets remain ringfenced for 2025 to 2026. The total ringfenced budget for dentistry for the financial year 2025 to 2026 is £4.10 billion, including PCR.

NHS primary care dentistry is currently delivered through contracts structured around Units of Dental Activity (UDAs). Each treatment is allocated a number of UDAs in proportion to the complexity and amount of work required. There are currently 4 UDA bands (with band 2 split into 3 sub-bands from November 2022). When procuring new dental contracts commissioners will agree, prior to mobilisation of the contract, the volume of UDAs the contractor will be expected to deliver each year and the associated contract value. Contract holders are paid 1/12th of the annual contract value each month, which is subject to an end of year reconciliation at year end.

Where a contract holder has delivered more than 96% of contract value, the contract is considered fulfilled. Where a contract holder has delivered less than 96% of contract value by the end of the financial year, funding for the contract under-delivery is recovered by the NHS in the following financial year. In addition, for the small number of contractors who persistently under-deliver their required activity, regulatory amendments made in 2023

gave ICBs additional powers to unilaterally and permanently reduce the contract value and associated activity to an achievable level. Making this amendment to the regulations allows ICBs to release resources on an ongoing basis to be used to commission dental care elsewhere to improve access.

Regional and ICB commissioning teams are now delivering a reformed system (announced in July 2022) whereby practices can deliver up to 110% of contract activity and more UDAs are available for complex work through the subdivision of band 2 treatments. In addition, the minimum UDA rate was uplifted to £28 from April 2024.

In October 2023, ICBs were also given the ability to raise the effective price per UDA within an existing General Dental Services Contract or Personal Dental Services Agreement. More information can be found at Flexible commissioning in primary care dentistry.

In the short-term, we will work with dentists to improve the dental contract. From 2026 to 2027, payments will better reflect the cost of treating patients with higher needs, and we will reduce low-value activity. These changes will improve access to care and ensure dentists are rewarded fairly.

We are clear that even greater change is needed. This year, we will begin the process of more fundamental contract reform. We want a contract that matches resources to need, improves access, promotes prevention and rewards dentists fairly, while enabling the whole dental team to work to the top of their capability.

Dental patient charges

From 1 April 2025, dental patient charges in England increased by 2.39%. This means that a dental charge payable for a band 1 course of treatment rose by 60 pence, from £26.80 to £27.40. For a band 2 course of treatment, there was an increase of £1.80 from £73.50 to £75.30. A band 3 course of treatment increased by £7.60 from £319.10 to £326.70.

To ensure that everyone has access to dentistry when needed, there are a range of exemptions to NHS dental patient charges for those who need the most financial support. Support is also available through the NHS Low Income Scheme for those patients who are not eligible for exemption or full remission. 49.3% of courses of treatment were delivered to non-paying adults and children in 2024 to 2025.

3. Workforce planning and strategy, education and training

Summary

This chapter sets out the actions of the government and NHS England to sustainably grow the workforce to meet developing patient demand. It covers the new vision for the workforce, as set out in the 10YHP, and how this will require a new workforce strategy in the upcoming 10 Year Workforce Plan. It also details our aims of reducing international recruitment while improving opportunities for domestically trained staff.

The chapter also sets out how we're educating and training our staff differently to support the 3 shifts outlined in the 10YHP. Additionally, the chapter covers the government and NHS England's approach to temporary staffing, and the 10YHP recommendations on leadership.

Medical Workforce Health and Community Health Services (HCHS)

Decisions around workforce growth are made by employers, mainly NHS trusts. Overall NHS workforce numbers (medical and non-medical) grew relatively quickly between 2019 to 2020, and 2023 to 2024. During this period, total medical workforce growth was 4.7% per year. In contrast to non-medical staffing groups, where growth slowed in 2024 to 2025, medical staffing growth continued at 5.1% for the year according to NHS workforce statistics June 2025. NHS operational plans show planned total workforce (medical, non-medical and bank and agency staffing) growth in 2025 to 2026 to be 2.0% lower than 2024 to 2025. We expect slower workforce growth over the next couple of year to be accompanied by continued investment in capital spending and ambitious plans for productivity.

The 10 Year Workforce Plan will focus on the reform to workforce needed to deliver the 10YHP, and while there will be fewer staff in 2035 than previously projected, those staff will be better treated

This section describes the trends in the medical workforce employed by NHS provider trusts and integrated care boards. It sets out a high-level picture of the staffing position, covering key issues with regards to patterns of recruitment, retention, and motivation. It does not replicate all the data that is already regularly published into the public. A data pack setting out more detail including unpublished data requested by PRB is also available.

As at March 2025, there were 158,324 medical staff in NHS, equivalent to 147,931 full time equivalent (FTE) staff. The medical workforce continued to grow at above average

rates in 2024 to 2025. Growth for medical staff was 5.1% which was well above the 3.0% growth per annum seen since 2011. Medical workforce growth in 2024 to 2025 also remained significantly above the non-medical workforce (5.1% compared with 2.2% Agenda for Change workforce growth).

The growth in medical workforce in 2024 to 2025 was driven mainly by increased numbers of domestically trained doctors. Numbers of internationally recruited doctors remained similar to levels seen 2023 to 2024 levels.

Leaver rates of medical staff continued to fall during 2024 to 2025 and are below pre pandemic levels. This is in line with the trend seen across NHS. Leaver rates reflect those leaving the NHS trust sector so will include those leaving to work in GP settings or elsewhere in the health and care sector.

Annual leaver rates from the General Medical Council (GMC) register give a sense of numbers leaving the profession entirely including those retiring; register rates are low at around 4.0% and have not changed significantly in recent years according to the GMC.

NHS Annual staff survey results suggest around 53% of medical staff considering leaving their current job intend to stay in the NHS, around 20% wanting to leave the NHS but stay in healthcare and 7% considering leaving for a job outside of healthcare. 20% of those considering leaving are due to retirement or a career break.

The review body has asked about why people leave. The wider labour market differs between different professional groups so we would not expect the reasons for all professionals to be the same and there is no single measure that can tell us why people leave. NHS England published data reflects the mechanism behind why people leave the NHS (for example, resignation, end of fixed-term contract) rather than why they leave.

Vacancy rates for medical staff have remained relatively steady over the past 3 years at around 5% to 6%. It can be difficult to disentangle the different factors driving vacancy rates. In particular it is not clear what the 'natural' level of vacancies would be as people also move between roles (churn), move sectors, or retire.

Workforce planning

The 10YHP, published in July 2025, set out a bold agenda to deliver the 3 big shifts needed to deliver an NHS fit for the future:

- move healthcare from hospital to community
- analogue to digital

- sickness to prevention.

To deliver this ambition and ensure we improve the NHS across all our communities and for the population as a whole, requires a new workforce strategy, to build a modern workforce that is better treated, better trained and more fulfilled.

Through the 10YHP, the department has committed to working with the Social Partnership Forum to develop a new set of staff standards to make the NHS a great place to work. Additional commitments included identifying further opportunities to ease the burden on staff, embedding a culture of lifelong learning and modernising staff terms and conditions. Leadership will be key in driving the change needed, and world-class leadership needs to be an ethos in the NHS, not just a training module. Furthermore, the 10YHP has committed to improving diversity and inclusion in the NHS, from widening access to medicine to increasing the diversity of the Graduate Management Training Scheme, to ensure the NHS is representative of the communities it serves at all levels.

The 10YHP has set a clear direction to the service, stakeholders and the public on the future shape of care, and a new workforce plan will be published later this year to ensure the workforce is equipped to deliver this. The 10 Year Workforce Plan will focus on the workforce we need to deliver the ambitions in the 10YHP, the roles they should carry out, where they should be deployed and the skills they should have. This will mean that while there will be fewer staff in 2035 than previously projected, these staff will be better treated, have better training and more exciting roles. The plan will be based on multi-professional teams, with the skills needed to enable delivery of the 3 shifts.

As well as the 3 shifts, the 10 Year Workforce Plan will also act as the delivery vehicle for many of the policy ambitions set out in the 10YHP. This includes the government's commitment to developing homegrown talent, recruiting from our local communities and giving opportunities to more people across the country to join the NHS. The 10 Year Workforce Plan will outline strategies for improving retention, productivity and training, and for reducing attrition - enhancing conditions for all staff and students while gradually reducing reliance on international recruitment, without diminishing the value of their contributions. The 10 Year Workforce Plan will consider how we can make our workforce truly sustainable, and how we can enable a sense of pride and enjoyment of work.

Undergraduate

The total maximum fundable limit for medical school places in England set by the Office for Students is 8,230 places for the 2025 to 2026 academic year. The limit is confirmed on an annual basis. Any future expansion will be set out in the 10 Year Workforce Plan.

This figure does not include the 50 medical doctor degree apprentices (MDDA) at Anglia Ruskin University. NHS England confirmed on 4 July that a decision has been made not to

expand NHS England’s MDDA funding further than the 2 pilot cohorts of 25 each in 2024 and 2025. This aligns with Skills England's recommendation and the government's decision to end the provision of apprenticeships for level 7 qualifications from September 2025.

NHS England remains committed to supporting the individuals in the 2 MDDA pilot cohorts and ensuring information is learned from the programme that can inform future policy. The government remains committed to widening participation in medicine, and future plans to enable this are set out in the 10YHP, including working with the university sector to ensure that everyone has an opportunity to study medicine - regardless of their background.

Postgraduate

The 10YHP sets out the ambition to tackle bottlenecks at foundation and specialty training places. There are 2 reasons for this bottleneck. Firstly, while the previous government expanded undergraduate medical places, there has not been a commensurate expansion in specialty places - noting that places did increase but at a lower rate than the undergraduate expansion. Secondly, as has been widely publicised, including by the British Medical Association (BMA), the 2020 decision to end the Resident Labour Market Test has meant international medical graduates are now applying on equal terms with UK medical graduates for speciality training roles. This has resulted in an increase in the number of applications and applicants.

In 2020, there were 13,901 unique applicants to the first round, compared to 26,203 in 2024. Consequently, competition for speciality training posts has grown significantly in recent years, from 2.4 applications per training post to 4.7 over the same period. While the NHS remains proud, and always will, of its international workforce, we acknowledge the impact bottlenecks have had on individuals and are committed to enabling UK graduates to continue their training within the NHS. We will therefore work across government to prioritise UK medical graduates for foundation training and to prioritise UK medical graduates and other doctors who have worked in the NHS for a significant period for specialty training.

In addition, over the next 3 years we will create 1,000 new specialty training posts with a focus on specialties where there is greatest need and train thousands more GPs.

Foundation programme allocation review

The allocation process for the UK Foundation Programme for the 2026 intake was changed to a 'preference informed allocation' method. This new process saw applicants being given a computer-generated rank and the removal of the requirement to sit the Situational Judgement Test. The move to the new system aimed to address concerns about the previous system – including that it was perceived as unfair and stressful for

applicants, and that there was lack of standardisation within and across schools. When confirming the move to the new system last year, HEE (now part of NHS England) set out that once implemented it would be kept under constant review. The review is aiming to commence in 2026.

Medical training review

Following the commission from Secretary of State in October 2024, the engagement and analysis of phase 1 diagnostic of the medical training review is now complete. NHS England engaged with over 8,000 stakeholders across the system, hosting national and regional events with resident doctors, educators, and service providers.

The diagnostic phase has identified key themes in relation to specific challenges and areas for improvement across postgraduate medical training, alongside what currently works well. The medical training review is included in the recently published 10YHP and following the publication of the report, we will commence work on phase 2 in the autumn. Phase 2 will focus on exploring the outputs of the diagnostic and developing reform options in response, alongside a prioritisation plan which will span the next 5 to 10 years.

International recruitment

The government is committed to developing homegrown talent from across our communities and giving opportunities to more people across the country to join our NHS. The 10 Year Workforce Plan will outline strategies for improving retention, productivity, training, and reducing attrition - enhancing conditions for all staff, while gradually reducing reliance on international recruitment, without diminishing the value of their contributions.

In the UK in 2023, 68% of doctors taking up or returning to a licence to practice on the GMC register had a non-UK Primary Medical Qualification according to the GMC.

Health and Social Care Worker visa data shows that across 2021 to 2023, the average quarterly number of Health and Care Worker visas granted for doctors was 1,943. This has been falling since 2023, with the latest data from the Home Office showing 1,320 visas granted in quarter one of 2025 - 20% fewer than in the same quarter in 2024. The number of Health and Care Worker visas granted to dentists is much smaller than those granted to doctors. Unlike doctors, the number of grants has not declined in the first quarter of 2025 (with 124 visas granted to dentists in quarter one of 2025, compared to 90 in quarter one of 2024).

National data for health and care worker visa grants to doctors and dentists shows in the first quarter of 2025, that those of Indian nationality made up the largest group with 337 visa grants. This is in comparison to 215 of Pakistani nationality and 128 of Egyptian nationality, who make up the second and third largest groups for that quarter.

The Immigration White Paper sets out reforms to legal migration, so that we can restore order, control and fairness to the system, reduce net migration and promote economic growth. The reforms set out include a complete overhaul of the relationship between the immigration system, training and the labour market to support sustainable growth as well as a sustainable immigration system.

The first set of changes took effect from 22 July 2025 and includes a rise to the skills threshold for the Skilled Worker visa route (of which the Health and Care Worker visa is a subset) to RQF level 6 or above. Doctors and dentists meet the new skill threshold and in turn are expected to remain eligible for the Health and Care Worker visa. However, roles below RQF level 6 including medical and dental technicians, and dental nurses no longer meet the skills threshold for the Health and Care Worker visa. Transitional arrangements are in place for those already working in the UK on Skilled Worker visas prior to 22 July. This means individuals working in occupations below RQF level 6 can continue to work, extend their visas, bring dependants, change employment and take supplementary employment provided they meet occupation salary thresholds.

We continue to hold high ethical standards in international recruitment through the Code of Practice for International Recruitment of Health and Social Care. This was updated in March 2025 with minor changes to add further clarity and streamline the guidance.

NHS temporary staffing

This section refers to medical staff in NHS trusts and does not include GP locums.

Influenced by seasonal factors and broader labour market fluctuations, NHS demand may lead providers to rely on temporary staff.

In 2016, measures were introduced to curb NHS agency spending, including price caps, mandatory use of approved procurement frameworks through the launch of the Agency Rules. These measures, regularly monitored for compliance and effectiveness, aim to reduce costs and give greater assurance of quality. Performance metrics on agency usage are included in the NHS Oversight Framework within the implied productivity levels, reinforcing compliance rules for NHS trusts and foundation trusts.

The measures were relaxed during the pandemic but re-established in September 2022, to control agency expenditure, including a system agency expenditure limit. Further measures to drive down the reliance on agency staff are being implemented in Q3 and Q4 of 2025 to 2026.

In 2024 to 2025, total expenditure on medical temporary staffing decreased by 11% (£334 million) compared to 2023 to 2024, largely due to an increase in spending on bank staff.

Bank staffing costs decreased by 8.5% (from £1.9 billion to £1.76 billion) in 2024 to 2025, and bank staff as a proportion of the overall medical pay bill a decrease by 1.6 percentage points, from 9.3% to 7.7%.

Agency costs made up 4.2% of the medical NHS pay bill in 2024 to 2025, down from 5.5% in 2023 to 2024, representing a cost reduction of approximately £170 million (15%).

While the BMA initially withdrew its rate card guidance as part of the medical pay deals agreed in 2024, the BMA consultant and SAS committees reinstated their rate cards following the PRB announcement on 22 May 2025. The NHS still has bank and agency locum rates that are significantly out of line with substantive pay rates.

The 10YHP states that we will eliminate agency staffing in the NHS by the end of this parliament, ensuring every pound spent delivers maximum value for patients. This will take a concerted effort to transition agency workers to staff banks. This will improve the quality-of-care patients receive and, we estimate, could release as much as £1 billion over the next 5 years.

The 2025 to 2026 NHS Planning Guidance states that trusts should reduce their agency spend by 30% and their bank spend by 10% in this financial year. The Secretary of State for Health and Social Care, Wes Streeting MP, and Sir Jim Mackey wrote to trusts and ICBs in June to emphasise the importance of this and set the ambition to eliminate agency spend.

DHSC and NHS England’s flexible staffing strategy supports NHS providers in reducing their agency staff bills and encouraging workers back into substantive and bank roles. Trusts are encouraged to develop and improve their strategy, procurement and commercial negotiation for temporary staffing.

Leadership

The recently published 10YHP reaffirms the importance of strong and effective leadership in driving performance and building a positive and open organisational culture within which the workforce feels valued, motivated and has the confidence to speak up.

The 10YHP makes a commitment to accelerate delivery of the accepted recommendations from the 2022 Messenger review leadership for a collaborative and inclusive future, which focused on the best ways to strengthen leadership and management across health and its key interfaces with adult social care. The report found that 'a well-led, motivated, valued, collaborative, inclusive, resilient workforce is the key to better patient and health and care outcomes.' Delivery of these recommendations by April 2026, also includes establishing new national and regional talent management systems to ensure a strategic national approach to identifying and developing future clinical and non-clinical leadership talent. Prioritising a focus on career pathways and identifying high potential at more junior levels will also be needed to build talent pools and pipelines for the future.

NHS England is also developing a leadership and management framework, including professional standards and a national code of practice across all levels of clinical and non-clinical management, which are due for completion in autumn 2025. This forms part of a wider programme of measures being taken forward to professionalise NHS leaders and managers while strengthening their professional accountability and includes the commitment to regulate senior NHS leaders (including senior clinical leaders) through a statutory barring system and establishing an NHS college of executive and clinical leadership to further support and develop managers and leaders across the NHS at all levels.

General practice workforce

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

In last year's evidence we showed that we were beginning to see consistent growth in the number of fully qualified GPs. This trend has continued, driven by the recruitment of newly qualified GPs through the Additional Roles Reimbursement Scheme (ARRS). In practices specifically, data for June 2025 showed that there was a total of 37,720 FTE doctors in general practice, of which 28,271 FTE were fully qualified. This compares to 37,041 FTE in June 2024, of which 27,670 FTE were fully qualified. GP specialty training places have been oversubscribed in recent years, suggesting that general practice remains a competitive and attractive career path.

Overall, the general practice workforce data shows the number of doctors in general practice grew by 4,171 FTE between June 2020 and June 2025, an increase of 12%. While the number of training places is driving some of this growth, we are also starting to

see consistent growth in the fully qualified workforce. However, the number of FTE GP contractors has continued to decline from June 2024 to June 2025.

In PCNs, the ARRS has delivered significant growth in the number of GPs. As of June 2025, 2,068 newly qualified GPs have been recruited through ARRS since its introduction in October 2024, and provisional data for May 2025 shows that these GPs were delivering 957 FTE.

General practice reform

This government has made a number of commitments in relation to general practice. From the outset, we have been clear about our intention to fix the front door of our health service and ensure everyone can access GP services.

We are committed to moving towards a neighbourhood health service, with more care delivered in local communities to spot problems earlier. Fit for the future: the 10YHP for England announced the introduction of 2 new contracts (with roll-out beginning next year), to encourage and allow GPs to work over larger geographies and lead new neighbourhood providers. These new contracts will exist alongside the current General Medical Services (GMS) contract. Separately, the government has committed to working with the BMA on reform of the GMS contract.

We will make sure the future of general practice is sustainable by training thousands more GPs, guaranteeing a face-to-face appointment for all those who want one and delivering a modern booking system. This government will bring back the family doctor for those who would benefit from seeing the same clinician regularly (for example, those living with chronic illness).

We also recognise the importance of ensuring funding for core services is distributed equitably between practices across the country and will therefore review the Carr-Hill formula to ensure that resources are targeted where they are most needed.

Changes to the Additional Roles Reimbursement Scheme (ARRS) in 2025 to 2026

As we set out in last year's evidence, in August 2024 we announced we were investing £82 million of additional funding into the ARRS in 2024 to 2025 to enable the recruitment of 1,000 recently qualified GPs to help address GP unemployment. Over 2,000 recently qualified GPs have now been recruited. Chapter 2 of our evidence also sets out further investment and changes to the ARRS in 2025 to 2026 to deliver increased flexibilities, including the addition of practice nurses to the scheme as well as continuing to recruit recently qualified GPs.

In order to support both the recruitment of GPs through the ARRS and the government’s ambition to bring back the family doctor, the salary element of the maximum

reimbursement amount that PCNs can claim for GPs was increased from £73,113 in 2024 to 2025 (the bottom of the salaried GP pay range) to £82,418 (an uplift of £9,305, the lower quartile of the salaried GP pay range) reflecting that some GPs will be entering their second year in the scheme. This amount was subsequently increased to £85,715 following the governments acceptance in full of the 2025 DDRB recommendations for GPs.

Dental workforce, education and training

Undergraduate training

The number of government-funded undergraduate training places in England for dentistry for the 2025 to 2026 academic year remains 809 places.

The maximum fundable limit for training places is set by the government for home and overseas students (defined as those from countries outside the European Economic Area (EEA)). According to Universities and Colleges Admissions Service (UCAS) Management Information, the number of unique applicants to study dentistry in 2024 was at an all-time high, with 4,990 applicants and 835 acceptances. This equates to a 17% success rate for applicants.

The 10YHP sets out that having consulted on the principle of requiring all dentists to work in the NHS for a minimum period, the government will now make it a requirement for newly qualified dentists to practice in the NHS for a minimum period.

Dental Foundation Training

Dental foundation training (DFT) plays a significant role in introducing graduate dentists to NHS general dental practice and is also the main route for UK dental graduates to be accepted onto the NHS Performers List.

As of September 2025, all DFT posts in England are filled. 96% of trainees satisfactorily completed DFT, with 3% requiring an extension and 1% exiting training.

A loss of training sites within DFT is a growing risk that impacts the placement of UK graduates. The decline is driven by several factors including the workload on training practices and educational supervisors, as well as the level of payment for service costs. Government uplifted the service costs payment for training practices in 2024 to 2025, the first time in more than a decade.

Dental core training

Dental core training (DCT) recruitment for 2025 again received an overall above-average rate of applications for posts across the UK. The application numbers from overseas-qualified dentists continued to increase, with over 2,200 applicants for approximately 500 posts across the UK. As of September 2025, England-only data showed an improved fill rate for DCT, with year 1 filling 91% of positions, year 2 filling 88% and year 3 filling 88%.

98% of trainees satisfactorily completed DCT. The option for trainees to extend DCT was introduced in 2022. No postgraduates completing DCT in 2025 required an extension to their training and 2% resigned from their post during training.

Despite high fill rates in DCT, more can be done to improve trainee satisfaction. An earlier review of DCT posts found a variety of reasons for trainee dissatisfaction. Location, out-of-hours duties, specialty rotations and run through programmes all contributed. However, the relevance of each factor varied across regions.

All regions are now rolling out versions of early and middle years programmes to incorporate Joint Dental Foundation Core Training (JDFCT), a 2-year longitudinal programme combining primary (DFT) and secondary (DCT) care. Work continues with the General Dental Council (GDC) on the initial application and supervision requirements for temporary registrants performing local service duties in DCT posts.

Dental specialty training

As of September 2025, England-only data shows that most dental specialties have full recruitment. Oral surgery, orthodontics (ST1 and ST4), paediatric dentistry (ST1 and ST4), restorative dentistry, oral medicine, dental and maxillofacial radiology and oral and maxillofacial pathology all filled 100% of their posts. However, special care dentistry had notable gaps, filling only 76.9% of posts, which is nevertheless an improvement to last year (53.3% fill).

The under-recruitment in special care dentistry (SCD) continues to be of concern given the patient groups they care for, including the aging population and those with medical and behavioural conditions. Effective promotion of the specialty is essential to ensure awareness and uptake of the SCD pathway, given its relative newness as a career option. NHSE have worked to promote SCD as a potential career path and are working with the sector on future communications.

Dental education reform

The Dental Education Reform Programme (DERP) includes work to develop more flexible training experiences in varied settings, build better training pathways for dentists and dental care practitioners (DCPs) and support more multidisciplinary working. Evidence

suggests that dentists could be released for more complex work if other members of the dental team were working to their full scope of practice.

The DERP dental training distribution workstream has sought to address patients' issues around lack of access to dental services in some geographic areas by distributing growth in training posts to areas of high need.

DERP delivery to date includes:

- early Years Postgraduate Dental Training Programme - a new, 2-year training pathway has been implemented, with early adopter regions in England implementing this in 2024, and all regions implementing in 2025. The new training programme will embed a broader range of skills, knowledge, and experience in the dental workforce

- Middle Years Postgraduate Dental Training Programme - a curriculum for the Middle Years Programme is in final stages of development to support a 2-year training programme spanning DCT Years 2 and 3. This will provide rotational posts across the different dental specialties and better support for trainees to gain enhanced skills in their career progression to dental specialty training

- return to dental therapy - a task and finish group has developed a set of recommendations for a consistent return to dental therapy approach across England

- lead employer - a lead employer for all foundation trainees was procured to provide consistent, high-level employment conditions for trainees

4. Staff experience

Summary

In order to ensure that the NHS is able to recruit and retain staff we need to continue to work at pace to improve the experience of staff in the NHS workplace. There has been progress as illustrated by the People Promise Exemplar programme, which has seen positive progress in terms of a reduction in leaver rates by those participating in the scheme.

The government recognises that more needs to be done to make the NHS a great place to work and this chapter sets out the aims of the 10YHP and builds on the work led by NHSE and DHSC to address retention in the NHS workforce.

10YHP

Over a quarter of a million engagement insights were received during the development of the 10YHP. NHS staff contributing to the engagement exercises and shared their views that NHS staff are overworked, undervalued, burdened by bureaucracy and that there was not enough support for training and career development.

The 10YHP recognises the issues and concerns of NHS staff and the government will be taking forward actions to create a workforce that is more empowered, more flexible and more fulfilled. For example, a series of staff standards outlining minimum standards for modern employment will be introduced by April 2026. These standards will include access to nutritious food and drink, reducing violence against staff and standards of 'healthy work' and flexible working. The standards will be produced in collaboration with the Social Partnership Forum and underpinned by the NHS Oversight Framework. They will also act as an early warning signal for CQC.

Ensuring that the staff have the time to care for patients is incredibly important to staff and the 10YHP addresses the need to make the most of digital technology to free up more time. We have also addressed the issue of the burden of training and will cut unnecessary mandatory training, with work already underway by NHS England.

Retention

NHS England continues to lead on a range of programmes dedicated to improving retention. These programmes, particularly the People Promise Exemplar programme, recognise there are a wide range of factors that influence whether people choose to work in the NHS, including opportunities to work flexibly, career progression, access to learning and development and workforce pressures.

A review of the People Promise Exemplar programme published in March 2025 found that the numbers of leavers fell by an average of 11.8% for organisations involved in the pilot, with those implementing more interventions improving their leaver rates the most.

In addition to reducing leaver rates, evaluation of the People Promise Exemplar programme found improvements in staff engagement and morale, with exemplar organisations reporting greater gains in NHS Staff Survey scores compared to the wider NHS. The programme also delivered a positive return on investment and contributed to a greater reduction in agency costs. The most effective approaches combined multiple interventions, such as flexible working, e-rostering, and local listening sessions, supported by strong board-level engagement.

The exemplar programme is now in its fourth year and continues to build on interventions such as flexible working, reward and recognition incentives, and health and wellbeing to achieve improved outcomes for staff, organisations and patients.

Leaver rates data from NHSE is indicating positive progress with leaver rates for medical and dental staff declining, dropping from a peak of 10.7% in August 2023 to 9.3% in May 2025. The consultant leaver rate fell from 4.0% in April 2019 to 3.2% in May 2025, with a peak of 4.5% in April 2022. Similarly, the leaver rate for fully qualified GPs decreased from a peak of 8.9% in June 2022 to 6.2% in March 2025.

Early career retention

To reduce early attrition, NHS England is implementing a national framework including the Multi-profession Preceptorship Quality Mark, a 'Beyond Preceptorship' offer for years 2–5, and multi-professional communities of practice. In line with the Secretary of State's non-pay deal commitments, organisations must appoint an executive SRO and implement a local newly qualified healthcare registrant policy. While current data reflects AfC staff, the framework is being expanded to support newly qualified doctors and dentists, ensuring a consistent approach to early career retention across the NHS workforce.

Recent internal analysis indicates marked improvement in early career retention rates for nurses, midwives and allied health professionals, reflecting positive impact of these targeted support measures. For example, the first-year leaver rate for registered nurses has declined substantially over recent years, and similar improvements have been observed for midwives and AHPs. These trends highlight the value of sustained investment in structured transition support for early career staff. National preceptorship frameworks, including the multi-professional preceptorship framework, have played a key role in supporting newly qualified staff as they move into practice. Building on this foundation, ongoing efforts will continue to strengthen retention by embedding consistent, high-quality transition support across all staff groups.

NHS Staff Survey

The NHS Staff Survey remains a key national tool for understanding staff experience, engagement, and morale across secondary care. Participation of the NHS Staff Survey is mandatory for NHS trusts. The General Practice Staff Survey (GPSS) is voluntary and does not cover dental organisations.

In 2024 the NHS Staff Survey received, 774,828 responses, including 50,341 from medics. The 2025 survey closes on 28 November, with results expected in early spring 2026.

The staff engagement score for medics rose from 6.61 in 2022 to 6.75 in 2024, though it remains below the 2019 pre-pandemic level of 7.09. All sub-scores for medics (motivation,

involvement and advocacy) have improved over the past 3 years. However, variation persists across groups, with doctors in training staff engagement score lower than the national average at 6.48.

Scores improved across all people promise elements and in both the staff engagement and morale themes, with morale increasing by plus 0.15 to 5.86. Despite this, only 8 of 207 trusts showed notable improvement across all elements and themes, down from 46 in 2023. In total, 44 trusts declined across all 9 measures; none had done so the previous year.

Satisfaction with pay among medics increased from 32.05% in 2023 to 48.40% in 2024, which is greater than the AfC average of 30.89% although still below the 2019 pre-pandemic level of 58%. Medical and dental staff in training reported the lowest satisfaction at 26.41% compared to consultants at 59.61%. However, this is significantly higher than the lowest AfC occupational group nursing and healthcare assistants as 19.27%. Pay satisfaction remains lower among medics recruited from outside the UK (37.60%) compared to those recruited domestically (50.23%), though both groups saw improvement.

Recognition also improved, with the ‘We are recognised and rewarded’ score rising from 5.74 to 6.4. Ambulance trusts, which had the lowest recognition scores in 2019, reported the highest in 2023 and 2024, though the number of medics in these trusts is small.

National Quarterly Pulse Survey

The National Quarterly Pulse Survey (NQPS) provides timely insight into staff experience and engagement across the NHS, with around 110,000 responses per quarter since becoming mandatory in April 2022. The data set includes both medical and non-medical staff, it cannot be disaggregated by staff group.

Staff engagement peaked at 6.67 in Q2 2023 to 2024 but declined to 6.46 in Q2 2025 to 2026, the lowest score since the survey’s launch. This drop was sharper than typical seasonal variation and was largely driven by a fall in the advocacy sub-score, which declined from 6.65 to 6.37 between Q2 2024 to 2025 and Q1 2025 to 2026. This is the lowest recorded advocacy score to date.

All 3 sub-scores; motivation, advocacy, and involvement have declined since Q2 2024 to 2025. Evidence links lower advocacy to reduced patient satisfaction and increased leaver rates. Research also suggests that advocacy has the strongest influence on patient experience, including perceptions of access, communication and care quality.

National education and training survey

In 2024, around 43,000 health and care trainees, students and doctors and dentists in training responded to the national education and training survey (NETS). The results highlight several improvements in education and training quality across many key indicators, reflecting the work of NHS England quality teams, the dedication of the healthcare educator workforce, and the commitment of education and placement provider organisations to deliver high quality healthcare education and training. The results also describe a challenging situation for healthcare learners with increased levels of stress, burnout and feeling overwhelmed, with 30% considering leaving their course or training programme in 2024. However, this marks an improvement from 2023 (32%) with individuals citing stress, workload and being overwhelmed. Work needs to continue to focus on improving learner experience to support improved learner outcomes, patient experience and the retention of learners and subsequent NHS workforce.

From 2021 to 2024 there has been an upward trend in the number of learners reporting a positive experience in several areas including:

- overall educational experience 87% (84% in 2021)
- overall quality of supervision 89% (87% in 2021)
- induction 86% (83% in 2021)
- range of learning opportunities 86% (84% in 2021)
- ability to learn from other professions 88% (87% in 2021)
- access to health and wellbeing resources 76% (72% in 2022)

Less than half of all learners (41%) state the balance between the workload and their learning is about right which is a notable reduction from 2023 (57%) and 2022 (53%), while over half (58%) state their workload is either too busy or too quiet to get the learning opportunities they need. NHS England continues to work with placement providers, through the standards set out in the education quality framework, to understand the concerns around workload and actions to improve.

There have been considerable improvements with learners reporting awareness of who their local Freedom to Speak Up guardian is from 50% in 2021, 65% in 2022, 70% in 2023, and 76% in 2024. In total, 95% of learners also report knowing how to raise concerns with 81% feeling comfortable to do so.

Around 75% of learners would recommend their placement area to friends and colleagues as a place to work or train. This measure has steadily improved since 2021 and has now exceeded pre-pandemic levels of 74% in 2019.

The number of learners that would recommend their placement area to family and friends if they should require the care or treatment provided there has also improved in 2024 to 78% (77% in 2023).

Health and wellbeing

Sickness absence continues to rise and reached 5.53% in February 2025, higher than the pre-pandemic level of 4.4% in February 2018. This figure reflects system-wide sickness absence and is not disaggregated by staff group. However, it provides important context for the working environment of medical and dental staff. Mental health (26.4%) and musculoskeletal issues (13.1%) remain the most prominent reasons for absence, beyond seasonal or long-term conditions. Ambulance, nursing and midwifery, support to clinical and medical, and estates and support staff continue to report the highest levels of sickness.

While burnout and stress scores have improved slightly in the 2024 Staff Survey, perceptions of organisational support for wellbeing and presenteeism have declined.

NHS England's ‘Staff Treatment Access Review’ (STAR) identified an annual economic impact of over £2 billion due to mental health and MSK-related sickness, reinforcing the need for targeted interventions. Implementation of the STAR recommendations has begun, with ICS level treatment hubs being established to address common causes of sickness absence. National wellbeing offers are being scaled back in line with the operating framework, contributing to increased variation in local provision. Menopause support is now embedded in the broader health and wellbeing offer. This includes national guidance, an absence-recording guide, and 3 tailored e-learning modules. The uptake of the menopause line manager training has increased from 75% to 85%.

Improving doctors’ working lives’ programme (IWDL)

The IWDL aims to fulfil commitments, innovate models and tackle systemic issues to NHS Payroll Improvement Programme which aims to enhance payroll operations and in reforms to statutory and mandatory training which aims to optimise, rationalise and redesign training to improve outcomes. In addition, the statutory and staff movement MOU provides the ability for new starters, rotating doctors and bank workers to present prior training for acceptance by new employers, effective from 1 May 2025.

Violence prevention and reduction

Incidents of physical violence against NHS staff have increased, affecting over 205,000 staff annually. These figures reflect all NHS staff and are not broken down by staff group. However, they highlight the scale of the issue and the importance of system-wide prevention efforts. Levels of harassment and bullying reported in the NHS Staff Survey have slightly decreased but the issue of bullying and harassment remains a continuing area for concern. The violence prevention standard was refreshed in 2024, and NHS England is implementing the 2023 AfC non-pay agreement recommendations, including improvements to data, guidance, training and leadership development.

Flexible working

Flexible working infrastructure has strengthened across the NHS. The proportion of organisations with board-level champions rose from 51% in Q1 2023 to 2024 to 65% in Q4 2024 to 2025. Flexible working action plans increased from 28% to 43% over the same period, and the inclusion of flexible working in health and wellbeing training rose from 63% in Q1 2024 to 2025 to 70% in Q4 2024 to 2025. Staff confidence in approaching managers about flexible working improved from 65% in August 2024 to 73% in January 2025. The proportion of staff who believe their organisation champions flexible working increased from 41% in January 2023 to 54% in January 2025. Satisfaction with opportunities for flexible working patters is at a 5-year high with medical and dental occupation group scores improving by 4 percentage points to 49.66%.

While these figures reflect all staff groups, flexible working remains a key retention lever for the medical and dental workforce, particularly in supporting work-life balance and reducing burnout.

The 'We Work Flexibly' national flexible working score rose to 6.31 in 2024 from 6.28 the previous year. However, disparities persist between patient-facing and non-patient-facing roles. New national initiatives include a promotional campaign, refreshed staff and manager guidance, a 3-part e-learning series, and updated dashboards.

Culture

As previously mentioned, reports of harassment and bullying remain an area of concern. However, confidence in reporting such incidents has increased to 54%. The compassionate leadership score is now 7.08, with improvements noted in ambulance trusts. More staff feel valued by their teams, now at 69.88%. Although these figures are not specific to medical and dental staff, the Culture and Leadership Programme is open to all staff groups and supports inclusive leadership across the NHS. The Culture and Leadership Programme has expanded its reach, with 823 delegates from 131

organisations attending learning events and pilots launched across 3 integrated care systems (ICSs). To date, 5,165 members of staff have engaged with the CLP online training programme.

Freedom to speak up

In 2024 to 2025, 690 individuals were supported through Freedom to Speak Up, representing a 59% increase from the previous year. While this data is not disaggregated by staff group, it reflects a growing culture of psychological safety across the NHS, including among medical and dental staff. In total, 27 people received support through the Speak Up Support Scheme. Confidence in raising concerns about unsafe clinical practice has increased for the first time since 2021, rising from 71% to 72%, while other indicators have remained stable.

Equality, diversity and inclusion

The NHS equality, diversity and inclusion improvement plan (EDI IP), published in June 2023, aims to attract new talent, enhance staff experience and retain staff to help deliver the NHS Long Term Workforce Plan, the People Promise and the People Plan.

To further build system capability, NHS England hosted a series of learning events to support equality, diversity and inclusion (EDI) Leads and People Professionals, to explore how to use the EDI dashboard, an online platform hosted on the Model Health System, to influence local strategic decision making and measure impact of delivery.

In 2025, a 2-year review of the EDI Improvement Plan will be conducted, to review content and ensure the high impact actions and supporting metrics are aligned to the ambitions set out in the NHS 10 Year Health Plan and forthcoming 10 Year Workforce Plan.

NHS England will launch a bespoke EDI improvement plan for primary care in autumn 2025, which will outline a series of best practice ambitions that primary care organisations are asked to deliver to address some of the challenges and inequalities faced by staff.

Bullying and harassment

The percentage of staff experiencing harassment, bullying or abuse from other staff in the last 12 months was higher for Black and minority ethnic (BME) staff (24.9%) than for White staff (20.7%). Although disparities between the experiences of BME and White staff persist, the trend for harassment, bullying and abuse from staff has been largely downward since 2018. Source: NHS Workforce Race Equality Standard (WRES) for 2024

Career progression

There are signs of progress on representation in leadership positions, with the number of very senior managers in the NHS from Black and minority ethnic (BME) backgrounds increasing by 85% since 2018. However, 80% of trusts reported that White applicants were significantly more likely than BME applicants to be appointed from shortlisting. Only 42.3% of staff from a Black background believed their trust provides equal opportunities for career progression or promotion.

EDI should inform our clinical delivery and people management at all levels. Managers need to be given the tools to tackle discrimination, champion inclusivity and uplift their teams. NHS England partnered with Henley Business School to launch a bespoke Senior Leader Apprenticeship - Future Leaders for NHS colleagues, placing EDI at the heart of people management and patient care.

Pay gap reporting

High impact action 3 of the EDI IP sets out that NHS organisations should develop and implement an improvement plan to eliminate pay gaps.

Over the last 5 years, the UK gender pay gap has fallen by a fifth to 14.3 percent for all employees in 2023 and this includes the health and care sector. However, the gender pay gap still persists, with male health professionals, on average, still paid 10.2 per cent more than their female counterparts in 2023.

Sources:

ONS Gender Pay Gap in the UK:2023

The King's Fund 'Why there's still more work to be done in close the gender pay gap in the NHS and social care

Further to the Independent Review into Gender Pay Gaps in Medicine in England published in December 2020. NHS England commissioned the development of gender pay gap guidance to help systems to learn about the process of reporting and tools and resources to support the development of action plans to address your gender pay gaps locally.

To further address the gender pay gap NHS England has asked all lead employers of resident doctors in training to report annually on ethnicity and gender pay gaps.

NHS England has responded to the government's consultation regarding the Equality (Race and Disability) Bill, on introducing mandatory ethnicity and disability pay gap reporting and is awaiting the outcome.

From 2025 NHS workforce systems, such as the Electronic Staff Record, as well as our annual national workforce surveys, will capture socio-economic background information. This will allow organisations to further understand how reflective our workforce is of the communities we support and to improve how people experience recruitment, training and work in the NHS, supporting retention, productivity, patient care and economic growth.

Gender and ethnicity pay gaps

NHS England continue to be responsible for ethnicity, diversity and inclusion and do so through the both the WRES and their NHS EDI Improvement Plan. The plan set out a series of hight impact actions and includes one to address pay gaps in relation to gender, ethnicity and disability.

Work is continuing with the Gender Pay Gap in Medicine Implementation Panel, chaired by Professor Dame Jane Dacre. Steady progress is being made on the recommendations with a particular focus on culture, a factor in retaining women in the workforce. Although, the focus of the implementation panel is on the medical workforce, the recommendations do have an influence on the wider workforce particularly in relation to improving the working culture and career progression.

The Race and Health Observatory have announced a review into ethnicity pay gaps across the NHS. This will address the structural and systemic factors that contribute to ethnicity pay disparities in the NHS, with a view to informing practical and sustainable solutions.

Gender and ethnicity pay gaps in general practice

The Independent Review into Gender Pay Gaps in Medicine identified a wider gender pay gap among salaried GPs compared to hospital and community health service doctors, clinical academics and contractor GPs. Table ‘14. GPMS combined GP earnings by age and gender’ provides the most recent available data, comparing pay per head for men and women salaried GPs and contractor GPs in the same age bracket. However, this GP earnings and expenses estimates data has accuracy and quality limitations and accurate conclusions cannot be drawn from it. Comparing pay per full time equivalent (FTE) would give a better picture of the gender pay gap for salaried GPs, given the difference in average working hours between male and female salaried GPs.

The GP Earnings and Expenses Estimates data published by NHS England for 2023 to 2024 (the latest data available), contains a breakdown of GP earnings by ethnicity. Since May 2023, NHS England has published quarterly data on ethnicity of GPs by job role.

General practice staff survey

2024 was the second year that the NHS staff survey has been extended to general practice on a voluntary basis. The General Practice Staff Survey (GPSS) supports a ‘one workforce’ approach and aims to give a voice to staff working in general practice organisations. It provides standardised actionable data on staff experience, benefiting individual practices, PCNs and ICSs. However, year-on-year comparisons or trend analysis has not been provided in this evidence as the survey is not mandatory and as such the makeup of ICBs and participating practices differs annually. This data will help guide efforts to enhance recruitment and retention and mitigate the prevalence of burnout.

The introduction of the GPSS is a critical step toward implementing the WRES and the Workforce Disability Equality Standard (WDES) in primary care settings. National, ICB and PCN footprint reports include results against the survey questions, benchmarked against averages, as well as 4 of the 9 WRES and 5 of the 9 WDES indicators.

In 2024, 33 ICSs participated in the second year of the GPSS, and nearly 25% of practices in those systems shared staff lists. This created a survey sample of more than 1,700 organisations and 46,849 individuals, 38% of whom responded to the request to share their views. We expect the sample size and response rate to grow.

In 2024, the average staff engagement score for medics working in general practice was 7.66. The highest average engagement score was from partners at 8.33 and the lowest was from salaried GPs at 7.10. 53.23% of all medics working in general practice were satisfied with their level of pay. Locums had the greatest levels of satisfaction with pay at 59.67% and trainee GPs had the lowest satisfaction with pay at 38.98%. In 2024, 63.43% of medics in GP practices were satisfied with recognition for good work. Trainee GPs had the highest score in this area 76.05% whereas locums had the lowest score 52.83%.

Results for the GPSS are not publicly available. However, the move to a nationally provided survey for general practice is a positive shift. We know that listening to employee voices is a key enabler of employee engagement. Source: MacLeod and Clarke, 2009

GP workload and morale

The GP Worklife Survey is commissioned by DHSC and carried out by a team based at the University of Manchester, on behalf of the National Institute for Health Research’s (NIHR) Policy Research Unit in Health and Social Care Systems and Commissioning. The twelfth iteration of the GP Worklife Survey was carried out in autumn 2024 and includes responses from over 1,800 GPs.

The findings were published in July 2025 and show that overall job satisfaction has not changed between 2019 and 2024. GPs were asked to rate their satisfaction with 9 specific

domains, and to rate their ‘overall’ satisfaction. Ratings were provided on a 7-point scale, where 1 equals 'extremely dissatisfied', and 7 equals 'extremely satisfied'. In total, 58% of GPs reported being satisfied with their job overall, 22.2% reported being dissatisfied and 19.8% were neutral. The mean score on the 7-point scale showed satisfaction with remuneration has dropped by 0.37 points (49.8% of GPs satisfied, 31.0% of GPs dissatisfied). Recognition for good work also decreased by 0.19 as a mean score, and satisfaction with physical working conditions decreased by 0.18, all of which were statistically significant decreases. There were no other statistically significant changes from 2019. In questions about job stressors, more than 8 out of 10 GPs reported experiencing considerable or high pressure from ‘increasing workloads’ and ‘managing patients waiting for hospital treatment’.

GP retention

The government's commitment to growing the GP workforce includes doing more to address reasons GPs leave the profession. We recognise it is vital for roles to be satisfying, rewarding and sustainable so that our experienced GPs continue to contribute throughout their career. As described earlier in the evidence, the 10YHP describes how we will reform general practice to ensure better access for patients and a better experience for staff.

We know that workload is a key concern for GPs. To address this, the government has set out plans to reduce bureaucracy, ensuring GPs spend less time filling in forms and more time caring for patients. To this end, the government and NHS England launched a Red Tape Challenge to cut down on bureaucracy and free up time to spend with patients.

The 10YHP set out our commitment to delivering the top 10 recommendations of the ‘Red Tape Challenge’. These recommendations were a result of engagement across ICBs, stakeholder groups and networks, patients and carers and a diverse range of charities through our Health and Wellbeing Alliance, who highlighted these as the issues that mattered most to people. They focus on making improvements at the interface between primary and secondary care, a key cause of bureaucracy concern for GPs. NHS England regional teams will support ICBs and providers in taking these ideas forward in local systems. A series of case studies of work already happening to improve interface working have been shared and the GIRFT (Get It Right First Time) team have worked with ICBs involved in PCN test site pilots to produce new guidance: Bridging the gap between primary and secondary care, mental health and community service. 6-monthly self-assessment returns through ICBs will allow NHS England to be able to monitor uptake and analyse impacts.

This is in addition to the contract uplift for 2025 to 2026 investment of over £1 billion in the core contract and network contract DES covered earlier in this evidence. This includes uplift to ARRS funding.

Dentists' working patterns, motivation and morale

The most recent Dentists’ Working Patterns, Motivation and Morale survey was published on 25 April 2024. The headline information provided on working patterns, motivation, and morale for self-employed primary care dentists in England for 2022 to 2023 was included in the Department of Health and Social Care's written evidence to DDRB for the pay round 2025 to 2026.

5. NHS workforce groups

This chapter provides further detailed information on each of the groups within DDRB's remit. This includes information relating to pay arrangements, issues specific to particular groups and deals to end industrial disputes. The chapter also responds to some of the additional requests for information DDRB made in their last report setting out their recommendations on pay

Resident doctors in postgraduate training

In 2024, resident doctors' salary scales were increased by 6% plus a consolidated increase of £1,000, from 1 April 2024. In 2025, the government has accepted DDRB recommendation for a 4% increase to pay points plus an increase of £750 from 1 April 2025.

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

In July 2024, the government announced that an offer had been agreed with the BMA Junior Doctor Committee (now known as the Resident Doctor Committee) which ended the industrial dispute which had been ongoing since 2022. The details of this deal have been set out in previous publications of DDRB.

Resident doctors in postgraduate training

Data from 2025 shows that the NHS employs approximately 1.4 million FTE staff, including around 141,000 FTE qualified doctors. Qualified doctors in postgraduate training represent a diverse group, ranging from newly qualified foundation doctors to clinicians with over a decade of experience. There are currently around 75,600 doctors in postgraduate training in England, accounting for just over half of the medical workforce.

Medical Training Review and previous medical education reform initiatives

The 10YHP emphasises the need for a workforce that is adaptable, digitally literate, and able to deliver integrated, person-centred care across a range of settings. It also highlights

the importance of addressing health inequalities and ensuring that training and workforce planning are closely aligned with the changing needs of patients and populations.

Recognising these shifts, NHS England was commissioned by the Secretary of State to conduct a review into medical training.

Phase 1 of the Medical Training Review (MTR) has been a diagnostic listening phase, extensively engaging with stakeholders. There were over 7,000 responses (and 30,000 free text submissions) to a national call for evidence and input from all key stakeholder groups, including doctors in training, educators, national organisations, service providers and patients.

The review acknowledged that the UK's postgraduate medical training system continues to be internationally respected, supported by rigorous curricula and high standards. However, it also highlighted a number of pressing and systemic challenges within the training environment that need to be addressed to ensure the system remains responsive and sustainable.

While concerns around pay were noted in some contexts, these are governed by separate national frameworks and fall outside the scope of this review. The review's focus is on identifying and addressing training-related issues, such as access, structure, support and progression, where policy solutions can have the most meaningful impact.

Key challenges raised by stakeholders included:

- increasing competition for training posts at key transition points, leading to bottlenecks and limited development opportunities for many doctors
- instability caused by frequent rotations
- rigidity and lack of flexibility in training pathways
- service pressures that often override educational needs
- variable quality and inclusion across regions and specialties
- curricula that are slow to adapt to digital, community, and population health needs

Future reforms will be explicitly informed by the results and evaluation of these programmes (such as the Enhance Generalist Skills Programme, Less Than Full Time Training reforms, the introduction of Out of Programme Pause and Flexible Portfolio Training, alongside the redistribution of training places), ensuring that what has worked well is embedded, persistent challenges are addressed, and new models are developed in a coherent and joined-up way.

Looking ahead, phase 2 of the MTR will focus on the co-design and prioritisation of reform options. This next phase will involve working closely with stakeholders to develop, test, and implement new models for postgraduate medical training, building on the diagnostic findings and engagement from phase 1.

The aim is to deliver a clear, actionable plan for system-wide reform over the next 5 to10 years, ensuring that future training pathways are flexible, inclusive and aligned with the ambitions of the NHS 10YHP and that they support both the needs of the workforce and the evolving needs of patients and populations.

The recommendations from the medical training review are currently being considered and will undergo further engagement and consensus-building. Encouragingly, the evidence highlights a clear opportunity for meaningful, system-wide education reform to ensure the training model is equipped to meet the evolving needs of the NHS workforce in the years ahead.

Rotations Review

The Rotations Review was a commitment made under the 2024 pay deal agreed between the government and BMA. As of August 2025, the review work is ongoing and it responds to longstanding concerns from doctors in training about the impact of frequent rotations on wellbeing, continuity of care and workforce stability. These concerns were strongly reflected in the BMA's 2025 survey of doctors in training, which highlighted the disruption to personal lives, challenges for those with caring responsibilities or disabilities, and difficulties in building relationships with teams and patients caused by frequent moves between placements. The findings from the diagnostic phase of the MTR will further support and reinforce these survey results, with extensive stakeholder engagement confirming that the current rotations model can undermine wellbeing, continuity, and retention, particularly in rural and underserved areas.

Once complete, the intention is for the findings and recommendations from the Rotations Review to be fully integrated into the next phase of the MTR and the broader NHS workforce reform programme, supporting the ambitions of the 10YHP and the commitments made following the 2023 to 2024 industrial action. The 10YHP announced a review of medical training in England, led by Professor Sir Chris Witty and Professor Sir Stephen Powis to modernise postgraduate medical education. The 10YHP also promises to prioritise medical graduates for foundation training as well as specialty training. Furthermore, it commits to creating 1,000 new specialty training posts over the next 3 years, focusing on specialties where there is the greatest need.

The foundation programme

A new allocation model for medical graduates applying to the foundation programme was introduced in 2024. This gives applicants a computer-generated ranking based on their geographic preference, removing the need to sit a situational judgment test.

The aim was to give more graduates their first-preference location, reduce bias and promote fairness. The new allocation model has been successful in placing more applicants in their first-choice locations in 2024 and 2025. All 10,634 eligible applicants for the 2025 foundation programme were allocated to a foundation school, with 84% of those applicants getting their first preference. This is an improvement on 2024 when 9,702 applicants were placed and 75% got their first preference.

The higher proportion of first-preference placements and the more even distribution of overseas applicants has resulted in a more consistent withdrawal rate across the country and reduced vacancy hotspots in less popular regions or trusts. NHS England will continue to review and improve the allocation methodology based on the data for 2024 and 2025.

Applications to the foundation programme have increased substantially over recent years. This has been fed in part by immigration rule changes leading to an increase in eligibility to work in the UK and so an increase in international applicants, and also by expansions of government-funded medical school places and an increase in graduates from medical schools in England that do not receive government funding. The total number of applicants grew from 7,963 in 2020 to 11,205 in 2025.

GP specialty training

NHS England continues to expand the GP Specialty Training (GPST) programme. An additional 250 places will be available from September 2025, bringing the total number of training places to 4,250 and the 10YHP commits to train thousands more GPs in the coming years. Historic fill rates for 2024 round 1 and 2 of medical specialty recruitment are publicly available and included in the supporting data pack. Round 3 recruitment data is not published but we can confirm that a total of 4,000 GPST places were filled in 2024 across the recruitment rounds.

Previously, NHS England offered a one-off payment of £20,000 to GP specialty trainees committed to working in a select number of training locations in England that either had a history of under-recruitment or are in under-doctored or deprived areas under the Targeted Enhanced Recruitment Scheme (TERS). The scheme was designed to test whether additional financial incentives could improve workforce supply in areas facing the severest recruitment pressures. From 2025, DHSC and NHS England agreed to stop the scheme due to record numbers of applicants applying to GPST, including in those areas where take up has been historically low, meaning that there is not currently a need for financial

incentives to fill GPST places. We will monitor the continued impact of removing TERS on application rates including to those areas previously targeted by the scheme.

Addressing bottlenecks in postgraduate training

Over recent years there has also been an increase in the numbers of eligible domestic and international applicants for specialty training, increasing the application ratios from 1.9 applications per place in 2019, to nearly 5 per place in 2024. The increasing competition for training posts has led to bottlenecks and limited development opportunities for many doctors.

To address this, the 10YHP has committed to create 1,000 new specialty training posts with a focus on specialties where there is greatest need.

We are working to explore how to ensure UK medical graduates progress into foundation training then into specialty training along with other doctors who have worked in the NHS for a significant period.

Lead employer arrangements

Resident doctors have long expressed frustration with the need to complete new employment checks every time they rotate to a different NHS trust, a process that is time-consuming and prone to administrative errors such as payroll issues, delays in system access and inconsistent employment terms.

Although the Lead Employer Model (LEM) has been proposed as a solution for several years, its adoption has been inconsistent across regions, continuing to place unnecessary strain on doctors in training.

To address this, NHS England has launched a national project in partnership with KPMG to design a comprehensive and financially sustainable roadmap for expanding LEM coverage to all resident doctors, supported by a robust business case outlining the operational, financial and workforce benefits.

The project is structured around 4 key workstreams:

1. contracts and procurement, which will develop a scalable and legally sound contracting framework

2. costing and funding, focused on detailed financial modelling to assess costs and potential savings

3. service catalogue requirements and pricing, which will define the core services and pricing models for Lead Employers

4. business case and roadmap for expansion, which will deliver a compelling case for national rollout, complete with timelines, milestones and governance arrangements.

Payroll improvement programme

We know that due to the need for frequent rotation, resident doctors experience a disproportionally high level of payroll errors. In June 2024, NHS England launched a Payroll Improvement Programme to reduce payroll errors across 31 NHS trusts, delivering significant results including a 48% reduction in pay error rates across 27 trusts reporting monthly KPIs, a 72% reduction in 5 trusts receiving targeted support and a £0.6 million monthly reduction in overpayments, equating to a potential £7.2 million for the NHS if annual saving are sustained.

Following publication of the 10 point plan, NHS England is now moving to national rollout of the payroll improvement programme. This next phase will include expanding the existing dashboard, developing a data collection tool to track benefits and share insights, prioritising rollout in areas of greatest need, creating targeted communications (including for resident doctors) and completing the full programme of engagement and development by March 2026.

Reform of exception reporting processes

Under the 2024 pay deal, it was agreed that the exception reporting system would be reformed based around 12 principles set out in the deal language. NHS Employers, the government and the British Medical Association Resident Doctor Committee (BMA RDC) have agreed the changes and published a new terms and conditions for the 2016 Doctors and Dentists in Training contract on 19 September. This new contract and the associated reformed system will be implemented in all trusts in England by 4 February 2026.

The reformed process aims to remove perceived barriers that previously discouraged reporting, ensuring employers can address concerns as they arise and doctors are fairly compensated for additional hours worked while maintaining safe working hours and patient safety. It also introduces measures to provide timely access to systems and restrictions on unnecessary sharing of personal information.

Resident doctors will be better supported to report exceptions, with a simplified process. The Guardian of Safe Working Hours will continue to oversee all exception systems, ensuring consistency and accountability.

Trust leadership

Trusts across the NHS have reported encouraging local progress in improving the working lives of resident doctors, with initiatives ranging from enhanced sexual safety and wellbeing measures to upgrades in local facilities such as doctors’ messes, on-call rooms,

and car parking. In 2024, trusts were asked to appoint a nominated resident doctor lead to address and escalate issues, and 90% of those surveyed confirmed they had done so, with these leads reporting directly to trust boards.

Looking ahead, all trusts will be expected to maintain a senior named individual in this role and ensure that resident doctor issues are regularly discussed at board level, informed by national and local data sources such as the General Medical Council (GMC) National Training Survey and Guardian of Safe Working reports. Boards will also be required to develop local improvement plans with the same rigour as staff survey responses and complete a Board Assurance Framework, which will be included in each trust's annual report.

Study leave and upfront payment of course fees

We have made it easier for resident doctors to pursue continuous professional development by making sure they are reimbursed immediately for courses when they book, rather than on completion. A 'fast reimbursement' approach has been put in place, which allows for reimbursement upon booking (as opposed to completion of courses). Work is being undertaken which will allow for the creation of a digital solution to allow upfront payments, it is intended that this new system is launched during the autumn of 2025.

Statutory and mandatory training reform

A common frustration for Resident Doctors is the repeated completion of core statutory and mandatory training each time they rotate to a new employer, even when still within compliance periods. This duplication wastes valuable time and contributes to administrative burden. To address this, a national reform was introduced on 1 May 2025, with 262 NHS organisations in England; including all provider trusts, ICBs, CICs, CSUs, and most national bodies, signing a Memorandum of Understanding (MOU) to accept prior training aligned with the Core Skills Training Framework (CSTF). This includes 11 CSTF subjects plus Learning Disabilities and Autism (LD&A).

This agreement marks a significant step forward in reducing unnecessary training repetition, helping to redirect an estimated 6,000 hours of resident doctor time each month back into patient care. It also addresses a key point of contention for doctors in training, supporting a more efficient and consistent approach to workforce development across the NHS.

Rota code of practice compliance

NHS England is working to improve the timeliness and consistency of work schedule and rota processes for resident doctors, supported by enhanced information sharing with trusts ahead of rotations.

The aim is to ensure that all key milestones set out within the Rota Code of Practice is adhered to and detailed roster information provided in a timely manner, helping to reduce uncertainty and improve workforce planning.

While current monitoring shows 91% compliance with the 12-week allocation target, NHS England will begin to track performance across all stages of the process and report on national trends.

To support this, data collection will take place twice a year, focusing on doctors who start or rotate in February and August. Trusts are expected to ensure compliance with these standards and take corrective action where needed, with board-level oversight encouraged to maintain accountability and drive improvement.

Locally employed doctors (LEDs)

LED Blueprint for Change

The NHS England LED Blueprint for Change, co-produced with LEDs and stakeholders sets out targeted high-impact actions to address the challenges facing LEDs. Many of these high-impact actions aim to enhance existing medical training and career pathways, so there is a wider range of more flexible opportunities available to the LED medical workforce from early in their careers. NHS England and its partners will ensure the LED role is supported, developed and enabled as a viable medical career pathway.

The GMC's Workplace Experiences Report (2024) highlights that LEDs are the group of doctors most likely to have taken concrete steps toward leaving their roles and, in comparison with other groups, fewer LEDs felt part of a supportive team.

In response, the LED Blueprint for Change contains high-impact actions trusts can take to improve the experience of LEDs by improving opportunities for progression, skills development, induction and access to educational opportunities, while creating a culture that fosters inclusion and belonging.

As we have set out in previous evidence, centrally held information on locally employed doctors (LEDs) is limited. It is difficult to gain a completely accurate picture of the numbers of locally employed doctors due to the different ESR codes utilised by employers for these staff. However, table 10 below uses an analysis of ESR data to set out the proportions of doctors in various contractual arrangements in the years 2022 to 2023 and 2024 to 2025.

Table 10: estimated HCHS medical workforce split by grade and contract status average for 2022 to 2023 and 2024 to 2025

Role	2022 to 2023 estimated FTE	2022 to 2023 estimated FTE share	2024 to 2025 estimated FTE	2024 to 2025 estimated FTE share
Consultants (open contracts)	53,952	41%	57,845	40%
SAS - specialist contract (open contracts)	483	0%	1,255	1%
SAS - specialty contract (open contracts)	3,207	2%	5,811	4%
Resident doctor - 2016 contract (open contracts)	45,409	35%	50,591	35%
Resident dentist - 2016 contract (open contracts)	273	0%	326	0%
Closed grades	17,528	13%	13,246	9%
Trust grades (LEDs)		7%		10%

	9,776		14,763	
Other	40	0%	29	0%

Table 10 shows that on average in 2022 to 2023, only 7% of the medical workforce were employed on 'trust grades', which could be alternatively described as LEDs. However, in the year 2024 to 2025, the average rises to 10%, showing a gradual increase in LEDs over the last 2 years.

It is our understanding that the majority of LEDs are employed on terms and conditions which mirror national contracts and national pay scales. We believe that these posts are likely to be occupied by doctors who have stepped out of formal training, many of whom will return to training when the time is right. This arrangement allows flexibility for doctors to continue to provide service to the NHS and build their experience while taking a pause from training. This of course also benefits employers who can maintain retention of experience doctors which ultimately benefits patients.

The increase in locally employed doctors would become concerning in a certain set of circumstances: either if significant numbers of doctors were feeling 'forced' into taking time out of training due to a lack of suitable opportunities, or if doctors on local contracts were being treated unfavourably compared to those on national contracts. We do not believe these circumstances are the case and that the above discussion highlights the likely circumstances, however we are keen to do more to understand the picture on the ground, for example, through the work looking into training bottlenecks.

As part of the deal agreed for SAS doctors in England, DHSC, NHS England and NHS Employers committed to undertaking a joint piece of work with BMA to determine how LEDs can be better supported to progress in their careers. Guidance on how LEDs can be better supported to progress in their careers has been prepared and is progressing.

Speciality and specialist doctors (SAS)

In 2024, salary scales for specialty and specialist doctors on the 2021 contracts, and for the staff grade, specialty and associate specialist group of practitioners on pre-2021 contracts, were increased by 6% to basic pay from 1 April 2024. In 2025, salary scales for specialty and specialist doctors on the 2021 contracts, and for the staff grade, specialty and associate specialist group of practitioners on pre-2021 contracts, were increased by 4% to basic pay from 1 April 2025.

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

2024 SAS deal

In 2024, the government made a pay and reform offer to the BMA to bring an end to the industrial dispute with SAS doctors. The offer provided uplifts to pay points on the 2021 contracts aimed at reducing unintended divergence between pays scales and a £1,400 consolidated uplift to pay scales on all pre-2021 contracts.

The SAS Deal Implementation Group was created in August 2024 to act as a temporary subgroup of JNC (SAS) to provide oversight of the implementation of the offer negotiated between government, employers and the BMA in June 2024. The group is temporary and focused on implementation. Once implementation of the deal is concluded, monitoring will be part of the normal governance arrangements of JNC(SAS). The SAS Deal Implementation Group is currently stood down.

New contracts

The latest figures to May 2025 show that 67% of specialty doctors are now on the new 2021 contract, an increase from 54% to May 2024. Since April 2021, about 14% of all doctors on the 2021 specialty doctor contract were on the 2008 contract the month before they transferred. Due to data limitations, previous contracts have only been identified for roughly half of specialty doctors on the 2021 contract.

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

One of the key outputs of the SAS Deal Implementation Group is producing guidance for a process for LED doctors to move to a SAS contract. This transfer guidance will allow LEDs working substantively in an NHS trust, who meet the professional requirements to transfer to a SAS contract. The guidance is currently under revisions before being presented to the department and NHS Employers for consideration.

Specialist grade

The specialist grade was introduced as part of the multi-year agreement in 2021. The intention behind opening the grade was to provide career progression opportunities for skilled and experienced SAS doctors. Specialist posts are created by employers where

there is a service need for expert clinical decision makers in a specialised area. The posts are filled through fair and open recruitment.

The 10YHP recognises the importance of specialists and states 'we will work with stakeholders to ensure a more streamlined and predictable pathway is in place for experienced specialty doctors to develop and operate at a specialist level.'

Since the new grade was introduced, the number of specialists has been steadily increasing. As of May 2025, there are a total of just over 1,600 specialist doctors. In the 24 months to May 2025, the number of specialist doctors increased on average by 33 each month.

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

Since April 2021 around 40% of all specialist doctors were on one of the 2 specialty doctor contracts the month before they transferred and around 8% were on the Associate Specialist grade the month before they transferred. Due to data limitations, previous contracts have only been identified for roughly three-quarters of specialists.

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

Furthermore, the department commissioned a piece of research to understand why more specialist roles are not being created. The SAS Deal Implementation Group is currently considering recommendations and deciding how they can be taken forward.

Supporting the career development and progression of SAS doctors

Concerns around opportunities for career support and development have consistently been raised by SAS doctors over a number of years. As mentioned above, this was the impetus for introducing the specialist grade in 2021 and the commitment to improving development is reiterated in the 10YHP.

The SAS development guidance will be published in Autumn 2025. This guidance has been revised to specifically support career progression for SAS doctors and ensure that for speciality doctors undertaking a specialist role have the acting up clause in the terms and conditions utilised.

SAS excellence in development (SEiD) award

NHS England is working with partners to deliver the SAS Excellence in Development (SEiD) Award, which is a recognition award in the form of a digital badge. This will formally recognise trusts that are meeting specific outcomes in promoting an inclusive culture and supporting the development and retention of their SAS workforce. Due to launch in spring 2026, this recognition award, opening for self-assessment applications from autumn 2025, will be a valuable recruitment and retention tool for this cohort of the medical workforce.

Consultants

In 2024, salary scales for medical consultants were increased by 6% to basic pay from 1 April 2024. In 2025, salary scales for medical consultants were increased by 4% to basic pay from 1 April 2025.

NHS consultants are senior doctors who have completed full medical training in a specialised area of medicine and are listed on the GMC's specialist register. Since the year 2022 to 2023, consultant FTE in NHS trusts and core organisations has grown by 7.5%, from an average of around 53,800 in 2022 to 2023 to an average of 57,900 in the year 2024 to 2025.

2024 consultant deal

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

One element of the 2024 consultant deal was an agreement for the BMA to not promote the BMA rate card for consultants in England, although the BMA reserved the right to re-introduce the BMA rate card for consultants in the event of a future industrial dispute. Thus, the BMA consultant and SAS committees reinstated their rate cards following the PRB announcement on 22 May 2025.

Consultant job plans

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

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

The advisory committee on clinical impact awards (ACCIA) only collects data from a small proportion of the consultant population (around 2% annually) and relies on self-reporting of programmed activities worked, so the information they have available is not representative of the consultant workforce.

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

National clinical impact awards

The reformed National Clinical Impact Awards (NCIA) scheme was launched in 2022. The new scheme was introduced to broaden access and was based on a public consultation in 2021, recommendations by DDRB in 2012 and wider evidence including the Gender Pay Gap in Medicine Review. The reforms included increasing the number of awards available, changing awards values, making payments non-consolidated and non-pensionable and removing the pro-rating of less than full time (LTFT) applicants.

Since this, ACCIA has seen success rates increase from 29.3% in the 2021 award round (legacy scheme) to an average of 47% from 2022 to 2024. Less than full time applicants also now make-up 17% of clinicians awarded an NCIA since 2022, including several younger consultants with no prior national award, some of whom have received the highest level of national award on their first application to the scheme.

Moreover, on the back of NHS Pension scheme changes, ACCIA introduced changes to enable senior experienced clinicians who would have lost their award when accessing pension benefits to continue receiving an award, providing they continue to deliver services in the NHS. As a result, around 13% of the total award holders, who would have otherwise lost their award, remain in the scheme and continue making an impact on the health service.

Our award holders are leaders and innovators from various specialties and are spread across the country, with the highest success rate being achieved by West Midlands (49.1%) in 2022, Cheshire and Mersey (48.9%) in 2023 and East of England (55.6%) in 2024.

Awards are granted to applicants from major teaching hospitals, medical schools, smaller trusts in under doctored areas and increasingly consultants employed by organisations such as charities who deliver contracted out NHS services. Examples of recognised work

have included nationwide treatment pathway changes and reviews, research that has fundamentally changed national and international guidelines and introduction of new therapies that have positively impacted patients globally. Award holders have also served as role models and mentors for other clinicians, providing training and mentorship.

ACCIA runs a yearly feedback exercise for applicants following the application window closure. In 2025, of those who responded, 98% of applicants highlighted that they would feel validated and recognised if they received an NCIA for their hard work and commitment to the NHS. Consultant responses demonstrate that they continue to value the scheme for its purpose of recognising and rewarding those who go above and beyond their contractual duties to significantly impact the NHS at a national level.

The government is considering DDRB's 2024 recommendations and will inform DDRB once a decision has been made. We ask DDRB to not make further recommendations on award values until we can fully understand the impact of the uplifts. Contractual transition arrangements for legacy award holders mean that the impact of uplifts to NCIAs are not felt by all award holders, but this position will change over time.

Equalities data

ACCIA publishes annual reports providing detailed summaries of the equalities data collected from applicants. The application portal introduced alongside the reformed scheme in 2022 collects information on all 9 protected characteristics set out in the Equality Act 2010. All diversity data are self-reported by applicants and there is an option to not declare for every option.

Source: Annual report for the 2024 award round

We are currently mid-cycle for the 2025 awards rounds and expect to publish the 2025 annual report in 2026.

We have completed 3 full cycles of the reformed scheme and have seen positive advances towards our inclusivity goals.

In 2024, 82.7% of new awards were given to applicants with no previous award. Additionally, we have seen a marked increase in earlier career consultants applying with success rates of 35 to 44-year-old age group increasing from 26.9% in 2023 to 44.4% in 2024.

In 2024, we received 37.1% of applications from females and 61.2% from males in England and Wales, showing a 3.6% rise in the proportion of applications from female consultants in 2023. Moreover, for the first time ever, female applicants achieved higher overall success rates than male applicants (49.0% versus 48.8%).

Looking at ethnicity data, the application pool now broadly resembles the wider consultant population. White ethnic groups make up 56% of applications, whereas all other ethnic groups combined represent 41.6%%. 2.4% preferred not to say.

ACCIA recognises that, although there have been many positive advancements, disparities in outcomes are still present. We continue to work towards providing a scheme that attracts applications and grants awards that are representative of the wider consultant population.

General medical practitioners (GPs)

In 2024, the minimum and maximum of the pay range for salaried GPs employed on the salaried GP contract were increased by 6% to £73,113 and £110,330 respectively from 1 April 2024. In 2025, the minimum and maximum of the pay range for salaried GPs employed on the salaried GP contract were increased by 4% to £76,038 and £114,743 respectively from 1 April 2025.

DDRB provide recommendations on the minimum and maximum pay range for salaried GPs and earnings uplifts for contractor and salaried GPs. The GP Educator Pay Scale and the GP Trainer Grant is usually uplifted by the same amount as the pay recommendation for salaried GPs; it is recommended that this continues. Government usually provides an increase to core funding for practices to allow the pay uplift to be passed on to salaried and contractor GPs. The additional funding will also allow general practice contractors to implement pay rises for other salaried general practice staff in line with the uplift in funding they receive. Recommendations will need to be informed by affordability and the contract resources available to practices. This information will also inform GP practice decisions about the pay of their salaried GPs and other practice staff.

Most GPs partners work under General Medical Services (GMS) contracts as independent contractors. They are self-employed or members of partnerships running their own practices as small businesses. As of 31 March 2024, there were 1,520 Personal Medical Services (PMS) contracts (23.4% of all contracts). Any uplifts in investment for PMS contracts are a matter for local commissioners to consider. In addition, a small number of GPs work, or hold contracts, under a locally contracted Alternative Provider Medical Services (APMS) arrangement across 334 practices (5.1% of all contracts).

Recruitment and retention

General practices, as independent contractors, are responsible for recruitment decisions. However, in response to concerns from the GP profession of fewer employment opportunities for recently qualified GPs, GPs within 2 years of CCT were added to the

Additional Roles Reimbursement Scheme from October 2024 as discussed in chapter 2. Over 2,000 recently qualified GPs have now been recruited with ARRS funding.

To increase the supply of qualified GPs, NHS England continues to fund the GP Return to Practice Programme, which provides a route for qualified GPs to return to NHS general practice in England, and the GP International Induction Programme, which offers a supported pathway for overseas qualified GPs to be inducted safely into NHS general practice.

Information on the national retention offer is covered in the retention section of our evidence.

GP leavers, joiners, turnover and vacancies

In their 2024 evidence, NHS England provided an overview of work to improve the data on the movement of GPs. This includes data published quarterly on GP joiners and leavers (also included in the supporting data pack), previous and next roles of partner and salaried GPs and the progress of GPs from training into fully qualified general practice roles.

As practices do not have fixed establishment positions against which they report vacancies, we do not collect and publish data on vacancies in general practice. NHS England previously published high-level figures on vacancies reported by practices through the National Workforce Reporting Service, however as the completeness and coverage of the data were very low this analysis was suspended.

Working hours

Data on work commitments of GPs is included in the supporting data pack. This uses information on contracted hours recorded by practices and PCNs through the National Workforce Reporting Service (NWRS). However, we know that this will not give a complete view of how and where GPs work. Some GPs will also work as locums in addition to their salaried role: NWRS data shows that in April 2025, of the 2,307 individual ad hoc GP locums reported by practices, 27% were also found in another GP role.

Additionally, in the Twelfth GP Worklife Survey, 62% of GPs surveyed reported performing work other than their GP role. 49% of GPs reported additional work for the NHS including research, as GP trainers or other medical education work, as prison doctors, as GP appraisers, in management roles in a PCN and as GPs with special interests. These are all valuable contributions to NHS general practice. We do not collect data on the proportion of doctors providing private GP services.

GP partners

We recognise that fewer GPs are going into partnership, and that the partnership model is not the only model currently delivering general practice. GP practices can and do choose to organise themselves in different ways, many of which have evidence of good outcomes in terms of staff engagement and patient experience.

Where the traditional GP partnership model is working well, it should continue. But through the delivery of the 10YHP we want to create an alternative that supports the neighbourhood health model, provides resilience and allows economies of scale - securing the sustainability of general practice into the future.

As stated in the plan, we will develop 2 new contracts enabling general practice to work over larger geographies. The single neighbourhood contract will build on GMS and PCN arrangements to deliver enhanced services for groups with similar needs over a neighbourhood of around 50,000 people. The multi-neighbourhood contract will enable larger providers to deliver care across multiple neighbourhoods with a total population of around 250,000 or more. These providers will unlock the benefits of at-scale working - offering improvement support to practices, easing administrative burdens through shared back-office functions and supporting digital transformation and data insights. They can draw from experience to actively support and coach individual practices on finances or performance, including running a practice if necessary.

In addition to the 2 new contracts, we have also committed to working with the GPCE on substantive reform of the GMS contract within the parliament following GPCE's acceptance of the 2025 to 2026 contract.

GP educators

In their 2024 report, DDRB requested information on whether appropriate rewards and incentives are in place for experienced members of the medical profession to deliver the required increase in GP training. We know GP educators are under pressure. The GMC's The State of Medical Education and Practice in the UK Workplace Experiences (2024) report found that GPs with training responsibilities were under more pressure than their non-trainer colleagues and the National Training Survey (2025) found that 47% of trainers were at high or moderate risk of burnout. Around 60% of GP trainers said they always or often felt worn out at the end of a working day, a reduction of 8 percentage points from 2024. Anecdotal feedback suggests that the additional income provided by the GP trainer grant and the GP Educator pay scale is not considered sufficient recompense for the increased workload, and that recruitment is becoming more challenging.

Information on work to improve retention of experienced GPs is set out in chapter 4 alongside the update on the Educator Workforce Strategy included in this chapter. In addition, NHS England has developed a 'Shape the Future of Primary Care' campaign to

promote the benefits of becoming a trainer in primary care - communicating how trainers and learning environments are shaping the future of primary care.

General dental practitioners

In 2024, the pay scales for salaried primary care dental staff have been increased by 6% to basic pay from 1 April 2024. In 2025, the pay scales for salaried primary care dental staff have been increased by 4% to basic pay from 1 April 2025.

Providers of primary care dental services are individuals or corporate bodies who hold a contract with the NHS. NHS dentists can be either performer only (also known as associates), who subcontract with or are employed by dental contract holders to deliver NHS dentistry; or providing-performers (contract holders who perform NHS dentistry). Dentists can also offer private care alongside NHS services.

Dental workforce data

As of August 2025, there are 37,604 dentists registered with the General Dental Council.

24,543 dentists performed NHS activity (any amount over 1 unit of dental activity) during 2024 to 2025, an increase of 350 (plus 1.4%) on the previous year and 133 fewer than the number who performed NHS work in 2019 to 2020.

The number of dentists per 100,000 population in England was 42 in 2024 to 2025, the same as in 2023 to 2024. However, the number of dentists per 100,000 population varies across England by ICB.

NHS England published findings from its dental workforce data collection on 17 July 2025. The publication indicates that, as of December 2024, 10,727 FTE general dentists are delivering dental services for the NHS, a 1.8% increase since March 2024. Nationally, the vacancy rate for NHS general dentists is 19%, with 2,516 FTE vacancies, down 2 percentage points since March 2024. The region with the highest NHS vacancy rates for general dentist posts is the South West, with a vacancy rate of 33%; London has the lowest NHS vacancy rates at 11%. This data can be found on the NHS website:: dental workforce statistics.

The 2024 to 2025 NHS dental statistics continue to show a positive trend in the recovery of NHS dentistry following the reduction in access that started during pandemic. 18.5 million adults were seen by an NHS dentist in the 24 months up to 30 June 2025, an increase of 55,000 (0.3%) when compared to the previous year. 7 million children were seen by an NHS dentist in the 12 months up to 30 June 2025, an increase of 260,000 (3.8%) when compared to the previous year.

Furthermore, 35.4 million courses of treatment were delivered in 2024 to 2025, an increase of 3.8% compared to the previous year. In total, 49.3% of courses of treatment were delivered to non-paying adults and children in 2024 to 2025 compared to 48.6% for 2023 to 2024.

Table 5 shows the number of dentists with NHS activity by dentist type, including as a percentage of the total, from 2019 to 2020 and 2024 to 2025.

Dentist type	2019 to 2020	2024 to 2025	% of total (2019 to 2020)	% of total (2024 to 2025)
Providing performer	4,850	4,383	19.7%	17.9%
Associate (performer)	19,786	20,155	80.2%	82.1%
Unknown	40	5	0.2%	0.0%
Total	24,676	24,543	100%	100%

Source: NHS BSA, Dental Statistics 2024/25, Workforce Overview, table 1b

Table 6 shows the number of dentists with NHS activity by dentist type, from 2019 to 2020 through to 2024 to 2025.

Dentist type	2019 to 2020	2020 to 2021	2021 to 2022	2022 to 2023	2023 to 2024	2024 to 2025
Providing performer	4,850	4,684	4,752	4,604	4,458	4,383
Associate (performer)	19,786	19,024	19,485	19,512	19,714	20,155
Unknown	40	25	28	35	21	5
Total	24,676	23,733	24,265	24,151	24,193	24,543

Source: NHS BSA, Dental Statistics 2024/25, Workforce Overview, table 1b

Demographics

As of 2024 to 2025, there were more female dentists performing NHS dental activity than males, with a headcount of 13,422 females (54.7%) compared to 11,121 males (45.3%). By comparison, in 2019 to 2020 there were still more female dentists performing NHS dental activity than males, though by a smaller proportion (51.3% female to 48.7% male).

In 2024 to 2025, the age group with the highest proportion of female dentists was the under 35 band (60.7%). The age group with the highest proportion of male dentists was the 55 or over band (65.9%).

Table 7 shows the number of dentists with NHS activity by gender, from 2019 to 2020 through to 2024 to 2025.

Dentist gender	2019 to 2020	2020 to 2021	2021 to 2022	2022 to 2023	2023 to 2024	2024 to 2025
Female	12,654	12,301	12,775	12,931	13,172	13,422
Male	12,022	11,432	11,490	11,220	11,021	11,121
Total	24,676	23,733	24,265	24,151	24,193	24,543

Source: NHS BSA, Dental Statistics 2024/25, Workforce Overview, table 1c

Table 8 shows the percentage of dentists with NHS activity by gender across age groups, for 2024 to 2025.

Age band	Female	Male
Under 35	60.7%	39.3%
35 to 44	59.3%	40.7%
45 to 54	52.2%	47.8%
55 and over	34.1%	65.9%
All	54.7%	45.3%

Source: NHS BSA, Dental Statistics 2024/25, Workforce Overview, table 1c

International workforce

Overseas-trained dentists remain an important part of the NHS workforce. As of December 2024, 31.1% of the 46,362 dentists registered with the General Dental Council (GDC) in the UK qualified outside of the UK. Of those that qualified outside of the UK, the largest individual group was dentists with a European Economic Area qualification (headcount of 8,514, 18.4% of the total), followed by those dentists that qualified through the GDC's Overseas Registration Exam (headcount of 4,326, 9.3% of the total).

Table 9 shows the number of dentists on the GDC register as of 31 December 2024 by region of qualification, including as a percentage of the total.

Region of qualification	Amount	% of total
UK qualified	31,953	68.9%
EEA qualified	8,514	18.4%
ORE - UK statutory examination	4,326	9.3%

Rest of the world qualified	1,569	3.4%
Total	46,362	100%

Source: General Dental Council, Registration Statistical Report 2024, Dental professionals on the register by route to registration, Dentists, by route to registration 2024

Community dental services

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

NHS England published findings from its dental workforce data collection on 17 July 2025, including a community dental subset. Around 640 dentists working within CDS services submitted a return. Vacancy rates for dentists within CDS remains lower than those reported within high street dental practices (11% versus 19%). Across the 9-month period ending 31 December 2024 there were 55 dentist leavers, but this was counterbalanced 64 joiners.

DDRB recommended in its 53rd report that government undertake a review of pay and progression for salaried dentists working in CDS. The government has implemented a 3.55% uplift to contract values (net of pay and expenses) to dentists in 2025 to 2026, backdated to 1 April 2025.

Findings from the January 2025 NHS clinically led Getting It Right First Time (GIRFT) report highlighted several areas where data collection could be improved. From August 2025 a new waiting list collection launched across CDS providers to better understand the wait times of patients accessing these services. The data set provides:

- a national, comparable, standardised waiting list data set covering waiting times in CDS
- full visibility of CDS waiting times for adults and children
- information to support operational management of services
- information to provide oversight and understanding of any health inequalities
- baseline information for the future local and national development of CDS
- data which can be used to support oral health needs assessments

Work is also progressing on a set of national key performance indicators for CDS.

Urgent dental appointments

As set out in the 10YHP, the government's first step is to stabilise NHS dentistry and make sure the budget we have is spent on those who need care most, initially prioritising urgent care.

The government will deliver 700,000 extra urgent dental appointments per year, and ICBs have been making extra appointments available from April 2025. The appointments are available to NHS patients experiencing painful oral health issues, such as infections, abscesses, or cracked or broken teeth. Appointments will be available across the country, with specific expectations for each region. These appointments are more heavily weighted towards those areas where they are needed the most.

2026 Quality and payment reforms

In the short-term, the government will work with dentists to improve the dental contract.

The government recently held a public consultation on a package of changes to improve access to, and the quality of NHS dentistry, which will deliver better care for the diverse oral health needs of people across England. The consultation closed on 19 August.

The government is considering the outcomes of the consultation and will publish a response in due course.

These changes have been designed to:

- support a focus on the highest priority patient groups
- help deliver important and evidence-based prevention activity
- introduce a quality related element into the contract for the first time

In doing so, we would be starting to move away from some of the features of the unit of dental activity (UDA) system, which dental teams tell us makes NHS care frustrating to deliver. The aim of this is to make the NHS a more professionally fulfilling and rewarding place in which to work.

The implementation timing for each of these proposals may vary and will need to be confirmed following the consultation period. Our expectation is that the package can be implemented from April 2026.

The proposals we consulted on were:

- mandate a proportion of contract capacity to be directed to unscheduled care, supported by new payment arrangements and in line with a national service specification

- create new long-term and planned pathways with improved payments to support care and treatment for patients with significant dental decay and/or significant gum disease

- create a new course of treatment for the application of fluoride varnish on children, without a full dental check-up and which can be applied by extended duty dental nurses (EDDNs) between full check-ups

- incentivise greater use of resin-based fissure sealants in children's permanent molar teeth by re-banding the treatment from band 1 to band 2 to reflect better the time and cost associated with this treatment

- introduce a new band 2 sub-band for denture modifications, relining and repairs

- options to support reducing clinically unnecessary check-ups

- introduce funded quality-improvement activities for practices

- provide practices with funding for annual appraisals for associate dentists, dental therapists and dental hygienists who provide clinical NHS care

- develop minimum terms of engagement set out in an NHS model contract for dental associates.

- extend minimum requirements of NHS service for discretionary support payments to include all NHS service, not just time on the dental Performers List.

- develop an NHS handbook for dental teams.

More information is available at NHS dentistry contract: quality and payment reforms - consultation document.

Dental contract reform

As set out in the 10YHP, by 2035 the NHS dental system will be transformed, so it provides high quality care at the right time, and nobody goes without because they cannot afford it. We will build a service which is attractive to, and values dental care professionals.

This year, we will begin the process of more fundamental contract reform.

The government is committed to reforming the dental contract, with a shift to focus on prevention and the retention of NHS dentists. The government's ambition is to deliver fundamental contract reform before the end of this Parliament. We want a contract that matches resources to need, improves access, promotes prevention and rewards dentists fairly, while enabling the whole dental team to work to the top of their capability.

There are no perfect payment models and careful consideration needs to be given to any potential changes to the complex dental system so that we deliver genuine improvements for patients and the profession.

The government is continuing to work with the British Dental Association and other representatives of the dental sector to deliver our shared ambition to improve access to treatments for NHS dental patients.

6. Earnings and expenses

Introduction and key messages

This chapter is split into distinct sections. The first section provides an introduction to the pay structure, how it works and how people move between contracts. It then covers HCHS earnings in 2024 to 2025. It shows that average pay and earnings increase with seniority. Pay and earnings increased following pay awards and pay agreements (after accounting for removal of Local Clinical Excellence Awards), and over a longer period career progression and promotion remain important.

The final part covers labour market comparisons. Earnings growth is relatively high but is slowing and this is forecast to continue this year; pay settlements are consistently around 3% with most settlements being lower than last year. We also show that in general the position within the income distribution has been maintained, though data do not yet show the impact of recent pay awards and pay agreements. Finally, it shows that medical degrees remain highly valuable with medical graduates towards the very top of earnings and employment curves.

Separate data are provided to cover doctors working in different settings with sections for the HCHS, general practice and dental workforces.

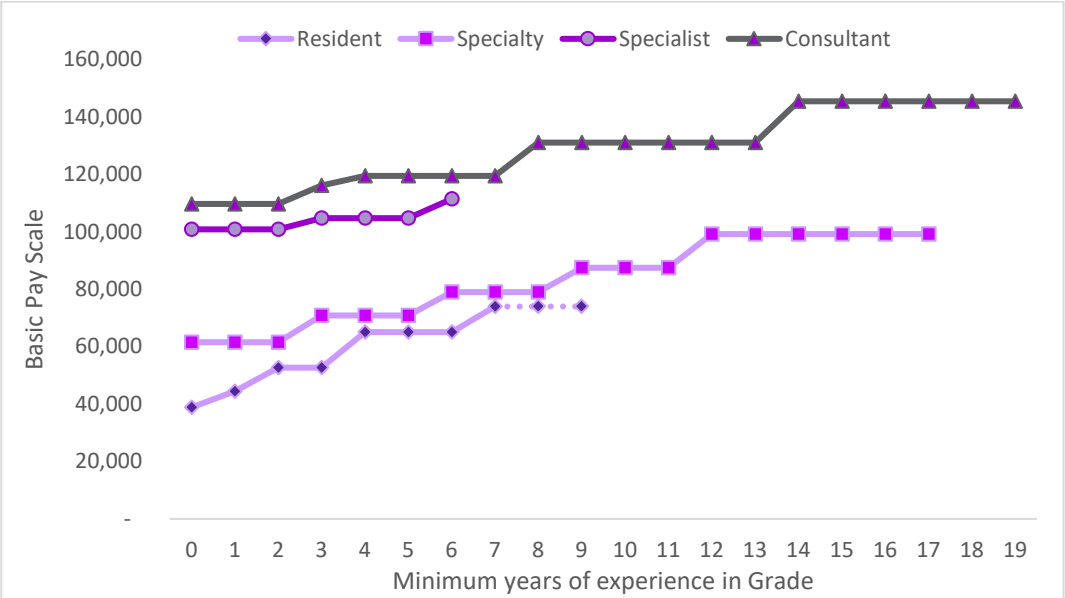
Medical pay structures

Medical staff benefit from clearly defined routes of career advancement from leaving university to being 'doctors in training' and eventually to long term careers as consultants, SAS doctors or GPs. In 2025 to 2026, basic pay for medical staff on national contracts ranges from £38,831 for foundation year 1 through to £145,478 for the most experienced consultants. Staff who complete additional work, work unsocial hours, or who are recognised through Clinical Impact Awards, receive additional payments as set out in their respective medical contracts.

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

specialty training most doctors will seek a senior clinical role as either a consultant or SAS doctor, enter general practice and can be a path toward roles in senior management. This highlights that DDRB should consider the appropriate pay range for each medical contract based on the skills and responsibilities of those roles but also remember the interlinking nature of the pay system.

Figure 3 shows the current system of national pay contracts for medical staff in 2025 to 2026 and the minimum number of years of experience in each grade required to reach each pay point - note that in most cases to pass through progression points doctors must demonstrate competence against set criteria as well as have a given length of service.



Source: [NHS Employers pay circulars]

This is a chart of basic pay scale values on the 4 main national contracts (2016 resident doctors, 2021 specialty doctor, 2021 specialist doctor and 2003 consultant contract) and is based on pay scales in 2025 to 2026 after the implementation of pay agreements and DDRB recommendations. The specialist grade was established in 2021 to offer additional progression routes for SAS doctors and sit above the specialty scale.

Table11 highlights the extent of pay progression in the 4 main, open, national contracts for hospital doctors and the total pay progression that is possible between entry into the foundation programme and the top of the consultant pay scale. For example, resident doctors basic pay almost doubles between nodal point 1 (FY1) and nodal point 5 (which takes at least 7 years) and basic pay can nearly quadruple over the full career path from FY1 through to the top of the consultant pay scale.

Table 11: minimum and maximum pay values by medical contract in the year 2025 to 2026

Career grade	Payscale minimum	Payscale maximum	In-grade progression
measure	(£)	(£)	(%)
Resident	£38,831	£73,992	91%
Specialty (2021 contract)	£61,542	£99,216	61%
Specialist (2021 contract)	£100,870	£111,441	10%
Consultant	£109,725	£145,478	33%

Source: NHS Employers pay circulars

HCHS earnings in 2024 to 2025

In this section we provide information on pay and earnings for HCHS doctors in 2024 to 2025 and show that:

- pay and earnings for doctors vary with medical grade and in line with medical pay structures and some doctors earn more than basic pay should they undertake additional work or operate during unsocial hours

- pay and earnings increased broadly in line with the outcome of previous pay awards and additional pay agreements. For consultants the increase in earnings is lower than the increase in basic pay due to the removal of new Local Clinical Excellence Awards

- over a longer period, it remains the case that the system of career progression allows many doctors to benefit from progression to more advanced practice

Average pay and earnings in English HCHS

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

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

There are 3 principal measures to measure average pay and earnings with the choice of measure depending on the context of the question.

- total basic pay per FTE - this is the average level of basic pay across the group if it is assumed that all staff were working full time. Due to the system of national contracts, it reflects the distribution of staff across different medical grades and pay points

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

- total earnings per person - this is the average level of earnings across the group and includes all pay elements including basic pay, additional activity and clinical impact awards. This reflects the combination of how staff are distributed across pay bands and points as well as the extent to which people undertake additional work or operate during unsocial hours

- for HCHS staff in the 12 months to March 2025 average basic pay per FTE ranged from over £34,000 for doctors in foundation year 1 to over £125,000 for consultants, while average earnings per person ranged from over £43,000 for foundation year 1 doctors, to over £144,000 for consultants

- these earnings statistics are based on monies paid between April 2024 and March 2025. In some cases, including for consultants and resident doctors, some payments that were made in 2024 to 2025 were for activity and backpay during a previous financial year

Table 12: average pay and earnings by medical grade for staff working in Hospital and Community Health Sector - 12-months to March 2025 and comparison with previous year

Medical grade	average FTE (count)	pay scale range (£)	basic pay per FTE (£)	earnings per person (£)	growth in basic pay per FTE (%)	growth in earnings per person (%)
All grades	148,781	N/A	£86,447	£100,019	12%	8%
Consultant	59,203	about £105k - £139k	£125,694	£144,823	13%	6%
Associate specialist	2,726	about £96k - about £107k	£107,402	£113,449	9%	5%
Specialty doctor	9,566	about £59k - about £95k	£82,120	£86,098	10%	5%
Staff grade	367	N/A	£64,926	£79,497	3%	4%
Core training	35,108	about £49k - £70k	£58,227	£74,665	12%	12%
Specialty registrar	24,269	about £49k - £70k	£51,451	£66,946	13%	14%
Foundation year 2	7,332	about £42k	£39,066	£52,291	12%	15%
Foundation year 1	8,264	about £36k	£34,059	£43,262	14%	14%
Hospital Practitioner / Clinical Assistant	768	N/A	£129,599	£47,404	3%	5%
Other and local grades	1,176	N/A	£109,763	£55,979	4%	5%

Source: NHS England earnings statistics

The change in pay and earnings in 2024 to 2025 is broadly consistent with the expected impacts of the 2024 to 2025 pay decision and additional pay agreements made with medical workforces. For most workforces, including consultants, SAS doctors and resident doctors there were increases in basic pay per FTE of 9% - 13% which is broadly consistent with DDRB decision (6% to 9%) plus the impact of additional pay agreements.

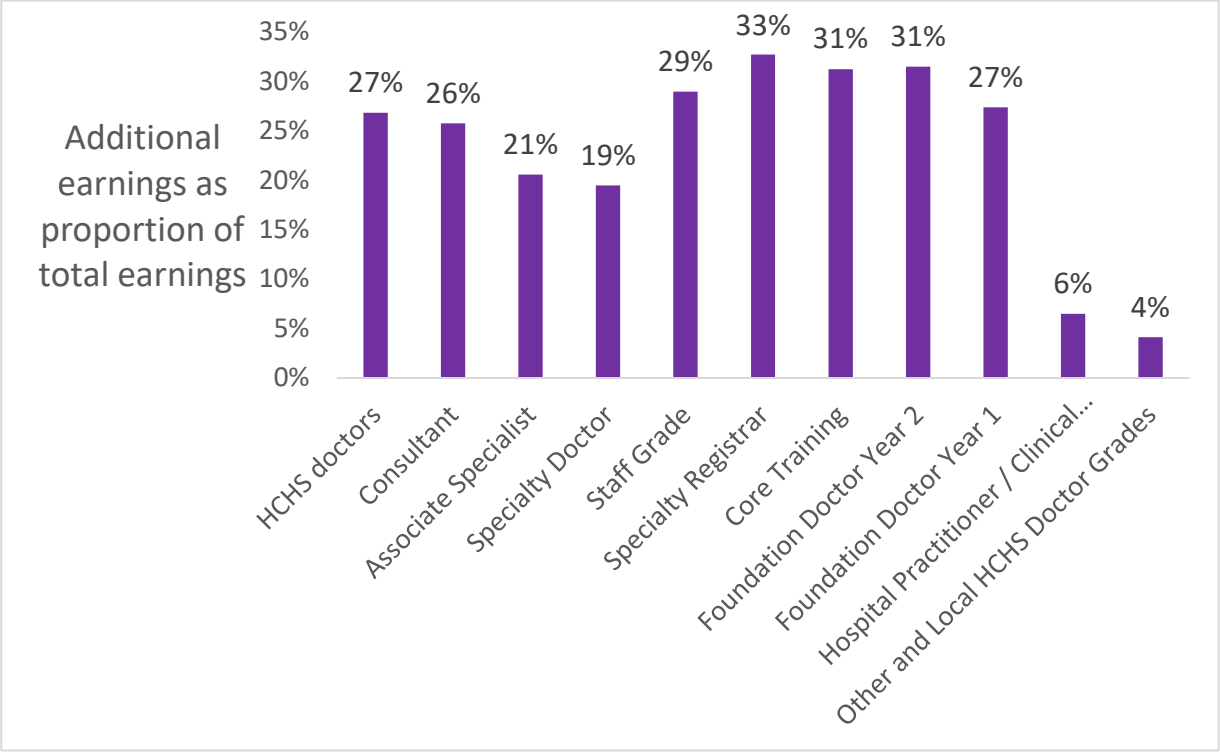
We note there are some instances where average basic pay per FTE is below the pay scale range for the grade (for example foundation year 1) Potential reasons for this include the impact of industrial action in 2024 to 2025 which will have reduced pay for individuals who took strike action as well as a methodological challenge relating to the annual rotation process for resident doctors.

Additional earnings

National medical contracts contain provisions by which staff can increase their earnings beyond basic pay should they work additional hours or undertake additional programmed activities beyond the standard job plan, work during unsocial hours or are in receipt of one of the remaining clinical impact awards.

On average additional earnings are worth between around 20% to 30% of total earnings, however these payments are not guaranteed and for pay setting purposes we believe that comparisons should be made using basic pay; where earnings are higher than basic pay it is generally because people are doing more work or doing so during times the pay system judges to be more difficult.

Figure 4: additional earnings (non-basic pay) as proportion of total earnings by medical career grade - 12 months to March 2025



Source: NHS England earnings statistics

Figure 4 is a chart showing average non-basic pay as a proportion of average total earnings in the 12 months to March 2024 and is split by medical career grade. It shows that non-basic pay contributes between 5% and 33% of total earnings with all grades except for 'hospital practitioners' and 'other doctors' being in the range of 19% to 33%.

Earnings distribution for HCHS doctors

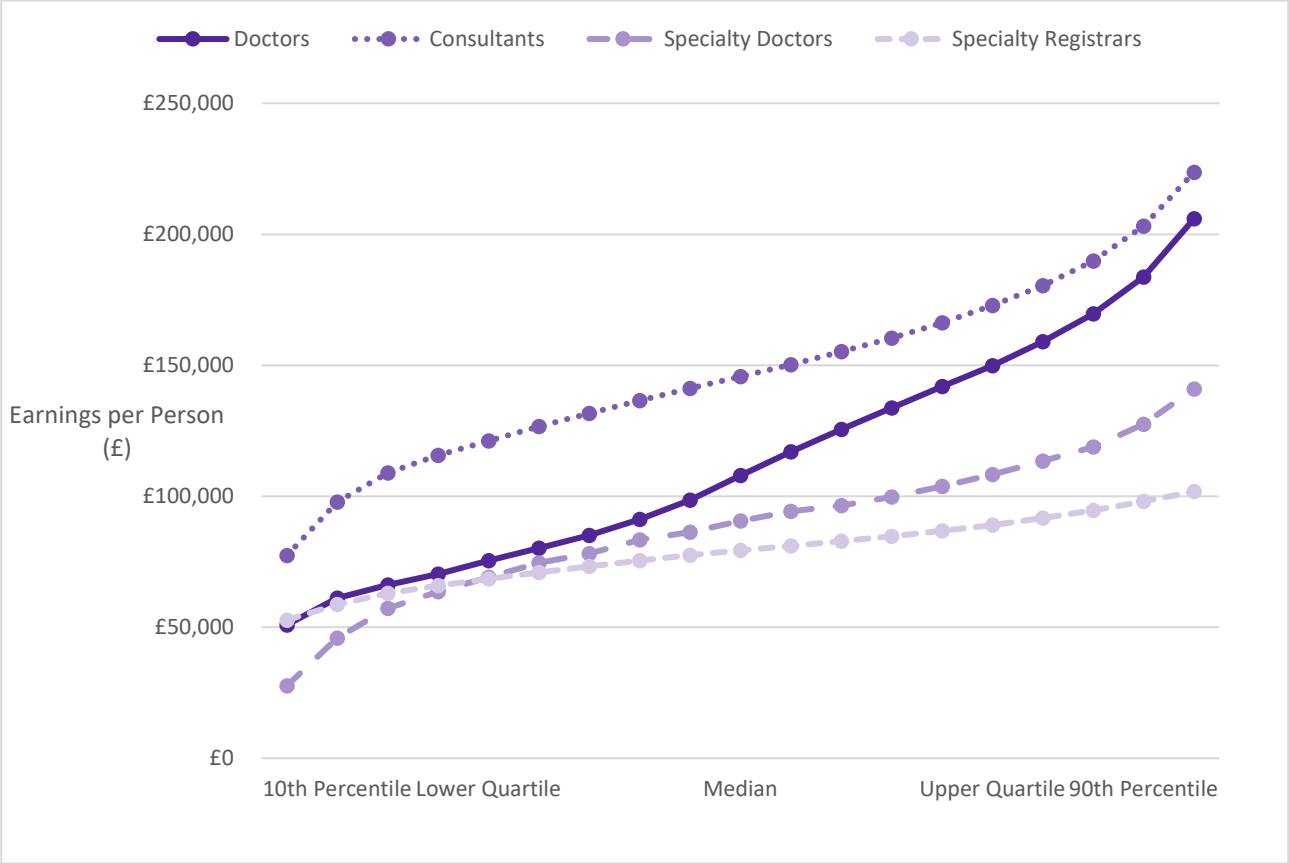
Across the medical workforce, and within individual career grades, there will be differences in earnings linked to factors including an individual's pay point, contract and working patterns. As previously stated, when making pay decisions we believe that basic pay should be the core comparator.

Figure 4 is based on data on the income distribution for medical staff provided by NHS England. To ensure that this analysis is not impacted by people leaving or switching grades, this data only include staff who were employed in the same career grade throughout the period April 2024 to March 2025, which is why it does not include F1 and F2 doctors who would have expected to work across different grades over the year.

Consultants have the highest earnings at all points in the earnings distribution and had median earnings of around £145,000 in the 12 months to March 2025, while the median across all grades was almost £108,000. Median earnings for specialty registrars were just under £80,000, which will include the impact of back-pay following the pay agreement with resident doctors, which included a retrospective increase to 2023 to 2024 pay scales.

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

Figure 5: earnings distribution for selected medical grades in English HCHS in 12-months to March 2025



Source: NHS England Earnings Statistics, Data Pack Tab DE1

Figure 5 shows the earnings distribution for different medical grades between April 2024 to March 2025. It shows that at all points in the earnings distribution earnings are higher for consultants than other grades. It also shows variation between staff within a grade reflecting differences in working hours or earnings patterns.

The impact of the 2025 to 2026 pay decision

Due to the timing of the 2025 pay round and the government's decision to bring forward the timetable for the 2026 pay round no data is available showing the impact of the 2025 pay round, however, we do know what those decisions were and the expected likely outcomes for consultants and resident doctors are:

- for consultants and SAS doctors all pay points were increased by 4% from 1st April 2025

- for resident doctors all pay points were increased by 4% plus an additional £750 from 1 April 2025. This results in pay points on the 2016 resident doctor contract increasing by between 5.1% and 6.0%. Between 2022 to 2023 and 2025 to 2026 the 2016 pay scales have increased by between 26.7% (NP5) and 32.2% (starting pay)

The pay award was implemented from August 2025, along with relevant backpay, and we would expect the impact to be seen in other statistics as the year progresses.

Longitudinal pay in HCHS sector

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

Table 13 presents data on the change in average basic pay per FTE for around 64,000 medical staff who were employed in the HCHS sector in both March 2015 and March 2025 and is split according to the individual's grade in March 2025.

The median increase in basic pay per FTE was over 67% (around 5.3% per annum) while one-quarter of the workforce experienced an annual increase of over 10% pa, which will generally be associated with promotion to more senior grades. For staff who were employed in the same grade in both 2015 and 2025 the median increase was around 57.5% which is equivalent to around 4.7% per year, while the increase for those who had moved grades, mainly entering the consultant grades, was an equivalent of over 10% per annum.

Table 13: longitudinal pay analysis for doctors in hospital and community health sector between 2015 and 2025.

Medical grade in 2025 for people employed in 2015	count	lower quartile	median	upper quartile	mean
Consultant	50,500	55.0%	65.2%	189.5%	116.7%
Associate specialist	2,000	44.4%	54.4%	81.9%	72.8%
Specialty doctor	3,500	50.1%	77.7%	118.5%	90.9%
Staff grade	100	36.5%	36.8%	36.9%	43.8%
Core training	1,000	86.2%	120.5%	150.8%	119.0%
Specialty registrar	6,100	104.7%	134.7%	173.1%	134.7%
Total	64,100	55.0%	67.5%	176.4%	115.1%

Source: DHSC Analysis of Electronic Staff Record

Career movements for HCHS doctors

Data extracted from electronic staff record (ESR) can be used to observe an individual's movements around HCHS over time. Table xx considers staff who were employed in the HCHS sector in March 2015 and shows their change in career grade by March 2025. This can be used to give a sense of how individual members of staff may experience and move through the pay system including detail on the extent to which resident doctors may progress to SAS or consultant levels.

The data shows:

- around two-thirds of those working as consultants in 2015 were still working as consultants 10 years later. Most of the remainder appear to no longer be working in the HCHS sector, this likely reflects the age profile of the consultant workforce and includes those leaving the workforce following retirement

- Around 41% of those working at resident level were either consultants (38%) or SAS (3%) doctors after 10 years. While around 44% were not working in HCHS, this is consistent with the numbers who would usually be expected to move into general practice

Table 14: movement of doctors working in hospital and community health sector between March 2015 and March 2025, by career grade

	resident in 2025	SAS in 2025	consultant in 2025	other grades in 2025	not present in HCHS in 2025	rounded count in 2015
Resident in 2015	14%	3%	38%	0%	44%	51,500
SAS in 2015	1%	37%	17%	0%	44%	10,000
Consultant in 2015	0%	0%	66%	0%	33%	44,600
Other Grades in 2015	0%	2%	2%	23%	73%	1,800

Source: DHSC analysis of the ESR data warehouse

To interpret table 14 if we take the opening row, it is saying that:

- there were around 51,500 Resident Doctors in the sample in 2015

- of those 51,500 around 14% of people were still employed as a Resident Doctor in 2025

- just under 40% of people who were Resident Doctors in 2015 were Consultants in 2025

- around 45% of people who were Resident Doctors in 2015 were not employed in HCHS in 2025 (many of these will have been GPs)

Pay and earnings for locally employed doctors

Locally employed doctors (LEDs) are members of the medical workforce who are employed by NHS organisations but not employed under the terms of one of the main national contracts and so we are interested in being able to access information on pay for the LED workforce and the extent to which previous DDRB recommendations are passed on.

We understand that a clear majority of LEDs are employed on contracts which mirror national terms and conditions with many of these on pay which mirrors either the 2002 or 2016 resident doctors contracts. As such, whenever DDRB makes a pay recommendation this should be routinely passed through to LEDs.

Drivers of growth in HCHS average earnings

In this chapter we have previously provided information on average pay and earnings for the HCHS medical workforce in 2024 to 2025. This section provides more information on factors contributing to the increase in average earnings in 2024 to 2025, and in particular:

- why the increase in total earnings may differ from the increase in basic pay per FTE
- why the increase in earnings per FTE may differ from the headline pay award

Average total earnings per FTE increased by 8.1% in 2024 to 2025, with basic pay per FTE increasing by 12.8% but additional (that is non-basic pay) earnings per FTE decreasing by 6.4%. The reduction in additional earnings per FTE was mainly driven by:

- the shift of earnings for consultants from non-basic pay to basic pay as part of the 2024 negotiated pay deal, which increased basic pay scales while removing the contractual entitlement to access an annual Local Clinical Excellence Awards round
- a reduction in 'local' payments per FTE, which is consistent with a reduction in payments for cover for staff taking part in industrial action compared with 2023 to 2024

The growth in total earnings per FTE can be split into contributions from (a) the headline pay award (including negotiated pay deals, where applicable) and associated impacts, and (b) factors other than the pay award, such as changes in how staff are distributed across the pay structure or changes in the use of additional earnings such as shift working payments. The impact of factors other than the pay award is measured by 'earnings drift', the difference between total earnings per FTE growth and the headline pay award.

The headline pay award impact was 11.6% in 2024 to 2025, which reflects the combined effect of:

- 11.4% for consultants (average of increases to basic pay scales as part of the April 2024 pay deal followed by the 6% pay award, combined with no change in the value of clinical excellence awards, discretionary points and distinction awards). This excludes the impact of removing the entitlement to an annual Local Clinical Excellence Awards round, as part of the pay deal, which is reflected in earnings drift rather than the pay award impact

- 12.3% for resident doctors (average of increases to basic pay scales due to the September 2024 pay deal followed by the 6% plus £1,000 pay award)

- 10.1% for SAS doctors (average of increases to basic pay scales as part of the June 2024 pay deal followed by the 6% pay award)

Pay deals for consultants and resident doctors were backdated to before 1 April 2024 (to 1 March 2024 for consultants and 1 April 2023 for resident doctors). Eligible doctors received one-off payments in 2024 for the associated backpay which contributed around a further 1.5% to average earnings growth for HCHS medical staff in 2024 to 2025.

The combined impact of pay awards and backdating of pay deals was higher than growth in total earnings per FTE in 2024 to 2025 (13.1% versus 8.1%), implying negative earnings drift of minus4.9%. This reflects the combined impact of:

- a negative ‘additional earnings drift impact’ of minus 4.4% due to additional earnings growing by less on average than basic pay (even after allowing for the freezing of clinical excellence award, discretionary point and distinction award values as part of the consultant pay award)

- a negative ‘grade mix effect’ of minus 0.5%, reflecting a shift in the workforce towards lower earning medical grades. 2024 to 2025 continued the recent trend of resident doctor and SAS doctor FTEs growing by more than consultant FTEs

As noted above, the lower growth in additional earnings compared to basic pay partly reflects the removal of the entitlement to an annual Local Clinical Excellence Awards (LCEA) round as part of the consultant pay deal, and a reduction in 'local' payments per FTE. Low growth in additional activity payments and a continuing decrease in the use of banding supplements as resident doctors remaining on the pre-2016 contract move out of the resident doctor workforce also contributed.

Table 15 gives further detail on the breakdown of average earnings growth for HCHS medical staff over recent years into its component drivers, where:

- average earnings growth equals headline pay award, plus earnings driftearnings drift equals basic pay drift, plus additional earnings drift impact, plus grade mix effect

Table 15: breakdown of average earnings growth for HCHS medical staff between 2019 to 2020 and 2024 to 2025

Pay growth element	2019 to 2020	2020 to 2021	2021 to 2022	2022 to 2023	2023 to 2024	2024 to 2025
Basic pay per FTE growth	3.3%	2.2%	3.0%	3.6%	5.1%	12.8%
Additional earnings per FTE growth	-2.8%	3.5%	2.8%	2.5%	9.8%	-6.4%
Total earnings per FTE growth	1.8%	2.5%	2.9%	3.3%	6.2%	8.1%
Components of total earnings per FTE growth	-	-	-	-	-	-
(a) headline pay awards	3.4%	2.7%	2.7%	3.7%	6.6%	11.6%
(b) one-off payment for backdating of 2024 pay deals	-	-	-	-	-	1.5%
(c) total earnings drift	-1.6%	-0.3%	0.2%	-0.4%	-0.5%	-4.9%
Components of (c) total earnings drift	-	-	-	-	-	-
(c1) basic pay drift (excluding grade mix effect)	0.3%	0.1%	0.2%	0.0%	-1.3%	0.0%
(c2) additional earnings drift impact (excluding grade mix effect)	-1.7%	0.4%	0.0%	-0.1%	1.3%	-4.4%
(c3) grade mix effect	-0.2%	-0.8%	-0.1%	-0.3%	-0.5%	-0.5%

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

The components of total earnings per FTE growth presented in the table are:

- ‘headline pay award', which measures the change in average earnings due to the annual pay award (including negotiated pay deals, where applicable)

- the impact of one-off payments in 2024 to 2025 related to backdating of the 2024 consultant and resident doctor pay deals to before 1 April 2024 - this is shown separately from the headline pay award for 2024 to 2025

- ‘total earnings drift’, the overall difference between total earnings per FTE growth and the headline pay award

- ‘basic pay drift’, which measures the contribution to earnings drift due to changes in the distribution of staff across pay points within medical grades, which affects growth in average basic pay

- 'additional earnings drift impact', which measures the contribution to earnings drift due to non-basic pay earnings growing at a different rate from basic pay (after allowing for

differences due to the pay award). This captures the impact of changes in the use of payments for additional activity, shift working, medical awards, and other non-basic pay earnings (for example, an increase in hours worked as additional activity)

- 'grade mix effect', which measures the contribution to earnings drift due to changes in the distribution of staff between higher and lower earning medical grades

Basic pay and additional earnings drift are presented excluding grade mix effects (so basic pay drift just reflects changes in staff distribution within medical grades), to avoid double-counting with the grade mix effect shown separately. The grade mix effect is based on the HCHS medical staff groups presented in NHS England published data (and used in table 15 above).

Pay growth estimates are based on data on workforce earnings and size published by NHS England. Drift estimates, the difference between pay growth and the pay award, are based on changes to pay values from pay circulars, weighted by pay point workforce size estimates based on NHS England workforce data. The analysis is for NHS trusts and core organisations and NHS support organisations and central bodies combined (so figures for average basic pay and earnings growth may differ slightly from figures based on NHS trusts and core organisations in table 15). Growth in earnings per FTE may also differ from growth in earnings per person due to changes in average FTE per person.

Wider labour market analysis

This section provides information on how pay and earnings for medical staff fit into the wider economy with particular attention on economic forecasts for the coming year as well as comparisons against other high-income professions. The available evidence suggests:

- available data on pay settlements indicate median settlements currently averaging around 3% and with most firms offering less than last year. Surveys suggest this is likely to continue over the coming year

- there is some evidence that staff grades have remained in broadly the same section of the income distribution over time, but we do not yet have data to show the impact of targeted pay awards or additional pay awards with medical workforces

- data from LEO education outcomes continue to show the value of medical degrees for earnings potential with medical graduates having consistently high earnings and predominately remain in the health sector.

Earnings forecasts for 2026 to 2027

To maintain the position of the NHS within wider labour markets it will usually be the case that the change in NHS pay might expect to broadly align with wider economy earnings growth. We also believe that the pay review body should give consideration to the expected change in earnings over the forthcoming pay period rather than reflecting current conditions.

Average earnings growth is forecast to be lower over 2026 to 2027 than 2025 to 2026, at 2.2% according to the OBR's March 2025 forecast with a reduction over the course of the year, at around 2.4% in the Q2 2026 to 2.0% in Q4 2026 and Q1 2027.

In the August Monetary Policy Report the Bank of England forecast average private sector earnings growth of 3.25% in Q4 2026. This is an increase from its previous forecast (2.75%) and remains higher than OBR forecasts.

Pay settlements - data and forecasts

General growth in earnings can be broader than that generated through pay settlements alone as it will encompass any changes to average pay and/or earnings resulting from changes to the composition of the workforce (for example, having more people in higher paid positions) or any changes in additional pay (for example, more people doing additional hours)

While there are no official statistics covering pay settlements we can look to surveys from the likes of Brightmine (formerly XPertHR), Incomes Data Research (IDR) and the Bank of England for insight on the current value of pay awards which may align with decisions facing the pay review bodies.

In August 2025 Brightmine reported that median pay settlements for the quarter to June 2025 stood at 3% and this had remained stable for 8 consecutive rolling quarters. Previous data showed that median pay awards were higher (4.3%) in the public sector following the impact of targeted pay awards for some groups. They noted that over one-quarter of awards in the sample were worth exactly 3% while nearly 60% of awards were between 2% and 3%. They also stated that current awards tended to be below those of a year ago with almost 80% of awards being lower than in the previous pay cycle.

Data from Incomes Data Research (IDR) showed median pay increases in 2025 of 3.3% with those in the private sector being around 3.2%. Some industries, such as retail or hospitality, saw higher than average awards following increases to the National Living Wage. While those within DDRB remit are unlikely to be directly impacted by the National Living Wage it can have exert pressure further up the income distribution if firms attempt to maintain pay differentials.

Data from the Bank of England decision maker panel can also provide insight as to what wage pressures firms expect to face. In the 3 months to July 2025 firms reported wage growth of 4.7% but expected wage growth over the next 12-months was expected to fall by just over one percentage point to 3.6%.

In aggregate this would suggest that for much of the past year pay settlements have been in the region of 3%, and with most settlements in 2025 being lower than in 2024.

Broader economic conditions

In addition to being aware of changes in wider earnings we should also be aware of other economic indicators and the impact they may have on labour markets including any impact for the NHS including things like recruitment and retention.

As of June 2025, unemployment stood at 4.7% which represented an increase of 0.2pp over the previous quarter and around 0.7pp above pre-pandemic levels. The OBR forecast that unemployment will be relatively stable over the coming year.

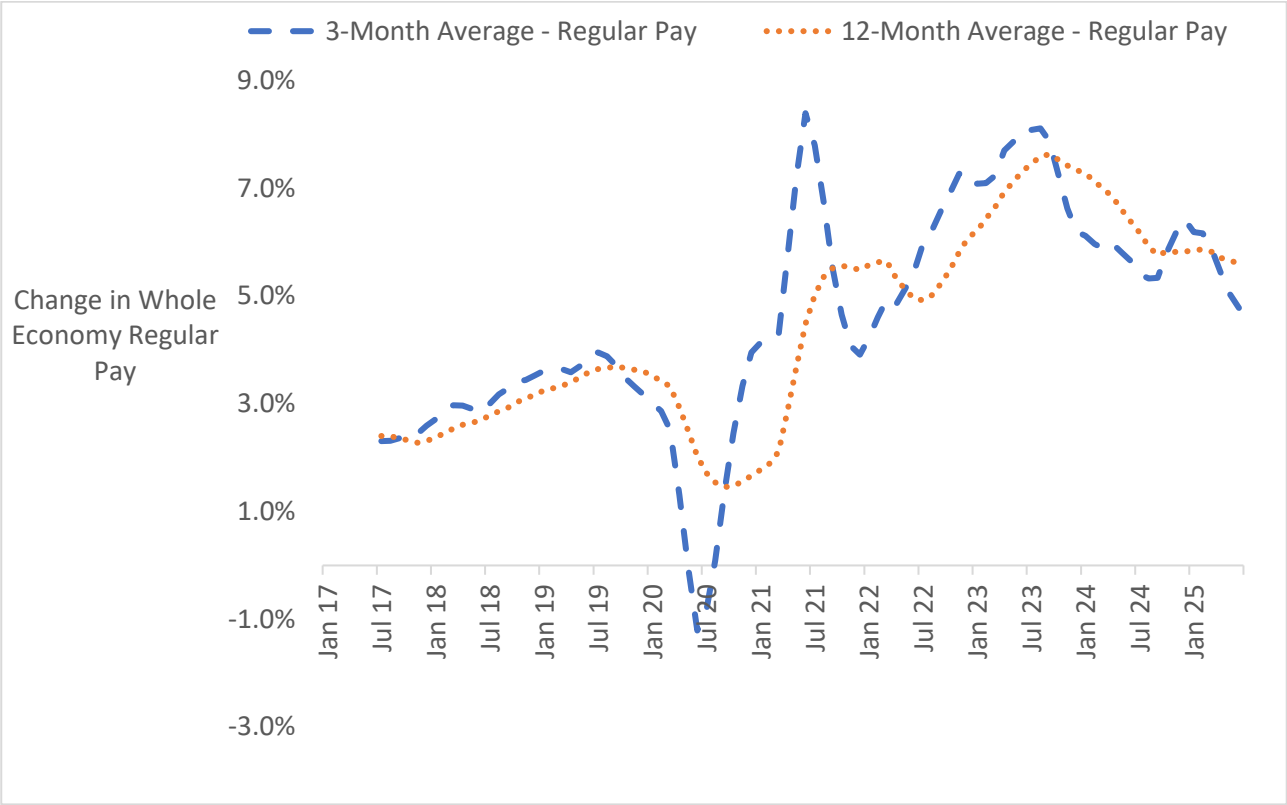
Alongside a rise in unemployment the number of vacancies has continued to fall - ONS data shows around 718,000 vacancies in the 3 months to July 2025 which represent a figure that has fallen for 37 consecutive quarters and is back below pre-pandemic levels. The ratio of vacancies to unemployed people, a measure of economic tightness, has continued to fall indicating a looser labour market.

While we may not think that inflation should be central to pay setting it is currently forecast to average around 1.9% in 2026 to 2027 (OBR, March 2025 forecast) which would be a reduction from the forecast 3.2% in 2025 to 2026 (OBR, March 2025 forecast) and would be broadly in line with the government's 2% inflation target.

Previous growth in earnings

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

Figure 6: increase in average weekly earnings in the private sector, 3-month and annual growth rates between January 2017 and June 2025, £ per month, 3 month moving average



Source - Office for National Statistics

Figure 6 is a chart showing the increase in average weekly earnings in the private sector between July 2017 and June 2025 on both a 3-month and annual average basis. It shows that the increase in earnings, using the 3-month average, is 4.8% as of June 2025 but has reduced from around 8% during 2023.

As data on pay growth is broader than the impact of pay awards solely, we are also interested in pay settlement data which closely resembles the decision facing PRBs and does not include the impact of changes to workforce composition or pay drift. Brightmine data shows that settlements are expected to average 3% in 2025 and has been at 3% for 8 rolling quarters from 3 months to the end of December 2024 to the end of July 2025. Information from the Bank of England Decision Maker Panel estimated year ahead wage growth of 3.6% in July 2025.

Earnings growth across the earnings distribution

In addition to a general understanding of earnings growth we can assess how earnings growth is changing across the income distribution. For medical staff we might be particularly interested in earnings growth toward the top of the income distribution.

ONS data, based on 'real-time' information from the pay as you earn (PAYE) system shows that in the 3 months the June 2025 median earnings growth was (5.8%) but this varied substantially across the earnings distribution with much higher growth (7.8%) for those in the 25th percentile and lower growth (2.6%) at the very top of the income distribution - this is likely impacted by increases to the NLW in April 2025.

Table 16: estimated growth in earnings by income distribution percentile - 3-month moving average to June 2025 compared to 3-month average to June 2024

	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile	95th percentile	99th percentile
June 2025	7.6%	7.8%	5.8%	4.7%	3.7%	3.2%	2.6%

Source: Real Time Information, UK - Office for National Statistics

Earning percentile analysis

In previous years we have provided evidence on how average pay and earnings for medical staff place different groups of medical staff in the wider income distribution with results showing that ocnsultants were consistently in the top 1 or 2 per cent of the income distribution followed by those in the SAS grades and then resident doctors. Similar analysis was used by DDRB to support the targeted pay award for resident doctors as part of the 2025 to 2026 pay decision as this indicated the relative position of some staff groups had fallen.

We note that no new data is currently available as this analysis is dependent on data from the ASHE which is expected to be published in the autumn. It is however reasonable to expect that the position for resident doctors will have improved following the impact of recent pay awards for these groups which have delivered above average increases compared to the wider economy.

Table 17: estimated income percentile for NHS career grades based on average earnings per person in the NHS mapped against ASHE

Grade	2018	2019	2020	2021 (SOC 10)	2021 (SOC 20)	2022	2023	2024
HCHS doctors	96	96	96	96	96	96	96	96
Consultant	98	98	98	98	98	98	98	98
Associate specialist	97	97	97	97	97	97	97	97
Specialty doctor	93	93	93	94	94	95	94	94

Staff grade	92	92	93	94	94	94	93	93
Specialty registrar	91	91	91	92	92	92	91	90
Core training	87	87	86	89	89	88	86	85
Foundation year 2	79	79	77	80	80	77	75	73
Foundation year 1	70	70	67	69	69	67	64	62

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

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

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

Longitudinal education outcomes

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

In summary:

- data suggests that medical and dentistry graduates remain a highly skilled group and benefit from above average employability and long-term earnings potential compared to other graduates

- 10 years after graduation median earnings were around £61,000 which is 67% higher than average and over 89% are employed or in further study

- most medicine and dentistry graduates remain in human health and social work, between 85% to 95% from 1 to 5 years after graduation and evidence doesn't suggest that earnings are being inflated by those who have left the sector.

Table 18 compares median earnings for medicine and dentistry graduates to median earnings for graduates from other subjects one, 3, 5 and 10 years after graduation. Earnings after one year of graduation are just over 62% higher than average (excluding medicine and dentistry), and after 10 years of graduation, are just over 67% higher than the average which helps underline the value of these degrees.

Table 18: median earnings for medicine and dentistry graduates 1, 3, 5 and 10 years after graduation with comparisons to other subjects based on earnings in fiscal year 2022 to 2023

Median earnings for first degree students	1 year after graduation (graduated 2020 to 2021)	3 years after graduation (graduated 2018 to 2019)	5 years after graduation (graduated 2016 to 2017)	10 years after graduation (graduated 2011 to 2012)
Medicine and dentistry	£40,200	£49,600	£53,300	£61,000
Medicine and dentistry rank (35 subjects)	1	1	1	2
Subject average (all subjects excluding medicine and dentistry)	£24,700	£28,300	£31,700	£36,500

Source: Longitudinal education outcomes (LEO) (Department for Education). Data includes graduates not working in NHS too, however the vast majority (86%) after 5 years work in the health sector.

LEO also includes information on employment which further highlights the value of medical and dental degrees. Those with medicine and dentistry degrees are most likely to be in sustained employment or training 5 years after graduating. Although the proportion of individuals in sustained employment or training remains high in all stages after graduation and are above the average, it does fall slightly over time. This is seen across all degrees and will include the impact of things like family commitments. This is shown in table 18.

LEO also publishes information on which industry graduates are working in. One year after graduation, over 95% of first-degree medicine and dentistry graduates worked in human health and social work activities. 3 years after graduation, over 85% remained in the same industry. 5 years after graduation, over 86% remained in the same industry which highlights that it is a small number of people who study medicine and then exit the healthcare industry.

Table 19: proportion of medicine and dentistry first degree graduates in sustained employment, training, or both after 1, 3, 5 and 10 years with comparison to other subjects in 2022 to 23 fiscal year

Proportion in sustained employment, further study or both % (first degree only)	1 year after graduation (graduated 2020 to 2021)	3 years after graduation (graduated 2018 to 2019)	5 years after graduation (graduated 2016 to 2017)	10 years after graduation (graduated 2011 to 2012)
Medicine and dentistry	97.6%	93.6%	92.9%	89.3%
Medicine and dentistry rank (35 subjects)	1	3	3	4
Average (all subjects excluding medicine and dentistry)	89.5%	88.8%	88.5%	85.8%

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

Note, ranking includes "Celtic Studies" which has around 25 graduates per year.

Local, regional and international labour markets

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

- the need to attract, recruit, retain and motivate doctors and dentists, including consideration of local and regional labour market factors, in view of their contribution to the health of the nation

- developments in doctors' and dentists' earnings in the context of long-term trends in the wider labour market, alongside comparator professions, including relevant international comparators

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

Local and regional labour markets

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

While specific evidence is limited, we acknowledge there may be cases where organisations may struggle to recruit specific types of staff using national terms and conditions. In these cases, the pay system includes a series of flexibilities including the

use of recruitment and retention premia to help alleviate such issues. Our understanding is that these flexibilities are very rarely used with earnings data published by NHS England suggesting that less than 0.5% of the medical workforce receive this kind of payment. For general practice the Targeted Enhanced Recruitment Scheme offered one-off payments for some locations but this was closed in 2025 due to the oversubscription of GP training.

International labour markets

The Organisation for Economic Co-Operation and Development (OECD) compiles some information on the remuneration of medical staff as part of its annual 'Health at a Glance' report including estimates of how wages for specialists and general practitioners compare to the national average wage for that country based on national accounts data. In the 2024 report this shows that most countries, including the UK, have salaries substantially above this measure of average pay although the extent of this differential does differ between countries.

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

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

Section 4 - GP and dentistry earnings and expenses

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

The figures reflect GPs' total earnings, including NHS and private work, and they do not distinguish between full and part time workers. This year's published data also includes a breakdown of earnings and expenses by ethnicity.

Trends in pay and earnings for contractor GPs

In England, the estimated average income before tax of a contractor GP in either a General Medical Services (GMS) or a Primary Medical Services (PMS) practice was £158,700 in 2023 to 2024. This is a statistically significant increase of 13.2% from 2022 to 2023.

For context of recent previous years, the average pre-tax income for a contractor GP in England working in either a GMS or PMS practice in 2022 to 2023 was £140,200, compared to £153,400 in 2021 to 2022, an 8.6% reduction following the cumulative 25.9% increase over the previous 2 years. The reduction between 2021 to 2022 and 2022 to 2023 was mainly due to the reduction in additional funding provided for the delivery of the COVID-19 vaccination programme.

Trends in the earnings and expenses of salaried GPs

In England, the estimated average income before tax of a salaried GP in either a GMS or a PMS practice was £72,200 in 2023 to 2024. This is a statistically significant increase of 4.3% from 2022 to 2023.

The average income before tax for salaried GPs in England working in either a GMS or PMS practice in 2022 to 2023 was £69,200, compared to £68,000 in 2021 to 2022, a statistically significant increase of 1.8%.

General dental practitioners' earnings and expenses

While pay elements for General Dental Services and Personal Dental Services contracts are uplifted in line with DDRB process (4% for 2025 to 2026), expenses (costs) are uplifted in line with inflation (calculated using GDP deflators) at the same time each year.

The final uplift figure applied to the value of each contract combines both DDRB's recommended uplift rate (for pay) and the inflation uplift rate (for expenses) based on proportion of pay (around 72% for 2025 to 2026) and expenses (around 28%) in the contract. We formally consult with the British Dental Association (BDA) on the uplift proposals each year before implementing them.

There is a strong rationale for using the GDP deflator for calculating expenses. The GDP deflator is a much broader price index than other measures of inflation, such as the Consumer Price Index, which only measures consumer prices. By comparison, the GDP deflator has wider coverage, reflecting the prices of all domestically produced goods and services in the economy, and also includes the prices of government services. Furthermore, use of the GDP deflator is justified based on how NHS England's funding settlement is calculated, and is consistent with other NHS primary care areas, including in general practice and ophthalmology.

While each year we strongly recommend that providing-performer dentists apply this uplift to their associate dentists' remuneration, DHSC is unable to mandate that practices do so. As practices are private businesses, it currently falls to them to set employee and sub-contractor pay and conditions.

Dentistry cost survey

The government is conducting a research project to better understand the costs and pressures associated with running a dental practice in England.

This will help support our ambitions on dental reform by ensuring government has an objective and accurate understanding to inform policy development. It will also improve understanding around the sustainability of the current system.

As part of this research, a survey was launched on 13 May which closed on 16 June 2025. The government received around 500 responses to the survey and is currently reviewing and analysing these.

The findings will be used to strengthen the evidence we provide to DDRB in future years.

Dental earnings and expenses data publication

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

In 2023 to 2024, there was a 3.2% increase in taxable income of self-employed dentists who perform NHS services in England from £75,800 in 2022 to 2023 to £78,200 in 2023 to 2024. The average expenses to earnings ratio for all self-employed dentists who perform NHS services decreased from 51.1% in 2022 to 2024 to 50.5% in 2023 to 2024.

Table 19 shows the average gross earnings, expenses, taxable income and expenses to income ratio for all dentists who performed some NHS dental services from 2018 to 2019 through to 2023 to 2024. This data is for England only. For the years marked with an asterisk, the methodology changed in these years and are not comparable to earlier years. There was a small number of dentists in these years where it was unknown whether they were a providing-performer or associate.

	Average gross earnings	Average expenses	Average taxable income	Expenses ratio
2018 to 2019*	£147,100	£78,500	£68,600	53.4%
2019 to 2020*	£144,700	£76,100	£68,600	52.6%
2020 to 2021*	£141,400	£68,900	£72,500	48.7%
2021 to 2022*	£156,100	£78,200	£77,900	50.1%
2022 to 2023	£155,200	£79,300	£75,800	51.1%
2023 to 2024	£158,100	£79,900	£78,200	50.5%

Source: Dental earnings and expenses estimates 2023 to 2024 - NHS England.

In England, the earnings of a dentist vary depending on whether they are a contract-holder or an associate dentist. Providing-performer dentists hold a contract with NHS England to provide a given number of units of dental activity or units of orthodontic activity. Associate dentists work as performers under the contract - they deliver NHS dental services and hold a contract with their providing-performer but do not hold a contract with the NHS. Generally, providing-performers tend to earn more (higher gross earnings and taxable income). In 2023 to 2024, providing-performer dentists had an average taxable income of £134,400, an increase from £128,800 in 2022 to 2023. Associate dentists also saw their average taxable income increase, to £66,700 in 2023 to 2024 compared to £64,300 in 2022 to 2023.

A number of factors make it difficult to compare the level of earnings and gross income from one year to another. These factors include variations in hours worked, variation in the balance between NHS and private sector activity, the evolving nature of practice business

models, the new methodology used to collect data, and the rise in practices becoming corporates or becoming parts of corporates.

Table 20: average taxable income, in cash and real terms, for providing-performer dentists in England, from 2018 to 2019 through to 2023 to 2024

Providing performer dentists			
Year	Cash terms	Real terms	
	Average taxable income	GDP	CPI
2018 to 2019	£113,100	£137,300	£140,000
2019 to 2020	£112,600	£133,500	£137,100
2020 to 2021	£132,200	£148,700	£159,900
2021 to 2022	£135,000	£153,100	£157,000
2022 to 2023	£128,800	£136,800	£136,200
2023 to 2024	£134,400	£134,400	£134,400

Source: Dental earnings and expenses estimates 2023 to 2024 - NHS England.

Table 21: average taxable income, in cash and real terms, for associate dentists in England, from 2018 to 2019 through to 2023 to 2024

Associate dentists			
Year	Cash Terms	Real Terms	
	Average Taxable Income	GDP	CPI
2018 to 2019	£57,600	£69,900	£71,300
2019 to 2020	£58,100	£69,000	£70,800
2020 to 2021	£58,700	£66,000	£71,000
2021 to 2022	£64,900	£73,600	£75,500
2022 to 2023	£64,300	£68,300	£68,000
2023 to 2024	£66,700	£66,700	£66,700

Source: Dental earnings and expenses estimates 2023 to 2024 - NHS England.

7. Total reward

Introduction

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

The total reward package in the NHS includes a generous holiday allowance, which increases each year on top of public holidays (up to 33 days), sickness absence arrangements of up to 12 months of payment, access to a defined benefit pension scheme with an employer contribution rate of 23.7%, enhanced parental leave, and support for learning, development, and career progression. These benefits are above the statutory minimum and exceed those offered in other sectors.

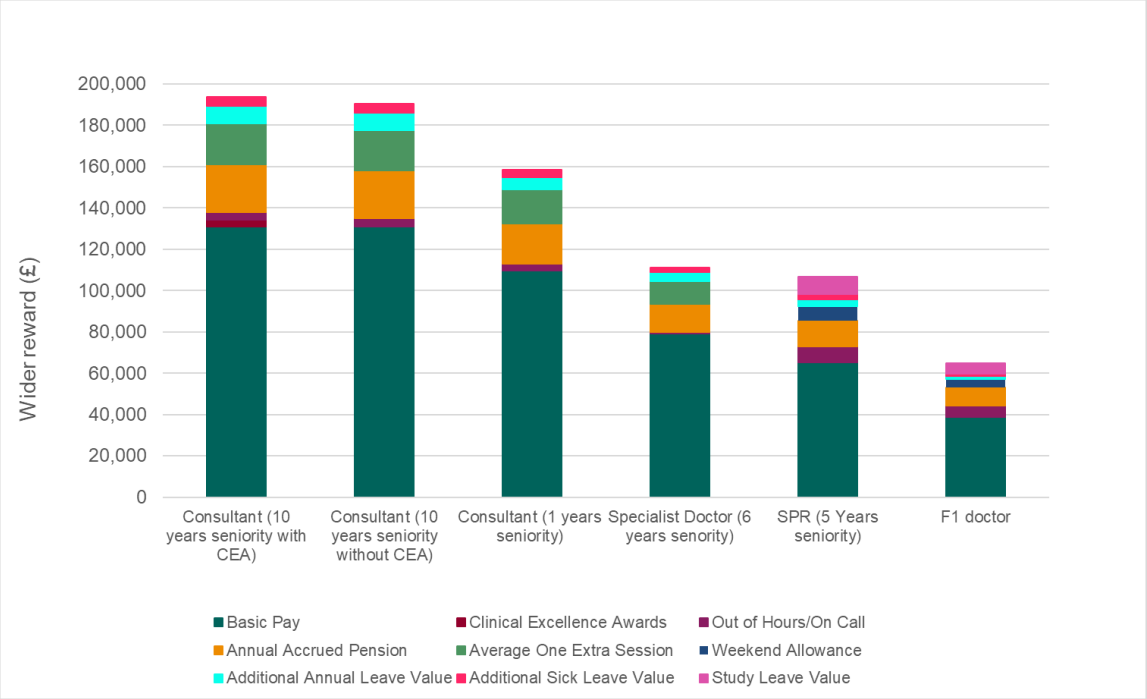
Measuring the value

The department commissions the Government Actuary's Department (GAD) to measure the value of the total reward package for a range of medical roles. The elements included in the package are basic pay, annual accrued pension, additional annual leave value, Clinical Excellence Awards, average one extra session, additional sick leave, out of hours or on-call, weekend allowances and study leave value. Annual accrued pension is a measure of 2015 Scheme pension, which is calculated as the pension accrued over the year multiplied by a factor of 20, less employee contributions.

Clinical Excellence Awards recognise consultants and GPs who contribute to high-quality performance, service improvement, training, teaching and research. Members can hold either a National Clinical Impact Award (NCIA) or a Local Clinical Excellence Award (LCEA). 'New' LCEAs ceased on 1 April 2024 meaning that the 2023 to 2024 award round was the last opportunity for people to receive a new award. However, those who became consultants before 2018, can retain 'old' LCEAs. Figures suggest that currently around 10,000 consultants (20% of the workforce) have retained their awards.

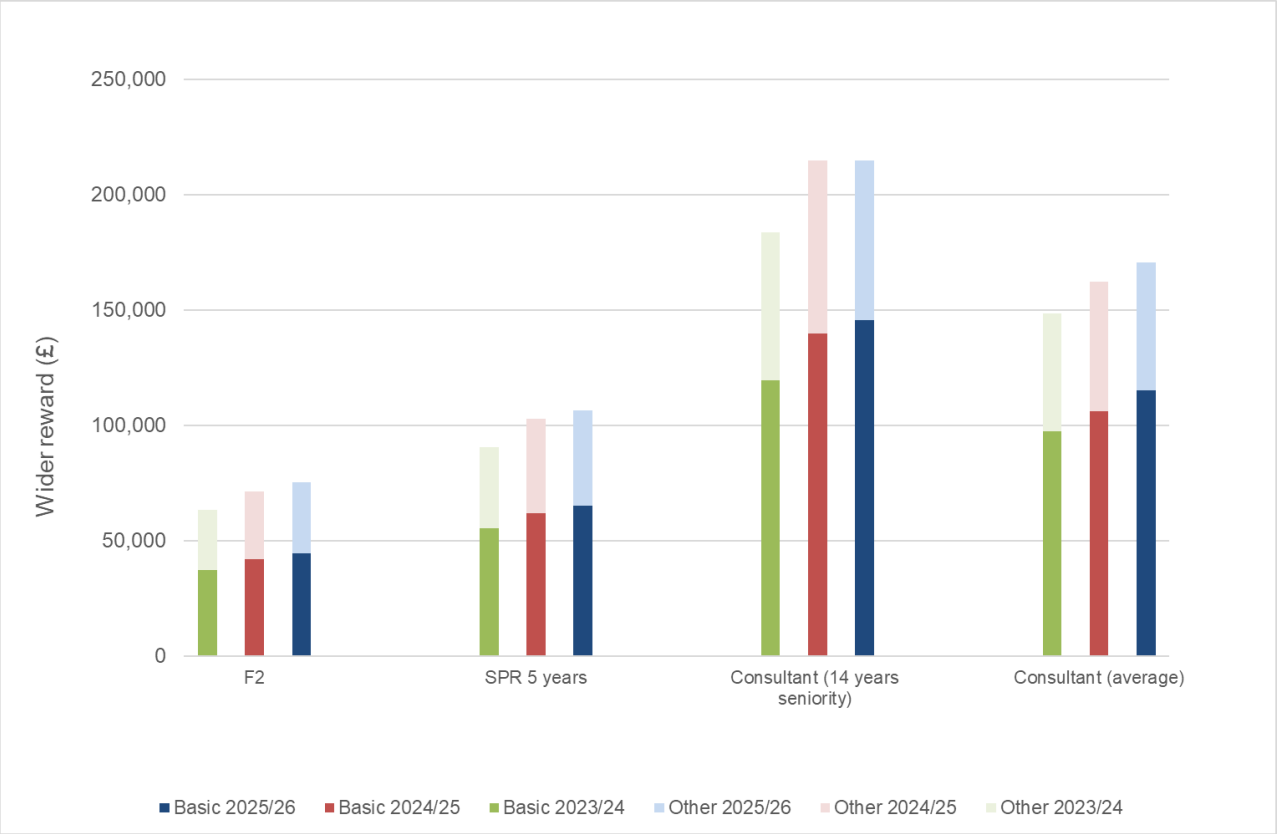
GAD have changed their approach to CEAs this year and based on the new contract, have moved on to the new LCEAs. These awards are £3,092 and are treated as non-pensionable pay. It is important to note that, as in previous years, the basic pay definition used for the analysis is mean annual basic pay per person.

Figure 7: value of the total reward package for NHS doctors



The analysis above for NHS roles shows the split of total reward packages between basic and other pay over the years 2023 to 2024, 2024 to 2025 and 2025 to 2026.This shows that all the doctor roles considered as part of this analysis have experienced an increase in total wider reward in monetary terms over the period 2023 to 2024 to 2025 to 2026.

Figure 8: wider reward trend for NHS doctors over the period 2023 to 2024 to 2025 to 2026



The chart above shows that for multiple staff groups, basic pay and other pay have continuously increased over the past three years. All doctor roles considered in the analysis have at least 34% of the total reward made up of non-basic pay.

From 2023/24 to 2025/26, F2 doctors have received a 19.2% increase in their overall total reward and Specialist Registrars (in their fifth year of training) have received a 17.6% increase. Similarly, Consultants with 14 years seniority and average Consultants have seen their total reward increase by 17% and 14.9% respectively. This supports the evidence in the chart above, demonstrating that total reward is increasing each year for doctors.

NHS Pension Scheme

The NHS Pension Scheme remains a valuable and generous part of the total reward package available to NHS staff.

There are 2 NHS Pension Schemes. A legacy Scheme, which includes the 1995 and 2008 sections, and the 2015 Scheme. Both are defined benefit schemes but they have some key differences; the way benefits are calculated, the normal pension ages and the accrual

rates. The legacy scheme is now closed to new members and all NHS staff who joined the Pension Scheme since 1 April 2022 are automatically in the 2015 scheme.

Table 22: comparison of retirement ages and accrual rates for members of the 1995 Section, 2008 Section and 2015 Scheme

Scheme or section	Normal pension Age (NPA)	accrual rate
1995 Section	60	1/80th
2008 Section	65	1/60th
2015 Scheme	State pension age	1/54th

NHS pension scheme contributions

Members and employers are required to pay towards the cost of benefits built up in the NHS Pension Scheme. At present, employers contribute 23.7% of each member's pensionable earnings, plus a charge of 0.08% to fund the administration of the scheme.

The department reviewed member contributions in 2021 and introduced changes in October 2022 and April 2024. More information on these changes is available from the relevant NHS Pension Scheme: proposed policy changes for April 2024 consultation documents. Following these changes, the member contribution tier thresholds are now updated automatically each April, in line with CPI from the previous September. If the AfC pay award in England is higher than this figure, the thresholds are updated again. This is known as the 'better of' test. This policy acts to ensure that the tier thresholds remain up to date, and to reduce the likelihood of members moving into the next contribution tier solely as a result of receiving a nationally agreed pay award. While doctors and dentist are not paid under AfC, the contribution tiers are increased in line with the AfC pay award because this is the pay award that applies to the largest cohort of staff eligible to join the NHS Pension Scheme.

The thresholds for the first tier and entry to the second tier are not increased (either by CPI or AfC) unless the threshold for basic rate income tax changes.

Table 23: NHS Pension Scheme member contribution threshold structure (as of 1 April 2025):

Pensionable pay range	Contribution rate from 1 April 2025, based on actual annual pensionable pay
Up to £13,259	5.2%
£13,260 to £27,797	6.5%
£27,798 to £33,868	8.3%
£33,868 to £50,845	9.8%
£50,846 to £65,190	10.7%
£65,191 and above	12.5%

Pension projections

GAD calculates that scheme members can generally expect to receive around £2 to £6 in pension benefits for every £1 contributed.

GAD have produced a series of pension projections, which are based on example members with existing service in the NHS Pension Scheme built up prior to 2025. These example members are assumed to have continuous membership in the scheme from the point of joining, and to qualify in their respective fields in 2025. They assume that the example members remain in service and work full-time before retiring at age 65, this being the current average retirement age.

The GP partner and salaried GP examples are assumed to have joined the 2015 Scheme in 2020 aged 25 and to have qualified as GPs in 2025. The consultant example is assumed to have joined the 2015 Scheme in 2016 aged 25 and to have qualified as a consultant in 2025.

We expect that many NHS doctors will choose to commute some of their pension for a tax-free lump sum. We also recognise that a large number of doctors now work less than full time and this will be reflected in their pension accrual. However, for simplicity, the illustrative projections shown below are based on a member continuing in full-time employment throughout their career. The table below therefore shows the pension benefits the example members above could expect to receive, assuming that they commute 20% of their pension for a tax-free pension commencement lump sum (PCLS) at retirement, on current commutation terms. The projected lump sums are below the maximum amount of £268,275 for a tax-free lump sum allowing for real-terms increases by retirement.

Table 24: projected annual pensions and lump sums for NHS doctors qualifying in their respective fields in 2025 and retiring age 65 (in today's monetary terms)

Role	Year of joining	No commutation	Allowing for commutation	Allowing for commutation
		Projected pension (per year)	Projected residual pension (per year)	Projected pension commencement lump sum (PCLS)
GP partner	2020	£75,000	£60,000	£180,000
Salaried GP	2020	£59,000	£47,000	£141,000
Consultant pathway	2016	£81,000	£65,000	£195,000

The projections provided this year are higher than previous years as the updated pay profiles use a higher pensionable pay the those used previously. However, these members are projected to exceed the annual allowance (AA) before retirement, which partially offsets the impact of higher pensionable pay. Calculations assume the AA remains fixed at £60,000, in line with the current policy position.

NHS pension scheme membership

The department continues to monitor scheme membership rates for HCHS doctors through ESR. The table below shows the percentage of doctors, by grade, who were members of the scheme in June 2025 in comparison with June 2024.

This shows that while overall membership rates remain high, there have been reductions in the membership rates for doctors at some grades, most notably. In comparison, there have been large increases in speciality doctor, core training, and hospital practitioners and/or clinical assistant membership rates. Across all HCHS doctors, memberships have increased slightly over the last 12 months.

Table 25: NHS Pension Scheme membership for HCHS doctors as at June 2025 and comparison with June 2024

	June 2025	One Year Change (Percentage point change)
All HCHS doctors	89.0%	Plus 1.0pp
Consultant	93.0%	Plus 1.2pp
Associate specialist	90.3%	Plus 0.7pp

Specialty doctor	85.1%	plus3.4pp
Staff grade	90.7%	minus 3pp
Core training	79.4%	plus 3.4pp
Foundation doctor year 1	91.2%	plus 1.0pp
Foundation doctor year 2	87.1%	plus 1.5pp
Specialty registrar	89.9%	plus 2.8pp
Hospital practitioner and/or clinical assistant	72.2%	plus 3.3pp
Other and Llcal HCHS doctor grades	90.3%	minus 2.4pp

Source - DHSC Analysis of Electronic Staff Record Data Warehouse

Retirement options

Doctors and dentist who wish to retire earlier than their normal pension age (NPA) have the option of taking voluntary early retirement which allows staff to fully retire up to 10 years earlier than their NPA (subject to normal minimum pension age legislation).Their pension will be actuarially reduced (by around 5% per year), to account for the fact that it is being paid earlier and therefore longer.

The generosity of the accrual model, potentially combined with retirement flexibilities, enable members to take early retirement, with an actuarial reduction, before the normal pension age in the scheme and still receive a good value pension relative to the amounts they have contributed to the scheme. If a member is physically or mentally unable to reach NPA within their role, ill-health retirement is a feature of the scheme that is available at any age.

As highlighted in previous evidence submissions, doctors and dentists also have the option, with the agreement of employers, to take partial retirement or retire and return. These flexibilities allow members to claim their pension when it is most valuable to them but don notrequire them to leave or change their job. As well as supporting doctors and dentists with their work-life balance later in their careers, partial retirement may also support NHS employers, by allowing them to retain experienced doctors and dentists for longer.

Average GP retirement ages

Data is not held on overall age of retirement for GPs as there are 2 types of retirement - voluntary early retirement (explained above) and age retirements. The normal pension age is the age that you can retire from NHS employment and have your pension paid without reduction or enhancement. The 1995 section has a normal pension age of 60, and the

2008 section has a normal pension age of 60. Age retirements are taken at or after pension age, while voluntary early retirements are taken before reaching pension age. Members of the 1995 section can take early retirement from age 50 or 55 depending on active membership periods, and for the 2008 section the minimum age is 55.

In October 2023, partial retirement was extended to 1995 NHS Pension Scheme members aged 55 and over in an effort to retain more doctors. This means that members of the NHSPS aged 55 or older can take between 20% and 100% of all their pension benefits in one or 2 drawdown payments, without having to leave their current job. Since October 2023, 3,965 hospital doctors have taken partial retirement which equates to 12.06% of all NHS staff who have selected this retirement option. The majority of these doctors are taking partial retirement once they have reached NPA (1,231 of the 3,965) or after NPA (1,518 of the 3,965) which suggests that they want to continue working in the NHS instead of fully retiring.

Pension tax

As discussed in previous evidence submissions, the generosity of the NHS Pension Scheme and well-remunerated careers has meant that some senior doctors and dentists exceed the AA threshold. As a result of the 2023 Budget, the minimum tapered annual allowance increased from £4,000 to £10,000 and the adjusted income threshold for the tapered AA increased from £240,000 to £260,000. The 2023 Budget also announced the abolition of the lifetime allowance (LTA) for tax-free saving and an increase to the AA, which meant that fewer doctors and dentists were likely to breach this threshold.

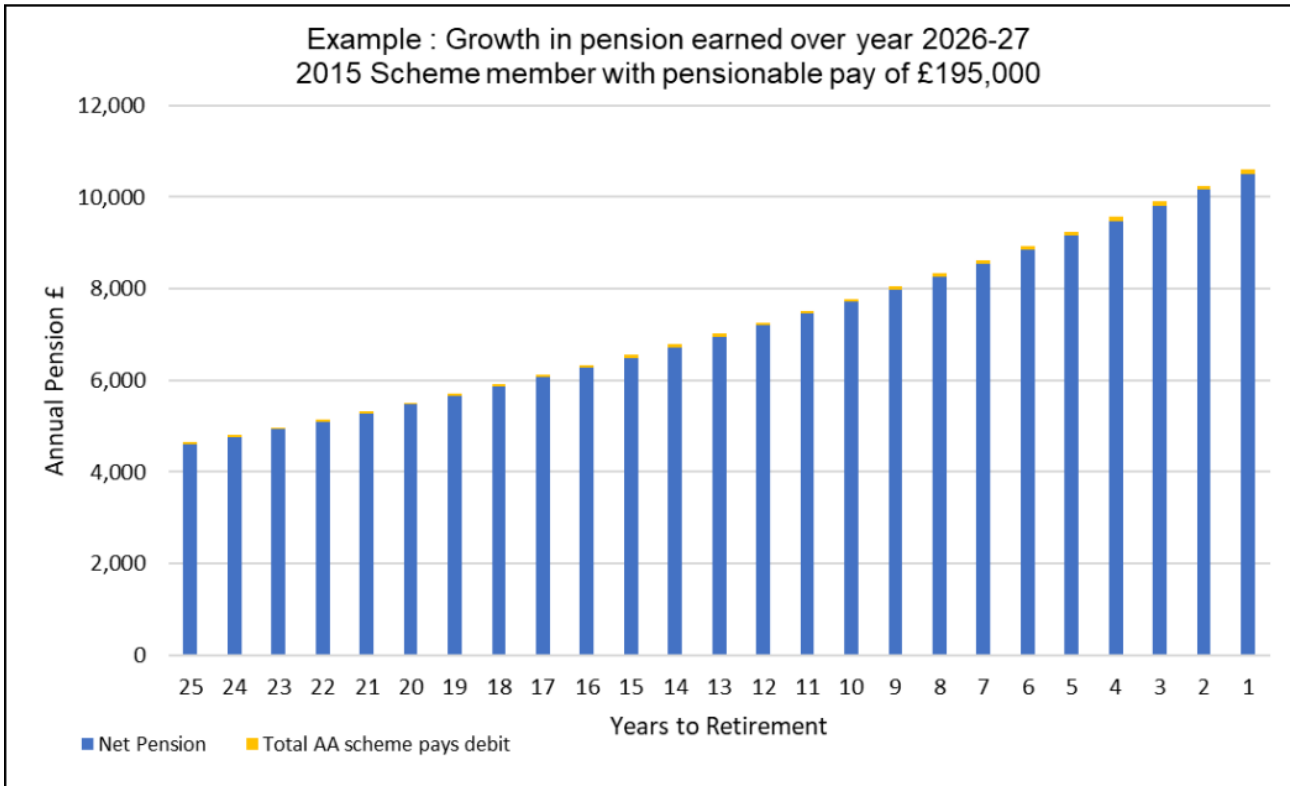
For clinicians who receive AA charges, the ‘scheme pays’ facility allows them to meet the cost of a tax bill from the value of their pension benefits, without needing to find funds upfront. Where a member uses scheme pays, their tax charge is paid through a deduction to their pension benefits at retirement.

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

The chart below shows the pension growth of a 43-year old who joins the 2015 Scheme with 25 years until retirement and pensionable pay of £195,000. Over 2026 to 2027, the member's accrued pension is expected to increase by around £4,600 per year. Based on projection with CPI plus 1.5%, this is expected to be £10,600 per year at retirement age 68. Once the scheme pays debit is applied, this would reduce by around 1% to £10,500

per year. The graph illustrates the progression up to retirement of pension benefits accrued and the annual allowance charges incurred over a single year. 2020 valuation assumptions have been used for long-term CPI and salary increases.

Figure 9: illustrative growth in pension earned over year 2026 to 2027 for a member with pensionable pay of £195,000



The scheme pays charge in this example is relatively small as the member is below the AA taper threshold. Exceeding the AA taper can lead to larger tax charges. This could occur in the example above if the member also has non-pensionable earnings during 2026 to 2027.

Communicating the package

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

All NHS Pension Scheme members also receive an annual benefit statements (ABS) every August, which shows the current value of their scheme benefits. On 25 July 2025, there were 3,073,848 statements available, of which 1,091,850 have been viewed by members. In comparison, on 21 September 2024, there were 3,054,253 statements available and 374,657 views.

As part of the NHSBSA 5-year strategy, there is a commitment to invest in communication with members through the UK Pensions Dashboard Programme. This will enable members to access their pension information online, securely, and all in one place. The dashboard will provide clear and simple information about all an individual's pension savings, including their State Pension.

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