



Review Body on Doctors'
and Dentists' Remuneration

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Fifty Fourth Report – 2026

Chair: Mark Hoble JP



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

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

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

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

by Command of His Majesty

March 2026



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Review Body on Doctors' and Dentists' Remuneration

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

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

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

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

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

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

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

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

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Executive summary

1. The Review Body on Doctors' and Dentists' Remuneration provides advice to ministers in the governments of the UK on the remuneration of all doctors and dentists employed by, or providing services to, the NHS in England, Scotland and Wales and the HSC in Northern Ireland.
2. Our 2025 headline pay recommendations were accepted for all remit groups and in all nations for which they applied. We received mixed responses from the governments to our additional recommendations which we discuss in more detail later in this report. Since last year the UK Government has set out an ambitious 10-year plan for healthcare in England, and the aspirations of this have been echoed by other nations. There has been some improvement in the workforce position across many parts of our remit group, although ongoing industrial relations challenges and strikes by resident doctors in England reflect dissatisfaction with pay and training places and concerns over working lives.
3. Despite a very delayed response from the UK Government to our full set of 2025 recommendations, we have been able to submit our report six weeks earlier than last year and three months earlier than in 2024. We thank all parties for timely and valuable participation and submission of evidence. We will continue to work with governments and evidence providers to bring the process forward. We expect governments and employers to implement our recommendations as soon as they are able. Many remit group members, especially those working in Northern Ireland and in dentistry, have raised the issue of late payment of uplifts with us, which is both demoralising and financially destabilising, and we hope payment is made promptly this year.
4. In this report, we make our recommendations for the 2026-27 financial year. Our recommendations are based on our independent assessment of the data and evidence, in line with our terms of reference. We consider each factor in our terms of reference independently and separately from the others, with the importance of each factor reflecting the evidence received.
5. Our terms of reference ask us to take into account the overall strategy that the NHS should place patients at the heart of all it does. We firstly wish to recognise the enormous contribution that the doctors and dentists in our remit group make to the NHS and the health and wellbeing of the nation. Doctors and dentists will be responsible for delivering future healthcare to patients with increasingly complex needs, and our role is to support and enable this.
6. All the governments of the UK are looking to make significant reforms to the way healthcare is delivered. This requires an engaged and committed workforce. Appropriate workforce planning, linked to the changing healthcare needs of the population, will be crucial in delivering these reforms.
7. We make our recommendations in the context of the wider UK economy and NHS funding. NHS providers report extremely tight financial settlements and are required to make substantial productivity gains. Many are reducing wider recruitment as a result, which is likely to be detrimental for our remit group if medical support roles are removed.
8. Despite the very many pressures on NHS budgets, and the tight affordability constraints that have been set out to us, it is crucial that doctors and dentists remain appropriately

rewarded for their high levels of expertise and the very significant demands placed on them.

9. The wider labour market has weakened over the last year, with a notable reduction in job opportunities across the economy, especially for recent graduates. Despite this, average earnings growth has remained strong and early pay settlement data for 2026 show medians of 3.2 per cent. CPI inflation is at 3.0 per cent and is forecast to fall close to 2 per cent over 2026-27. This forecast does not take into account recent geopolitical uncertainty, in particular in the Middle East, and the potential impact on energy prices.
10. We see a general picture of improved recruitment and retention across the secondary care medical and dental workforce, as evidenced by growing workforce numbers, improved retention, falling vacancies, and lower retirement rates. There has also been growth in the GP workforce, with an increase in the supply of GPs, and a fall in the number of vacancies. Although the number of leavers from the medical register to practise overseas has increased, this is concentrated among doctors who are not GPs, consultants or in training, and many of these doctors are unlikely to have held an NHS post.
11. There are, however, ongoing recruitment and retention challenges within some clinical specialties, and in rural, remote and coastal areas, which have a substantial impact on service delivery. These cannot be addressed through a general pay uplift, and we expect to see governments and employers pay more significant attention to how these can be mitigated.
12. We have continued to expand and develop our work on pay comparability, in line with our revised terms of reference, using a range of methodologies. Resident doctors in England have seen both basic and total real earnings growth over the last decade. Consultants have seen real basic pay growth, but falls in real total earnings, linked to reform of clinical excellence awards. Specialty doctors in England have seen real terms growth in earnings over the last decade, while specialists have seen falls. The picture for GPs diverges by nation and by group.
13. Resident doctors have improved their relative position in the earnings distribution over the last year, supported by higher pay awards, while senior doctors have maintained their position. More so than comparator professions, doctors and dentists working in secondary care typically experience very strong in-role pay progression and structured pathways for promotion over their career. All groups of doctors have a total remuneration package, including NHS pensions, that is ahead of comparator roles, although basic pay is lower in some cases. The body of evidence on pay comparability does not support the case for a significant adjustment to pay for our remit groups.
14. There appears to be some improvement in motivation, morale, engagement and wellbeing among our remit groups, from a low point in 2022, but not to the levels seen before the pandemic.
15. Talks with resident doctors in England over pay and jobs are ongoing as we make our recommendations. We understand these also reflect longer-term concerns about wider working conditions. The recent focus on improving working conditions, especially for resident doctors, is welcome and we hope it will translate into demonstrable improvement in working lives.

16. Our remit covers all four nations of the UK, and we receive separate evidence on each. When making our recommendations, we are cognisant of differences between the nations, in terms of the economy, affordability, health policy, and recruitment and retention. However, governments and parties have stressed to us the benefit of a review body that makes UK-wide pay recommendations, and the desire for pay parity. Consequently, we make recommendations for all four nations, but this is not to understate variation both between and within nations, which requires a more targeted approach to address specific local issues.
17. Considering all these factors, **we recommend a 3.5 per cent increase to the pay ranges and the pay element of contracts from 1 April 2026.** This applies to: resident doctors and dentists; consultants; SAS doctors and dentists; locally employed doctors; contractor general medical practitioners; and salaried GP pay ranges. This applies to all the nations of the UK, with the exception of resident doctors and dentists, where it only applies in England, Wales, and Northern Ireland.
18. We see a different situation for dentistry than the other parts of our remit, with significant workforce issues, persistent under-delivery of NHS care, poor access for patients, and a lack of attractiveness of NHS dentistry, driven in large part by the underlying contracts. In England, there has been both a notable fall in real terms expenditure on dentistry since 2009-10, of around 13 per cent, despite an increase in the most recent year, and large-scale under-delivery of contracts equal to £900 million over the last two years. Many dentists have seen falls in real terms earnings over recent years, and associate dentists are earning less than some comparator professions. While these issues should be addressed directly by governments through contract reform and long-term workforce planning, there is a need for us to take action on pay to make NHS dentistry more attractive to dental practitioners. **We therefore recommend a 3.75 per cent increase to the pay element of dental contracts and to pay for salaried dentists working in Community Dental Services (CDS) and the Public Dental Service (PDS).**
19. This UK-wide recommendation on dentistry does not downplay the differences between nations or the need for continuing action by governments. The Scottish Government has already significantly increased the value of dental fees. The Welsh Government is looking to introduce a new contract from April. The UK Government has committed to long-term contract reform and has current policies to increase access to urgent dental care. We do not imagine these steps or our pay recommendation will fully resolve the significant challenges in NHS dentistry. As we have stated in previous reports, substantial reform to the contracts is needed to make NHS dentistry attractive. We hope to see significant progress made over the next year. This is the first time in decades that we have made a differential pay recommendation for dentistry, and we will keep this under review for subsequent reports.
20. Last year we highlighted the urgent need for an effective uplift mechanism in primary care contracts to reflect the actual cost of providing care. Existing mechanisms, linked to general inflation indices or our recommendations, are not appropriate. The UK and Northern Ireland governments have made some progress on this, in terms of undertaking work to better understand the costs of providing care. However, this issue has not been resolved and remains critical in ensuring the sustainability of primary care.
21. Additional resource has been provided to support general practice, but we have not seen similar resource invested in dentistry, and incentives to deliver NHS dental care continue to deteriorate. Consequently, we again recommend **that the four governments work with dentists' representatives to develop an index of dental costs in each nation.**

The development of such an index for dentistry is the priority, but we will continue to keep the issue of the cost uplift for general practice under review and revisit this next year.

22. The under-provision of general dentistry has severely increased the demand for and pressure on the Community Dental Service and the Public Dental Service. This service is continually neglected, especially in England. Last year we recommended that each government undertake a review of pay and progression for salaried dentists working in Community and Public Dental Services to assess whether the reward structure was appropriate to support recruitment, retention and service delivery.
23. Our visits this year again highlighted substantial issues with workload and stress across the service. Employers report difficulty in recruiting dentists to the service, and special care dentistry training places remain unfilled. It is encouraging to see some engagement between governments and CDS and PDS dentists in Scotland, Wales and Northern Ireland. However, workforce issues have not been addressed.
24. This is a neglected service under severe strain which is picking up the slack from the under-provision of high street dentistry, and which supports the health of some of the most vulnerable patients in society. Again, **we recommend that governments review pay and progression for salaried dentists working in Community and Public Dental Services to assess whether the reward structure is appropriate to support recruitment, retention, and service delivery.** This needs to start with a strong evidence base on the current workforce and service delivery.
25. We were able to conduct a very valuable visit programme this round, with 20 primary care discussion groups and 18 secondary care discussion groups across 10 UK-wide locations. These groups are very informative and have helped to shape our recommendations, and we are grateful to those who took part in and hosted these sessions. We look forward to meeting more members of our remit group in the coming round.

Chapter 1 Introduction and recommendations

The Review Body on Doctors' and Dentists' Remuneration

- 1.1 The Review Body on Doctors' and Dentists' Remuneration (DDRB) provides advice to ministers in the governments of the UK on the remuneration of all doctors and dentists employed by, or providing services to, the National Health Service (NHS) in England, Scotland and Wales, and Health and Social Care (HSC) in Northern Ireland. In this report, we make our recommendations and observations for the 2026 pay round, covering the 2026-27 financial year.
- 1.2 We are governed by our terms of reference which are reproduced at the start of this report. Our annual pay review process begins with a programme of visits, where we meet members of our remit groups and local health service leaders in a variety of locations and healthcare settings across the UK. We take written and oral evidence from a range of organisations, including governments and trade unions, before making our recommendations. Following receipt of our recommendations, it is up to the governments to decide how to respond, and it is them, and the leaders of the health services they oversee, who ultimately implement annual pay uplifts for doctors and dentists.

Our remits for this year

- 1.3 Our remit letters from each of the four governments are in appendix A. We received our remit letter from the Secretary of State for Health and Social Care on 22 July 2025. The Cabinet Secretary for Health and Social Care wrote to us on 23 July 2025 to commence the pay round for medical and dental staff in Wales. The Minister of Health wrote to us on 29 July 2025 to commence the pay round for doctors and dentists in Northern Ireland. The Cabinet Secretary for Health and Social Care wrote to us on 24 September 2025 to commence the pay round for doctors and dentists in Scotland, with the exception of resident doctors and dentists.

Evidence

- 1.4 We received written and oral evidence from the following organisations which are parties to our process:
 - The Department of Health and Social Care (DHSC).
 - The Scottish Government.
 - The Welsh Government.
 - The Department of Health in Northern Ireland.
 - NHS Employers.
 - The British Dental Association (BDA).
 - The British Medical Association (BMA).
 - The Hospital Consultants and Specialists Association (HCSA).
- 1.5 NHS England submitted joint evidence with the DHSC. We held separate oral evidence sessions with the ministers for primary and secondary care in England. We also held five separate oral evidence sessions with the BMA for: consultants; specialty, associate specialist and specialist (SAS) doctors; resident doctors; general medical practitioners (GPs); and the national chairs. We also received evidence from His Majesty's Treasury (HM Treasury) and the Association of Dental Groups (ADG).

- 1.6 We undertook ten visits in autumn 2025 across England, Scotland, Wales, and Northern Ireland, and would like to thank everyone involved in organising them and those who took part in discussion groups. The following visits were undertaken:
- Northern Ireland GPs.
 - Norfolk Local Dental Committee and East of England community dentists.
 - Sheffield Teaching Hospitals NHS Foundation Trust.
 - Northern Ireland dentists and community dentists.
 - Sunderland Local Medical Committee.
 - NHS Western Isles.
 - Belfast Health and Social Care Trust.
 - Cwm Taf Morgannwg University Health Board.
 - NHS Lothian.
 - East Kent Hospitals University NHS Foundation Trust.
- 1.7 Across these visits, we held 18 discussion groups with consultants, SAS doctors and dentists, and resident doctors. We also held 20 discussion groups with GPs, general dental practitioners (GDPs), and dentists from the Community Dental Service (CDS) and the Public Dental Service (PDS).
- 1.8 We also considered economic and workforce data prepared by our secretariat, policy developments from the governments, and broader research on the medical and dental workforces including UK and international pay data, and commissioned research on pay comparability.

Our terms of reference

- 1.9 The 2024 agreement with consultants in England brought in changes to our terms of reference, which are set out at the start of this report. The changes include an additional factor to be considered in our recommendations: doctors' and dentists' earnings in the context of long-term trends in the wider labour market, alongside comparator professions, including relevant international comparators. The revised terms of reference also ask us to evaluate the weight of each consideration independently, in parallel and non-contingently.
- 1.10 We have again reflected the changes made to the terms of reference in our deliberations this year. We make our independent recommendations having fully considered the evidence we receive. Reflecting our revised terms of reference, we have also undertaken an external review of our approach to pay comparability which is discussed further below and in appendix E.
- 1.11 As in the past, we consider each of the factors within our terms of reference on its own merits and take a balanced approach across them. In our deliberations, we consider each factor independently and separately from the others, reflecting the evidence received. The importance each is given reflects the weight of the evidence. This is an element of the process that has been made more explicit in our new terms of reference.

Our recommendations last year

- 1.12 Our 2025 report was published on 22 May 2025. We recommended:
- A 4 per cent increase to salary scales, pay ranges and the pay element of contracts from 1 April 2025. This applied to the following groups in all four nations of the UK: consultants; SAS doctors and dentists; salaried dentists, including those

working in the CDS and the PDS; contractor GPs; salaried GP pay ranges; and the pay element of dental contracts.

- A 4 per cent increase plus a consolidated uplift of £750 to the pay points for resident doctors and dentists in England, Wales and Northern Ireland from 1 April 2025.
- That governments consider a separate pay framework for locally employed doctors.
- The government reviews flexible pay premia in England to assess their value for money and effectiveness.
- An increase in the value of national clinical impact awards in England and Wales from 1 April 2025.
- That the four governments work with GPs' and dentists' representatives to develop an index of general practice costs and an index of dental costs. These indices should then be used to determine the expenses element of the GP and dental contract uplifts in each nation.
- That each government should undertake a review of pay and progression for salaried dentists working in Community and Public Dental Services to assess whether the reward structure is appropriate to support recruitment, retention and service delivery.

1.13 All four governments accepted our recommended pay uplift of 4 per cent.¹ The recommendation for resident doctors was accepted in England, Wales and Northern Ireland. We set out responses to our additional recommendations in more detail below.

1.14 In his remit letter this year, the Secretary of State said that the recommendation last year was above the figure set out as affordable. The DHSC said that the 2025 pay uplift was met from within DHSC budgets through decisions on reprioritisation, the dissolution of NHS England, and reshaping and reducing Integrated Care Board costs. The Scottish Government said it believed the recommendations were reflective of the economic conditions within Scotland and the UK at large.

1.15 Although accepted, the pay uplift in Northern Ireland was not confirmed until November 2025, with implementation in February 2026 for secondary care staff.²

1.16 The BMA said it was extremely disappointed by the recommendation of a 4 per cent pay uplift. It said that, with the retail prices index (RPI) rate of inflation at 4.5 per cent, this represented a pay cut for doctors that did nothing to redress historic losses in doctors' pay. The BMA Resident Doctors Committee in England announced a strike ballot before our report was published. The BMA's consultants and SAS committees in England both entered formal disputes with the Government after the pay uplift was announced. The BMA Northern Ireland consultants committee also entered formal

¹ UK Parliament, *NHS Workforce*. <https://questions-statements.parliament.uk/written-statements/detail/2025-05-22/hcws663>

Welsh Government, *Written Statement: Responding to the 38th NHS Pay Review Body and 53rd Doctors and Dentists Review Body*. <https://www.gov.wales/written-statement-responding-38th-nhs-pay-review-body-and-53rd-doctors-and-dentists-review-body>

Northern Ireland Assembly, *Written statement to the Assembly by health Minister Mike Nesbitt MLA – 28 May 2025 – Health Service Pay*. https://www.niassembly.gov.uk/globalassets/documents/official-reports/written-ministerial-statements/2022---2027/bv177_doh_280525.pdf

The Scottish Parliament, *Meeting of the Parliament*. <https://www.parliament.scot/chamber-and-committees/official-report/search-what-was-said-in-parliament/meeting-of-parliament-12-06-2025?meeting=16486>

² Department of Health, *Minister confirms restoration of pay parity for health service staff*. <https://www.health-ni.gov.uk/news/minister-confirms-restoration-pay-parity-health-service-staff>

dispute with the Department of Health in July 2025 over the pay uplift and the timing of its implementation.

- 1.17 The HCSA said that the outcome of the 2025-26 pay round came as a disappointment to the medical profession. It said that, for senior doctors, the 4 per cent uplift lagged inflation, undoing some of the work to address pay erosion that had been achieved in the previous year's settlement. It said that the award had done little to reinforce the value of hospital doctors.
- 1.18 The BDA said that the DDRB's recommendation of a 4 per cent pay rise was insufficient to have a substantial impact on the recruitment, retention, morale and motivation of dentists working for the NHS.
- 1.19 NHS Employers said that the differential in pay awards between medical and dental staff and Agenda for Change staff prompted concern across the NHS workforce regarding fairness, morale, and cohesion. NHS Employers said that the NHS operated as a single, integrated multi-professional workforce, with nurses, allied health professionals, support staff, and doctors working together to deliver patient care. They said that when pay awards were perceived as inconsistent or unjustified, it risked undermining trust in the pay review process and weakening the sense of shared purpose that underpinned effective multidisciplinary working.
- 1.20 NHS Employers said that greater coordination between the pay review bodies was essential to improve the understanding of the rationale behind any decisions to apply differential pay awards between staff groups. They said that, while each body operated within its own remit, the interdependency of NHS roles meant that decisions made in isolation could have unintended consequences across the wider system. They said that a more integrated approach, where pay review bodies considered the broader impact of their recommendations, could help ensure greater consistency, transparency and fairness.
- 1.21 NHS Employers acknowledged that there remained a certain rationale for treating groups of staff differently in particular years. However, they said that these separate processes were not always easily described and communicated, leaving simple and somewhat misleading comparisons to be made when headline pay awards differed.

Timing of the pay round

- 1.22 We received our remit letters from governments for the 2026-27 pay recommendation between 22 July and 24 September 2025, earlier than 30 September to 11 December 2024 for the 2025-26 pay recommendation. Our written evidence this round was received between late September 2025 and late January 2026, compared with late November 2024 to early February 2025 for the previous round. We held 14 oral evidence sessions between late November 2025 and early February 2026, compared to late January to early March 2025 for the previous round.
- 1.23 The UK Government did not respond formally to our additional recommendations from the 2025 report until March 2026. This was very late in the process and caused challenges to our deliberations this year. Despite this, we have been able to submit our report six weeks earlier than last year and three months earlier than in 2024.
- 1.24 A number of parties raised the very late payment of uplifts in Northern Ireland with us. In oral evidence, the Northern Ireland Health Minister said that, although there was a commitment to bring forward the timing of the review body process, they were going

to prioritise funding for pay and give a down payment in April 2026 in advance of implementing the review body recommendation. However it is administered, we hope that the 2026 pay award is paid to doctors and dentists much earlier in the year than the 2025 uplift.

- 1.25 The BDA said it regretted that measures to bring forward the pay round had had no impact on governments regarding the timeliness of the implementation of the uplift. It said that delayed uplifts exacerbated challenges to practices' financial sustainability and dentists' personal finances and eroded already poor morale.
- 1.26 Our remit from the Secretary of State asks us to deliver our recommendations at the earliest point that allows us to give due consideration to the relevant evidence, which we have done. As we set out in last year's report, we fully endorse actions to bring the pay round forward. All parties would like to see further improvement the timeliness of the pay round.
- 1.27 We address a great breadth of issues in our work and are committed to a full and detailed consideration of the evidence. This process takes time and needs to be built into a realistic timetable. We expect parties to discuss and agree on a timetable for the next round that will enable our recommendations to be submitted, agreed and implemented as close to 1 April as possible. This will require remit letters in the summer and the submission of written evidence by all parties in early September, in order that oral evidence sessions can be completed in the autumn. As we highlighted last year, earlier reporting shifts the body of evidence available to us at the point that we make our recommendations. For example, we have not been able to consider the results from the 2025 NHS staff survey this year.
- 1.28 An earlier round requires action from all parties, starting with a timely response to our recommendations. In particular, we ask that the devolved governments consider how an earlier review body round can be made compatible with their budget setting processes, which are currently not concluding until the start of the calendar year.

Pay proposals from the parties

- 1.29 The DHSC said it had developed financial and delivery plans which allowed for a pay uplift of 2.5 per cent without having to make trade-offs against headline government health commitments. It said that, should the independent pay review bodies recommend an award above this level, it would need to consider whether and how this could be made affordable from within existing DHSC budgets. It said that accepting such an award would inevitably have an impact on healthcare delivery.
- 1.30 NHS Employers said they would like investment in headline pay award uplifts to be prioritised. They said that awards should be fully funded and sustainable, allowing employers to continue prioritising workforce growth and service improvements. NHS Employers did not recommend any targeted pay actions across the medical workforce and said that any pay uplifts should be applied equally to all staff.
- 1.31 The Scottish Government pointed to its public sector pay policy, which set out a multi-year pay envelope of 9 per cent across 2025-26, 2026-27, and 2027-28. It said that, to maintain financial and service sustainability, particularly in the face of rising workforce costs and easing inflationary pressures in 2026-27, it was vital that pay decisions continued to be made within this framework.

- 1.32 The Welsh Government said it did not support the use of targeted pay to specific staff groups. It said that, although there were shortages of staff in specific specialities, these were UK-wide issues and related to the numbers of staff training in these areas, rather than the financial rewards.
- 1.33 The BMA called for the DDRB to recommend a significantly above inflation pay uplift, in real (RPI) terms, to restore doctors' pay to 2008-09 levels by 2027-28, in line with BMA policy. Different branches of the BMA called for different levels of pay uplift: above inflation (Northern Ireland branches); 15 per cent (SAS doctors in England); 16.6 per cent (consultants in England); and 20 per cent (salaried GPs in England). BMA Scotland asked for a higher uplift to the specialist pay scale. BMA consultants in England asked that the highest pay point be uplifted by more than the rest of the pay scale; and that pay point 2a be increased to bring it in line with pay point 2b.
- 1.34 The BDA called on the DDRB to recommend an overall uplift of 8.99 per cent for all NHS general dental contracts, fees and allowances. This included a 9.5 per cent uplift in GDP pay. It also asked the DDRB to recommend a pay uplift of 9.5 per cent for employed dentists, to attract and retain a sustainable NHS workforce. It did not recommend targeting awards.
- 1.35 The HCSA called for a good-faith multi-year agreement to restore the value of resident doctor pay through a series of above inflation annual pay rises and a future commitment to maintain pay at least level with inflation after that.

Factors in making our recommendations

- 1.36 As set out above, we consider each factor in our terms of reference independently and separately and take a balanced approach across them, reflecting the weight of the evidence received.

The broader context for the NHS

- 1.37 Our terms of reference ask us to take into account the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved, as well as the contribution of doctors and dentists to the health of the nation.
- 1.38 Recent trends in NHS activity vary across the UK. Activity has increased in some nations over the last year and compared to pre-pandemic levels, while in other nations activity is still below pre-pandemic levels. Waiting lists for treatment remain high across all nations, albeit with some improvement over the last year. Long waits for care can worsen the health of patients and increase the complexity of their conditions, thereby further adding pressure on NHS staff. The number of patients accessing NHS dentistry remains lower than before the pandemic across all UK nations which is also a significant concern.
- 1.39 Healthcare productivity figures show, at best, only moderate improvement, and remain below pre-pandemic levels. Analysis by the Institute for Fiscal Studies points to a marked increase in the amount of activity required before patients can be removed from the waiting list to explain why progress has been limited in this area. Despite this, NHS financial planning relies on substantial efficiency gains being made by NHS trusts and health boards to meet targets. While the NHS 10-year health plan for England recognises the need for investment, this will take a long time to deliver benefits.

- 1.40 The Welsh Government said that pay, retention and training investments were practical enablers of productivity gains, and they helped convert pathway reforms and performance management. It would be instructive for all governments to consider how reward and workforce can enable increased productivity and performance.
- 1.41 A workforce plan for England is expected in the Spring, to support the aims of the 10-year health plan. The other nations are also undertaking workforce planning. We welcome this increased focus, and hope in particular that the workforce plan in England will set out the workforce requirements to support the objective of moving care into the community and more details on how governments will address the non-pay concerns of staff.

The macroeconomic picture

- 1.42 Our terms of reference ask us to look at wider macroeconomic factors. Economic growth slowed over 2025 and is forecast to be moderate, at 0.9-1.4 per cent in 2026. This constrains public funding for investment in healthcare. Consumer prices index (CPI) inflation was at 3.0 per cent in January 2026 and CPIH inflation (including owner occupiers' housing costs) was at 3.2 per cent. CPI inflation was forecast to fall towards 2 per cent over 2026, with the Bank of England expecting CPI inflation to fall back to around the 2 per cent target from April. These forecasts do not take into account the recent geopolitical uncertainty, in particular in the Middle East, and its potential impact on energy prices. The labour market has shown signs of further weakening over the last year, reducing external opportunities for employment, and increasing the relative job security of NHS employment.
- 1.43 In making our recommendations, we consider trends in average earnings growth and pay settlements across the wider economy which indicate the typical increases being received by other employees and provide a useful reference point. Average private sector earnings growth was at 3.5 per cent in the three months to December 2025. Earnings growth at the upper end of the earnings distribution, which is a better match for most of our remit group, was below 2 per cent. Median pay settlements are expected to be at 3.0-3.5 per cent over 2026 and early pay settlement data for 2026 show medians of 3.2 per cent.

NHS funding and affordability

- 1.44 Our terms of reference ask us to have regard to the funds available to health departments. There are nominal increases in health budgets for 2026-27 of 4.8 per cent in England, 3.8 per cent in Scotland, 3.6 per cent in Wales and 0.9 per cent in Northern Ireland.
- 1.45 The DHSC has developed financial and delivery plans which allow for a pay uplift of 2.5 per cent and said that accepting an award above this would inevitably have an impact on healthcare delivery. The Scottish Government said that a 3 per cent uplift had been budgeted for, in line with its public sector pay policy. The Welsh draft budget assumed an uplift of 2.2 per cent for public sector pay. An explicit pay affordability budget in Northern Ireland was not shared with us. Both the UK and Welsh Governments have been explicit that pay awards need to be funded from within departmental budgets.
- 1.46 NHS providers report extremely tight financial settlements, are required to make substantial productivity gains, and many are reducing wider recruitment as a result. If support roles are removed, this could reduce both the current support for doctors and

dentists, and also the ability to improve working lives through, for example, a reduction in payroll errors or improved rostering.

- 1.47 HM Treasury said that, should the review bodies recommendations exceed the affordability figures, departments would have to carefully consider if further efficiencies or cuts were possible, and recommendations would have to be rejected if they proved unaffordable. If recommendations above affordable levels were accepted, it would mean challenging trade-offs, with the potential to impact the government's wider commitments to improve public services.
- 1.48 As we said last year, the evidence we receive on affordability is not an overriding factor in our deliberations, as we have demonstrated over a number of years by making pay recommendations above the governments' stated affordability levels, sometimes significantly so. However, the available funding to health departments remains an important consideration, alongside all other factors.

Recruitment and retention

- 1.49 The overall trend appears to be improvement in recruitment and retention across the secondary care medical and dental workforce, as evidenced by the growing workforce, improved retention, falling vacancies, and lower retirement rates. This is despite overall increasing demand and the creation of new roles in some areas. High and increasing training fill rates suggest this will continue in the medium term.
- 1.50 There are, however, ongoing recruitment and retention challenges within some clinical specialties and in rural, remote and coastal areas. It is clear that, where vacancies persist, they have a substantial impact on service delivery, lead to high agency and locum costs, and intensify workloads and stress levels among other staff.
- 1.51 There has been some workforce growth in the number of GPs over the last year, but this is concentrated among salaried GPs, with the number of GP partners falling. The workforce growth is substantially below that seen in secondary care, although it has enabled the number of GPs per 100,000 registered patients to improve in England and Wales over the last two years.
- 1.52 Workforce evidence indicates that recruitment for GPs has become easier, with an increase in the supply of GPs, and a fall in the number of vacancies. NHS England data indicate that the number of current GP job adverts is just over half the level seen in 2022-23. The GP vacancy rate halved in Scotland between 2023-24 and 2024-25. There is evidence of under-employment among GPs, especially in England. GP training places are full, and incentive payments have been removed in England and Scotland without impacting recruitment.
- 1.53 There is significant evidence indicating difficulty in both recruiting dentists to undertake NHS work and in maintaining NHS activity among existing dentists. The dental workforce increased in England, Scotland and Northern Ireland over the most recent year, but decreased in Wales. Over the medium term, the NHS dental workforce has only grown in Northern Ireland. The NHS dentistry vacancy rate in England was 19 per cent in December 2024. Golden hellos for dentists are not reported to have been effective. There are particular problems in recruiting dentists to rural areas in Scotland and Wales. CDS employers also report difficulties in recruiting dentists to band A.

Pay comparability and trends in the wider labour market

- 1.54 As set out in our terms of reference, we examine in detail developments in doctors' and dentists' earnings in the context of long-term trends in the wider labour market.
- 1.55 Pay comparability, particularly growth in pay compared to inflation, has been a key element of industrial disputes by doctors in recent years. The BMA's position is that pay should be restored to 2008 in real terms (using the retail prices index) in recognition of the fact that the value of a doctor to society has not reduced since that time.
- 1.56 Our role is to make recommendations on pay based on the considerations in our terms of reference, rather than to ensure that pay for our remit group tracks inflation or any other measure. However, it is also not the case that all groups of doctors and dentists have experienced real term declines in pay. The conclusion of real terms pay losses depends on the specific choice of starting year; 2008 was an historic peak, and different starting years show different outcomes. Conclusions of significant real terms pay losses also depend on the use of the retail prices index, which is considered by statisticians not to be a good measure of inflation and therefore we do not use it in our analysis.³ Moreover, a comprehensive assessment of pay comparability is more appropriate than a single measure.
- 1.57 The long-term trend varies significantly depending on the measure of pay, the comparator or price index, and the starting year of any comparison. Consequently, we consider a number of different time periods (partly reflecting data availability across different workforce groups) and measures of earnings in our analysis to give a balanced picture. We also commissioned an independent review of our pay comparability methodology which included an assessment of the current position of earnings across our remit group alongside comparator professions. This is set out in appendix E and published separately alongside this report.
- 1.58 Resident doctors have seen real terms increases in both basic pay and total earnings since 2015 and 2019. Consultants have seen real terms growth in basic pay since 2015 and 2019, but a real terms fall in total earnings over both periods, likely driven by the reduction in the scope of clinical excellence awards. Using 2010 as the starting year (the earliest year for which earnings data is available), some resident doctors have seen real terms growth in basic pay; however, total earnings per head have declined in real terms across all doctor groups.
- 1.59 The picture on earnings growth for GPs varies by nation. Contractor GPs in England and salaried GPs in Wales and Northern Ireland have seen real terms increases in pre-tax income since 2015-16, the earliest year for which data are available. Contractor GPs in Wales and Northern Ireland, and salaried GPs in England, have seen real terms falls in pre-tax income since 2015-16. Both contractor and salaried GPs in Scotland have seen real terms increases in pre-tax income since 2015-16 but falls since 2019-20.
- 1.60 Data on pre-tax earnings for GDPs only goes back to 2017-18. Over this period, providing-performer dentists in England, Scotland and Northern Ireland, and associate dentists in England, have seen real-terms falls in average pre-tax incomes. Providing-

³ UK Statistics Authority, *UK Statistics Authority Statement on the future of the RPI*.
<https://uksa.statisticsauthority.gov.uk/news/uk-statistics-authority-statement-on-the-future-of-the-rpi/>

performer dentists in Wales and associate dentists in Scotland and Wales have seen real terms growth in average pre-tax incomes.

- 1.61 As well as considering real terms trends in pay, it is also important to position doctors' and dentists' pay in the broader economy over time, and to consider comparisons with roles of similar scope. Resident doctors have fallen back in the earnings distribution since 2010-11, although there have been gains over the latest year. The position is likely to continue to improve, given the strong recent annual earnings growth among this group. Specialty doctors, specialists, consultants, GPs and GDPs have maintained their position in the earnings distribution. This partly reflects lower earnings growth across the economy at the top end of the earnings distribution than lower down.
- 1.62 Benchmarking against broadly comparable roles indicates a general pattern of pay for medical and dental roles being in line with comparators in terms of basic pay, but moving ahead when comparing total earnings and, especially, total remuneration including pensions. Some roles indicate basic salaries below market comparators, specifically foundation year 1, core trainees, registrars and consultants, although total earnings for these roles are in line with comparators, reflecting their greater access to additional pay.
- 1.63 More so than comparator professions, doctors and dentists in training and those working in secondary care typically experience very strong in-role pay progression and structured pathways for promotion over their career. Data from the DHSC highlights significant pay growth for those that remain in post: at the median, consultants saw pay growth of 65 per cent over the decade to 2025, compared to CPI growth of 37 per cent. The median specialty registrar saw pay growth of 135 per cent over the 10-year period.
- 1.64 Comparisons of total earnings for both associate and providing-performer dentists show pay behind comparators. Pay comparisons for these roles are especially difficult, as they are self-employed and often work across both the NHS and the private sector. We also do not have measures of working hours for dentists, and it is likely that many associate dentists in particular are working part time. However, given the broader issue of attracting dentists to undertake NHS work, and the very significant issues in accessing NHS dentistry in some areas, this evidence cannot be ignored, and links to the recommendation we make below.

International pay comparisons

- 1.65 While the number of doctors leaving to practise overseas has increased in recent years, from 1,629 in 2021 to 3,641 in 2024, this accounts for less than 1 per cent of doctors on the General Medical Council (GMC) register. Around two-thirds of these were GMC-registered doctors who were not consultants or GPs and were not in training, and many of these doctors are unlikely to have held an NHS post. The leaving to practise abroad rate among those on the GP/specialist register or in training was around 0.5 per cent.
- 1.66 Organisation for Economic Co-operation and Development (OECD) data show that pay for consultants in the UK is above countries such as Belgium, Denmark, New Zealand, Spain, Norway, and Sweden, while the Netherlands, Germany, and the Republic of Ireland offer higher levels of pay. Data for Australia, Canada and the US is not available in the OECD breakdown.

1.67 Consultant pay in Australia is generally much higher than in England, with some states offering significantly more. Pay bands for doctors in New Zealand are generally lower than in England, including those at the start of their careers and those in more senior positions. Compared to England and Northern Ireland, pay for doctors in the Republic of Ireland is generally lower at the start of their careers but much higher at consultant level. While adjustments can be made for purchasing power parity, in any international pay comparisons, jobs are often not equivalent across countries, and the operational context may be very different.

Broader developments in reward

1.68 Beyond pay, doctors and dentists place high value on career development opportunities and are greatly impacted by day-to-day working conditions. We welcome the commitments made by NHS England and NHS Employers through the review of medical training and the 10-point plan to improve resident doctors' working lives. As we said last year, investment in working facilities and arrangements for resident doctors is likely to be cost effective in terms of the improvement to motivation, wellbeing and commitment. NHS England has said that progress will be reported and data published on meeting targets. We believe this is vital, not only to ensure that commitments are delivered, but to demonstrate and communicate progress to resident doctors.

1.69 Employers and governments continue to stress the value and importance of the NHS pension scheme to recruitment and retention. Pension scheme membership is high across our remit group and has increased over the medium term. Options around flexible retirement appear to have been well received.

1.70 The pension tax annual allowance remains an issue, especially for higher-paid consultants taking on additional work, but much less so than in 2022-23. It would be helpful to have a fuller evaluation of how the very substantial changes to pension taxation in 2023-24 impacted working hours and incentives for senior medical and dental staff both to undertake additional work and to stay in NHS employment, as well as how much of a constraint the current annual allowance continues to be.

Motivation and morale

1.71 UK-wide survey data show overall improvement in motivation, morale, engagement and wellbeing over the latest year, from a low point in 2022, but not to the levels seen before the pandemic. The NHS staff survey in Scotland indicates broad stability in morale and working experience, while the survey for Wales shows a small fall in engagement and morale.

1.72 The recent focus on improving working conditions, especially for resident doctors, is welcome. We hope this can translate into demonstrable improvement in working lives.

The industrial relations context

1.73 As with the last two years, the pay and industrial relations environment is evolving as we make our recommendations. Resident doctors in England took 15 days of strike action in 2025. Other groups have lodged formal disputes but have not gone to strike ballots. The disputes are formally over long-term real terms falls in pay and the lack of training places but also reflect longer-term concerns about wider working conditions. Talks with resident doctors in England over the pay and jobs dispute are ongoing. The Medical Training (Prioritisation) Act 2026, to prioritise medical training places for graduates of UK medical schools, has recently been passed.

- 1.74 The challenging industrial relations environments over the past year across the four nations, alongside the strikes by resident doctors in England, suggest issues of low morale and motivation within some parts of the medical workforce, particularly in secondary care. Strikes not only have a direct impact on patients but also on the capacity of the workforce to improve productivity and deliver long-term reform.
- 1.75 Employers appear to have coped better with recent industrial action, and it has had less of a disruptive impact. However, it still brings substantial costs in terms of paying for cover, delays in elective care, pressures on management and non-striking staff, and taking resource away from core and longer-term activities. NHS Employers have highlighted that, under the Employment Rights Act, successful strike ballots will become easier to achieve, given the removal of the turnout threshold and the move to electronic ballots.
- 1.76 A new contract and pay structure have been agreed for resident doctors in Wales. While the structure is similar to the current contract in England, pay rates are higher and it will constitute an average 4 per cent paybill increase in addition to our recommendation. Implementation will not start until August 2026, and the Welsh Government has confirmed it wishes our pay recommendation to apply to pay rates under both the old and new contracts.

Differences across nations

- 1.77 Our remit covers all four nations of the UK, and we receive separate evidence on each. When making our recommendations, we are cognisant of differences between the nations, in terms of the economy, the labour market, health services, and government policies. While many parties highlighted disparities between nations, none called for differential pay uplifts to resolve them.
- 1.78 The Welsh Government said that, where possible, Wales aimed to maintain parity with the other nations regarding pay. It said that any deviations could create difficulties in recruiting staff across borders. The Welsh Government wanted to see continuity of this approach. The Northern Ireland Executive has indicated in public statements that pay parity with England is also a priority.
- 1.79 NHS Employers said that cross-border recruitment and retention were not currently significant issues for employers in England. It said that pay levels remained relatively aligned across the UK, although noted that there might be financial incentives beyond pay scales that could significantly affect recruitment or retention.
- 1.80 We see notable differences between the nations in areas such as the economy, labour markets, health funding, delivery, affordability, medical/dental earnings, recruitment, retention, and motivation/morale. Differences in primary care are especially noticeable between the nations, in terms of the workforce position, contractual terms, average earnings and overall delivery. The Scottish Government has drawn our attention to better provision of NHS dentistry in Scotland.
- 1.81 These differences between nations do not follow a consistent pattern or translate easily to recommendations. Parties have highlighted the value of a single UK-wide recommendation and are consistent in not wanting differentiation, despite sometimes highlighting differences between nations.
- 1.82 Given the strong views of parties on this issue, and the lack of a clear case to support differentiation, our core pay recommendations this year cover all four nations of the

UK. We will continue to consider the differential positions on health funding, delivery, affordability, earnings, recruitment, retention, motivation and morale across the nations to see if a differential approach is required in future.

Our recommendations

- 1.83 We make our recommendations with regard to all the factors in our terms of reference. While many parts of the NHS have seen improvements in activity over the last year, the system is under substantial pressure from increasing patient demand and complexity, and financial planning relies on optimistic gains in productivity. Doctors and dentists play a huge part in delivering these improvements and will be critical in delivering reform of the way NHS services are delivered.
- 1.84 Governments have budgeted between 2.2 per cent and 3.0 per cent for pay increases for our remit group for 2026-27, while making it clear that any pay uplift beyond this will come from within health budgets, reducing the scope for service delivery, workforce growth and reform. However, these aims require pay levels that support the recruitment, retention and motivation of the workforce. Appropriate investment in pay can lead to long-term savings by reducing reliance on agency staff and improving workforce stability and engagement.
- 1.85 While the overall picture is one of improvement in recruitment and retention, pay uplifts need to be set at a level to sustain this. This is why we give weight to pay increases elsewhere in the economy, which are expected to be 3.0-3.5 per cent over 2026, with early pay settlement data for 2026 showing medians of 3.2 per cent. CPI inflation is currently at 3.0 per cent but is expected to fall sharply in April and to average 2.2 per cent over 2026-27. The CPIH rate of inflation, which includes housing costs, is at 3.2 per cent and is forecast to average 2.4 per cent over 2026-27. These forecasts do not take into account recent geopolitical uncertainty, in particular in the Middle East, and the potential impact on energy prices.
- 1.86 Most of our remit group have seen real terms growth in basic pay over the last decade. Senior doctors and dentists have maintained their position in the overall earnings distribution. Resident doctors have seen a fall back over the longer term, but relative improvement over the last one to two years, supported by targeted higher pay increases for this group. Pay for most groups is in line with comparator professions, especially when total earnings and pensions are taken into account.
- 1.87 **Considering all these factors, we recommend a 3.5 per cent increase to the pay ranges and the pay element of contracts from 1 April 2026.** This applies to: resident doctors and dentists; consultants; SAS doctors and dentists; locally employed doctors; contractor general medical practitioners; and salaried GP pay ranges. This covers all the nations of the UK, with the exception of resident doctors and dentists, which only applies in England, Wales, and Northern Ireland.
- 1.88 We recognise that there are specific recruitment and retention issues across the medical and dental workforces which a general pay uplift will not resolve. Workforce planning plays a substantial role in securing long-term workforce recruitment and retention, and we hope that the imminent plan for England considers this. However, national pay structures require flexibility to deal with specific issues, such as shortages in certain specialties, or difficulties in recruiting to rural, remote and coastal areas. Governments have made clear that they wish to address these issues locally rather than through UK-wide approaches. At present, the evidence indicates that this is not being done in a systematic or effective way.

Recommendation 1

We recommend a 3.5 per cent increase to pay ranges and the pay element of contracts from 1 April 2026 for the following groups:

- Resident doctors and dentists in England, Wales, and Northern Ireland.
- Specialty, specialist and associate specialist (SAS) doctors and dentists in all four nations of the UK.
- Consultants in all four nations of the UK.
- Locally employed doctors in all four nations of the UK.
- Contractor general medical practitioners in all four nations of the UK.
- Salaried GP pay ranges in all four nations of the UK.

1.89 We would like to see all NHS employers have a far deeper and evidence-based understanding of where specific recruitment and retention issues lie, both in terms of locality and specialty, the impact these are having on service delivery, the cost of temporary staff to cover vacancies, and the effect on the wider team. This analysis should be accompanied by a review of the levers and tools that might support specific recruitment and retention issues, which can then be integrated into local workforce plans.

Dentistry

1.90 We see a different situation for dentistry than the other parts of our remit, with significant workforce issues, under-delivery of NHS care, poor access for patients, and a lack of attractiveness of NHS dentistry, driven in large part by the underlying contract. Many dentists have seen falls in real terms earnings over recent years, and associate dentists are earning less than some comparator professions. For many patients, accessing NHS dental care remains a significant challenge, with some areas reporting no available NHS dentists. This underscores the need for immediate action to make NHS dentistry more attractive to dental practitioners.

1.91 We note that total expenditure on NHS dental services in England increased in 2024-25 to £3.6 billion, up from £3.0 billion in 2023-24. However, despite this recent increase, total expenditure has declined by around 13 per cent in real terms since 2009-10. There is large-scale under-delivery of contracts in England, of over £900 million over the last two years, likely reflecting the lack of incentives to deliver NHS work at current fees.

1.92 For some years we have said that the best way to resolve these issues would be through contract reform. This has not happened in England or Northern Ireland. There has been payment reform in Scotland which appears to have had a positive impact, in terms of stabilising delivery of NHS dentistry. There will be a new contract for dentists in Wales from April 2026. While we recognise this may put NHS dentistry in a stronger position in these two nations, parties have made clear to us the value of a UK-wide recommendation.

- 1.93 We have also not seen governments introduce an effective mechanism for uprating the value of contracts to reflect the average cost increases in providing dentistry, as we recommended in our last report. This serves to destabilise the sector and accelerate the shift to private provision.
- 1.94 Given an overall picture of workforce shortages, under-delivery, and a lack of attractiveness of NHS dentistry, we recommend a higher uplift for general dental practitioners in all parts of the UK. This will determine the pay uplift element of contracts, and we expect it also to be passed on to associate dentists delivering NHS care. This recommendation also applies to salaried dentists working in Community Dental Services and the Public Dental Service. It does not apply to dentists on equivalent medical contracts in secondary care or to dentists in training.
- 1.95 Recognising the specific circumstances of NHS dentistry, **we recommend a 3.75 per cent increase to the pay element of dental contracts and to pay for salaried dentists working in Community Dental Services and the Public Dental Service from 1 April 2026.**

Recommendation 2

We recommend a 3.75 per cent increase to the pay element of dental contracts and to pay for salaried dentists working in Community Dental Services and the Public Dental Service.

- 1.96 We do not imagine this recommendation will resolve the significant challenges in NHS dentistry. Substantial reform to the contracts is needed to make NHS dentistry attractive. This requires significant commitment from the relevant governments. However, we hope it will serve to support the sector until more in-depth reform can be delivered. This is the first time in decades that we have made a differential pay recommendation for dentistry, and we will keep this under review for subsequent reports.
- 1.97 We discuss the need for an effective mechanism to uprate the cost element of dental contracts below.

Costs of recommendations

- 1.98 We estimate that implementing our recommendations will cost around £950 million. It will add around £810 million to the substantive HCHS paybill in England, against a total DHSC resource departmental expenditure limit in 2025-26 of £211 billion. We estimate that they will add around £55 million to the paybill in Scotland, £55 million to the paybill in Wales, and £30 million to the paybill in Northern Ireland. This does not include GPs and dentists in primary care, for whom we do not have paybill estimates.

Our additional 2025 recommendations

1.99 We set out the government responses to our 2025 recommendations in table 1.1 and discuss each in more detail below.

Table 1.1 Responses to our 2025 recommendations

	England	Scotland	Wales	Northern Ireland
A 4 per cent increase to salary scales, pay ranges and the pay element of contracts from 1 April 2025	Accepted	Accepted	Accepted	Accepted
A 4 per cent increase plus a consolidated uplift of £750 for resident doctors	Accepted	Not applicable	Accepted	Accepted
Consider a separate pay framework for locally employed doctors	Not accepted at this time; will be kept under review	Locally employed doctors are on mirror national contracts	Covered by the new resident doctors' contract	Undertaking scoping exercise
Review flexible pay premia to assess value for money and effectiveness	Not accepted at this time; will be kept under review	Not applicable	Not applicable	Not applicable
Increase the value of national clinical impact awards	Accepted	Not applicable	Accepted	Not applicable
Indices of general practice and dental costs	Not accepted	Not accepted	Under consideration	Under consideration
Review pay and progression for dentists in the CDS/PDS	Not accepted	Under consideration	Under consideration	Under consideration

Locally employed doctors

1.100 Our headline pay recommendation applies to all locally employed doctors in the NHS.

We recommended last year that governments consider a separate pay framework for locally employed doctors. This was in recognition of the disparate and opaque terms and conditions in use across the nations for this group, that these doctors were not in training programmes, and that they were working across broader equivalent grades than just resident doctors.

1.101 The UK Government said it could not accept the recommendation on locally employed doctors at this time due to the need for further work to better understand this growing part of the workforce. It said it recognised the key role locally employed doctors played in service delivery, and the challenges they faced. It said its priority would be to improve the data on locally employed doctors to increase its understanding of the needs of this workforce. Once this work was complete, it would re-assess the case for a separate pay framework.

1.102 In Scotland, doctors in these roles are already on national terms and conditions. The new contract for resident doctors in Wales encompasses locally employed doctors at this level.

1.103 The Department of Health in Northern Ireland said it was undertaking a scoping exercise to better understand the specific needs and circumstances of locally employed

doctors. This would inform a full and considered response to our recommendation. In oral evidence, the Department said that standardised arrangements for doctors without a training number could strengthen the locally employed doctor role and help to reduce locum staffing.

- 1.104 The BMA said it did not support a separate pay scale for locally employed doctors as this opened the possibility of creating an underclass grade.
- 1.105 The evidence on the roles undertaken by locally employed doctors and their pay is limited. The ability to identify them in the payroll data in England and Northern Ireland in particular is poor. The gap between the GMC estimate of locally employed doctors in England and Wales and the workforce numbers reported by the Welsh Government and the DHSC (which only counts five nodal points) is around 20,000.
- 1.106 The BMA has said that employers should be compelled to share information on the distribution of locally employed doctors across the NHS and the terms and conditions these doctors are engaged on. We would encourage this.
- 1.107 If accepted, our recommendation would have necessitated government and employers review locally employed doctors across all levels, improve the evidence base, ensure fairness and consistency, and develop a rationale and guidance for their employment. Any framework would need to recognise both the differences from and similarities with doctors in training and those on national contracts and should be linked to workforce planning.
- 1.108 Both the BMA and the HCSA have raised substantial concerns with us about the poor treatment of locally employed doctors. A very high proportion (estimated at over 90 per cent by the GMC) are on fixed-term contracts. As well as supporting equal pay, a review and rationalisation of the range of locally employed doctor roles could enhance support for this group, help avoid discriminatory practices, and enable better understanding of progression and development both within role and to other roles, as well as give a better understanding of how these doctors contribute to service delivery, and how fit into a coherent future workforce strategy.
- 1.109 Without a clear pay framework for locally employed doctors, it is difficult to ensure equal pay with doctors on national contracts doing equivalent work. The high representation of those with a non-UK primary medical qualification among the locally employed doctor workforce suggests a significant risk of pay discrimination without a framework to ensure equal pay. Given these concerns, we will continue to monitor developments on locally employed doctors closely and will review the situation next year. We request that the UK and Northern Ireland governments share the conclusions of their scoping exercises with us as soon as they are available, and additional workforce data on the locally employed doctor workforce in Wales will also be valuable.

Flexible pay premia

- 1.110 We recommended last year that the government review flexible pay premia in England to assess their value for money and effectiveness. We said that, given the very high fill rates at core training, there was limited evidence to support their continued payment. There was also little evidence that payments were correctly targeted within higher levels of training.

- 1.111 Since then, we continue to see very high fill rates for core training and increasing fill rates at higher training levels. The case for a review of flexible pay premia for value for money and effectiveness has increased. Giving different reward for different specialties at the same level of training needs to be fully justified, and we cannot support the continuation of the current payments without a review by the Government or NHS England to ensure both equity and value for money.
- 1.112 The UK Government acknowledged that flexible pay premia had not been reviewed for some time. However, it did not wish to commit to undertake a review at this time due to ongoing discussions with workforces seeking to resolve industrial relations disputes, but this would be kept under review.
- 1.113 NHS Employers said there was clear support from employers for a review of flexible pay premia, particularly those covering hard-to-fill specialties. They said that, since the implementation of the 2016 contract, neither flexible pay premia nor the hard-to-fill specialties had been reviewed, raising questions about whether the listed specialties were still considered to be the most difficult to recruit. They noted that the list of hard-to-fill specialties was maintained by NHS England.
- 1.114 The BMA noted with concern our recommendation to review flexible pay premia, particularly as this was made following commentary on the current very high fill rates. It said this had caused significant concern among members working in these specialties that these premia may be removed. The BMA acknowledged that the system was not perfect but said it provided a useful function in reducing the financial disincentive to doctors undertaking an academic career and it should not be removed until a better, workable alternative could be put in place.
- 1.115 The Royal College of Emergency Medicine has set out a strong case for the continued payment of the flexible pay premium for higher training in emergency medicine. This level of evidence should be compiled for each specialty. It may be the case that recruitment to other specialties could be supported by a flexible pay premium, notably special care dentistry.
- 1.116 We remain of the view that our recommendation from last year, that the government reviews flexible pay premia in England to assess their value for money and effectiveness, needs to be taken forward. Ideally, this should be linked to a clear picture on future training place requirements from a refreshed workforce plan and should then feed into future contract negotiations. We would expect any changes to be for future recruitment and to not impact those currently in training posts with a flexible pay premium.

Clinical impact awards

- 1.117 Last year we recommended an increase in the value of national clinical impact awards, of £500 to £2,000 depending on the level, in England and Wales from 1 April 2025. This was accepted by the UK and Welsh Governments.
- 1.118 We will consider clinical impact awards periodically rather than every year. We would like future consideration to be better informed by evidence on the effectiveness of these awards, that they are driving improvements to the NHS that would not have been otherwise achieved, and that they are not a cause of pay inequality in the consultant workforce.

1.119 The current evidence base gives a mixed picture on these issues and raises a number of questions that need to be addressed. In particular, we would like evidence that clinical impact awards are the best use of this part of the consultant paybill, around £105 million. We note that there is not an active national consultant award scheme in either Scotland or Northern Ireland, without any reported detrimental impact on outcomes. Before we consider any further uplifts, we would like the UK and Welsh Governments to consider a more in-depth review of clinical impact awards, to encompass their purpose, effectiveness and value for money, as well as their equality impact. This might form part of wider discussions on contractual reform for consultants.

Index of costs in primary care

1.120 We recommended last year that the four governments work with GPs' and dentists' representatives to develop an index of general practice costs and an index of dental costs. These indices should then be used to determine the expenses element of the GP and dental contract uplifts in each nation. The recommendation followed on from strong evidence that expenses uplifts to primary care contracts, especially for dentistry and in England, were not meeting the rising costs. This was driving the decreased attractiveness of NHS dentistry and creating instability in general practice.

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

1.122 The UK Government said it welcomed the recommendation to improve the evidence base on dental practice running costs. The DHSC was conducting a research project to better understand the costs and pressures associated with running a dental practice in England. It said this would support its ambitions on dental reform by ensuring the government had an objective and accurate understanding to inform policy development. It would also improve understanding around the sustainability of the current system.

1.123 However, the UK Government said it must reject the recommendation to develop an index of general practice and dental costs. It said it used the GDP deflator to calculate uplifts to the expenses element of the dental contract, consistent with other primary care areas, including general practice and ophthalmology. It said there was a strong rationale for continuing to use the GDP deflator, but it would keep this under review. The Government said it was not in a position to make changes to how it approached uplifting expenses for GPs ahead of the outcome of the Carr Hill review and General Medical Services contract reform.

1.124 In his remit letter, the Scottish Cabinet Secretary said it was impractical to compile a detailed and meaningful index of typical expenses which accurately reflected the costs faced by contractors in Scotland. He said that officials were working with the Scottish General Practitioners Committee on an approach to non-staff expenses, as well as with the Scottish Dental Practice Committee to agree realistic approaches to recognising expenses in service contracts.

1.125 In oral evidence, the Scottish Government said it was working to directly reimburse general practices for non-staff expenses. It is our view that, while this may be effective in supporting practices, it could reduce one of the key benefits of contracted out

services by removing the incentive for practices to operate efficiently. However, we would expect this to provide useful evidence on the costs incurred in the sector.

- 1.126 In written evidence, the Scottish Government said it would like the DDRB's recommendation on pay to include an assessment of the dental expenses position in Scotland. Its strategic focus was to maintain the positive engagement from the sector by ensuring that the comparative attractiveness of the new fees kept pace with the cost to deliver care and treatment.
- 1.127 In oral evidence the Welsh Government said it was keen to make progress but needed to find practical and proportionate ways to do this and build partnerships over the longer term. In written evidence, the Welsh Government acknowledged that the combination of rising costs and falling real-terms income highlighted the growing sustainability challenge in Wales.
- 1.128 The Department of Health in Northern Ireland said it recognised the need to review how General Medical Services were delivered and the underpinning contractual arrangements, to ensure that services were sustainable in the medium and long term. Work was being taken forward with GP representatives to review the delivery of general practice, contractual arrangements and the funding model.
- 1.129 The Department said a General Dental Service cost-of-service review was being undertaken, with expenses being included within the scope. Our recommendation would be considered following the results of this review and in line with the reform of General Dental Services.
- 1.130 The BDA said that neither the approach of applying the GDP deflator nor the approach of substituting the DDRB's recommendation on pay for the practice operating costs element was appropriate. It therefore welcomed our recommendation that an index of dental costs be devised and agreed by the parties and regretted that to date no Government had accepted this proposal.
- 1.131 The BDA said that such an index was technically feasible. It said there was existing data from official sources, such as NHS dental earnings and expenses, official data, and industry reports. It said that the DHSC and the Department of Health in Northern Ireland were undertaking economic reviews of general dental practice that could inform the baseline of this index. It said there might be a need for some bespoke data gathering to meet gaps.
- 1.132 The BDA said it was open to working collaboratively with the governments to develop this index. It had previously submitted papers to the DHSC proposing a mechanism of this nature, which had not been taken forward.
- 1.133 The ADG welcomed our recommendation on the development of a dental cost index. It asked us to apply further pressure on the development of the dental care index in a timelier manner, and to revert to a recommendation on expenses in the intervening period. It also asked us to support the principle of applying the contract uplift to all elements of the contract, including the tariffs and units of dental activity in the potential new contracts for England and Wales.
- 1.134 In oral evidence, BMA GPs said our recommendation for a cost index was helpful, but they had been disappointed with the progress. They were keen to progress this and to get the expenses mechanism updated.

- 1.135 We have made clear in past reports that we do not have the appropriate evidence base to make recommendations on the expenses uplift in primary care and this is not our role. This needs to be led by governments, informed by an assessment of typical costs. As we said last year, this could be based on the NHS cost inflation index used by the Office for National Statistics to inform its healthcare productivity estimates.
- 1.136 It is disappointing that governments are failing to fully grasp the need to both support GP and dental practices to deliver NHS services through appropriate funding, and to provide incentives and value for the taxpayer. Having an appropriate, evidence-based mechanism to uplift the cost element of contracts, in line with the average in the sector in each nation, is key in both sustaining services and incentivising efficiency. The current mechanisms lack transparency, bear little relation to actual cost increases, and create financial uncertainty for practices.
- 1.137 This appears to be more of an issue in dentistry, in part because general practice has seen additional financial support as well as health authorities taking over practices in some areas. We also see dentists moving to the private sector as NHS dentistry become financially unsustainable. We therefore believe that governments need to address the issue of an effective cost uplift mechanism to support NHS dentistry as a particular priority.
- 1.138 Given the strong support from stakeholders in the sector, and the progress already made in England and Northern Ireland on establishing an evidence base on dental costs, we believe this must be the priority for the development of cost indices. We again **recommend that the four governments work with dentists' representatives to develop an index of dental costs in each nation**. This should then be used to construct changes over time in each nation and to determine the expenses element of the contract uplifts in each nation. This should form part of discussions on contract reform. We will continue to keep the issue of the cost uplift for general practice under review and revisit this next year.

Recommendation 3

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

Community and Public Dental Services

- 1.139 Last year we recommended that each government undertake a review of pay and progression for salaried dentists working in Community and Public Dental Services to assess whether the reward structure was appropriate to support recruitment, retention and service delivery. We said this should include whether pay ranges were positioned correctly, and whether there was a sufficiently attractive career path to attract and retain high quality dentists. We expected this to align with a broader workforce strategy which supported future service delivery and reviewed the overall workforce size and skill mix.
- 1.140 NHS Employers, the BDA, and the ADG all welcomed this recommendation.

- 1.141 The UK Government said it recognised the vital role CDS dentists had in ensuring some of the most vulnerable members of society were able to access dental treatment and it would continue to consider the CDS as part of its long-term reform of the dental system. It said that pay scales for CDS dentists were comparable to other medical professionals, such as salaried GPs, with a common pay spine and competency-based progression. It said that the available workforce data did not show that CDS dentists were facing unique recruitment and retention issues. The Government therefore did not see a compelling case to undertake a review of salaried dentists in this setting at present; however, it would continue to monitor recruitment and retention in the CDS.
- 1.142 The Scottish Government said that officials were in discussion with the BDA on the issues. NHS Employers in Scotland were investigating if there was scope to move PDS dentists on to the specialty doctor contract. The Welsh Government said that consideration of our recommendation would take place in social partnership and there was a piece of work around gathering evidence on the specific issues in Wales, including the current pay structure and progression arrangements. The Department of Health in Northern Ireland said it was considering the recommendation and highlighted the need for clear and robust data to determine whether the current reward structure was a barrier to recruitment, retention, or service delivery.
- 1.143 There are still large evidence gaps in terms of understanding service delivery and workforce trends in the CDS and PDS, and we agree with the Department of Health in Northern Ireland that any review needs to start with a clear evidence base. The lack of evidence is one of the reasons why a review is necessary, rather than a reason not to do it. The absence of a comprehensive evidence base for this workforce makes determining appropriate pay recommendations much more difficult.
- 1.144 Our visits highlighted substantial issues with workload and stress across the service. Both NHS Employers and the ADG reported significant problems in recruitment of band A dentists and said that starting salaries were too low. This was impacting service delivery. While the vacancy rate in the CDS may be lower than high street dentistry, it is still of concern, with dental vacancies having a severe impact in small teams. The band A starting salary should be considered as part of the broader review.
- 1.145 We are struck by the lack of government understanding and leadership of this vital service in our written and oral evidence, especially in England. This is in stark contrast to those responsible for front-line delivery. It is encouraging to see some engagement with CDS and PDS dentists in Scotland, Wales and Northern Ireland.
- 1.146 This is a neglected service under severe strain which is picking up the slack from the under-provision of high street dentistry. Again, **we recommend that governments review pay and progression for salaried dentists working in Community and Public Dental Services to assess whether the reward structure is appropriate to support recruitment, retention, and service delivery.** This needs to start with a strong evidence base on the current workforce and service delivery.

Recommendation 4

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

- 1.147 A specific issue has been highlighted to us around training for special care dentistry. Despite the importance of this specialty, and the small number of training places, places are being unfilled each year. This could be supported by a flexible pay premium. However, it has been highlighted to us that dentists in practice face a pay cut if they return to specialty training, which is proving a barrier. We therefore advise that governments consider offering pay protection for dentists moving from practice in general or community dentistry into specialty training.

Our 2026 report

1.148 The rest of our report sets out the evidence base to support our recommendations, and our comments on the evidence, as follows:

- Chapter 2 considers the wider context for our recommendations including the economy and the labour market, NHS activity and productivity, health spending and affordability, workforce planning, equalities, and pensions.
- Chapter 3 considers dentists.
- Chapter 4 considers GPs.
- Chapter 5 considers cross-cutting issues for the secondary care workforce.
- Chapter 6 looks at specific workforce groups – resident doctors, locally employed doctors, SAS doctors, and consultants.
- Chapter 7 looks ahead to our next round and highlights specific data and evidence requests.
- Appendices A to H cover supporting information, including our remit letters, recommended pay rates for 2026-27, and the evidence on pay comparability.

Chapter 2 Wider context

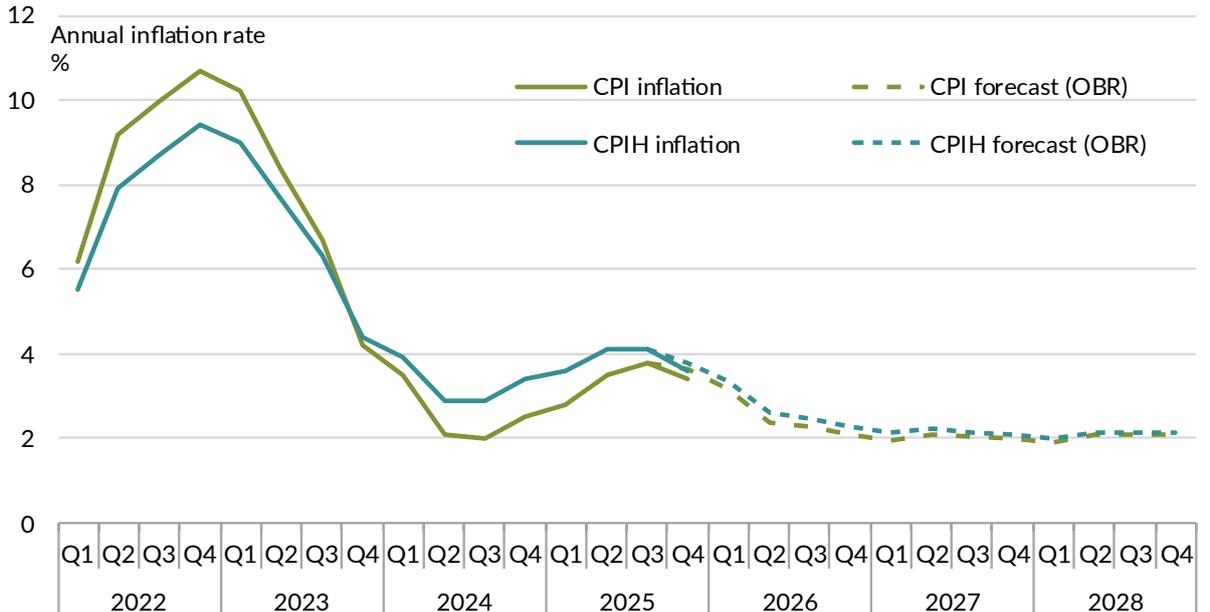
2.1 This chapter considers the wider context for our recommendations including the economy and the labour market, NHS activity and productivity, health spending and affordability, workforce planning, workforce equalities and diversity, and developments in pensions.⁴

The economy and the labour market

2.2 UK economic growth was estimated to have been 1.3 per cent in 2025, with growth slowing to 0.1 per cent in the fourth quarter of 2025. Economic growth was forecast to be 0.9-1.4 per cent in 2026.

2.3 Consumer Prices Index (CPI) inflation was 3.0 per cent in January 2026. The CPI including owner occupiers' housing costs (CPIH) rate of inflation was 3.2 per cent in January 2026. The Retail Prices Index (RPI) rate of inflation was 3.8 per cent in January 2026.⁵ In November, the Office for Budget Responsibility (OBR) forecast inflation to fall back over 2026, with CPI inflation expected to average 2.2 per cent in 2026-27 and CPIH to average 2.4 per cent. In February, the Bank of England expected CPI inflation to fall to 2.1 per cent in the second quarter of 2026. These forecasts do not take into account the recent geopolitical uncertainty, in particular in the Middle East, and its potential impact on energy prices.

Figure 2.1: Inflation and forecasts, 2022 to 2028



Source: ONS, CPI inflation, quarterly (D7G7), CPIH inflation, quarterly (L55O); OBR, *Economic and fiscal outlook*, November 2025.

2.4 The labour market has shown signs of further weakening over the last year. Pay as you earn (PAYE) data indicated that the number of employees on payrolls fell by 134,000 (0.4 per cent) over the 12 months to January 2026. The Office for National Statistics

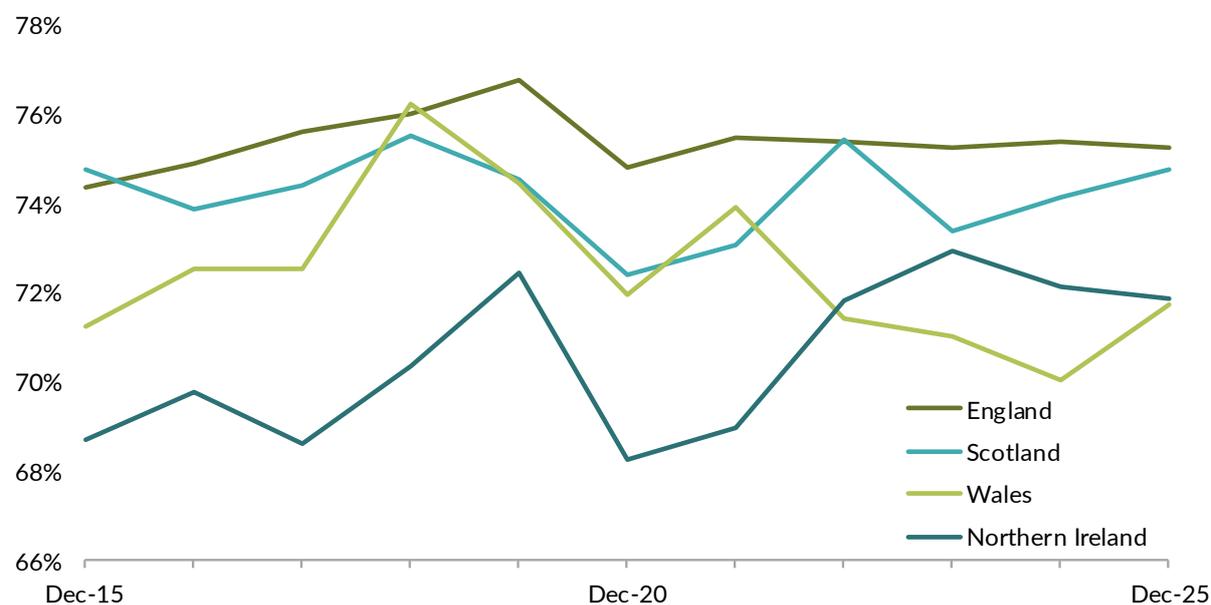
⁴ This chapter contains economic data published up to the end of February 2026.

⁵ The CPI is used in the government's target for inflation and is produced to international standards in line with European regulations. The CPIH is the ONS' lead inflation index as it is the most comprehensive measure and includes owner occupiers' housing costs and council tax. The RPI does not meet the required standard for designation as a national statistic, as the methods used to produce it are not consistent with internationally recognised best practice, so we do not use it in our analysis.

(ONS) recorded 726,000 job vacancies in the three months to January 2026, a fall of 9.2 per cent over the year. The unemployment rate was at 5.2 per cent in the three months to December 2025, up from 4.4 per cent a year earlier.

2.5 Employment rates varied across the UK.⁶ Employment fell by 0.1 percentage points over the year in England to 75.2 per cent in December 2025, increased by 0.6 percentage points in Scotland to 74.8 per cent, increased by 1.7 percentage points in Wales, to 71.8 per cent, and fell by 0.3 percentage points in Northern Ireland, to 71.9 per cent. Compared with 2019, Scotland's employment rate in December 2025 was slightly higher (+0.2 percentage points), while employment rates in England (-1.5 percentage points), Wales (-2.7 percentage points) and Northern Ireland (-0.6 percentage points) were below pre-pandemic levels.

Figure 2.2: Employment rate (16-64), by nation, 2015 to 2025



Source: ONS, HI00 Regional labour market: headline Labour Force Survey indicators for all regions.

2.6 Unemployment increased by 1.0 percentage points over the year in England, to 5.6 per cent in December 2025, and increased by 0.6 percentage points in Northern Ireland, to 2.3 per cent. Unemployment fell slightly, by 0.04 percentage points, in Scotland, to 3.8 per cent in December 2025, and fell by 1.2 percentage points in Wales, to 4.5 per cent. Relative to 2019, unemployment in December 2025 was higher in England (+1.7 percentage points), Wales (+1.5 percentage points), and in Scotland (+0.2 percentage points), but lower in Northern Ireland (-0.1 percentage points).

2.7 Economic inactivity fell by 0.7 percentage points over the year in England, to 20.3 per cent in December 2025, fell by 0.6 percentage points in Scotland, to 22.3 per cent, fell by 0.9 percentage points in Wales, to 24.8 per cent, and fell by 0.2 percentage points, in Northern Ireland, to 26.5 per cent. Compared with 2019, inactivity in December 2025 was higher in England (+0.2 percentage points), higher in Wales (+1.6 percentage points) and Northern Ireland (+0.7 percentage points), and lower in Scotland (-0.4 percentage points).

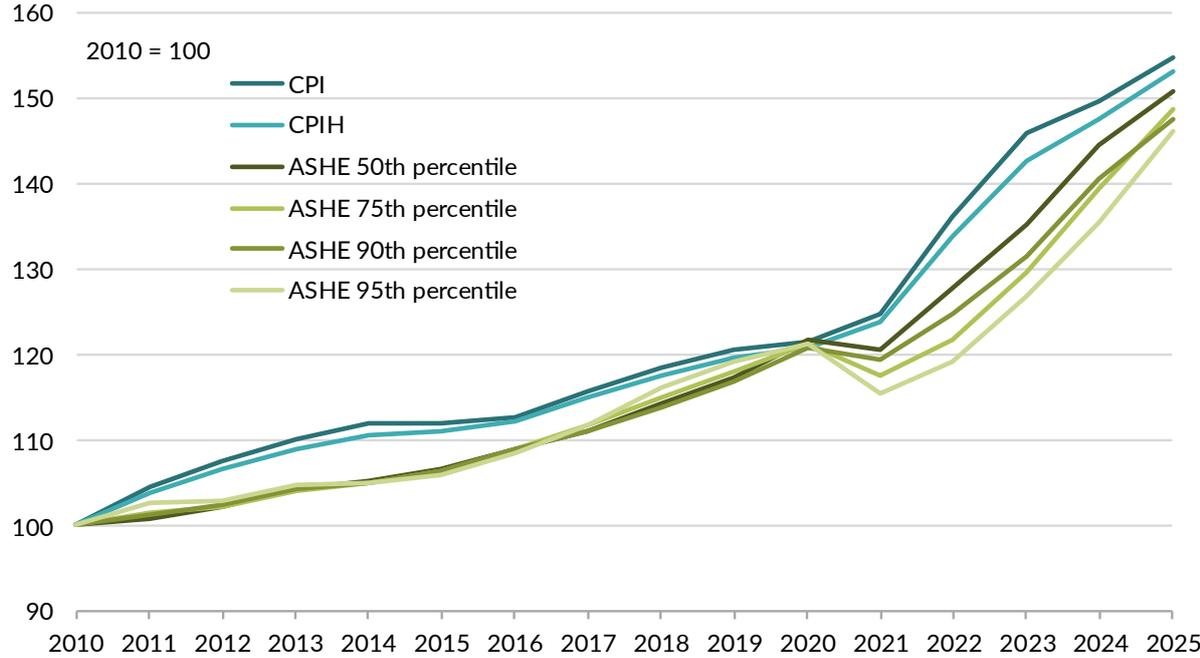
⁶ Employment, unemployment and inactivity rates are for those aged between 16-64 using the ONS' labour market in the regions of the UK data. Data are for the three months to December 2025.

2.8 UK-wide average earnings growth was fairly strong over 2025, and above inflation, averaging 4.8 per cent, but fell back at the end of the year. Whole economy annual average weekly earnings growth was at 4.2 per cent in the three months to December 2025. Private sector average earnings growth was at 3.5 per cent and public sector average earnings growth was at 7.0 per cent, with the latter pushed up by the earlier payment of annual uplifts in 2025.

2.9 We pay particular attention to earnings at the upper end of the wage distribution, as this is more relevant to our remit group. PAYE data showed that earnings growth over the last year was stronger in the lower half of the earnings distribution and weaker at the top end. Annual earnings growth in the year to December 2025 was 4.8 per cent at the 25th percentile; 3.5 per cent at the median; 2.6 per cent at the 75th percentile; 1.8 per cent at the 90th percentile; and 1.3 per cent at both the 95th percentile and 99th percentiles.

2.10 Average earnings have grown by less than inflation since 2010, in particular between 2020 and 2023. There was real earnings growth across the earnings distribution over 2024-25.

Figure 2.3: ASHE annual earnings percentiles for full-time employees and CPI index, 2010 to 2025



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

2.11 Pay settlement medians were 3.0-3.3 per cent over 2025. Forecasts for 2026 median pay settlements were for 3.0 to 3.5 per cent, with pay award medians at 3.2 per cent in the three months to January 2026. NHS staff on Agenda for Change contracts will receive a pay award of 3.3 per cent from 1 April 2026.

NHS activity

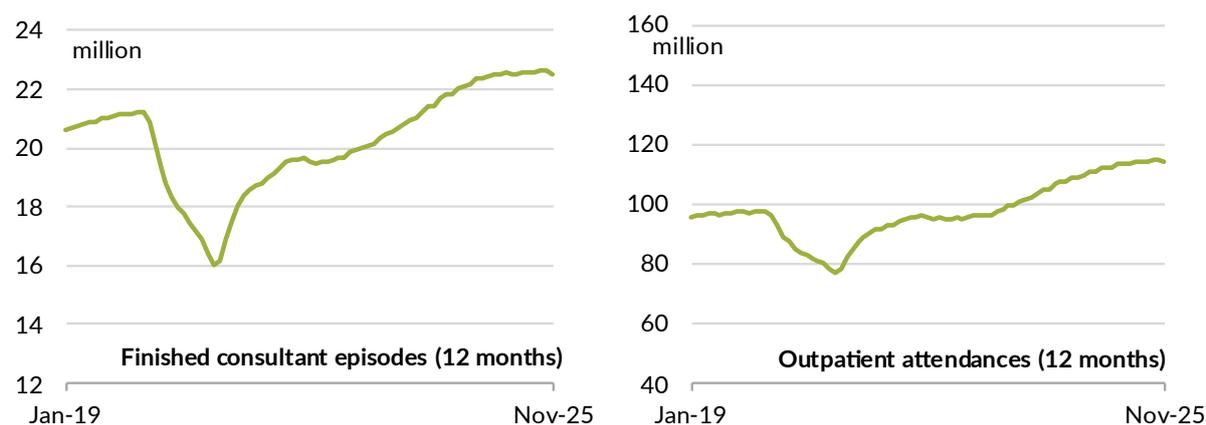
2.12 NHS activity trends vary across the UK. Activity has increased in some nations compared with last year and with pre-pandemic levels, while in other nations activity is still below pre-pandemic levels. The following sections set out recent patterns in hospital activity, outpatient activity, emergency care and waiting times across the four nations.

Hospital activity

2.13 In the 12 months to November 2025, there were 22.5 million finished consultant episodes in England, up by 0.13 million (0.6 per cent) from the 12 months to November 2024 and by 1.38 million (6.5 per cent) from the 12 months to November 2019.

2.14 In the 12 months to November 2025, there were 114.5 million outpatient attendances in England, up by 3.4 million (3.1 per cent) from the 12 months to November 2024 and by 17.5 million (18.1 per cent) from the 12 months to November 2019.

Figure 2.4: Finished consultant episodes and total outpatient attendances, England, 2019 to 2025

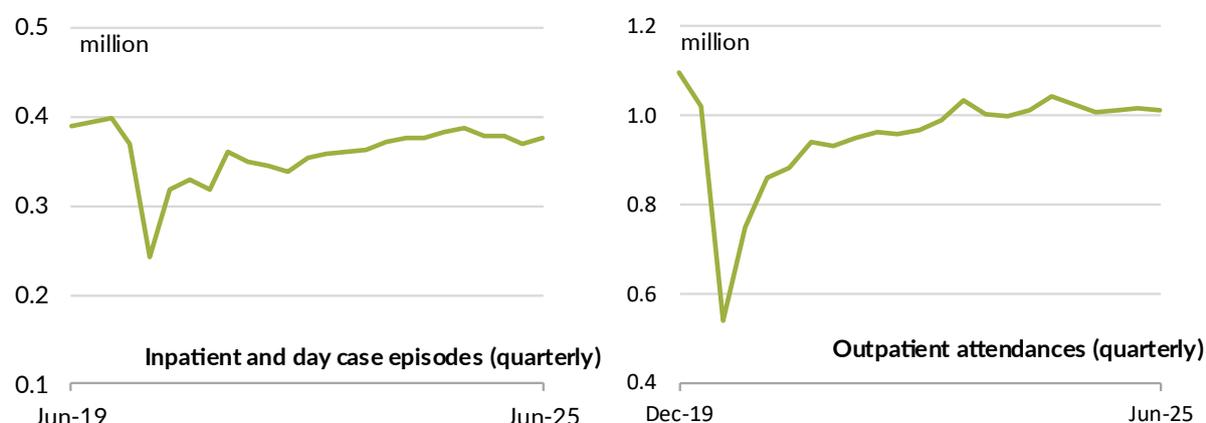


Source: NHS England, Hospital Episode Statistics.

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

2.15 In the quarter to June 2025, there were 375,495 inpatient and day case episodes in Scotland, down by 10,475 (2.7 per cent) from the quarter to June 2024 and by 14,091 (3.6 per cent) from the quarter to June 2019.

Figure 2.5: Inpatient and day case episodes and total outpatient attendances, Scotland, 2019 to 2025

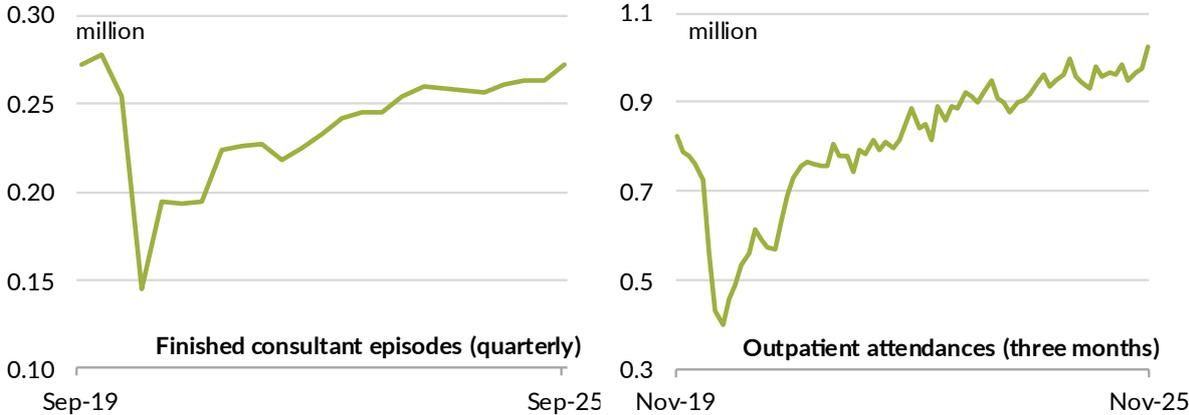


Source: Public Health Scotland, Acute Hospital Activity and NHS Beds Information.

Notes: Total episodes/attendances over previous three-month period. Total episodes represent all acute speciality inpatient and day-case episodes. Data relating to 2019 are taken from previous publications and so may have been revised since initial publication in 2024.

- 2.16 In the quarter to June 2025, there were 1,012,110 outpatient attendances in Scotland, down by 3,433 (0.3 per cent) compared to the quarter to June 2024 and by 57,052 (5.3 per cent) from the quarter to June 2019.
- 2.17 In the quarter to September 2025, there were 271,930 finished consultant episodes in Wales, up by 16,109 (6.3 per cent) from the quarter to September 2024 and marginally down by 17 (0.0 per cent) from the quarter to September 2019.
- 2.18 In the three months to November 2025, there were 1.02 million outpatient attendances in Wales, up by 25,555 (2.6 per cent) from the three months to November 2024 and up by 201,683 (24.5 per cent) from the three months to November 2019.

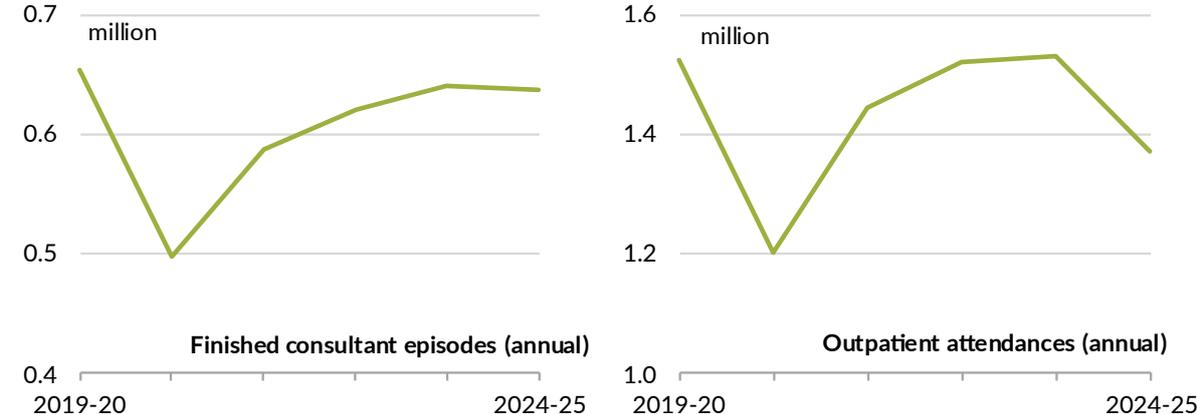
Figure 2.6: Finished consultant episodes and total outpatient attendances, Wales, 2019 to 2025



Source: Digital Health and Care Wales, Hospital Data.

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

Figure 2.7: Finished consultant episodes and total outpatient attendances, Northern Ireland, 2019 to 2025



Source: Department of Health, Hospital Statistics.

Notes: Total episodes/attendances over annual period. Finished consultant episodes are the total number of periods of care under a single consultant and include regular day and night patients, unlike the other nations. A single stay in hospital may consist of one or more episodes of care.

Data for Northern Ireland should be interpreted with caution following a change to a new electronic patient record system. The data may not be fully comparable with previous years.

2.19 In 2024-25, there were 636,338 finished consultant episodes in Northern Ireland, down by 3,761 (0.6 per cent) from 2023-24 and down by 18,140 (2.8 per cent) from 2019-20.

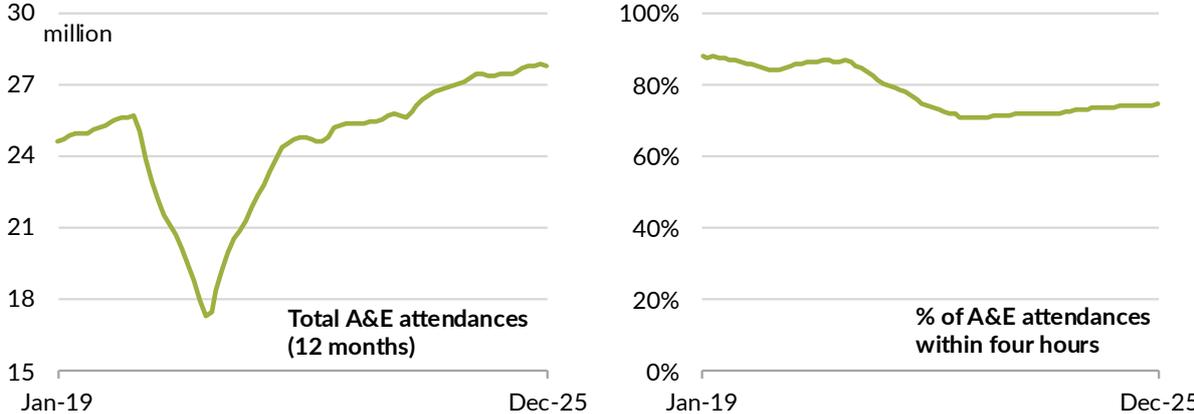
2.20 In 2024-25, there were 1,370,901 consultant-led outpatient attendances in Northern Ireland, down by 158,825 (10.4 per cent) from 2023-24 and down by 154,370 (10.1 per cent) from 2019-20.

Accident and emergency

2.21 In the 12 months to December 2025, there were 27.8 million accident and emergency (A&E) attendances in England, up by 367,196 (1.3 per cent) from the 12 months to December 2024 and by 2.16 million (8.4 per cent) from the 12 months to December 2019.

2.22 The proportion of A&E attendances that took less than four hours was 74.7 per cent in the 12 months to December 2025, up from 73.4 per cent in the 12 months to December 2024 but down from 84.7 per cent in the 12 months to December 2019.

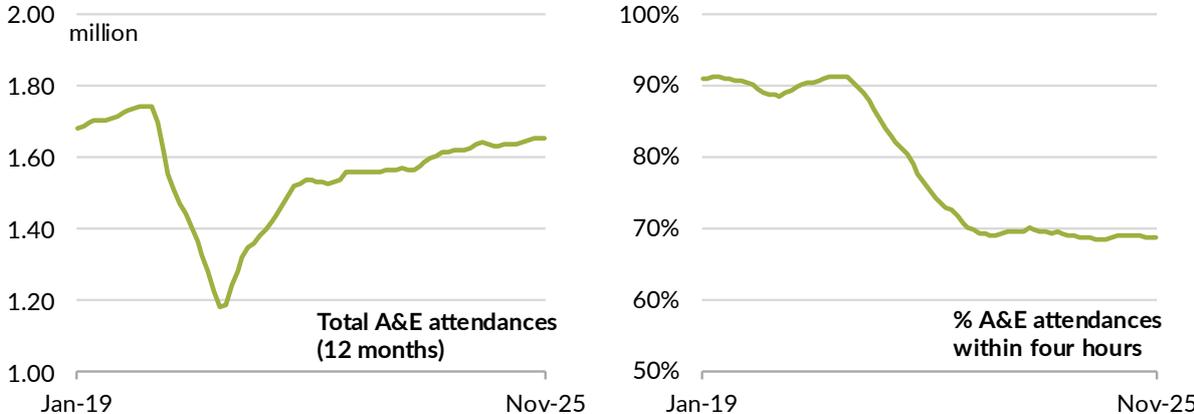
Figure 2.8: Accident and emergency attendances, England, 2019 to 2025



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

Notes: The waiting time measure is the percentage of patients whose total time in the department, from arrival to admission, transfer, or discharge, was under four hours.

Figure 2.9: Accident and emergency attendances, Scotland, 2019 to 2025

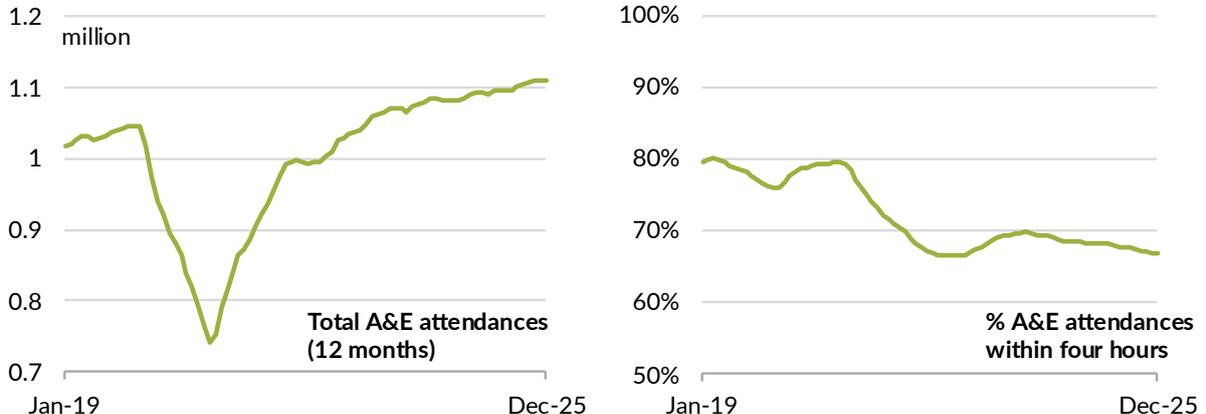


Source: Public Health Scotland, Accident and Emergency.

Notes: The waiting time is measured from arrival until the patient leaves the department, whether discharged, admitted, or transferred.

- 2.23 In the 12 months to November 2025, there were 1.65 million accident and emergency attendances in Scotland, up by 21,276 (1.3 per cent) from the 12 months to November 2024 but down by 83,296 (4.8 per cent) from the 12 months to November 2019.
- 2.24 The proportion of A&E attendances that took less than four hours was 68.6 per cent in the 12 months to November 2025, the same in the 12 months to November 2024 but down from 89.5 per cent in the 12 months to November 2019.
- 2.25 In the 12 months to December 2025, there were 1.11 million accident and emergency attendances in Wales, up by 16,973 (1.6 per cent) from the 12 months to December 2024 and up by 64,090 (6.1 per cent) from the 12 months to December 2019.
- 2.26 The proportion of A&E attendances that took less than four hours was 66.7 per cent in the 12 months to December 2025, down from 68.1 per cent in the 12 months to December 2024 and down from 76.6 per cent in the 12 months to December 2019.

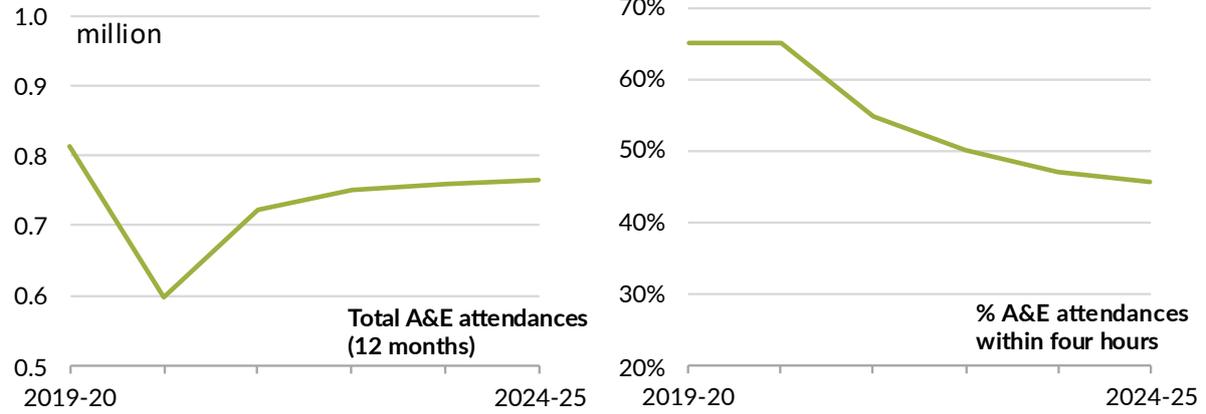
Figure 2.10: Accident and emergency attendances, Wales, 2019 to 2025



Source: Digital Health and Care Wales, Emergency Department Data Set.

Notes: The waiting time is measured from arrival to admission, transfer, or discharge.

Figure 2.11: Accident and emergency attendances, Northern Ireland 2019-20 to 2024-25



Source: Department of Health, Hospital Statistics: Emergency Care Activity.

Notes: The waiting time is measured from arrival to admission, transfer, or discharge. Total A&E attendances include new and unplanned attendances; planned attendances are excluded. Recent figures may be affected by digital system changes.

2.27 In 2024-25, there were 764,681 new or unplanned accident and emergency attendances in Northern Ireland, up by 4,721 (0.6 per cent) from 2023-24 but down by 49,388 (6.1 per cent) from 2019-20.

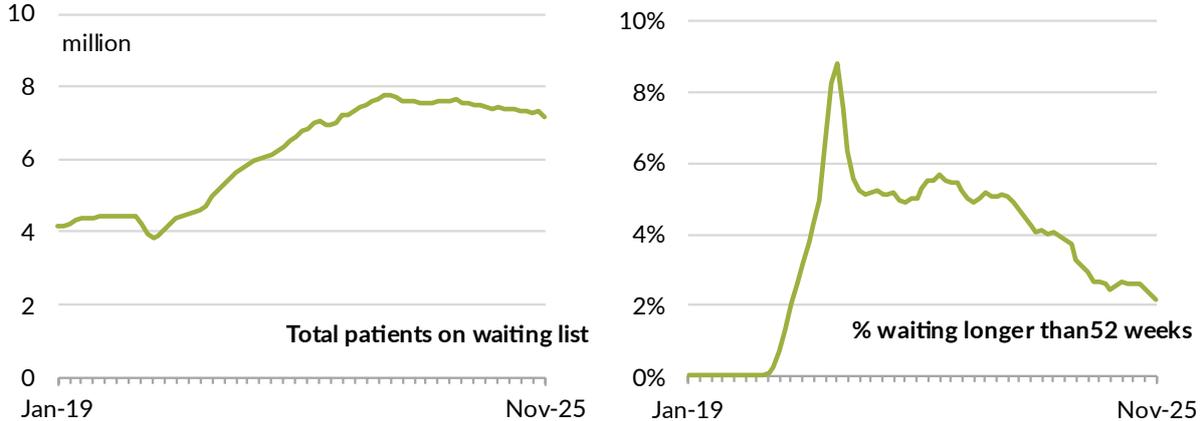
2.28 The proportion of A&E attendances that took less than four hours was 45.5 per cent in 2024-25, down from 47.1 per cent in 2023-24 and down from 65.1 per cent in 2019-20.

Waiting times

2.29 In November 2025, there were 7.16 million patients waiting for NHS treatment in England, down by 320,857 (4.3 per cent) from November 2024 but up by 2,745,532 (62.2 per cent) from November 2019.

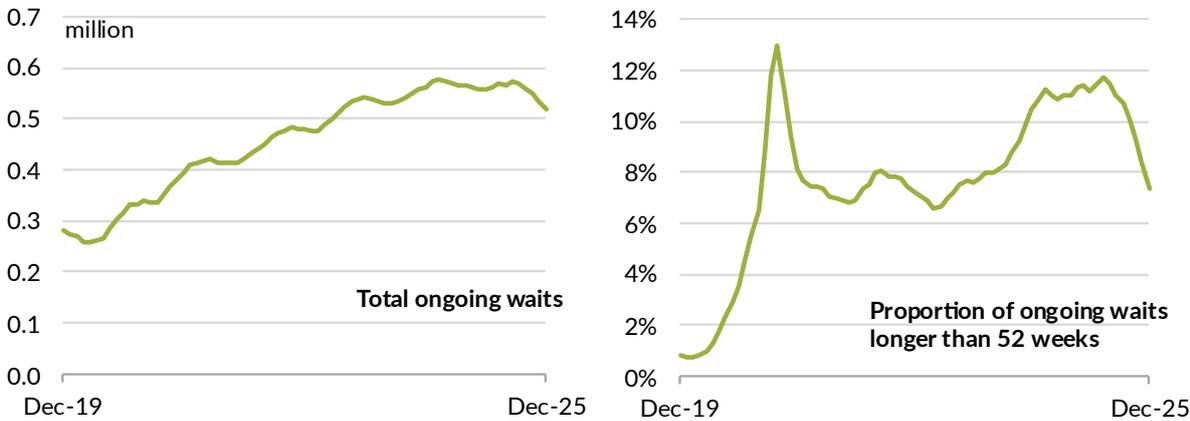
2.30 In November 2025, the number of patients in England waiting longer than 52 weeks for NHS treatment was 154,121, down by 67,446 (30.4 per cent) from November 2024 but up by 152,723 (10,924 per cent) from November 2019. The proportion of patients in England waiting longer than 52 weeks (out of all patients waiting) was 2.2 per cent, down from 3.0 per cent in November 2024 but up from 0.0 per cent in November 2019. The UK Government’s target for the NHS in England is that 92 per cent of patients should wait no longer than 18 weeks for treatment by the end of the parliament.

Figure 2.12: Patients waiting for treatment, England, 2019 to 2025



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

Figure 2.13: Ongoing waits for an outpatient appointment, Scotland, 2019 to 2025



Source: Public Health Scotland, NHS Waiting Times – Stage of Treatment.

- 2.31 In December 2025, there were 517,415 ongoing waits for new outpatient appointments in Scotland, down by 46,195 (8.2 per cent) from December 2024 but up by 235,807 (83.7 per cent) from December 2019.
- 2.32 In December 2025, the number of ongoing waits longer than 52 weeks in Scotland for a new outpatient appointment was 37,930, down by 24,126 (38.9 per cent) from December 2024 but up by 35,733 (1,626 per cent) from December 2019. The proportion of ongoing waits for a new outpatient appointment longer than 52 weeks was 7.3 per cent in December 2025, down from 11.0 per cent in December 2024 but up from 0.8 per cent in December 2019.
- 2.33 The NHS Scotland Operational Improvement Plan said that waiting times would be reduced by March 2026 to ensure that no-one was waiting longer than a year for their new outpatient appointment or inpatient/day-case procedure.⁷
- 2.34 In November 2025, there were 382,424 pathways waiting for a new outpatient appointment in Wales, down by 83,124 (17.9 per cent) from November 2024 but up 111,821 (41.3 per cent) from November 2019.
- 2.35 In November 2025, the number of pathways waiting longer than 52 weeks for a new outpatient appointment in Wales was 38,138, down by 44,197 (53.7 per cent) from November 2024 but up by 37,387 (4,978 per cent) from November 2019. The proportion of pathways for a new outpatient appointment waiting longer than 52 weeks was 10.0 per cent in November 2025, down from 17.7 per cent in November 2024 but up from 0.3 per cent in November 2019.

Figure 2.14: Pathways waiting for a new outpatient appointment, Wales, 2019 to 2025



Source: Digital Health and Care Wales, Performance and Waiting Times.

- 2.36 At 30 September 2025, 542,451 patients were waiting for a first consultant-led outpatient appointment at hospitals in Northern Ireland, 301,753 of which were waiting more than 52 weeks for an appointment. This was 55.6 per cent of the total of those waiting. Due to wider digital system changes in Northern Ireland, it is not possible to accurately compare changes over time.
- 2.37 The Department of Health said that waiting times for elective care services in Northern Ireland were among the worst in the UK. It said they were unacceptable and had significantly increased in recent years. It said this was due to the challenging financial

⁷ Scottish Government, *NHS Scotland operational improvement plan*. <https://www.gov.scot/publications/nhs-scotland-operational-improvement-plan/>

situation, the residual impact of Covid, and an increasing gap between health service capacity and demand.

- 2.38 The Minister of Health published an Elective Care Framework Implementation Plan on 30 May 2025 which detailed how the £215 million ringfenced allocation in the 2025-26 health budget for waiting list activities would be invested across three areas: to expand core capacity to reduce the red flag/time critical capacity gap; increase core routine capacity; and non-recurrent funding to start tackling the backlog of patients waiting. The Minister of Health highlighted reductions in the longest waits on 2 September 2025: outpatient waits of over four years were down by 14 per cent, and surgical waits of more than four years were down by 21 per cent. In named specialties such as gallbladders and tonsils, waits had fallen by almost a quarter.

Primary care activity

- 2.39 Across the UK nations, access to NHS dental services remains below pre-pandemic levels. While there has been some recovery in the number of patients seen over the year to March 2025, activity had not returned to the levels recorded in 2019-20 in any nation. This is discussed in further detail in Chapter 3.
- 2.40 General practice activity in England has increased, with the total number of appointments in England rising over the last year and remaining above 2022 levels. General practitioner (GP)-delivered appointments also grew, although the proportion of all appointments delivered by GPs was stable over 2025 and remained lower than in 2022. This is discussed further in Chapter 4.

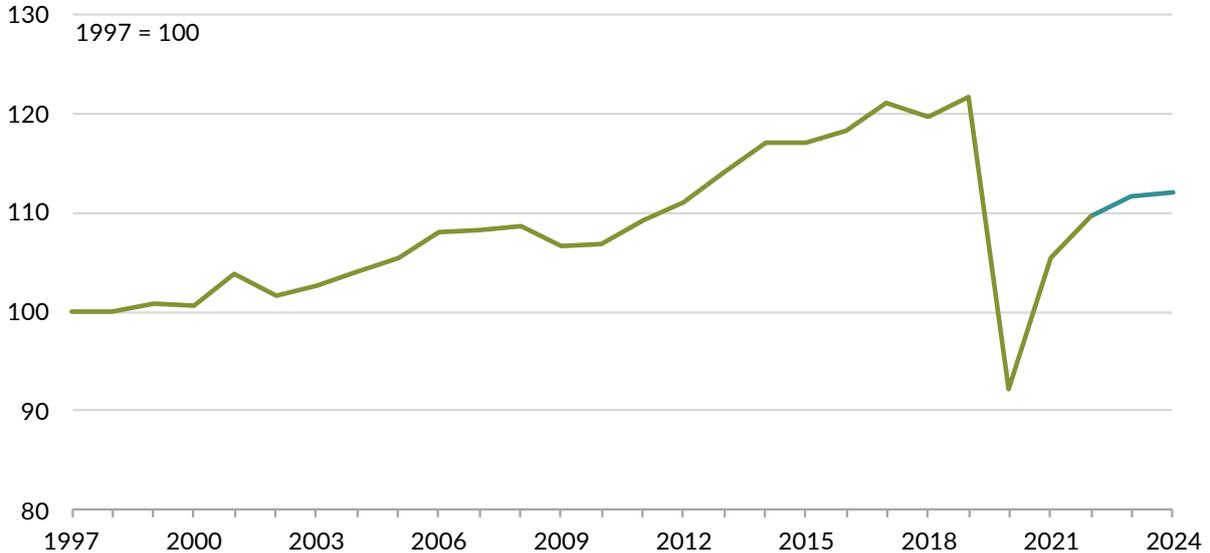
NHS productivity

- 2.41 Productivity in healthcare is generally measured by comparing the growth in outputs, such as activity delivered to patients, with the growth in inputs, including staff, goods, services and capital. The ONS measures total healthcare productivity on a whole-system basis and applies quality adjustments in its annual accredited series, whereas NHS England and other organisations produce operational or sector-specific measures that focus on particular settings, such as acute hospitals. These differences in scope, data sources and methods mean that productivity estimates from different organisations are not directly comparable.
- 2.42 The ONS publishes two distinct measures of public service productivity, which differ in purpose, methods and statistical status. The annual public service productivity statistics are accredited official statistics, remain the primary source for assessing long-term trends, include quality adjustments, and are currently available up to 2022. The quarterly estimates for total public services and healthcare are official statistics in development and provide a timelier indication of recent movements between annual publications, although they are subject to revision and are not directly comparable with the accredited annual statistics.
- 2.43 In the ONS quarterly statistics, healthcare productivity was estimated to have fallen by 1.5 per cent between April to June 2025 compared with the same period in 2024, as input growth (2.9 per cent) outpaced output growth (1.3 per cent).⁸

⁸ The ONS did not publish a healthcare-specific quarterly productivity estimate for July to September 2025 while work continues to improve the underlying health inputs data.

- 2.44 The annual healthcare productivity statistics published by the ONS provide the longer-run context for interpreting the short-term quarterly movements. These accredited annual estimates show sustained productivity growth prior to the pandemic, followed by a sharp decline in 2020-21 and a slight recovery in 2021-22 and 2022-23, though still below pre pandemic levels.
- 2.45 As a supplementary measure to the annual series, the ONS produces a linked time series that combines the accredited annual estimates with the quarterly official statistics in development to give an indicative comparison of growth since the pandemic. As noted above, these figures should be interpreted with caution because of differences in methods. The linked series suggests that healthcare productivity in 2024 was 7.9 per cent lower than in 2019. This compared with a 3.4 per cent fall in total public service productivity over the same period.

Figure 2.15: Public service healthcare productivity, UK, 1997 to 2024



Source: ONS, Public Service Productivity, quarterly, UK.
 Notes: Estimates from 1997 to 2022 are annual accredited official statistics. Estimates for 2023 and 2024 are official statistics in development and are annualised quarterly estimates.

- 2.46 While the ONS quarterly estimates suggested a decline in overall healthcare productivity between April and June 2025 compared to the previous year, NHS England reported a different pattern within the acute hospital sector.⁹ It reported that acute hospital productivity increased by 2.7 per cent in 2024-25 and by a further 2.4 per cent between April and June 2025. NHS England noted, however, that productivity in acute settings remained below pre-pandemic levels and that workforce growth had continued to outpace activity since 2019-20.
- 2.47 Analysis by the Institute for Fiscal Studies (IFS) showed that hospitals had exceeded many of their productivity targets in 2024-25 and the early part of 2025-26, yet progress in reducing waiting lists had been limited.¹⁰ The IFS found that this divergence was not explained by changes in funding, demand, or a greater focus on emergency

⁹ DHSC, *NHS recovery continues with above target productivity growth*. <https://www.gov.uk/government/news/nhs-recovery-continues-with-above-target-productivity-growth>
¹⁰ IFS, *Why isn't hospital productivity growth bringing down the waiting list more quickly?* <https://ifs.org.uk/articles/why-isnt-hospital-productivity-growth-bringing-down-waiting-list-more-quickly>

care. Instead, it reflected a marked increase in the amount of activity required before patients could be removed from the waiting list. The IFS estimated that, without this rise, the additional activity delivered in 2024-25 would have reduced the waiting list by around 1 million cases.

- 2.48 The Health Foundation's Productivity Commission suggested that the health service had effectively lost around a decade of productivity growth based on the latest official data for 2022-23.¹¹ It said that, if pre-pandemic trends had continued, the NHS would have been around 14 per cent more productive in 2022-23. This was equivalent to roughly £20 billion of additional care in 2022-23 alone.
- 2.49 The DHSC said that the Spending Review included a commitment that the NHS in England would deliver 2 per cent annual productivity growth between 2025-26 and 2028-29. This included 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. The DHSC said that these investments would free up staff time, improve patient experience, and ensure the NHS was better equipped to meet future demand.
- 2.50 The DHSC said that increasing NHS productivity and efficiency remained essential to meet the growing demand for health services, to support enduring improvements in performance, and ensure financial sustainability. It said that funding and workforce levels within the NHS had gradually increased in recent years, but this had not yet translated into significant corresponding improvements in productivity. The 2 per cent productivity growth target aimed to address this gap, to ensure that increased resources translated into measurable improvements in the quality of services patients received.
- 2.51 To deliver the 2 per cent productivity target, NHS England was focusing on five areas:
- 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.
 - Workforce: optimising workforce capacity through best practice standards of planning and deployment, improving retention and culture, upskilling staff, and reducing the volume of temporary staffing, which would reduce bank and agency spend.
 - Health rather than illness: focusing on increasing healthy life years through prevention and screening, and shifting care to primary, community, and mental health services.
 - 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.
 - Reducing waste: achieving efficiencies in medicines, enhancing commercial processes, and improving corporate services by exploring large-scale automation.
- 2.52 The Welsh Government said that the NHS in Wales faced rising demand and increasing costs. It said that increased funding would help the NHS meet some of these pressures, though health boards must continue delivering savings and efficiencies. Improvements in productivity and performance would be required. The Welsh Government said that a

¹¹ The Health Foundation, *From diagnosis to delivery*. <https://www.health.org.uk/reports-and-analysis/reports/from-diagnosis-to-delivery>

major transformation programme was shifting care from hospitals to community settings in NHS Wales. This included moving resources, the use of multidisciplinary teams, improved local co-ordination, and focusing GP contracts on community-based care.

2.53 One of the objectives in the NHS Wales Planning Framework was to maximise workforce productivity and efficiency, strengthening value and effective deployment of the workforce.¹² An independent review of NHS Wales performance and productivity was published in April 2025.¹³ The Welsh Government accepted the review's recommendations and said it was moving at pace to strengthen delivery, reduce unwarranted variation, and improve efficiency across planned care, diagnostics, cancer, and urgent and emergency care.

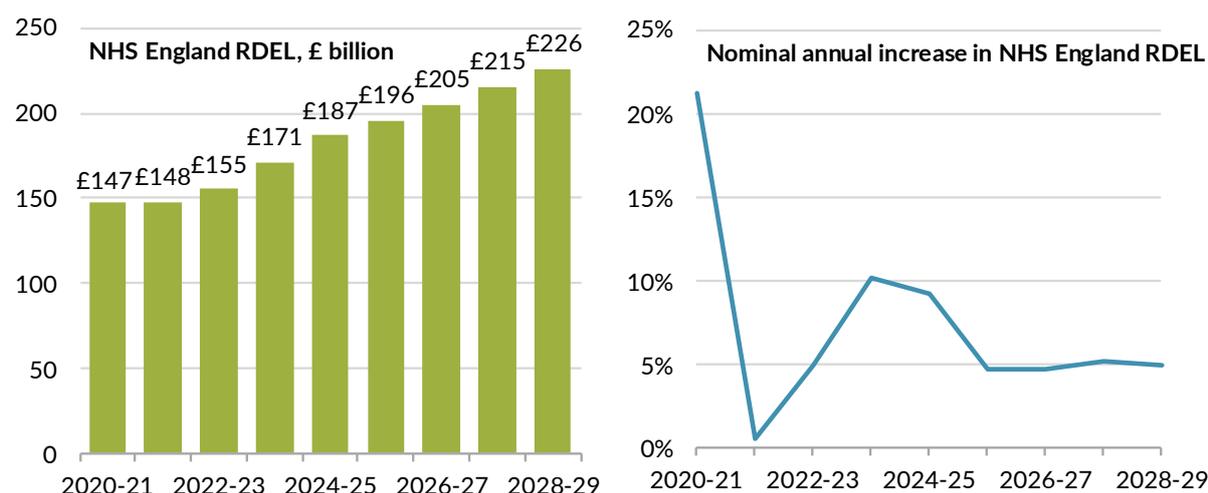
2.54 The Welsh Government said its productivity agenda was inseparable from workforce capacity and stability. It said that delivering these reforms, particularly outpatient transformation, standardisation at scale, and digital uptake, depended on a sustainably staffed, fairly rewarded workforce with reduced reliance on temporary staffing and the headroom to engage in service redesign and improvement. It said that pay, retention and training investments were practical enablers of the productivity gains, and they helped convert pathway reforms and performance management.

Health spending and affordability

2.55 Under the Spending Review, NHS funding in England was set to rise by an average of 3 per cent a year in real terms for the period 2026-27 to 2028-29; with a 4.8 per cent nominal increase in NHS England funding for 2026-27.

2.56 NHS spend on staff in England saw an annual increase of 9.6 per cent, to £89.9 billion in 2024-25, an increase of 53.8 per cent over five years. This was equivalent to 49.9 per cent of resource expenditure.

Figure 2.16: Mandate funding for NHS England, 2019-20 to 2028-29



Source: 2025 to 2026 financial directions to NHS England; Spending Review 2025.

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

¹² Welsh Government, *NHS Wales planning framework 2025 to 2028*. <https://www.gov.wales/nhs-wales-planning-framework-2025-2028>

¹³ Welsh Government, *NHS Wales performance and productivity: independent review*. <https://www.gov.wales/nhs-wales-performance-and-productivity-independent-review>

- 2.57 The DHSC said it had developed financial and delivery plans which allowed for a pay uplift of 2.5 per cent without having to make trade-offs against headline government health commitments. The UK Government's position was that pay awards must be funded from departmental budgets and there would be no access to the reserve.
- 2.58 The DHSC said that NHS pay was a significant material pressure where every 0.5 per cent increase to pay cost around £750 million, so anything above the pay plan would require difficult trade-offs. These trade-offs could include a reduction in ambitions for service or performance improvement, such as additional elective activity to reduce waiting lists, or additional investment in digital and technology to support productivity improvements in future years. As staffing costs were the largest single area of NHS expenditure, it was likely that higher pay awards would affect the ability for the NHS to afford to maintain or expand staffing levels.
- 2.59 HM Treasury said that departments would not be given additional funding for pay awards in 2026-27, continuing the approach for 2025-26. Any additional costs would need to be funded by savings elsewhere in departmental budgets. It also said that departments had been asked to make further efficiency savings of 0.5 per cent from 2028-29 since written evidence on affordability was submitted to the review bodies, with the NHS allowed to retain and reinvest savings to improve patient care.
- 2.60 HM Treasury said that, should the review bodies recommendations exceed the affordability figures, departments would have to carefully consider if further efficiencies or cuts were possible, and recommendations would have to be rejected if they proved unaffordable. If recommendations above affordable levels were accepted, it would mean challenging trade-offs, with the potential to impact the government's wider commitments to improve public services.
- 2.61 NHS Employers reported extremely tight financial settlements and constraints. They noted that:
- Providers were required to improve productivity by 4 per cent and reduce costs by 1 per cent, with many reducing recruitment to vacancies as a result.
 - Capital spending growth was also limited, with a slight increase but flat real terms growth over the near term, constraining investment especially in infrastructure and technology.
 - The NHS must improve key targets including elective waiting lists, emergency care response and waiting times, and accessibility to primary care, while operating under constrained budgets.
 - Unfunded costs like redundancy and the impact of industrial action added further financial uncertainty.
 - There was a mandated reduction of at least 30 per cent in agency spending and 10 per cent in bank staff use, to control costs.
- 2.62 NHS Employers said that, when pay uplifts were not matched by adequate central funding, employers were forced to make difficult choices, diverting resources from service delivery, delaying strategic investments, and increasing their reliance on non-recurrent savings.
- 2.63 The 10-year health plan for England said it would restore financial discipline by ending the practice of providing additional funding to cover deficits. The aim was for the NHS to move into financial surplus, with the majority of providers achieving that by 2030.

- 2.64 The Scottish Budget set out a nominal 3.8 per cent increase in fiscal resource for health and social care for 2026-27.¹⁴ The Scottish Government said this represented a real terms uplift of 1.8 per cent on health board baseline funding. This was to meet the expected costs of 2026-27 pay in line with public sector pay policy and included delivery of a minimum of 3 per cent recurrent savings for NHS health boards. However, the IFS said that, once funding top-ups in 2025-26 and transfers to other departments, such as to support social care, were taken into account, funding for the remaining element of the health and social care portfolio was set to be cut by 0.6 per cent in real terms in 2026-27.¹⁵
- 2.65 The Scottish Government said that inflation-linked clauses were essential to secure pay agreements during a period of increased inflation. It said these measures ensured workforce stability and service continuity and that future pay policies would review the role of inflation-linked clauses to maintain fiscal sustainability. It said that 2026-27 was the second year of the three-year public sector pay policy, which set out multi-year pay metrics of a 9 per cent pay envelope covering 2025-26, 2026-27 and 2027-28. The Scottish Government said that, to maintain financial and service sustainability, particularly in the face of rising workforce costs and easing inflationary pressures in 2026-27, it was vital that pay decisions continued to be made within this framework. In oral evidence, the Scottish Government said that a 3 per cent uplift had been budgeted for, in line with the public sector pay policy.
- 2.66 In its Integrated Public Sector Pay and Workforce Policy 2026-27, the Scottish Government said that it expected that portfolios agreeing pay deals that exceeded the pay metrics would deliver efficiencies through reform to ensure the paybill remained sustainable in the medium term and all deals were based on fairness and affordability.¹⁶
- 2.67 The Welsh Government said its settlement in the Spending Review included an additional £5 billion in resource and capital funding over the Spending Review period – £1 billion in 2026-27, £1.6 billion in 2027-28 and £2.4 billion in 2028-29 – as well as an extra £4 million in 2025-26. The Welsh Government said that, while the settlement meant more funding to support public services and investment in infrastructure, the fiscal environment for delivering public services remained exceptionally challenging.
- 2.68 The Welsh Government's Final Budget confirmed an increase in the health and social care resource budget for 2026-27 of £441 million, a nominal 3.6 per cent uplift, giving a total resource budget of £12.6 billion, more than 55 per cent of the Welsh Government's resource budget.¹⁷ At the Draft Budget stage, there was an uplift of 2.2 per cent on fiscal resource for public sector pay.
- 2.69 The total paybill cost for the whole NHS Wales workforce (including agency and locum staff) was £6.7 billion in 2024-25, up by 9.8 per cent over the year and by 40 per cent over four years. The Welsh Government said that NHS pay accounted for 56 per cent of NHS Wales operating costs. When compared to its original budget assumptions, the implementation of the 2025-26 pay awards created a £90 million financial pressure.

¹⁴ Scottish Government, *Scottish Budget 2026 to 2027*, table B.03. <https://www.gov.scot/publications/scottish-budget-2026-2027/documents/>

¹⁵ IFS, *The IFS Scottish Budget Report 2026–27*. <https://ifs.org.uk/publications/ifs-scottish-budget-report-2026-27>

¹⁶ Scottish Government, *Scottish Budget 2026 to 2027: integrated public sector pay and workforce policy*.

<https://www.gov.scot/publications/scottish-budget-2026-2027-integrated-public-sector-pay-workforce-policy/>

¹⁷ Welsh Government, *Final Budget 2026 to 2027*. <https://www.gov.wales/final-budget-2026-2027>

- 2.70 The Welsh Government said that, while it had flexibility over how it allocated its resources and acknowledged the importance of a fairly remunerated workforce, it also recognised that there were other workplace issues that contributed to a motivated workforce and effective public services – such as provision of supplies and support services – and in making its allocations there was a balance to be struck. It said that if it dedicated a disproportionate share of its revenue resources to funding public sector pay rises, this would negatively impact on a range of other areas of government spending.
- 2.71 As with the UK Government, the Welsh Government expected individual departments to fund the pay increases from within the allocations in the Final Budget. The Welsh Government did not hold reserves that could be used for subsequent additional allocations. Should recommendations be significantly higher than the growth in the Welsh Government’s budget, it would need to carefully consider its ability to fund them. It said it would be artificial to suggest that the difficult trade-offs it would have to consider in such a scenario would not have an impact on the experience of the workforce as it would mean cuts elsewhere within departmental budgets and potentially lead to the need to reduce staff numbers.
- 2.72 The Welsh Government said that the NHS in Wales was facing a challenging period. Both the performance and financial position of a number of health boards had worsened over the previous 12 months. Revenue out-turn for NHS Wales for 2024-25 was a deficit of £123.7 million. At month 4 in 2025-26, NHS Wales was forecasting a deficit for the year of £173.2 million, and savings of £275 million were required. This was in addition to the £300 million savings delivered in 2024-25. The Welsh Government said these savings were challenging and historic in scale, and more than could reasonably be delivered.
- 2.73 The Department of Health in Northern Ireland said that, while the Spending Review outcome provided the Executive with additional funding when compared to 2025-26, the position remained challenging as this must be viewed in the context of rising demand and the increasing cost of delivering public services. In particular, the 2026-27 outcome provided only a small increase to the 2025-26 position due to the end of the financial stabilisation package that was agreed on the restoration of the Executive.
- 2.74 The Northern Ireland Draft Budget set out a health budget for 2026-27 of £8.5 billion. This represented a nominal increase of 0.9 per cent on the 2025-26 opening budget, but a 4.7 per cent fall on the 2025-26 final budget.¹⁸ There were planned nominal budget increases of 1.8 per cent in 2027-28 and 1.9 per cent in 2028-29.¹⁹ The Department said that the Executive would remain financially constrained, particularly in 2026-27, as the biggest uplifts in day-to-day spending occurred in subsequent years. The Northern Ireland Fiscal Council noted that the Department of Health was being asked to deliver services next year with a baseline allocation that was below the level which would maintain their current spending levels.
- 2.75 The Department of Health said there was a small increase of £200 million in the health budget for 2025-26 compared to 2024-25 but this made no allowance for significant increases in cost as a result of pay and price inflation and rising demand. In the health

¹⁸ Northern Ireland Fiscal Council, 24 February 2026, *The Finance Minister's proposed 2026-27 to 2028-29/29-30 Budget*, table 4.2. <https://www.nifiscalcouncil.org/publications/finance-ministers-proposed-2026-27-2028-2929-30-budget-assessment>

¹⁹ Department of Finance, *Draft Budget 2026-2029/30*. <https://www.finance-ni.gov.uk/consultations/draft-budget-2026-202930>

budget, £165 million was ringfenced for waiting lists, which the Department said would intensify already severe pressures on Health and Social Care (HSC) trusts to make further savings and efficiencies. This would inevitably have consequences for services. The final health budget also provided funding for employer national insurance contribution increases which was significantly less than required and would add to the funding deficit. The Department said that, compared to funding requirements, this left a funding gap of £600 million.

- 2.76 Payment of the 2025-26 pay uplift in Northern Ireland led to a budget over-spend in the Department of Health of £100 million, with the funding shortfall at the end of 2025-26 being deducted from the Department's opening budget for 2026-27.²⁰
- 2.77 The Draft Budget for Northern Ireland said it was essential that vital public service workers were appropriately rewarded. It said that, as pay awards reflected ongoing costs, they should not rely on in-year funding which may not be available at the same level in future years. Therefore, the Draft Budget proposals had been prepared on the basis that appropriate pay awards, including those anticipated from pay review bodies, were factored into each departments budget plans from the start of the financial year. Public sector pay policy for 2026 to 2029 continued to be that pay must be affordable within each department's budget settlement.
- 2.78 The Draft Budget said that the cost of providing the services the Department of Health delivered was increasing by an estimated 6 per cent a year. This was due to an ageing population with greater and more complex needs, increasing costs for goods/services, and growing expertise and innovation which meant an increased range of services, supporting improvement in population health. All of these brought increases in the funding required each year to maintain services and meet demand. Under the proposed Draft Budget outcome, the main focus would be on preserving and protecting existing services.

NHS planning and workforce planning

- 2.79 The UK Government published the *10 Year Health Plan for England: fit for the future* in July 2025.²¹ The Government said it would reinvent the NHS through three radical shifts: from hospital to community, analogue to digital, and sickness to prevention. The intention was that the share of expenditure on hospital care would fall, with proportionally greater expenditure on out-of-hospital care.
- 2.80 In the 10-year health plan, the Government said it would create a new workforce model with staff genuinely aligned with the future direction of reform. It said the 2023 long-term workforce plan did little more than extrapolate from past trends into the future, concluding there was no alternative than continuation of the current care model, supported by an inexorable growth in headcount, mostly working in acute settings. The 10-year health plan said that, by 2035, there would be fewer staff than projected in the 2023 workforce plan, those staff would be better treated, more motivated, have better training and more scope to develop their careers.
- 2.81 The 10-year health plan said that staff, trade unions and employers had expressed growing frustration about the current national employment contracts in the NHS and

²⁰ Northern Ireland Assembly, AQO 2774/22-27.

<https://aims.niassembly.gov.uk/questions/printquestionsummary.aspx?docid=461185>

²¹ UK Government, *10 Year Health Plan for England: fit for the future*.

<https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future>

the difficulties in ensuring that they adapted and evolved to meet everyone's expectations and aspirations. The Government said it would continue to work with trade unions and employers through established processes to maintain, update and reform employment contracts.

- 2.82 The 10-year health plan said this work would consider a range of options to ensure coherence across contractual offers to all NHS staff. This would be a complex undertaking and would mean some realistic conversations about pay that better recognised performance and innovation, and terms and conditions which enabled the three shifts and a 24/7 service. The 10-year health plan said that employers would need to improve staff experience, and act to ensure consistent access to much more modern and flexible working arrangements.
- 2.83 The 10-year health plan said that, through a focus on flexible work, the need for expensive extra-contractual work would be significantly reduced. It said that agency staffing in the NHS would be eliminated by the end of this parliament,
- 2.84 The 10-year health plan said it would reorientate the focus of NHS recruitment away from its dependency on international recruitment, and towards its own communities, to ensure sustainability in an era of global healthcare workforce shortages. The 10-year workforce plan would set out actions on retention, productivity, training and attrition with the ambition to reduce international recruitment to less than 10 per cent by 2035.
- 2.85 The 10-year health plan said that providers would be given new flexibilities to make additional financial payments to clinical teams that had consistently high clinical outcomes and excellent patient feedback or were significantly improving care.
- 2.86 The Scottish Government said it recognised the need for a workforce plan to account for what patients and the public wanted and needed from their health service, and to ensure the attractiveness of medical careers. It was undertaking a Future Medical Workforce project to consider Scotland's future healthcare needs and the medical workforce required to deliver care in 15 to 20 years' time. The project would involve extensive engagement with the workforce and other stakeholders, as well as analytical scenario modelling to gain an understanding of future demand and supply, with the ultimate aim being to arrive at a workforce plan for Scotland's medical workforce. It said the Future Medical Workforce project would not cover current pay or terms and conditions.
- 2.87 The Welsh Government said it had asked Health Education and Improvement Wales (HEIW) to scope the parameters for a long-term workforce plan. It said that the NHS England 10-year health plan informed an ongoing and iterative discussion about the future shape of care, work and education, and how to achieve the right balance between them, to deliver the best possible care, with a key focus on digital technology.
- 2.88 It also recognised that there were going to be fewer younger people available to care for the older population, and so the opportunities for workforce supply would change, as would the way they worked, trained and viewed work. The Welsh Government said that the reliance on international colleagues was also a risk, particularly in the context of a global health workforce shortage.

- 2.89 Audit Wales published a review of workforce planning in each of the 12 health bodies in Wales last year.²² It said there was a strong argument for a detailed and holistic national workforce plan to underpin the national Workforce Strategy for Health and Social Care. It noted that NHS Wales was more reliant on doctors trained outside its borders than the three other home nations and comparatively Wales retained fewer of the doctors that it trained. As of December 2024, 43 per cent of doctors who undertook their primary medical qualification in Wales remained in Wales. In England, Scotland and Northern Ireland, the corresponding figures were 94 per cent, 61 per cent and 76 per cent respectively. It noted that the retention of postgraduate specialty trainees and GP trainees within Wales was higher.
- 2.90 It recommended that the Welsh Government should review, and where necessary strengthen, the national arrangements for education commissioning of medical undergraduates in Wales with the aim of:
- Ensuring the number of doctors in training aligned with forecast medical staffing needs.
 - Identifying what additional steps could be taken to encourage those in training to remain in Wales following their qualification.
- 2.91 Audit Wales also recommended that HEIW should lead work within NHS Wales aimed at strengthening workforce data to ensure that it was sufficient to enable the development of national and local workforce plans. It said this should particularly focus on medical and nursing sub-specialty level data and primary care workforce data.
- 2.92 The Department of Health in Northern Ireland said that the third action plan of the Health and Social Care Workforce Strategy would be published shortly, to cover the three-year period from April 2025.
- 2.93 The Department hoped to update the Medical Student Places Review in 2025. This would consider the overall number of training places, and address issues such as how access to medical education in Northern Ireland could be widened and how best to develop and retain the future medical workforce. The initial review, in 2019, had recommended an expansion in the number of funded medical school places in Northern Ireland by at least an additional 100 places a year, from 236 a year in 2019. A lack of funding had meant that the annual number of medical student places fell 30 short of this target.

Industrial relations

- 2.94 Governments observed that industrial relations challenges remained, raising concerns about the impact on patients and staff of further industrial action. In some cases, the industrial relations environment made progressing wider reforms harder.
- 2.95 Resident doctors in England last took strike action in December 2025 and have extended their mandate for future action until August 2026. The BMA said that future industrial action was likely to extend to consultants if pay did not continue on a path to pay restoration by 2027-28.
- 2.96 NHS Employers said that legislative and industrial relations changes, such as the repeal of the Strikes (Minimum Service Levels) Act 2023, and upcoming ballot reforms under the Employment Rights Bill 2025, had the potential to change the industrial relations

²² Audit Wales, *Addressing workforce challenges in NHS Wales*. <https://www.audit.wales/publication/addressing-workforce-challenges-nhs-wales>

landscape. They said that changes to trade union ballot rules under the Employment Rights Bill marked a significant shift in the UK's industrial relations framework. They said that the removal of the 50 per cent turnout threshold, and the requirement for 40 per cent support among members eligible to vote, would lower the bar for lawful strike action mandates to be secured, enabling trade unions to initiate industrial action with fewer votes. They said that the introduction of electronic balloting would streamline the process, making ballots more accessible, efficient, and responsive to workplace developments.

2.97 NHS Employers said that, coupled with the extension of strike mandates from six to 12 months and simplified ballot notice requirements, unions would gain greater flexibility and sustained momentum in coordinating collective action. Notably, the notice period for industrial action would be reduced from 14 to 10 days, allowing unions to act more swiftly and reducing the time employers had to prepare for the action. They said that these reforms had the potential to increase the frequency and ease of industrial action, as longstanding procedural barriers were dismantled.

2.98 NHS Employers set out the impact of the five days of strike action by resident doctors in July:

- A financial impact of approximately £300 million, to be managed within the existing NHS budget.
- Extensive use of internal locum cover and contingency planning, placing a significant burden on medical staffing teams.
- Delays in elective care and increased pressure on already stretched services.
- Additional strain on management and non-striking staff, potentially leading to fatigue and a decline in morale and motivation.
- Strained relationships with staff and the morale of the workforce.
- A substantial distraction from core business activities.
- A diversion away from progressing any new or established workforce priorities.
- The erosion of work on long-term planning and resilience.

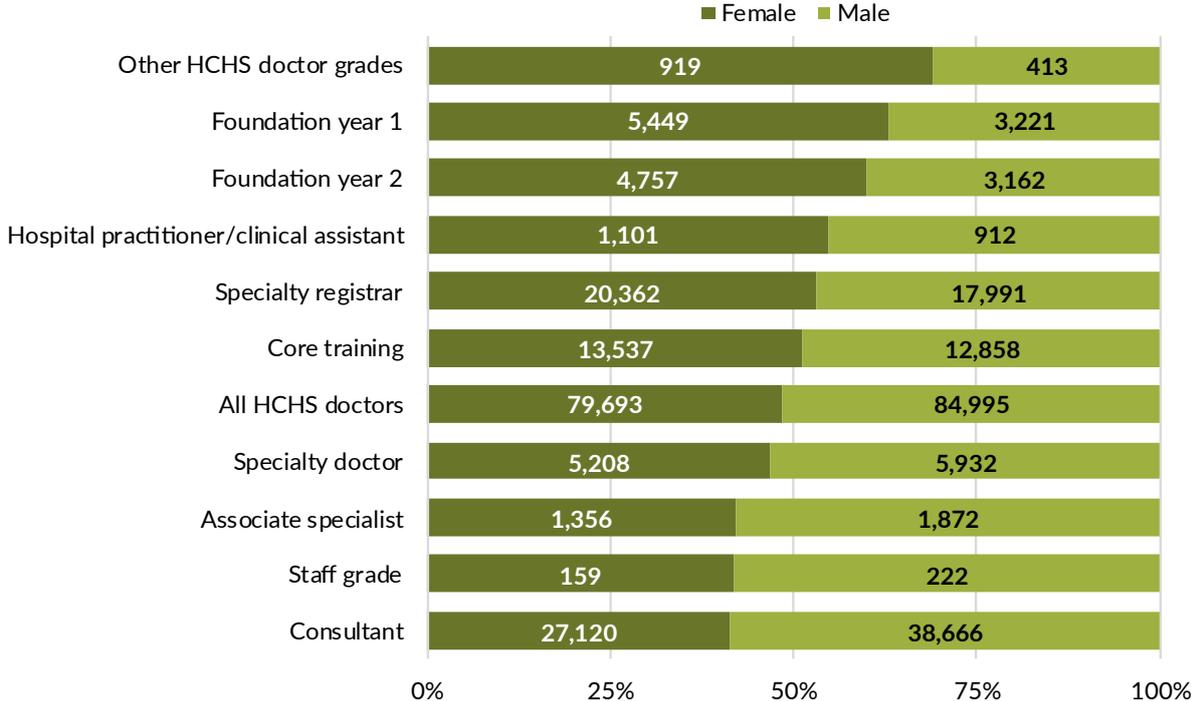
Workforce equalities and diversity

Secondary care workforce

2.99 In England, 48.4 per cent of medical and dental hospital and community health service (HCHS) staff were female in November 2025. While women made up the majority of doctors and dentists in training, men remained the majority in more senior roles, including consultants, associate specialists and specialty doctors.

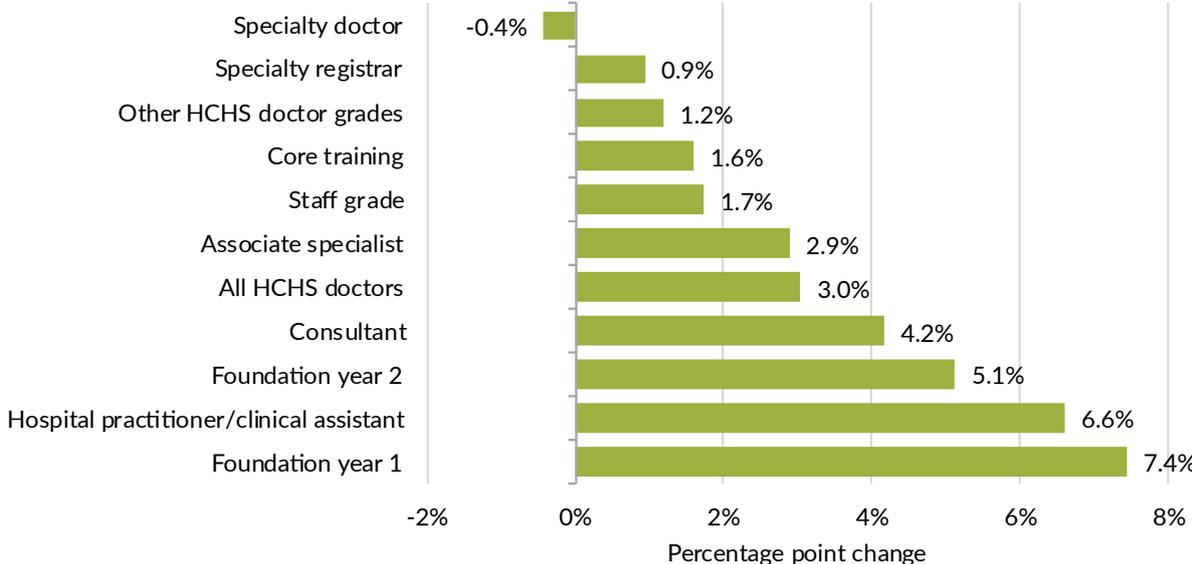
2.100 The proportion of medical and dental staff in England that were female increased by 3.0 percentage points between September 2019 and November 2025. There were increases across most grades over this period, with a small fall, of 0.4 percentage points in the proportion of specialty doctors that were female. Foundation doctors, hospital practitioners/clinical assistants and consultants saw the largest growth in the proportion that were female.

Figure 2.17: HCHS doctors and dentists, England, by gender and grade, November 2025, headcount



Source: NHS England, NHS Workforce Statistics.

Figure 2.18: Change in female proportion of HCHS doctors and dentists, September 2019 to November 2025, England, headcount



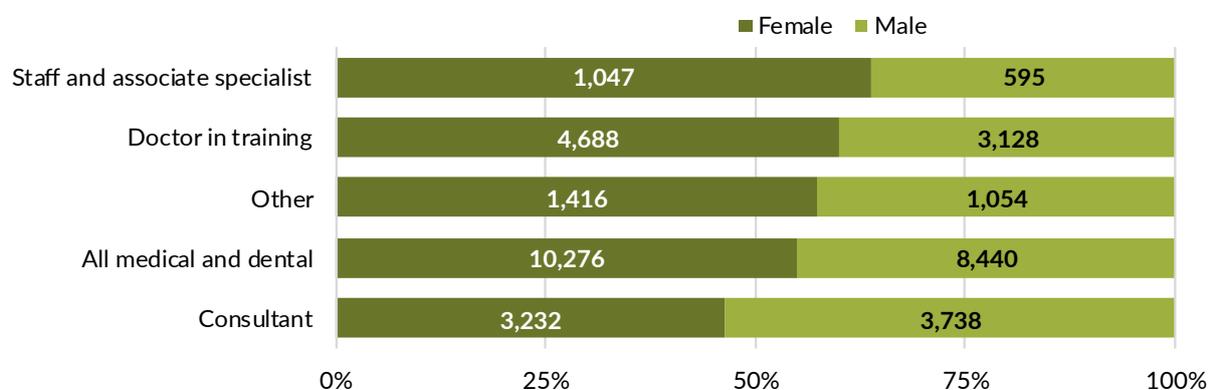
Source: NHS England, NHS Workforce Statistics.

2.101 In Scotland, 54.9 per cent of the medical and dental workforce were female in September 2025. Women made up a majority at most grades, except for the consultant grade, where 46.4 per cent were female.

2.102 The proportion of medical and dental staff in Scotland that were female increased by 2.1 percentage points between September 2019 and September 2025. There were increases across most grades over this period, with the exception of a fall of 1.3

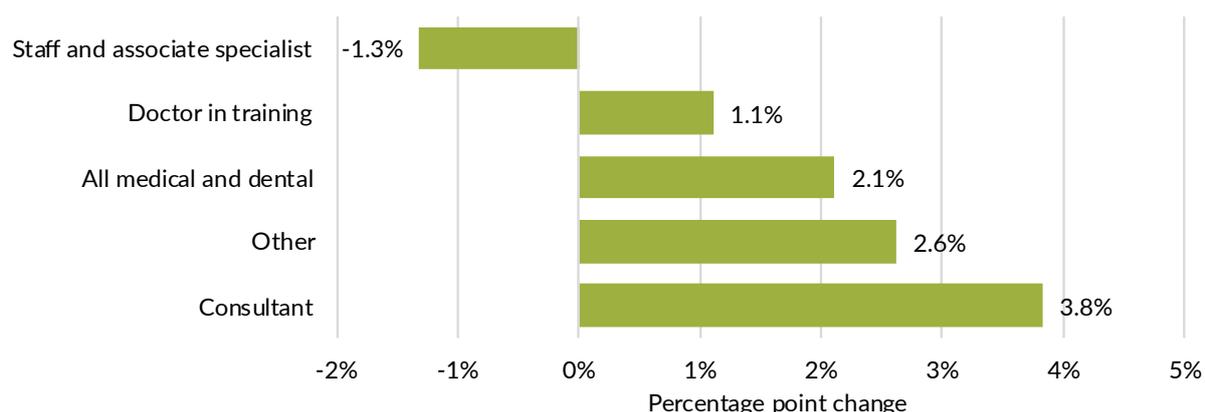
percentage points in the proportion of staff grade and associate specialists that were female. Consultants saw the largest growth in the proportion that were female.

Figure 2.19: HCHS doctors and dentists, Scotland, by gender and grade, September 2025, headcount



Source: NHS Education for Scotland.

Figure 2.20: Change in female proportion of HCHS doctors and dentists, Scotland, September 2019 to September 2025, headcount



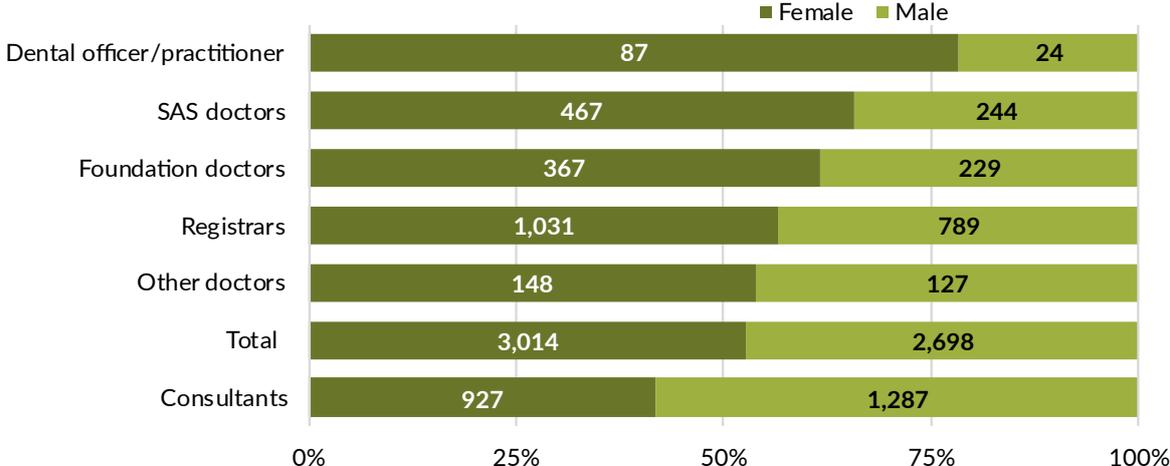
Source: NHS Education for Scotland.

2.103 In Wales, 47.4 per cent of the medical and dental workforce were female in September 2025. The proportion of medical and dental staff that were female increased by 1.7 percentage points between September 2022 and September 2025. Staff breakdowns prior to September 2022 are not published.

2.104 In Northern Ireland, 52.8 per cent of medical and dental staff were female in March 2025. Women made up a majority across most grades, except for the consultant grade, where 41.9 per cent were female.

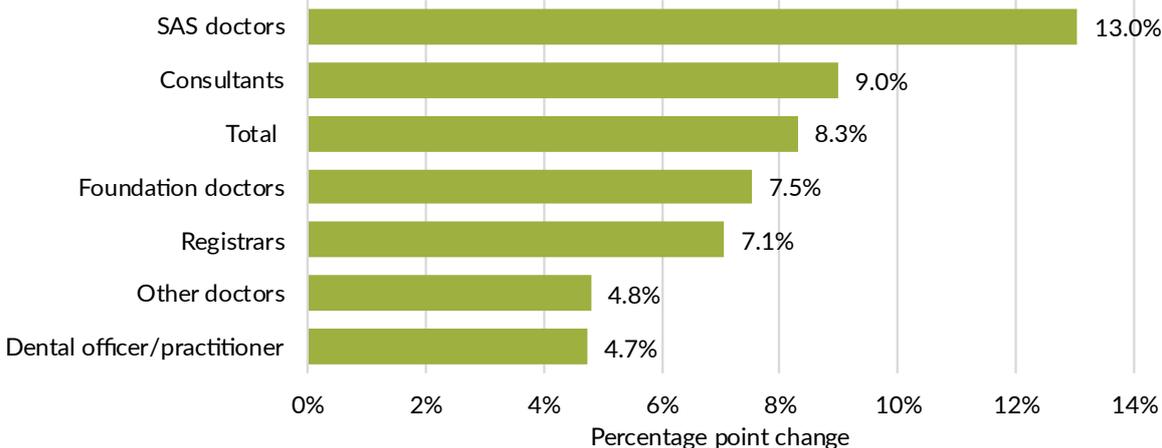
2.105 The proportion of medical and dental staff in Northern Ireland that were female increased by 8.3 percentage points between March 2019 and March 2025. There were increases across all grades over this period, with SAS doctors seeing the largest growth in the proportion that were female, followed by consultants.

Figure 2.21: HCHS doctors and dentists, Northern Ireland, by gender and grade, March 2025, headcount



Source: Office for the Pay Review Bodies (OPRB) calculations based on data from Northern Ireland health and social care workforce 2025.

Figure 2.22: Change in female proportion of HCHS doctors and dentists, Northern Ireland, March 2019 to March 2025, headcount



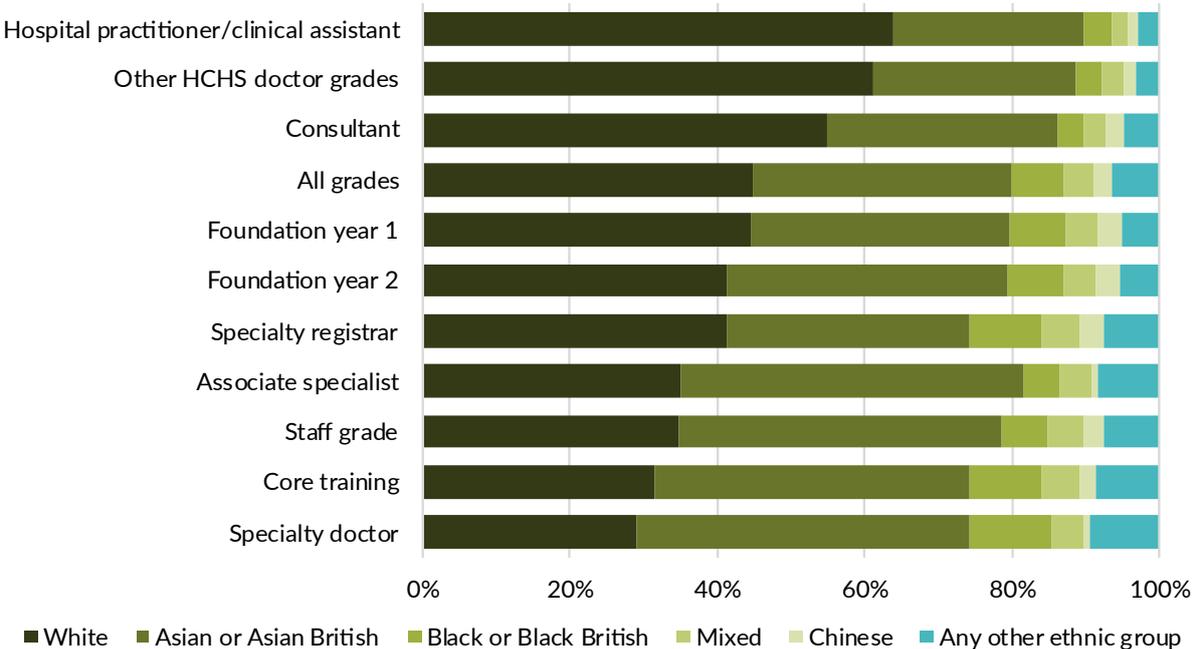
Source: OPRB calculations based on data from Northern Ireland health and social care workforce 2025.

Note: Some staff categories have changed since 2019, so the groups may not be fully comparable across the period. This is particularly the case for the 'other doctor' and 'SAS' categories.

2.106 In England, in November 2025: 44.8 per cent of HCHS medical and dental staff in England were White; 35.2 per cent were Asian or Asian British; 7.0 per cent were Black or Black British; 4.1 per cent had mixed ethnicity; 2.5 per cent were Chinese; and 6.3 per cent were from any other ethnic group.

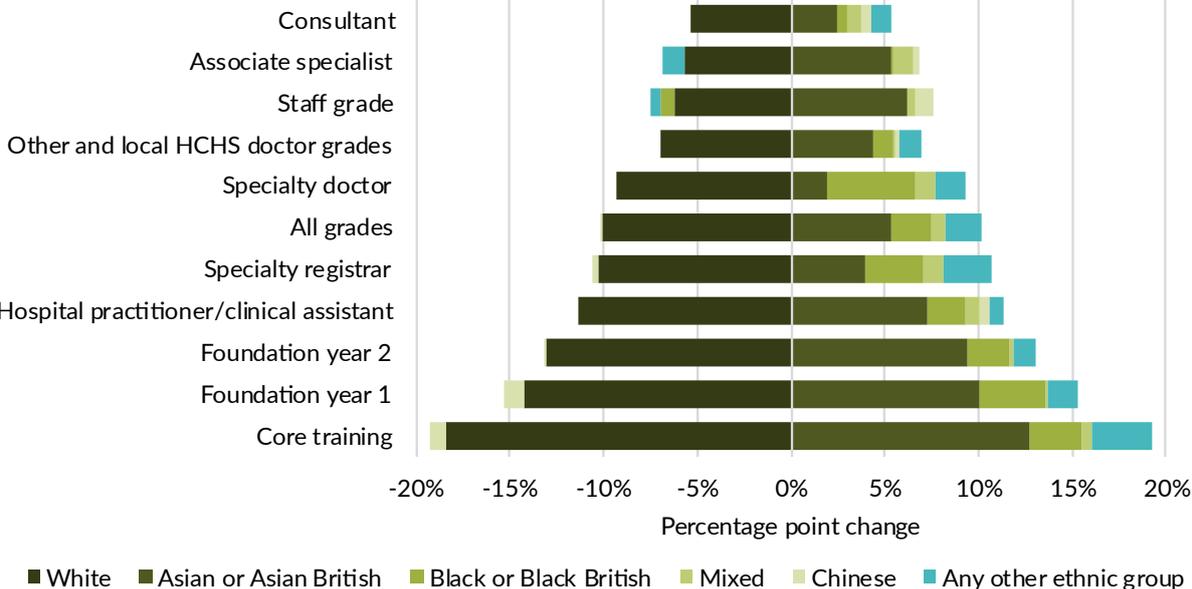
2.107 The proportion of HCHS medical and dental staff in England that were White decreased by 10.1 percentage points between September 2019 and November 2025. Over the same period, the proportions of staff who were Asian or Asian British, Black or Black British, mixed ethnicity or from any other ethnic group increased across most grades, with small falls recorded in the proportion of staff identified as Chinese. The largest changes occurred for core training and foundation doctors, where there were substantial decreases in the proportion of White staff and corresponding increases in Asian or Asian British and Black or Black British staff.

Figure 2.23: HCHS doctors and dentists, England, by ethnicity and grade, November 2025, headcount



Source: NHS England, NHS Workforce Statistics.

Figure 2.24: Change in ethnic proportion of HCHS doctors and dentists, England, September 2019 to November 2025, headcount



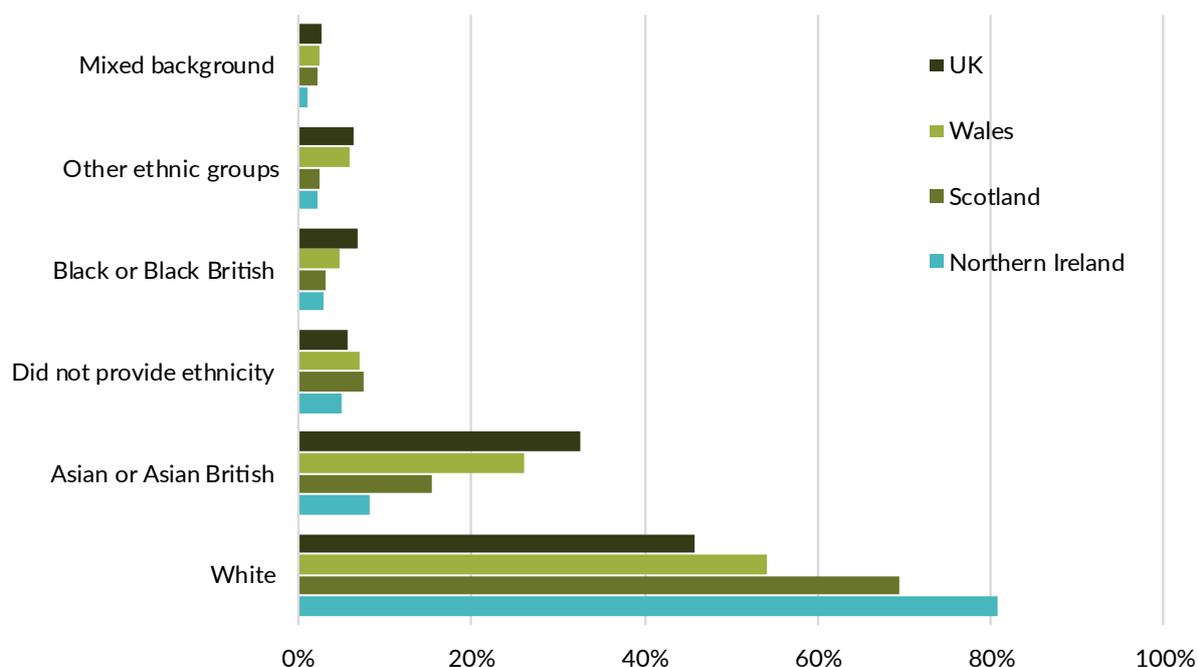
Source: NHS England, NHS Workforce Statistics.

2.108 In Wales, in September 2025: 47.7 per cent of the medical and dental workforce were White; 22.2 per cent were Asian/Asian British; 4.8 per cent were Black/African/Caribbean/Black British; 2.7 per cent were from mixed/multiple ethnic groups; and 6.5 per cent were from other ethnic groups. The proportion of medical and dental staff with an unknown or missing status fell from 35.3 per cent in September 2022 to 16.0 per cent in September 2025. As a result of this change in reporting, it is not possible to infer reliable medium-term trends in ethnicity status over this period.

2.109 A breakdown of the medical and dental workforce in Scotland by ethnicity using a consistent UK-wide methodology is not routinely published. However, data from the General Medical Council (GMC) provide an indication of the ethnic composition of doctors practising in Scotland. The GMC's 2024 report showed that: 69.3 per cent of doctors on the register in Scotland identified as White; 15.3 per cent as Asian or Asian British; 3.1 per cent as Black or Black British; 2.2 per cent as mixed ethnicity; and 2.3 per cent as from other ethnic groups; with 7.5 per cent not reporting their ethnicity.²³ Compared with the UK overall, Scotland had a higher proportion of White doctors and lower proportions of doctors from Asian, Black, mixed and other ethnic backgrounds.

2.110 A breakdown of the medical and dental workforce in Northern Ireland by ethnicity is also not currently published. The GMC's 2024 report showed that: 80.7 per cent of doctors on the register in Northern Ireland identified as White; 8.3 per cent as Asian or Asian British; 2.8 per cent as Black or Black British; 1.1 per cent as mixed ethnicity; and 2.2 per cent as from other ethnic groups; with 4.9 per cent not reporting their ethnicity.²⁴ Compared with the UK overall, Northern Ireland had a higher proportion of White doctors and a lower proportion of doctors from Asian, Black, mixed and other ethnic backgrounds.

Figure 2.25: Doctors on the GMC register, ethnicity, by UK nation, 2024



Source: GMC, *Our work in Scotland, Northern Ireland, Wales, 2024*.

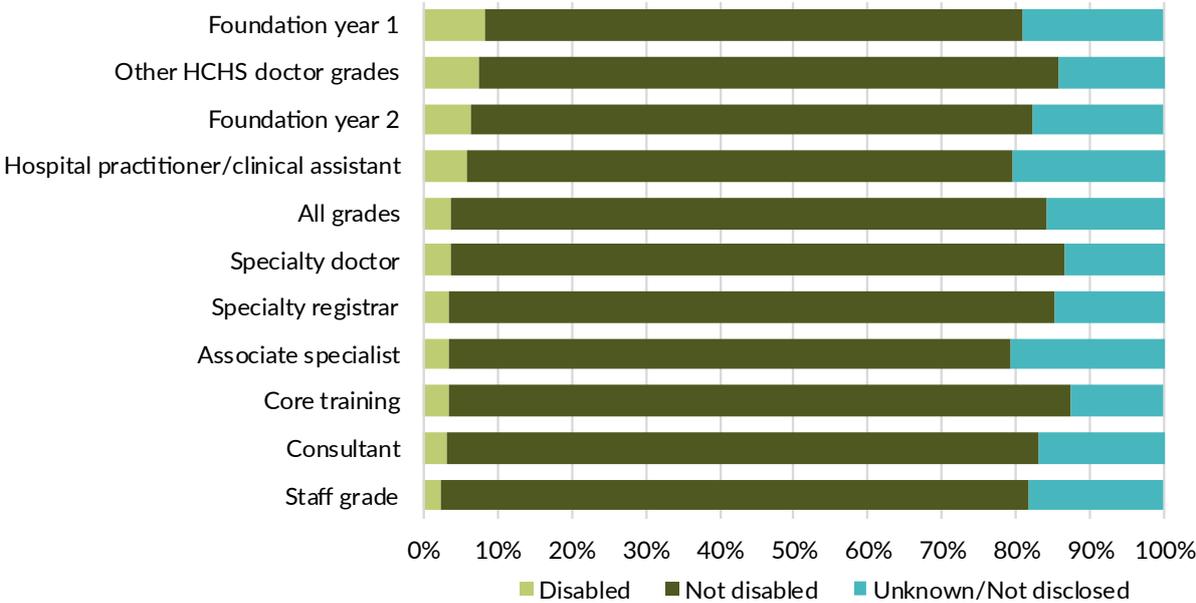
Note: Separate data are not available for England.

2.111 In England, 3.8 per cent of HCHS medical and dental staff in November 2025 said that they were disabled, compared with 7.9 per cent of all NHS staff. Foundation year 1 doctors (8.3 per cent), other HCHS doctors (7.4 per cent) and foundation year 2 doctors (6.3 per cent) were more likely to say they were disabled than other medical and dental grades.

²³ GMC, *Our work in Scotland 2024*. https://www.gmc-uk.org/cdn/documents/scotland-report-2024_pdf-111163203.pdf

²⁴ GMC, *Our work in Northern Ireland 2024*. https://www.gmc-uk.org/cdn/documents/northern-ireland-report-2024_pdf-111169620.pdf

Figure 2.26: HCHS doctors and dentists, England, by disability and grade, November 2025, headcount



Source: NHS England, NHS Workforce Statistics.

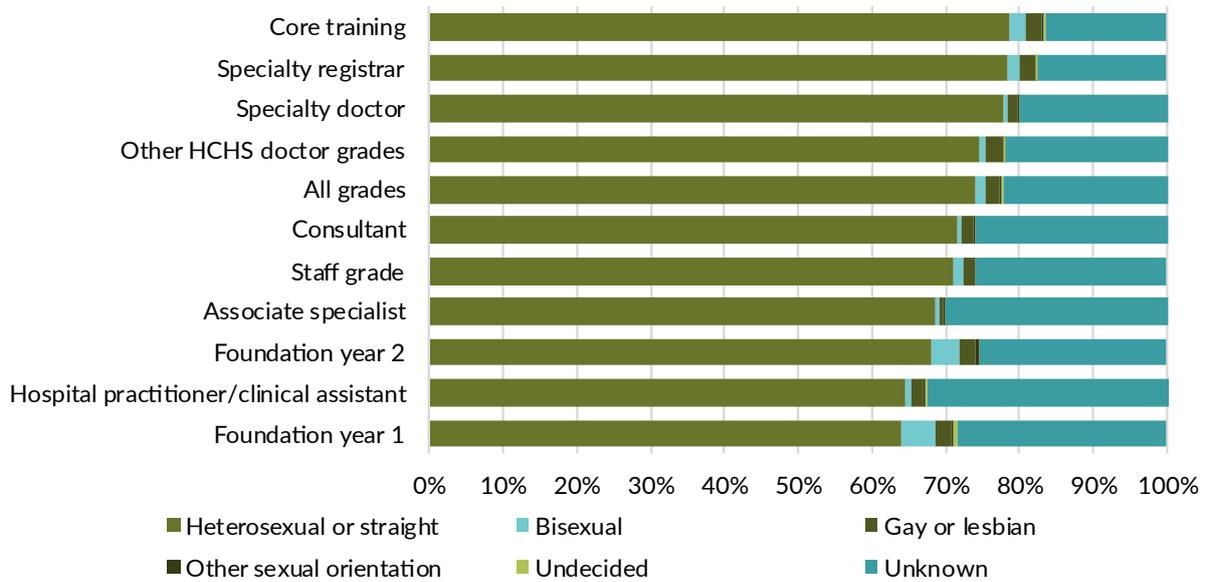
2.112 There was no disability data for 15.9 per cent of HCHS medical and dental staff, down from 28.4 per cent in September 2019. This compared with 10.4 per cent of all NHS staff. As a result of this change in reporting, it is not possible to infer reliable medium-term trends in disability status.

2.113 The Hospital Consultants and Specialists Association (HCSA) said that more than half of doctors it surveyed (54.2 per cent) who considered themselves as having a disability reported experiencing discrimination at work relating to their disability, and 30 per cent were dissatisfied with the workplace support and adjustments they received.

2.114 In November 2025, 74.1 per cent of HCHS medical and dental staff in England were heterosexual or straight; 1.9 per cent were gay or lesbian; 1.4 per cent were bisexual; 0.2 per cent said their sexual orientation was not listed; and 0.1 per cent were undecided.

2.115 The proportion of medical and dental staff with an unknown or not stated sexual orientation fell from 36.9 per cent in September 2019 to 22.5 per cent in November 2025. As a result of this change in reporting, it is not possible to infer reliable medium-term trends in sexual orientation.

Figure 2.27: HCHS doctors and dentists, England, by sexual orientation and grade, November 2025, headcount

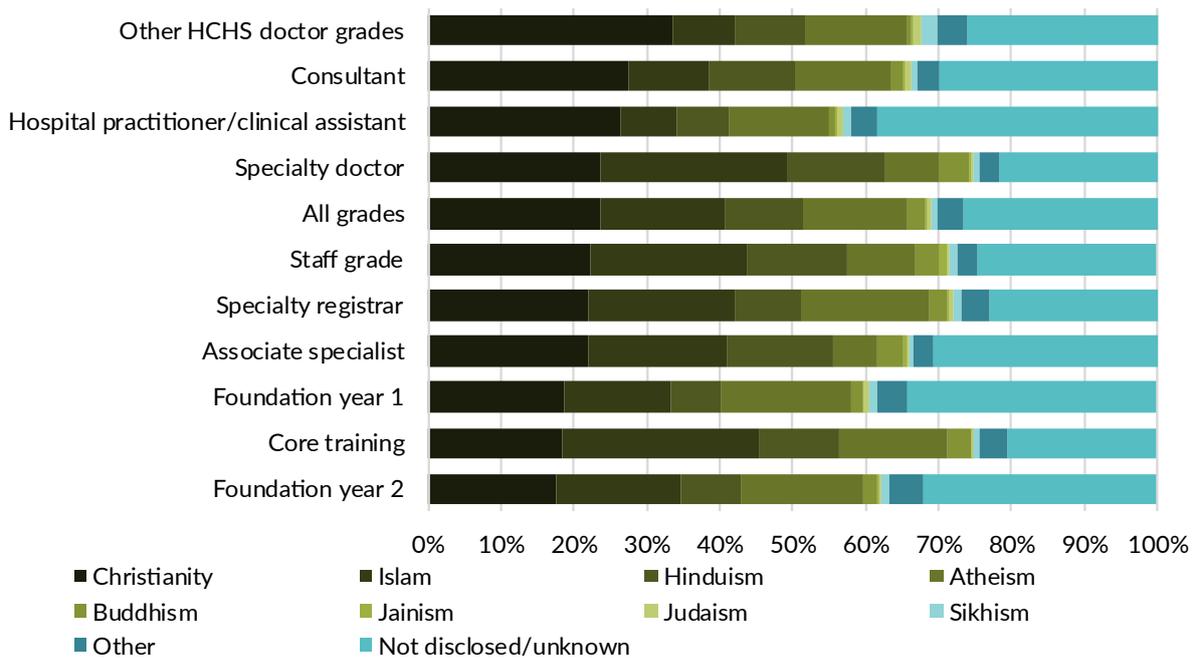


Source: NHS England, NHS Workforce Statistics.

2.116 In England, in November 2025: 23.5 per cent of HCHS medical and dental staff had Christian beliefs; 17.2 had Islamic beliefs; 14.4 per cent were Atheists; and 10.7 were Hindus. Compared with NHS staff as a whole, medical and dental staff were more likely to be Muslims and Hindus, but less likely to be Christians.

2.117 The proportion of medical and dental staff with unknown or not disclosed religious beliefs fell from 39.9 per cent in September 2019 to 26.8 per cent in November 2025. As a result of this change in reporting, it is not possible to infer reliable medium-term trends in religious beliefs.

Figure 2.28: HCHS doctors and dentists, England, by religious belief and grade, November 2025, headcount



Source: NHS England, NHS Workforce Statistics.

2.118 The HCSA said that discrimination and inequality remained embedded in medical careers. It said that addressing these challenges required systemic action: equal development opportunities; transparent recruitment processes; support networks; tackling bias; a zero-tolerance approach to discrimination; improving reporting mechanisms; and ensuring pay equity. It said that, without meaningful change, these issues risked undermining workforce morale, patient safety, and the sustainability of the NHS.

Primary care workforce

2.119 Across all UK nations, the proportion of women in both the GP and dental workforces has increased since the pandemic.

2.120 In England, female GPs made up 58.9 per cent of the GP workforce in December 2025 on a headcount basis, an increase from 56.9 per cent in September 2019. On a full-time equivalent basis, female GPs accounted for 54.3 per cent of GPs, up from 51.6 per cent in September 2019. Among dentists with NHS activity, female dentists made up 54.7 per cent of the workforce on a headcount basis in 2024-25, an increase from 51.3 per cent in 2019-20.

2.121 In Scotland, female GPs made up 63.2 per cent of the GP workforce in September 2025 on a headcount basis, an increase from 61.2 per cent in September 2019. Across the general dental and public dental service, female dentists made up 56.9 per cent of the workforce on a headcount basis in September 2025, an increase from 53.3 per cent in September 2019.

2.122 In Wales, female GPs made up 57.3 per cent of fully qualified GPs on a headcount basis in September 2024, a small reduction from 57.9 per cent in September 2021. Among dentists with NHS activity, female dentists made up 53.6 per cent of the workforce on a headcount basis in 2024-25, an increase from 47.6 per cent in 2019-20.

2.123 In Northern Ireland, female GPs made up 60.5 per cent of the GP workforce in the quarter to September 2025 on a headcount basis, up from 57.6 per cent in the same period in 2019. Across the general dentist service, women made up 60.4 per cent of the workforce on a headcount basis in the year to March 2025, an increase from 56.5 per cent in the year to March 2019.

Gender pay gaps in secondary care

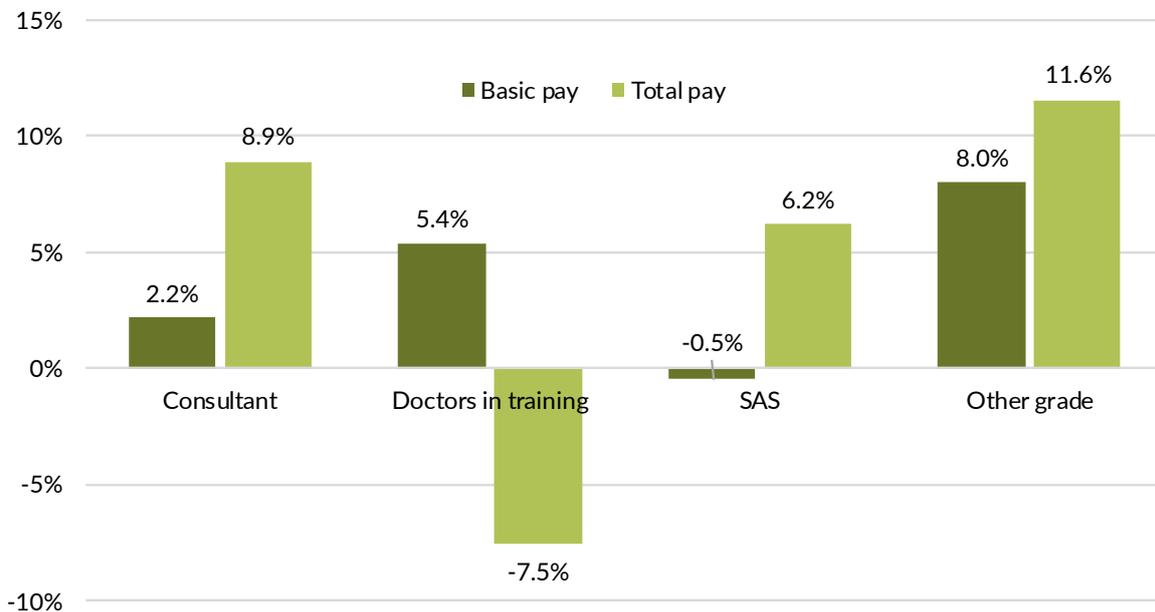
2.124 The Scottish Government provided evidence on the gender pay gap by workforce group. This showed pay gaps for most groups favouring men, with an exception being total earnings for doctors in training. The biggest difference in average total pay was in the consultant group where men earned on average 8.9 per cent (£15,000) more than women. This gap narrowed from 11.0 per cent in 2022-23.

2.125 The Department of Health in Northern Ireland said that HSC did not report on gender pay gaps. However, some data was provided on earnings for resident doctors. Looking at full-time equivalent banded earnings, there was a small gender pay gap in favour of men at each level: 1.2 per cent at foundation year 1; 4.6 per cent at foundation year 2; 2.0 per cent at core training; and 9.3 per cent at specialty training,

2.126 NHS England said it had asked all lead employers of resident doctors in training to report annually on ethnicity and gender pay gaps. The DHSC said that work was

continuing with the Gender Pay Gap in Medicine Implementation Panel, chaired by Professor Dame Jane Dacre.

Figure 2.29: Gender pay gap, Scotland, 2024-25



Source: Scottish Government.

Notes: Excludes temporary (bank and agency) staff.

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

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

2.127 The HCSA said that NHS trust-level data showed gender pay gaps exceeding 15-19 per cent. It said this reflected structural barriers, such as under-representation of women in consultant and senior leadership roles, part-time working patterns, career breaks and clinical excellence awards.

Gender pay gaps in primary care

2.128 . Average pre-tax incomes of female contractor GPs were lower than those of male contractor GPs in each nation in 2023-24, by 22 per cent in Northern Ireland, 21 per cent in Wales, 19 per cent in Scotland and 18 per cent in England. The income gap had narrowed over time in England, Scotland and Northern Ireland but remained the same in Wales. Earnings data for primary care do not adjust for working hours.

2.129 Average pre-tax incomes of female salaried GPs were also lower than those of male salaried GPs in each nation in 2023-24, by 27 per cent in Northern Ireland and Wales, 23 per cent in Scotland, and 21 per cent in England. The income gap had narrowed over time in England, Scotland and Northern Ireland but increased in Wales.

2.130 Across the nations, average earnings for female providing-performer dentists were between 9 and 14 per cent below the average for male dentists. For associate dentists, the difference in average earnings was greater, with female dentists earning 19 to 32 per cent less than male dentists on average.

Ethnicity pay gaps

2.131 In July 2025, the NHS Race and Health Observatory commissioned a review of ethnicity pay gaps across the NHS in England.²⁵ It said this would examine differences in pay, career progression, pension contributions and the potential impact on cumulative earnings between staff from different ethnicities. It would also explore potential explanations for any differences and provide recommendations, and evidence-based solutions, to reduce and eliminate unwarranted inequities where they were found to exist. It is due to conclude in December 2026.

Socio-economic background

2.132 The 10-year health plan for England said that access to the medical profession for those from disadvantaged backgrounds needed to be dramatically improved. It highlighted research from the Sutton Trust which said that only 5 per cent of medical school entrants were from the lowest socio-economic groups. The 10-year health plan said that this did not serve the country or the NHS well and that someone's background should not be a barrier to becoming a doctor.

2.133 The Government said that it would work with the Sutton Trust, the Social Mobility Foundation and other partners to improve access to medicine by creating a more diverse pipeline of homegrown talent. Expansion of medical school places would be targeted at medical schools with a proven track record of widening participation. The admissions process to medical school would be improved with better information, signposting and support for applicants, and more systematic use of contextual admissions.

2.134 The 10-year health plan said that expansion of medical school places would be focused on widening access to talented students from underprivileged backgrounds. The Department for Education would publish data on the relevant background of university entrants, starting with medicine. The 10-year health plan said that the cost of studying medicine was one of the important factors deterring working class students from applying. It said that options would be explored to improve financial support to students from the lowest socio-economic background so that they were able to thrive at medical school.

2.135 The DHSC said that, from 2025, NHS workforce systems, such as the electronic staff record, as well as annual national workforce surveys, would capture socio-economic background information.

2.136 NHS England decided to not continue the medical doctor degree apprenticeships beyond the current two pilot cohorts of 25 each in 2024 and 2025. The DHSC said that the government remained committed to widening participation in medicine.

2.137 The Scottish Government said that widening access to a career in medicine was key to creating a diverse environment that benefited students and medical practice in Scotland and was one of its key policy priorities. It funded a number of places each year for students meeting the criteria for widening access, targeting those from the lowest quintile of multiple deprivation.

²⁵ NHS Race & Health Observatory, *Observatory commissions review into NHS Ethnicity Pay Gap*. <https://nhsrho.org/news/observatory-commissions-review-into-nhs-ethnicity-pay-gap/>

Pensions and retirement

2.138 In our last report we noted that significant changes had been made to the NHS pension scheme, and pension taxation, in recent years, with increased flexibilities around retirement, a reduction in employee pension contributions for those earning above £70,630, an increase in the pension annual tax allowance, and the removal of the lifetime allowance. All of these served to enhance the value of the overall reward package, increase the incentives to work additional hours, stay in employment, and stay in the pension scheme.

2.139 NHS Employers said that the NHS pension scheme was a significant part of the total reward offer and a valuable tool for employers to use for recruitment, retention and motivation. The Scottish Government said that the NHS pension scheme remained an integral part of the NHS remuneration package and was a key recruitment and retention tool for doctors and dentists.

2.140 The DHSC gave projected values for NHS pensions. These assumed that members remained in service and worked full time before retiring at age 65. GPs were assumed to have joined the 2015 pension scheme in 2020 aged 25 and to have qualified as GPs in 2025, which gave an indicative pension of £75,000 a year for GP partners and £59,000 a year for salaried GPs. The consultant example was assumed to have joined the 2015 pension scheme in 2016 aged 25 and to have qualified as a consultant in 2025, which gave an indicative pension of £81,000 a year.

Table 2.1: Projected annual pensions for NHS doctors

	Year of joining	Projected annual pension	Allowing for commutation	
			Projected annual residual pension	Projected lump sum
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

Source: DHSC.

Notes: In current monetary terms. Assumes NHS doctors qualify in their respective fields in 2025 and retire age 65. Commutation exchanges £1 of annual pension for a £12 lump sum.

2.141 The British Medical Association (BMA) pointed to lost pension value as a result of pay erosion, pension taxation, tiered employee pension contribution rates, and changes that limited which elements of pay were pensionable and how added years/additional pension benefits could be purchased.

Pension scheme membership

2.142 Pension scheme membership in England increased across most grades in the year to June 2025, with consultants having the highest membership rate, at 93.0 per cent. NHS Employers said this might suggest that pension taxation was no longer a significant driver of opt outs within this group. While pension scheme membership was still lower among doctors in core training and specialty doctors, these groups saw the largest increases in scheme membership.

2.143 NHS Employers reported that opt-out rates were higher for international recruits, 26 per cent compared to a national rate of 10 per cent. Employers suggested that some internationally recruited staff might join the NHS with a short-term plan to earn, learn and return. In many cases, surplus income might be sent to support family abroad, and

many planned to return home themselves, so long-term pension benefits might not be a priority.

Table 2.2: NHS pension scheme membership for HCHS doctors, England, June 2025

	Pension scheme membership rate	One-year percentage point change
Consultant	93.0%	+1.2
Associate specialist	90.3%	+0.7
Specialty doctor	85.1%	+3.4
Staff grade	90.7%	-3.0
Core training	79.4%	+3.4
Foundation year 1	91.2%	+1.0
Foundation year 2	87.1%	+1.5
Specialty registrar	89.9%	+2.8
Hospital practitioner/clinical assistant	72.2%	+3.3
Other and local HCHS doctor grades	90.3%	-2.4
All HCHS doctors	89.0%	+1.0

Source: DHSC.

2.144 The Scottish Government said that participation in the pension scheme remained high, with evidence showing that staff continued to view the scheme as both affordable and valuable. High participation rates among hospital doctors and dentists (94.2 per cent) compared favourably with those across the wider NHS hospital workforce, where overall scheme membership was 93.4 per cent in March 2025. The member contribution structure in Scotland differs slightly from England. Earnings above £76,653 are subject to a 12.7 per cent contribution rate, compared to 12.5 per cent for all earnings above £65,191 in England.

2.145 Pension scheme membership also remained relatively high among GPs in Scotland, with 87.1 per cent of GPs participating in the pension scheme in March 2025. This was a largely unchanged from 87.0 per cent in March 2024 but an increase from 79.0 per cent in March 2023. For general dental practitioners (GDPs), participation was slightly lower, with 84.0 per cent participating in the pension scheme in March 2025, up from 83.6 per cent in March 2024 and 81.9 per cent in 2023.

Table 2.3: NHS Scotland pension scheme membership for hospital doctors and dentists, March 2025

	Pension scheme membership rate	One-year change	Five-year change	10-year change
Foundation year 1	96.4%	0.3%	0.5%	-2.8%
Foundation year 2	95.2%	-0.7%	0.9%	-2.2%
Specialty registrar	94.7%	1.4%	-1.9%	-3.2%
Consultant	94.1%	1.4%	6.4%	-0.2%
Specialty doctor	93.9%	0.1%	-0.5%	0.4%
Associate specialist	97.1%	0.7%	0.7%	-0.9%
Other	89.6%	1.7%	2.3%	0.0%
Total	94.2%	1.1%	2.4%	-1.1%

Source: Scottish Government.

- 2.146 The Department of Health in Northern Ireland said that the overall number of opt outs from the NHS pension scheme for GPs and GDPs decreased by 27, to 42 in 2024-25. For those who opted out, the main reasons given were personal/financial. The overall number of opt outs for hospital based medical staff decreased by eight, to 116 in 2024-25.
- 2.147 NHS Employers said they continued to advocate for greater flexibility for members over the level of contribution they paid into the scheme, and the value of benefits they received in return, to address opt outs caused by affordability issues. The Department of Health in Northern Ireland had issued guidance to enable HSC employers to offer employer contribution recycling, to help retain experienced senior clinicians within the HSC, which was implemented at the end of 2024. Eight applications had been received.
- 2.148 The British Dental Association (BDA) said that discussions had progressed on implementing a system of flexible pension accrual that would allow members to reduce their NHS pension and receive increased pay in lieu. It said this would be of particular value to those who opted out of the pension scheme due to affordability or because of annual allowance tax charges.
- 2.149 The BMA said that the tiered NHS employee pension contribution rates continued to unjustifiably penalise doctors and called for contribution tiering to be further flattened to ensure fairness for doctors. While the highest employee contribution rate had come down from 14.5 per cent to 12.5 per cent from April 2024, with the lowest contribution rate at just 5.2 per cent, it said that the tiering structure remained the steepest across the public sector. It also believed that the average contribution rate of 9.8 per cent was unnecessarily high, and higher than most other public sector schemes. The BDA advocated a flat rate pension contribution.

Pension taxation

- 2.150 Data provided by NHS Employers showed that the number of medical staff that exceeded the pension annual allowance fell from 28,743 to 3,168 as the annual allowance was increased from £40,000 to £60,000 in 2023-24. The number rose again, to 7,634 in 2024-25.

Table 2.4: Members in the NHS pension scheme that exceeded the standard annual allowance, 2020-21 to 2024-25

	Annual allowance	Total exceeding annual allowance	Total exceeding annual allowance (medical staff only)
2020-21	£40,000	26,674	18,691
2021-22	£40,000	48,455	32,755
2022-23	£40,000	38,946	28,743
2023-24	£60,000	4,593	3,168
2024-25	£60,000	9,763	7,634

Source: NHS Employers.

- 2.151 NHS Employers said they had noticed a decline in the number of employers reporting a reluctance to take on additional work due to pension tax concerns. They said that, while it was not possible to attribute any increased workforce capacity directly to the changes in pension tax, it might be considered that the standard annual allowance was no longer the significant barrier to potential increased workforce capacity that it once was.

- 2.152 The Scottish Government said it recognised that the annual allowance taper could lead to a cliff edge, where even a slight rise in earnings could activate the taper and result in a significant increase in tax liability. Consequently, the possibility of tapering might deter doctors from accepting additional work, as their extra earnings could be offset by pension tax charges.
- 2.153 The BMA said that the tapered annual allowance continued to disincentivise senior doctors from taking on additional work and that unresolved flaws in pension taxation design presented a major risk to NHS capacity. It said that crossing the tapered annual allowance threshold income by £1 could result in additional tax charges of up to £22,500. It said that doctors who exceeded the threshold income usually did so through non-pensionable additional earnings, so that the additional tax charge was not related to any additional pensionable benefit. If scheme pays was used to pay this tax charge, the amount of pension would fall because of taking on the extra work.
- 2.154 The BMA set out the scenario in which a consultant took on additional shifts on a non-pensionable basis, which pushed their earnings above the £200,000 threshold for the annual allowance to taper, resulting in a significant annual allowance tax charge with no additional pension accrual. It said that, in this scenario, a doctor would need to earn above £242,000 before being better off.
- 2.155 The BMA called for the annual allowance taper to be scrapped, and the annual allowance to be indexed in line with inflation. It said that the problems that doctors faced due to the poorly designed tapered annual allowance were exacerbated by the fact that pension scheme members did not know whether they faced a tax charge or were subject to the taper until after the tax year had ended. Several pension schemes, including those for doctors in Scotland, England and Wales, had failed to meet the statutory deadline for issuing pensions statements.
- 2.156 The HCSA said it remained deeply concerned about the impact of pension taxation on senior doctor retention and retirement rates. It said that consultants taking extra shifts or leadership roles often saw spikes in pension growth, pushing them over the annual allowance and triggering unpredictable tax bills of £20,000 or more. It said that punitive pension tax rules, particularly the annual allowance and tapered thresholds, were a major factor driving consultants to reduce hours or retire early. It said this had led to widespread avoidance of waiting list initiatives and extra shifts, directly reducing NHS capacity and worsening elective care backlogs. The HCSA said that the annual allowance was not appropriate for defined benefit schemes. It said that the current system created uncertainty, damaged mental health, and undermined workforce retention.
- 2.157 The HCSA also said that doctors crossing the £100,000 income threshold faced a major financial penalty that discouraged progression due to the steep marginal tax rate of 60 per cent between £100,000 and £125,140 and the loss of free childcare. It said this forced many consultants to reduce hours or decline additional responsibilities.

Flexible retirement

- 2.158 NHS pension scheme members may take between 20 and 100 per cent of their pension benefits while remaining in work. To be eligible, they must have reached the minimum pension age and reduced their pensionable earnings by at least 10 per cent for 12 months. Feedback from NHS employers indicated that partial retirement was helping with retention across all NHS staff groups:

- 5,535 hospital doctors had retired who were eligible to take partial retirement, and of these 3,597 (65 per cent) had chosen partial rather than full retirement.
- 43 per cent of eligible hospital dentists had taken partial retirement.

2.159 The DHSC said that 3,965 hospital doctors had taken partial retirement since October 2023. The majority of these doctors were taking partial retirement once they had reached normal pension age (1,231 of the 3,965) or after normal pension age (1,518 of the 3,965) rather than as part of early retirement. The DHSC said this suggested that they wanted to continue working in the NHS instead of fully retiring.

2.160 Employers had raised concerns about the complexities involved in applying partial retirement flexibilities for consultants, particularly in cases where individuals wished to access their pension benefits without reducing their total working hours. NHS Employers said this presented practical challenges, especially in meeting the requirement to reduce pensionable pay by 10 per cent. It also undermined the intention of the flexibilities, which was to support staff to stay in work on reduced hours as they moved towards retirement.

2.161 The Scottish Government said it had introduced significant changes to retirement flexibilities in recent years, with the aim of retaining senior doctors and dentists who might otherwise have left the workforce. Retire and return and partial retirement were introduced in 2023. The Scottish Government said that these flexibilities had proven popular. Around 30 per cent of new retirement applications from hospital doctors and dentists were for partial retirement. Uptake was lower among GPs and GDPs, with around 14 per cent of retirements being on a partial basis. In total, 164 GPs and GDPs took early retirement in 2024-25, an increase from 122 in 2023-24. It was not possible to provide early retirement figures for hospital doctors and dentists.

2.162 The BDA said that, while the introduction of partial retirement provided a means to access pension benefits without the need to end a contract, the requirement to reduce pensionable earnings by at least 10 per cent was creating some difficulties at a local level. Some dentists were reporting that employers were presenting barriers to the contractual variations required. The BDA said this requirement was arbitrary and unnecessary and should be scrapped.

2.163 The BMA said that, despite improved access to flexible retirement options in recent years and recognition of the importance of these options to enable the NHS to retain the expertise of skilled senior doctors, it remained concerned about reports of employers, particularly in England, creating unfair barriers to access to them. These reported barriers included:

- Hospital doctors seeking to partially retire being required to reduce their workload (and pay) to meet the 10 per cent reduction in pensionable pay for 12 months, rather than achieving this through split contracts that shifted the required pensionable workload to become non-pensionable.
- Hospital doctors seeking to retire and return facing pressure from employers to agree to return on less favourable terms.
- SAS doctors employed on the closed associate specialist contract in England being unable to retire and return to their closed grade. This had been supported in Wales.
- Consultants in Scotland losing their pensionable discretionary points following retire and return, which contrasted with the situation in England.

- 2.164 In response to reports that NHS staff opting for partial retirement had not been allowed to keep their original working hours, the HCSA said it recommended that all NHS trusts should be compelled to offer workable partial retirement arrangements without unnecessary barriers, and that policies should prioritise retention and wellbeing, not force senior clinicians into full retirement.
- 2.165 The Welsh Government said that the proportion of staff retiring and subsequently returning to NHS Wales had decreased across most staff groups over the past year. For medical and dental staff, the 12-month rolling retire and return rate was 5.1 per cent in March 2025, down from 8.0 per cent in March 2024.
- 2.166 The BMA said it welcomed developments in the devolved nations, particularly the pan-NHS Wales Flexible Pensions Policy agreed in October 2024. It said this contained many benefits designed to help retain NHS doctors in Wales, including recognition of pension flexibilities as contractual rights, and an expectation that flexible retirement applications would be supported and approved. The policy granted those who retired and returned the right to return on existing terms, i.e. not on a fixed term contract. A right to retire and return for SAS doctors on the closed associate specialist grade had been formally incorporated. Recognition had been included that those who retired and returned only need a 24-hour break in service. Partial retirement and the use of split contracts to convert some pensionable workload to non-pensionable workload had also been incorporated, which meant that doctors could achieve the required 10 per cent reduction in pensionable pay without reducing their gross pay or workload.
- 2.167 The Department of Health in Northern Ireland introduced changes to the HSC pension scheme in April 2024 including the introduction of partial retirement. The HSC Pension Service had received 49 applications for partial retirement from hospital-based medical and dental staff. The Department said there had been considerable interest in the partial retirement scheme but noted that it had significant implications for rota gaps and challenges in covering services. The implications were particularly relevant in services with on-call commitments.

Our comments

The economic context

- 2.168 Economic growth slowed over 2025 and is forecast to be moderate, at 0.9-1.4 per cent in 2026. This constrains public funding for investment in healthcare. Inflation fell back in January 2026, and both the Bank of England and the OBR expect CPI inflation to be close to 2 per cent in April, when our pay recommendation comes into effect. We note that these forecasts do not take into account the recent geopolitical uncertainty, in particular in the Middle East, and its potential impact on energy prices.
- 2.169 The labour market has shown signs of further weakening over the last year, reducing opportunities for employment, and increasing the relative value of the job security that NHS employment provides.
- 2.170 Whole economy average earnings growth was strong through most of 2025, averaging around 4.8 per cent, but fell back to 4.2 per cent at the end of the year, with private sector average earnings growth down to 3.5 per cent in December 2025. PAYE data indicated notably lower earnings growth in the top half of the earnings distribution – 2.6 per cent at the 75th percentile and 1.3 per cent at the 95th percentile. Early pay settlement data for 2026 shows medians of 3.2 per cent, and Agenda for Change staff will receive a pay award of 3.3 per cent from 1 April 2026. A number of parties,

including the DHSC and NHS Employers, highlighted the negative impact of differential pay awards across NHS staff working in a single team to deliver healthcare.

NHS activity and productivity

2.171 Recent trends in NHS activity vary across the UK. Activity has increased in some nations over the last year and compared to pre-pandemic levels, while in other nations activity is still below pre-pandemic levels. Waiting lists for treatment remain high across all nations, albeit with some improvement over the last year. We are concerned that the number of patients accessing NHS dentistry remains lower than before the pandemic across all UK nations, and in particular that there are children unable to access NHS dentistry when needed.

2.172 Healthcare productivity figures show, at best, only moderate improvement, and remain below pre-pandemic levels. Despite these increases in productivity, waiting lists have shown only small falls. Analysis by the IFS points to a marked increase in the amount of activity required before patients can be removed from the waiting list to explain why progress has been limited in this area. In addition, NHS financial planning relies on substantial efficiency gains being made by NHS trusts and health boards to meet targets. While the NHS 10-year health plan for England recognises the need for investment, this will take a long time to deliver benefits, and finances will continue to be constrained over the medium term.

2.173 The Welsh Government said that pay, retention and training investments were practical enablers of productivity gains, and they helped convert pathway reforms and performance management. It would be instructive for all governments to consider how reward and workforce can enable productivity and performance.

NHS funding and affordability

2.174 There are nominal increases in health budgets for 2026-27 of 4.8 per cent in England, 3.8 per cent in Scotland, 3.6 per cent in Wales and 0.9 per cent in Northern Ireland. Prior spending commitments in Scotland and Northern Ireland will reduce the effective health budget.

2.175 The DHSC has developed financial and delivery plans which allowed for a pay uplift of 2.5 per cent and said that accepting an award above this would inevitably have an impact on healthcare delivery. The Scottish Government said that a 3 per cent uplift had been budgeted for, in line with its public sector pay policy. The Welsh draft budget assumed an uplift of 2.2 per cent for public sector pay. An explicit pay affordability budget in Northern Ireland was not shared with us. Both the UK and Welsh Governments have been explicit that pay awards need to be funded from within department budgets.

2.176 Consequently, the four nations have presented markedly different affordability contexts, alongside significant variation in overall health budget settlements. This provides additional complexity for our considerations on the pay award.

Workforce planning

2.177 Workforce planning plays a key role in securing long term workforce recruitment and retention, and we look forward to the plan for England. We expect workforce plans to be linked to the broader objectives for the NHS, including supporting the shift to provide care in the community.

- 2.178 Many of the specific recruitment and retention issues across the medical and dental workforces are best addressed through effective long-term workforce planning, linked to current and future healthcare needs. We would expect the forthcoming workforce plan to include a reward strategy, with objectives for potential contract reform and how this can support the broader shifts.
- 2.179 As we said last year, a refreshed workforce plan will also need to be costed, so that appropriate prioritisation can be given to the areas that will deliver the greatest improvements in healthcare outcomes. This will support improvements in productivity. Progress has already been made in reducing expensive agency and locum spend.
- 2.180 The UK Government has said it would work with trade unions and employers to maintain, update and reform employment contracts. It said this would mean some realistic conversations about pay that better recognised performance and innovation, and terms and conditions which enabled the three shifts and a 24/7 service. We support this and urge that this reform is firmly linked to current and future service needs and delivery. A priority might be reform of the consultant contract; as we set out in chapter 6, the current contract is over 20 years old and does not meet the needs of the modern NHS. In particular, it could better enable flexible working – across the working week, across localities, and across types of clinical activity. This might require higher basic pay along with broader commitments to flexible working, with less reliance on incentivising additional hours.
- 2.181 National pay structures require flexible and agile levers to deal with specific issues, such as shortages in certain specialties, or difficulties in recruiting to rural areas. Governments have made clear that they wish to address these issues locally. However, the evidence indicates that this is not being done in a systematic or effective way. We would like to see all NHS employers have a far deeper and evidence-based understanding of where specific recruitment and retention issues lie, both in terms of locality and specialty, the impact these are having on service delivery, the cost of temporary staff to cover vacancies, and the effect on the wider team. This should be accompanied by a review of the levers and tools that might support specific recruitment and retention issues which can be integrated into workforce plans.
- 2.182 There also needs to be efforts from health education bodies to align the expectations of doctors in the early parts of their career with the overall needs of the NHS, in terms of where, and in which specialties, training places are needed. Specific plans need to be prioritised for those specialties where there are most notable shortages, such as psychiatry, and where there has been a reliance on international recruitment to fill training places, such as general practice.

Industrial relations

- 2.183 The challenging industrial relations environments over the past year across the four nations, alongside strikes by resident doctors in England, suggest issues of low morale and motivation within some parts of the medical workforce. Strikes not only have a direct impact on patients but also on the capacity of the workforce to improve productivity and deliver long term reform.
- 2.184 Employers appear to have coped better with recent industrial action, and it has had less of a disruptive impact. However, it still brings substantial costs in terms of paying for cover, delays in elective care, pressures on management and non-striking staff, and taking resource away from core and longer-term activities. NHS Employers have highlighted that, under the Employment Rights Act, successful strike ballots will

become easier to achieve, given the removal of the turnout threshold and the move to electronic ballots.

Workforce equalities and diversity

2.185 It is again disappointing not to see consistent and clear information on the extent of the gender pay gap in the medical and dental workforces across all nations. It is also disappointing that the DHSC has not provided an update on the work of the Gender Pay Gap in Medicine Implementation Panel. The Scottish Government is providing information on the gender pay grade across grades, and we would like to see the other nations taking a similar approach. Some individual trusts publish detailed gender pay gap reports that continue to highlight substantial gender pay gaps among the consultant workforce, driven by legacy clinical excellence awards. This reporting is important in understanding the problems of the current pay system and the impact of reforms to pay structures.

2.186 We note the view of HCSA that discrimination and inequality remain embedded in medical careers. We continue to be concerned that all governments are not proceeding at pace in progressing work to address gender, ethnicity and other pay gaps.

2.187 The 10-year health plan said that the Department for Education will publish data on the background of university entrants, starting with medicine. The DHSC also said that, from 2025, NHS workforce systems, as well as annual national workforce surveys, will capture socio-economic background information. These are very positive developments, and we look forward to receiving this evidence. They will also support the UK Government in meeting its commitment to widening participation in medicine.

Chapter 3 Dentists

- 3.1 Our remit covers all general dental practitioners (GDPs) and salaried dentists providing NHS/HSC services including dentists working in the Community Dental Service (CDS) in England, Wales and Northern Ireland and the Public Dental Service (PDS) in Scotland.²⁶ Hospital dentists are included in chapter 5.
- 3.2 This chapter looks at trends in the dental workforce, dental training, recruitment and retention, developments in dental contracts, earnings and pay comparisons, motivation and morale. Our comments on the data and evidence are at the end of the chapter.

Workforce

- 3.3 Current workforce data cover all dentists providing any NHS work. The dental working patterns survey for 2022-23 indicated that average hours spent on NHS/health service work by principal dentists in 2022-23 were 24.0 to 25.7 a week across the nations – 58-61 per cent of their time. Average hours spent on NHS/health service work by associate dentists ranged from 21.7 to 24.5 a week across the nations – 65-73 per cent of their time.
- 3.4 Dentist-to-population ratios improved in Scotland, Northern Ireland and England over the past year, but declined in Wales. Coverage remained below 2020 levels in England, Wales, and Scotland while Northern Ireland saw gains.
- 3.5 There were 24,543 dentists providing NHS services in England in the year to 31 March 2025, an increase of 1.4 per cent over the year and a 0.5 per cent decrease compared to March 2020. In 2024-25, 82.1 per cent of dentists providing NHS services in England were associates and 17.9 per cent were providing-performers. Compared to 2019-20, the associate share increased by 1.9 percentage points, while the providing-performer share decreased by 1.8 percentage points.

Table 3.1: Number of dentists providing NHS services, by nation, 2024-25

	Number of dentists providing NHS services	One-year change	Five-year change
England	24,543	+1.4 per cent	-0.5 per cent
Scotland	3,411	+5.5 per cent	-0.4 per cent
Wales	1,335	-4.6 per cent	-9.8 per cent
Northern Ireland	1,189	-1.7 per cent	+3.3 per cent

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

Notes: England data from 31 March 2025; Scotland data from 30 September 2025; Wales data for 2024-25; and Northern Ireland data for quarter ending December 2025.

The figures for England and Wales include dentists working under General Dental Services (GDS), Personal Dental Services (PDS), and Trust-led Dental Services (TDS), as well as mixed contractual arrangements. In Scotland, the figures cover dentists working within GDS and the Public Dental Service, while in Northern Ireland the figures relate only to activity delivered under GDS. Dental care professionals in Wales are excluded from the total.

²⁶ While terminology differs between the nations of the UK, GDPs delivering NHS/HSC services are generally split into two categories. Dentists that hold a contract with the NHS/HSC in their own right to provide services are referred to as providing-performer or principal dentists. Dentists that deliver NHS services under a contract held by another body, which can be a limited company or a providing-performer partnership, are referred to as associate or performer-only dentists. Associate dentists usually practise as sub-contractors.

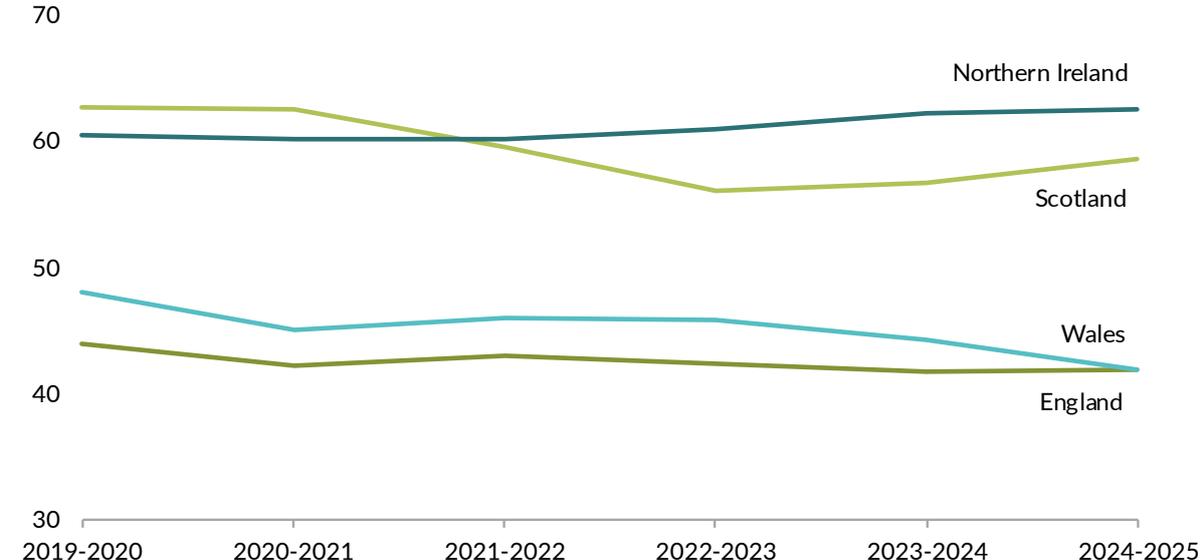
Figure 3.1: NHS dentists, by nation, 2020 to 2025



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

- 3.6 There were 3,411 non-hospital dentists providing NHS services in Scotland at 30 September 2025, an increase of 5.5 per cent on the previous year and a 0.4 per cent decrease compared to September 2020.
- 3.7 There were 1,335 dentists providing NHS services in Wales in the year to 31 March 2025, a decrease of 4.6 per cent on the previous year and a 9.8 per cent decrease compared to 2020.
- 3.8 There were 1,189 dentists providing NHS services in Northern Ireland in the quarter to December 2025, a decrease of 1.7 per cent on the same period in the previous year but a 3.3 per cent increase compared to the quarter to December 2020.
- 3.9 There were 41.9 NHS dentists per 100,000 population in England in 2024-25, up from 41.8 the previous year but below the 43.9 recorded in 2019-20. There were 58.6 non-hospital NHS dentists per 100,000 population in Scotland in 2024-25, up from 56.6 the previous year but below the 62.6 recorded in 2019-20. There were 41.9 NHS dentists per 100,000 population in Wales in 2024-25, down from 44.2 the previous year and from 47.9 in 2019-20. There were 62.6 NHS dentists per 100,000 population in Northern Ireland in 2024-25, up from 62.2 the previous year and above the 60.4 recorded in 2019-20.

Figure 3.2: NHS dentists per 100,000 of the population, by nation, 2019-20 to 2024-25



Source: Office for the Pay Review Bodies (OPRB) calculations using workforce data from NHS England, NHS Education for Scotland, Stats Wales, Department of Health Northern Ireland and applying to Office of National Statistics (ONS) mid-year population estimates. Figures may therefore be marginally different from any figures published on individual nations. Dental care professionals are excluded from the totals in Wales.

- 3.10 There were significant variations across regions: the number of dentists providing NHS services per 100,000 population ranged from 40.5 in the South West to 52.7 in London in the year to March 2025.
- 3.11 Data from the General Dental Council (GDC) showed that there were 46,362 registered dentists in the UK at 31 December 2024, up 2.6 per cent over the year and 9.2 per cent since the end of 2019.²⁷ In December 2024, 68.9 per cent of dentists on the register qualified in the UK, down from 69.7 per cent in December 2023 and from 71.8 per cent in December 2019.
- 3.12 In oral evidence, the Minister of State for Care said that the GDC was reforming its approach to overseas dentists and their registration, to double the number of dentists able to join the register by this route. This would address workforce shortages and access. He highlighted that there had also been two new dental schools approved at the University of East Anglia and the University of Portsmouth.
- 3.13 The Association of Dental Groups (ADG) said there was an increasing reliance on international dentists to provide NHS dentistry. It noted that there were 5,000 overseas qualified dentists waiting to sit the Overseas Registration Exam so that they could gain a place on the GDC register. It said that the increasing use of international dentists also brought additional costs for recruitment, sponsorship and training; one member estimated £12,000 for training costs.

²⁷ General Dental Council, *Registration Statistical Report 2024*. https://www.gdc-uk.org/docs/default-source/reports-and-publications/gdc-registration-statistics-report-2024.pdf?sfvrsn=17fb911_8

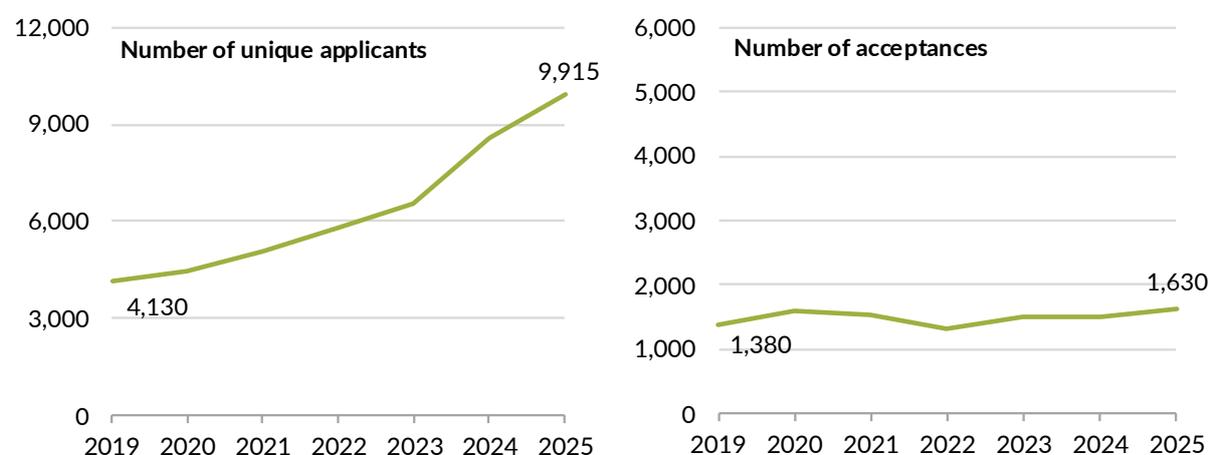
Dental training

Undergraduate admissions

3.14 There were 9,915 applicants to study undergraduate dentistry across the UK in 2025, an increase of 15.4 per cent from 2024. Following six years of consecutive growth, the number of applicants to study dentistry was 140.1 per cent higher than in 2019.

3.15 There were 1,630 acceptances to study dentistry in 2025, an increase of 9.8 per cent from 2024. The numbers accepted on to courses in 2025 to study dentistry were 18.1 per cent higher than in 2019. The acceptance rate fell from 33 per cent in 2019 to 16 per cent in 2025.

Figure 3.3: Number of applicants and acceptances for dentistry degrees, UK, 2019 to 2025



Source: UCAS.

3.16 The DHSC said that the number of funded undergraduate training places in England for dentistry remained at 809 for the 2025-26 academic year.

3.17 The Scottish Government said that the NHS Scotland Operational Improvement Plan, published in March 2025, set out a package of actions to improve the sustainability of the NHS dental workforce. This included a 7 per cent increase in domestic student dentist numbers from September 2025 – the first regular increase in student numbers in ten years – to ensure an expanded pipeline of new dentists entering the workforce from 2029.

3.18 The British Dental Association (BDA) said it was vital to encourage and incentivise qualified dentists to consider academia as a potential career to deliver high quality education for the dentists of the future. It said that incentivising more dentists to join academia was needed urgently to ensure there was sufficient capacity to support undergraduates studying dentistry.

Foundation training

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

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

- 3.20 The UK Committee of Postgraduate Dental Deans and Directors (COPDEND) said that all graduates from UK dental schools were offered a dental foundation training post for 2025-26.²⁸ In total, there were 937 dental foundation training posts (in England, Wales and Northern Ireland) in 2025-26, up from 913 in 2024-25. The DHSC said that all dental foundation training posts in England were filled at September 2025. It said that 96 per cent of trainees satisfactorily completed dental foundation training, with 3 per cent requiring an extension and 1 per cent exiting training.
- 3.21 In Scotland, 159 dental vocational training places were filled. The COPDEND reported that there was a significant increase in the uptake of rural posts. Exit data from the 2024-25 cohort indicated that 90 per cent of trainees intended to remain within the workforce in Scotland, the vast majority within NHS General Dental Services.
- 3.22 The DHSC said that a lead employer for all foundation trainees had been procured to provide consistent, high-level employment conditions for trainees. It said that a loss of training sites for dental foundation training was a growing risk that impacted the placement of UK graduates. The decline was driven by several factors including the workload on training practices and educational supervisors, as well as the level of payment for service costs. The DHSC said that the service costs payment for training practices was uplifted in 2024-25 for the first time in more than a decade. The COPDEND said that the difficulties encountered in 2025, and the likelihood of an increased number of applicants for 2026, would require further consideration to ensure there were enough training practices.
- 3.23 The Welsh Government said that dental foundation training posts were recruited through national recruitment and an incentivised local recruitment scheme, established to protect training places in rural areas of Wales where training was at risk as places were not filled through national recruitment. In 2024-25, 52 posts were filled through national recruitment, and 15 posts were filled through the incentivised local recruitment scheme. This represented a 100 per cent fill rate.
- 3.24 The Department of Health in Northern Ireland said that all 30 dental foundation training posts were filled for 2025-26.

Core and specialty training

- 3.25 There was an increase in fill rates for dental core training at years 1 and 2. The fill rate for year 1 was 97.0 per cent in 2025, up from 87.6 per cent in 2024. The fill rate for year 2 was 94.8 per cent in 2025, up from 78.9 per cent in 2024. The fill rate for year 3 was 76.1 per cent in 2025, down from 79.5 per cent in 2024 and likely reflecting the low fill rate for year 2 in 2024. The COPDEND noted the soaring number of international applications. The DHSC said that 98 per cent of trainees satisfactorily completed dental core training in England, with 2 per cent resigning during training.
- 3.26 The COPDEND reported that fill rates for most dental specialty training posts were at 100 per cent, with the exception of dental public health (zero out of one-two posts filled) and special care dentistry (10 out of 13 posts filled i.e. 77 per cent). The COPDEND said that the issues affecting recruitment into dental public health training

²⁸ COPDEND, *Issue No 4 August 2025*. <https://copdend.org/wp-content/uploads/2025/11/COPDEND-NEWSLETTER-SUMMER-2025-Final.pdf>

and special care dentistry were a cause for concern considering future workforce needs.

- 3.27 The DHSC said that the 77 per cent fill rate for special care dentistry was an improvement on the 53 per cent fill rate in 2024. It said that under-recruitment in special care dentistry continued to be of concern given the patient groups they cared for, including the aging population and those with medical and behavioural conditions. It said that effective promotion of the specialty was essential to ensure awareness and uptake of the special care dentistry pathway, given its relative newness as a career option. It said that NHS England had worked to promote special care dentistry as a potential career path and was working with the sector on future communications.
- 3.28 NHS Employers noted that special care dentistry continued to experience low fill rates despite efforts to expand training posts. While application numbers remained steady, they said that career-grade professionals might be deterred from re-entering training due to the removal of pay protection in the 2016 contract. NHS Employers said there was growing support for reviewing the flexible pay premia framework and designating special care dentistry as a hard-to-fill area to help address these gaps.
- 3.29 The ADG did not consider that the national recruitment process for special care and paediatric specialist training was fit for purpose. Its experience was that team members often had a career in a wide variety of training posts including the CDS before embarking on specialist training in special care or paediatric dentistry. It said the process of national recruitment leading to positions being allocated anywhere across England was a deterrent to recruitment.
- 3.30 The Welsh Government said there were 68 dental core training posts in 2024-25; 43 were filled through national recruitment and 15 through local recruitment, giving a fill rate of 95 per cent. At dental specialty training level, 33 posts were filled and three were vacant, giving a fill rate of 91 per cent. The Welsh Government said that recruitment to these vacant posts was on hold due to limited training capacity.
- 3.31 The Department of Health in Northern Ireland said that all five specialty dental training posts were filled in 2025. There was a 74 per cent fill rate for dental core training for 2025-26 (17 out of 23 posts filled).
- 3.32 The BDA said that many employers were using the need to ensure service provision as justification to place restrictions on training, including, for example, reduced study leave and reduced entitlements for attending learning events. It said there was significant uncertainty for resident dentists about being able to meet the specialty training curriculum, pass exams, and complete programmes arising from the imposition of these additional barriers. Training opportunities were described as steadily reducing with there being so much 'noise' it prevented resident dentists focusing on the important aspects of skill development, with not enough time to secure the vital training needed to progress within each specialty.

Recruitment and retention

- 3.33 The dental workforce survey indicated an overall vacancy rate for general dentists in England of 15 per cent in December 2024.²⁹ For NHS general dentists, the vacancy rate was 19 per cent, down 2 percentage points from March 2024. The region with the highest NHS vacancy rates for general dentist posts was the South West, with a vacancy rate of 33 per cent; London had the lowest NHS vacancy rate at 11 per cent. The survey reported that there were 1,823 vacant posts where recruitment had been tried but failed between April and December 2024.
- 3.34 Over the year to December 2024, there were 3,495 general dentist joiners and 2,187 leavers, giving a joining rate of 17 per cent and a leaving rate of 11 per cent. This includes dentists moving between contracts.
- 3.35 The BDA said that practice owners with a high NHS commitment continued to find it significantly harder to recruit associates and experienced longer periods of unfilled vacancies.³⁰ In its survey, 60 per cent of practice owners had a vacancy for an associate dentist in 2024-25. Among practice owners with a vacancy, 85 per cent reported difficulty filling the role, increasing to 94 per cent for those with a high NHS commitment. Among practice owners who had difficulty recruiting an associate in 2024-25, 70 per cent reported that the cause was that candidates were reluctant to deliver NHS or Health Service dentistry.
- 3.36 The ADG said there remained an increasing trend of associates looking to reduce NHS commitments and increase their focus on private treatment due to the clinical freedom it offered, and better work-life balance, as well as financial considerations. It said that, due to the workforce crisis, associates now had more control over their NHS workload, and practice owners faced pressure to accept reduced NHS activity to retain clinicians.
- 3.37 Both the BDA and the ADG noted in oral evidence that the golden hello scheme, to provide a £20,000 recruitment incentive for dentists in England, had not been effective. The ADG said that golden hellos just moved the problem from one area to another.
- 3.38 The 10-year health plan for England said that, having consulted on the principle, there would now be a requirement for newly qualified dentists to practise in the NHS for a minimum period, intended to be at least three years. In oral evidence, the ADG supported the graduate tie-in policy, although noted the lack of details on timescales and enforcement.
- 3.39 The BDA said it was regrettable that the 10-year health plan included pursuing plans for a tie-in to the NHS for new dental graduates. Its view was that this was both in principle unfair and in practical terms likely to backfire as a means to secure a long-term workforce. In oral evidence, the BDA said that forcing young dentists to work in NHS dentistry was not the best approach. Instead, they should be incentivised to work in NHS dentistry with an enhanced career pathway. It noted that, with the lead time for the tie-in to be implemented for new students, there would not be an impact before 2031.

²⁹ NHS England, *Dental Workforce*. <https://www.england.nhs.uk/statistics/statistical-work-areas/dental-workforce/>

³⁰ Practice owners or associates with a 'high NHS commitment' were respondents who indicated that their practice as a whole, or they as individual associates, delivered 75 per cent or more NHS activity.

- 3.40 The BDA said that the refreshed workforce plan would need to contend with the retention of existing dentists, not just the training of new ones. There would also need to be planning about where within the NHS capacity was needed so that, for example, there was a flow of dentists into the CDS. The BDA said that this would be as much about pay, conditions and contracts, as about education, training and registration.
- 3.41 The Scottish Government said that localised challenges remained in the dental workforce, particularly in rural areas such as Dumfries and Galloway, the Highlands, and in island areas. It was working with NHS boards to refine the financial incentives in place to support dentists moving to work in rural areas.
- 3.42 The NHS Scotland Operational Improvement Plan recognised that there was an urgent need to look at the dental workforce to ensure there was continued capacity to meet demand into the future and support equitable access to services across Scotland.³¹
- 3.43 The Welsh Government said that recruitment and retention difficulties were being encountered by all health boards in Wales to varying degrees. Particular issues remained in the more rural and remote areas of Wales. It said that this was having a significant impact on the provision of NHS dental services in some areas.
- 3.44 The Welsh Government said that health boards had continued to be successful in awarding several new contracts this year or distributing funding to existing NHS contract holders for additional activity. It said this suggested there was appetite from dentists wanting to become provider-performers and from existing practice owners to expand.

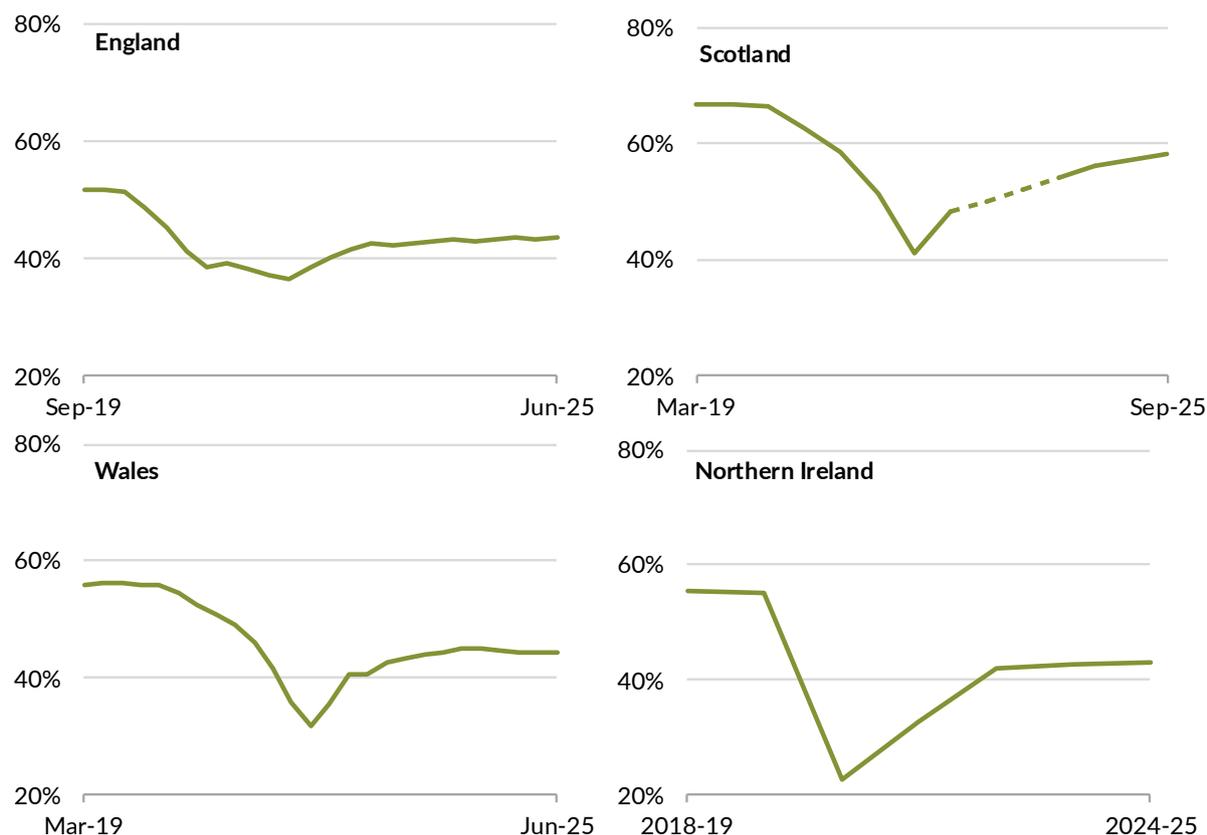
Provision of dental services

- 3.45 Across all UK nations, the number of patients accessing NHS dentistry remains lower than before the pandemic. While some recovery is evident, overall access has not returned to 2019-20 levels.
- 3.46 In England, 25.5 million patients were seen by an NHS dentist in the two years to June 2025 (43 per cent of the population), up slightly from 25.2 million in the previous period. This remained below the 29.0 million treated pre-pandemic (52 per cent) in the 24 months to September 2019.
- 3.47 In Scotland, 3.2 million registered patients contacted or received treatment in the two years to September 2025 (58 per cent of the population). While year-on-year comparisons are limited due to data breaks, this is below the 3.6 million contacted or treated in the two years to September 2019 (67 per cent).
- 3.48 In Wales, 1.41 million patients were treated in the two years to June 2025 (44 per cent of the population), broadly unchanged from the previous year but down from 1.73 million in the two years to June 2019 (56 per cent).
- 3.49 In Northern Ireland, 831,000 patients were seen in the financial year ending March 2025 (43 per cent of the population), based on claims paid during that year. This was 10,000 more than the previous year but well below the 1.05 million seen in the year ending March 2020 (55 per cent).

³¹ Scottish Government, *NHS Scotland operational improvement plan*. <https://www.gov.scot/publications/nhs-scotland-operational-improvement-plan/>

3.50 The proportion of patients seen or treated varies between adults and children as well as across the UK nations. In England, 39.8 per cent of adults and 57.3 per cent of children were seen by an NHS dentist in the two years to June 2025. In Wales, 40.1 per cent of adults and 61.0 per cent of children were treated over the same period. In Scotland, 54.8 per cent of adults and 73.7 per cent of children were registered and were contacted or received treatment in the two years to September 2025. In Northern Ireland, 37.8 per cent of adults and 61.3 per cent of children were seen in the financial year ending March 2025.

Figure 3.4: Proportion of population seen or receiving NHS dental treatment, by nation, 2019 to 2025



Source: NHS Business Services Authority; Stats Wales; Public Health Scotland; Business Services Organisation, HSC.

Notes: England reports patients seen over a 24-month period. Scotland includes patients contacted or treated over two years; data is unavailable between September 2022 and September 2024. Wales reports those treated over two years; Northern Ireland reports patients seen based on claims paid within a single financial year.

3.51 The 2025 GP Patient Survey for England showed a slight improvement in patient experience with NHS dental services. The proportion of patients who successfully obtained an NHS dental appointment increased from 76 per cent in 2024 to 78 per cent in 2025. Satisfaction also improved, with the proportion of patients rating their overall experience of NHS dental services as good increasing from 69 per cent in 2024 to 71 per cent in 2025.

3.52 The 10-year health plan for England said it would improve access to NHS dentistry, improve children’s oral health, and increase the number of NHS dentists working in the system by making the dental contract more attractive and introducing tie-ins for those trained in the NHS. It said the first step was to stabilise NHS dentistry and make sure the budget was spent on those who needed care most.

3.53 In oral evidence, the Minister of State for Care in England said that the ambition for dentistry was that everyone who needed a dentist could get one. The Government had prioritised urgent and unscheduled dental care and had directed ICBs to make more urgent appointments available, weighted to under-served areas, and had incentivised practices to deliver these.

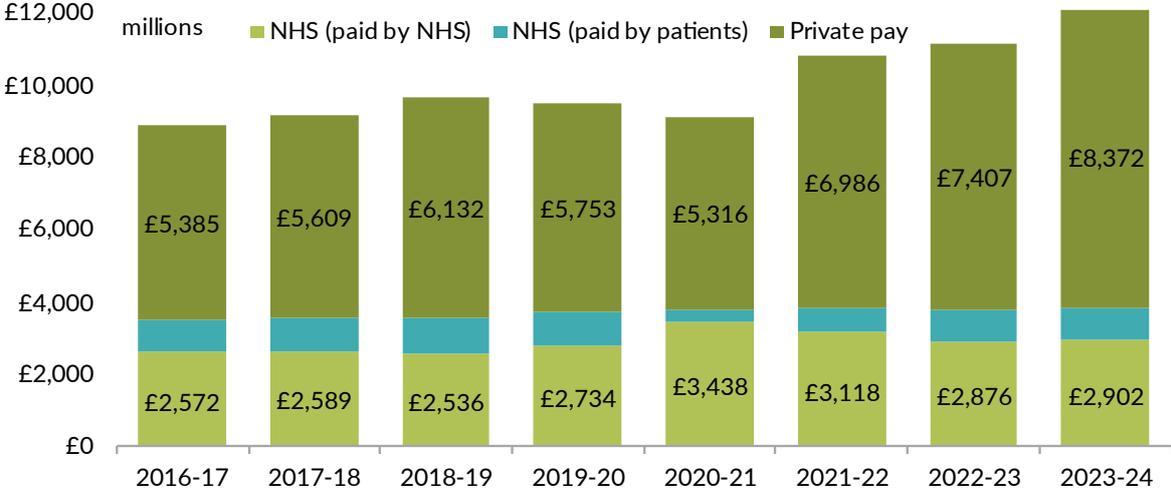
3.54 The Welsh Government said it recognised that the continued higher treatment need, and the continued introduction of new patients, had a material effect on practices being able to recover activity to pre-pandemic levels in terms of unique patient attendance and courses of treatment delivered. It said that, with the overwhelming majority of practices working under contract reform variation arrangements, it was very difficult to compare current activity to the pre-pandemic period on a like-for-like basis.

3.55 The Department of Health in Northern Ireland said that dentists were reducing their Health Service commitment and switching to private care and independent insurance plans. As a result, patients' registrations were lapsing and many of those patients had not been able to either re-register with the same dentist or register with another dentist.

3.56 The Department said that, although registration rates had decreased, the number of dental treatment claims submitted and paid in 2024-25 increased by 1 per cent from the previous year. Patients seen also increased by 1 per cent compared to 2023-24, with children seen increasing by 6 per cent and adults seen decreasing by 1 per cent. Based on item of service fees being paid, overall activity remained at around 70-75 per cent of pre-pandemic levels. The Department said that the impact for registered patients was longer waiting times and for unregistered patients it was a lack of access to Health Service dental care.

3.57 The LaingBuisson *Dentistry UK Market Report* estimated that the value of the UK high street dentistry market increased by 37 per cent, from £8.9 billion to £12.2 billion, between 2016-17 and 2023-24.³² This growth was driven primarily by private dentistry, which accounted for 69 per cent of total market value in 2023-24, up from 61 per cent in 2016-17.

Figure 3.5: Value of high street dentistry by funding sector, UK, 2016-17 to 2023-24



Source: LaingBuisson.

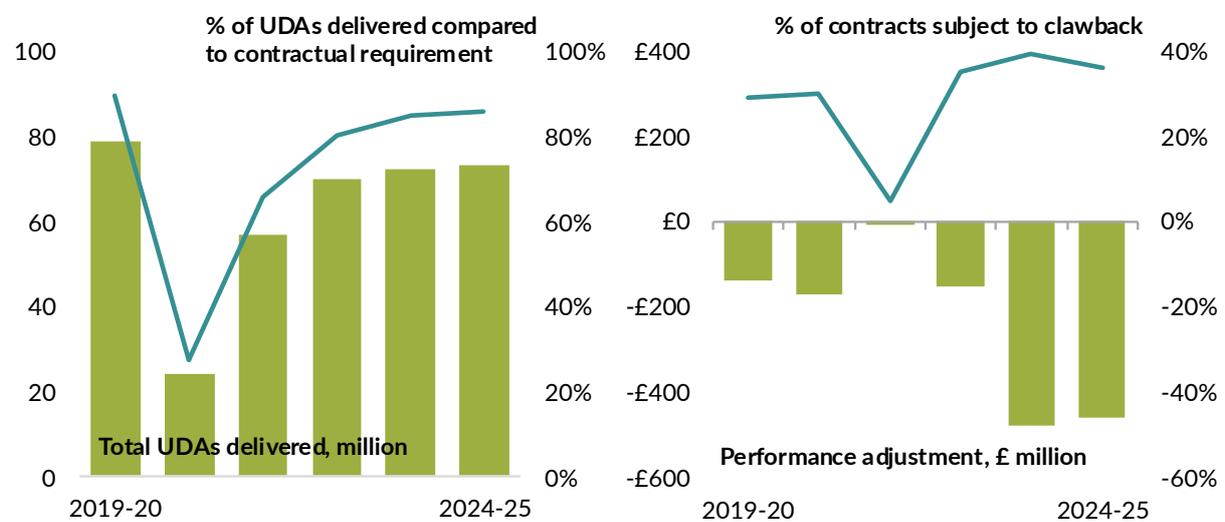
³² LaingBuisson, *Dentistry UK Market Report Seventh Edition*. <https://go.laingbuisson.com/dentistry-report-7>

Dental contracts in England

3.58 NHS primary care dentistry in England is delivered through contracts structured around units of dental activity (UDAs) – each treatment is allocated a number of UDAs in proportion to the complexity/amount of work required. Commissioners negotiate contracts with practices to deliver a certain number of UDAs each year.

3.59 The number of UDAs delivered fell sharply during the pandemic, from 83.1 million in 2018-19 to 24.1 million in 2020-21. The number of UDAs delivered increased to 73.1 million in 2024-25 but remained around 12 per cent lower than 2018-19. The proportion of contracted UDAs that were delivered dropped from 89 per cent in 2019-20 to 27 per cent in 2020-21, then improved steadily to 86 per cent in 2024-25, still slightly below pre-pandemic performance (90 per cent).

Figure 3.6: UDAs delivered and performance adjustment, England, 2019-20 to 2024-25



Source: NHS England, NHS payments to dentists.

3.60 Dividing the value of the contracts by the number of contracted UDAs indicates an average value of £38.70 per contracted UDA, an increase from £35.90 per UDA in 2023-24 and £32.90 per UDA in 2019-20.

3.61 Performance adjustments ('clawback') refer to funding recovered from dental contractors when they deliver less than 96 per cent of their contracted activity. These adjustments typically totalled around £140 million a year pre-pandemic, representing 5-6 per cent of contract values, but fell sharply to £10 million in 2021-22 as special provisions were introduced to support dental contractors during COVID-19.

3.62 Following the removal of these provisions, clawback returned to pre-pandemic levels in 2022-23 (£154 million) before increasing sharply to £479 million in 2023-24 and £457 million in 2024-25, equivalent to 15 per cent and 14 per cent of total contract values.

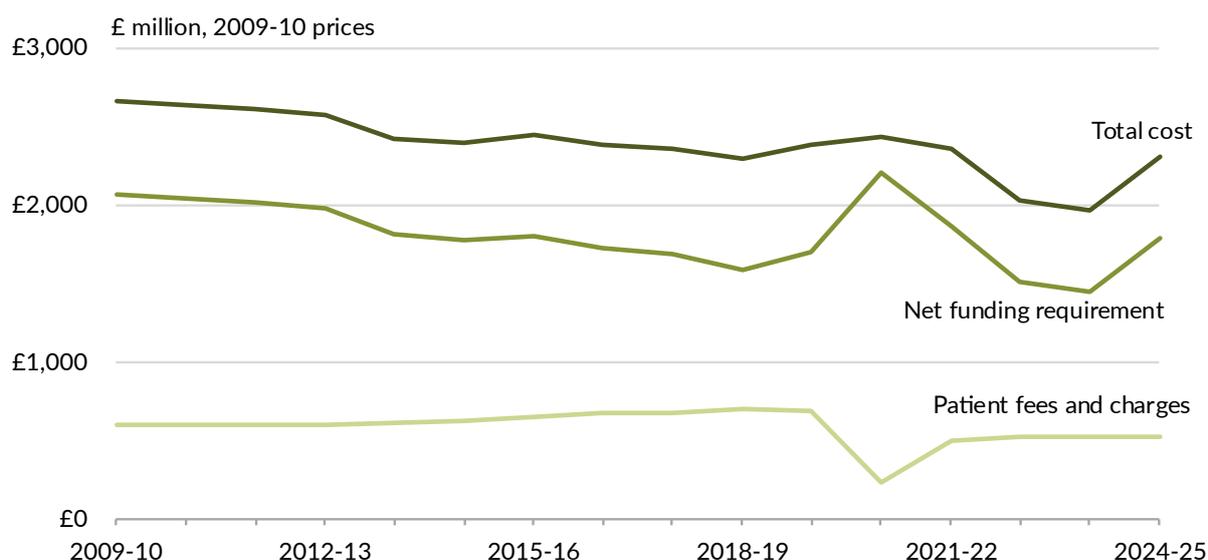
3.63 The share of contracts affected by clawback rose significantly, from around 30 per cent prior to the pandemic to 39 per cent in 2023-24, before easing slightly to 36 per cent in 2024-25, indicating that under-delivery remained widespread.

3.64 The DHSC said that the total ringfenced budget for dentistry in England for 2025-26 was £4.10 billion, including patient charge revenue. In oral evidence, it highlighted a

significant reduction in underspend of the dental budget from £392 million in 2023-24 to under £40 million in 2024-25.

3.65 Over the longer term, the gross cost of providing NHS dental services increased from £2.66 billion in 2009-10 to £3.55 billion in 2024-25. Much of this growth reflects a large increase in the most recent year. After adjusting for inflation (using the Consumer Prices Index, CPI), the real-terms cost of delivering contractual dental services by around 13 per cent, from £2.66 billion to £2.30 billion over the period in 2009-10 prices.

Figure 3.7: Real terms gross cost, patient charge revenue and net funding requirement for NHS dental services, England, 2009-10 to 2024-25



Source: Internal OPRB Calculations using DHSC Annual Reports and Accounts, 2009-10 to 2024-25.

3.66 Patient-charge revenue increased in nominal terms from £0.60 billion to £0.80 billion between 2009-10 and 2024-25 but fell in real terms to £0.52 billion. The net departmental funding requirement (total cost minus patient charge income) rose in cash terms from £2.06 billion in 2009-10 to £2.76 billion in 2024-25 but declined in real terms to £1.78 billion.

3.67 In September 2025, NHS England launched the Urgent Dental Care Incentive scheme to tackle access problems by incentivising contractors to provide more urgent dental appointments. The scheme offered £50 per additional urgent course of treatment above a baseline, with payments on top of annual contract values and flexibility for ICBs to allow up to 110 per cent of contract activity. The aim was to deliver 700,000 extra urgent appointments by March 2026, funded from existing dental allocations and historic underspends.

3.68 The Government consulted on proposed changes to the dental contract in England last year.³³ It said it was committed to fundamentally reforming the dental contract by the end of this Parliament. It said the proposed changes were intended to deliver benefits for both patients and the profession and represented a move away from some of the

³³ UK Government, *NHS dentistry contract: quality and payment reforms*.
<https://www.gov.uk/government/consultations/nhs-dentistry-contract-quality-and-payment-reforms>

features of the UDA payment model, which dental teams had said was a barrier to delivering NHS care.

- 3.69 Changes proposed included mandating a proportion of contracted activity to be dedicated to unscheduled care, new pathways for patients with complex care needs with set fees, and funded support for annual appraisals. The consultation also sought views on developing an NHS model contract and minimum terms of engagement for self-employed dentists.
- 3.70 The DHSC said that payments would better reflect the cost of treating patients with higher needs, and low-value activity would be reduced. It said that these changes would improve access to care and ensure dentists were rewarded fairly. The Government aimed to introduce legislation where necessary to support implementation of proposals from April 2026.
- 3.71 The BDA said it was supportive of many aspects of the proposals and noted that the changes were within the existing budget. It said the changes would retain the fundamental framework of the current contract but ameliorate its worst failings.
- 3.72 The Government implemented a 3.55 per cent uplift to dental contract values for 2025-26. This included a 2.39 per cent uplift for non-pay practice operating costs and a 4.0 per cent uplift for non-dentist staff pay.
- 3.73 The ADG said it was essential that annual contract uplifts were applied to both UDAs and tariffs each year as a principle. It said it was also essential that the minimum UDA rate continued to be reviewed to address the wide range of UDA levels that applied across England.
- 3.74 The DHSC said it would begin the process of more fundamental contract reform. It said it wanted a contract that matched resources to need, improved access, promoted prevention and rewarded dentists fairly, while enabling the whole dental team to work to the top of their capability.
- 3.75 The BDA said that the vision articulated for 2035 in the 10-year health plan was ambitious relative to the current parlous state of NHS dentistry. It said that, to meet the aspirations set out, the Government would need to deliver on its commitment to reform the contract, and this reform would need to be underpinned by investment.

Dental contracts in Scotland

- 3.76 The Scottish Government reformed payments for NHS General Dental Services in 2023. It said that the reform uplifted the value of fees by 20-25 per cent on average, bringing these in line with market rates and supporting practice profitability. Its broad position was that these changes had supported the sector significantly to deliver high volumes of care and treatment to NHS patients across Scotland. It said there were local challenges across certain remote and rural locations, where challenging workforce and wider economic factors had disproportionate impact on service delivery.
- 3.77 The Scottish Government said its core policy to maintain services and grow access to provision was being delivered through a range of interventions. The strategic focus of the Scottish Government was to maintain the positive engagement from the sector by ensuring that the comparative attractiveness of the new fees kept pace with the cost to deliver care and treatment. The Scottish Government said that the overall level of

funding provided for NHS dental services in the 2025-26 Budget reinforced its commitment with an increase of almost 15 per cent.

- 3.78 The Scottish Government said it had accepted DDRB pay recommendations for dentistry since the reform, maintaining the value of fees relative to the inflation position across the wider economy. Uplifts were generally applied to fee per item and capitation elements of the pay package.
- 3.79 The BDA pointed out that the 4 per cent uplift was not applied to all the elements of the remuneration package. It said that 69 per cent of dentists responding to its survey agreed that payment reform represented an improvement over the previous system. Only 7 per cent believed it enhanced access for NHS patients and only 3 per cent said it supported a reduction in oral health inequality. The ADG agreed that changes to the fees in Scotland had generally been well received.

Dental contracts in Wales

- 3.80 The Welsh Government said that, under reformed contracts, practices were required to see a given number of new NHS patients. For 2025-26, around 91 per cent of the total dental contract value commissioned in Wales was under the contract reform variation.
- 3.81 The Cabinet Secretary for Health and Social Care in Wales confirmed the 4 per cent uplift to dental contract values for 2025-26 in December.³⁴ He said that the uplift was subject to a set of conditions which were designed to continue to improve patient care and prepare for the upcoming reforms.
- 3.82 The Welsh Government said that the contract remuneration model for 2025-26 was:
- A maximum contract value of £197,725.
 - 25 per cent allocated to existing metrics (up to 1,500 UDAs).
 - 75 per cent allocated to new metrics: 10 per cent fluoride varnish; 3 per cent new urgent patients; 14 per cent new patients; and 48 per cent mandatory general dental services to existing patients.
- 3.83 The BDA said that contractual arrangements in Wales remained tied into the wider primary care reform programme, with dental services disproportionately affected by the policy of annual contract variation. Since 2021, practices had been operating under year-on-year changes to the 2006 framework, with adjustments framed around volumetric targets. It said these prioritised new and urgent patient access at the expense of continuity of care.
- 3.84 The BDA said that the process in Wales regarding the implementation of DDRB uplifts, with annual uplifts linked to contractual reform conditions, meant practices did not receive certainty on pay awards until protracted negotiations were concluded. The BDA said this left practices facing ongoing financial instability and threatened the wider financial sustainability of the sector. It said this placed NHS dentistry in Wales in an especially precarious position compared with the other nations, where uplifts were applied more straightforwardly and without further conditions.
- 3.85 The BDA said that repeated application of short-term contract variations had eroded trust in the reform process, driven contract hand backs, and fuelled the shift towards private provision. The BDA said that the model currently in operation was a crude,

³⁴ Welsh Government, *Written Statement: General Dental Services Contract Reform 2025-26*.
<https://www.gov.wales/written-statement-general-dental-services-contract-reform-2025-26>

unweighted form of capitation, with no recognition of case complexity, deprivation, or high-needs patients. It said that practices were left to absorb the cost of high-need cases and expensive treatments such as dentures, which were increasingly unaffordable. Annual retrospective mitigation based on intervention profiles created high levels of financial risk and made forward business planning near impossible.

- 3.86 The Welsh Government said that, following a consultation exercise, the new contract for 2026-27 would be allocated as follows:
- 3 per cent for the recall and monitoring of patients needing to be seen at intervals greater than 17 months.
 - 7 per cent for urgent treatment for new patients.
 - 10 per cent for new patient assessment.
 - 70 per cent for care packages.
 - 5 per cent for a prevention payment.
 - 5 per cent for local/national priorities.
- 3.87 BDA Cymru said the proposals imposed unrealistic volumetric targets that threatened continuity of care, destabilised practice finances and financial planning, and undermined clinical autonomy. It said the focus was on access without prevention or continuity of care.

Dental contracts in Northern Ireland

- 3.88 A contract uplift of 4.04 per cent was being applied in Northern Ireland, which included a 4.0 per cent pay uplift and an increase to expenses of 4.1 per cent, in line with CPIH inflation for June 2025. The Department of Health said in January 2026 that arrangements were being taken forward to progress implementation of the uplift.
- 3.89 The Department of Health said that a number of high-level options for the long-term future of dental services in Northern Ireland had been considered. To inform the most appropriate approach, a GDS cost-of-service review had been commissioned.
- 3.90 The BDA said that the cost-of-service review in Northern Ireland must be the precursor to a rebasing exercise which set the remuneration for dentistry at a level that reflected market realities. It said this should mean that a practice that was 100 per cent Health Service committed could make a reasonable return and be able to reinvest in providing a modern service without any cross-subsidy from private earnings.

Earnings for providing-performer dentists

- 3.91 Earnings data for providing-performer and associate dentists comes from His Majesty's Revenue and Customs (HMRC) and the most recent data is for 2023-24. It combines all income from private and NHS work, so is not a measure of NHS earnings. Estimates are presented on a headcount basis, meaning they reflect average earnings per dentist regardless of hours worked.
- 3.92 In 2023-24, mean pre-tax incomes of providing-performer dentists were highest in Scotland (£135,500), compared with England (£134,400), Northern Ireland (£121,200) and Wales (£114,100).
- 3.93 Average pre-tax incomes for providing-performer dentists grew by 4.3 per cent over the year in England. Average pre-tax incomes for providing-performer dentists fell by 2.7 per cent in Northern Ireland, by 6.9 per cent in Wales and by 7.6 per cent in Scotland. None of these year-on-year changes were statistically significant.

Table 3.2: Providing-performer dentists pre-tax income, by nation, 2023-24

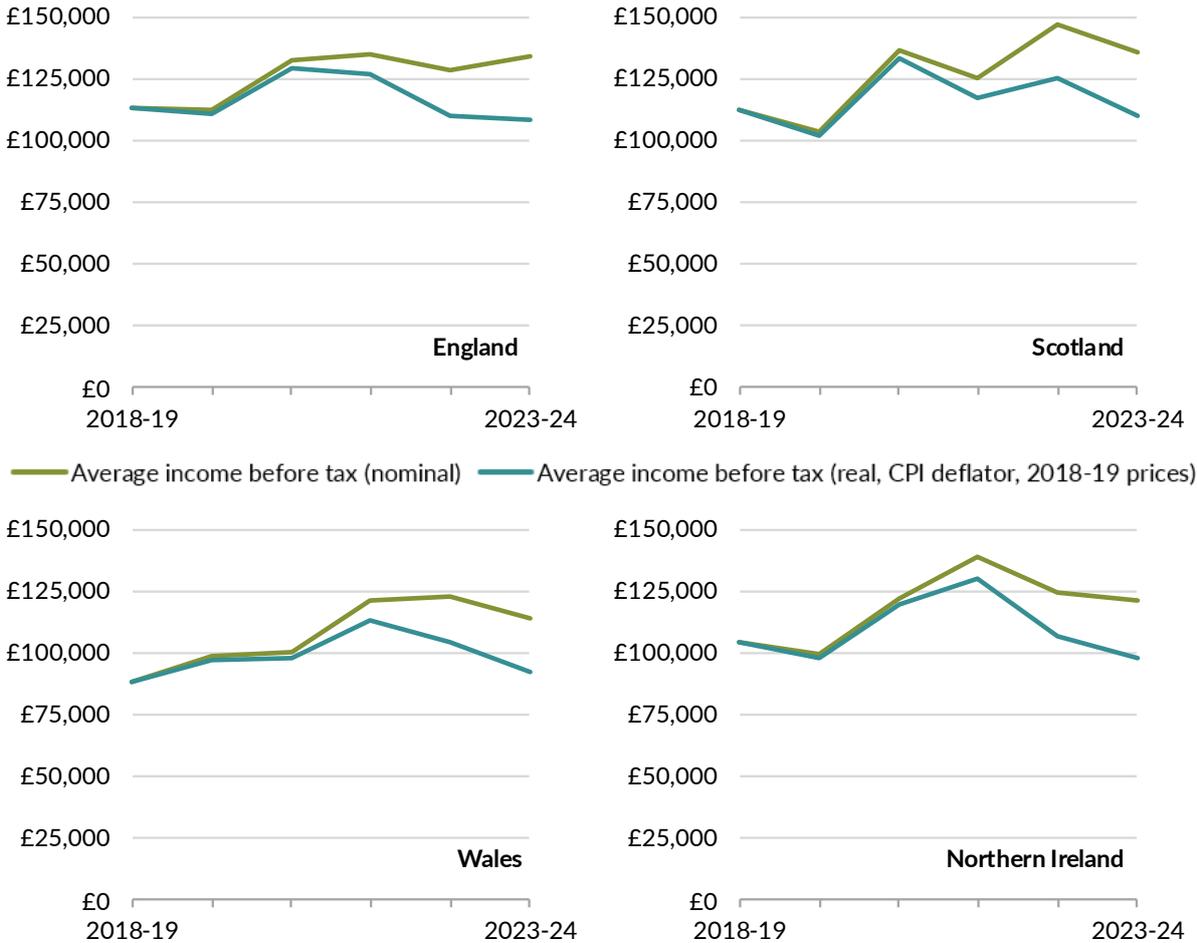
	England	Scotland	Wales	Northern Ireland
Mean (average)	£134,400	£135,500	£114,100	£121,200
Median	£102,400	£110,400	£105,900	£103,500
Lower quartile	£58,200	£77,400	£53,700	£71,600
Upper quartile	£170,400	£168,900	£158,600	£154,700

Source: NHS England.

3.94 Average pre-tax incomes of providing-performer dentists increased between 2018-19 and 2023-24: by 29.1 per cent in Wales; by 20.8 per cent in Scotland; by 18.8 per cent in England; and by 16.1 per cent in Northern Ireland.

3.95 In real terms, adjusted by the CPI, Wales is the only nation to have seen real terms growth in the average incomes of providing-performer dentists over the five-years from 2018-19, of 4.2 per cent. Average real incomes of providing-performer dentists fell by 2.4 per cent in Scotland, 4.0 per cent in England, and 6.2 per cent in Northern Ireland between 2018-19 and 2023-24.

Figure 3.8: Providing-performer dentists average pre-tax income, by nation, 2018-19 to 2023-24, nominal and adjusted by CPI



Source: OPRB calculations using data from NHS England and the ONS.

3.96 Since 2018-19, compared to a cumulative DDRB uplift of 23 per cent, the growth in providing-performer dentist income has exceeded DDRB recommendations in Wales

(with a cumulative 34 per cent increase) and Scotland (26 per cent), but fallen short in England (19 per cent) and in Northern Ireland (4 per cent).

Table 3.3: Providing-performer dentists changes to average pre-tax income compared with DDRB recommendations, by nation, 2018-19 to 2023-24

	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	Increase over the period
DDRB recommendation	2%	2.5%	2.8%	3%	4.5%	6%	23%
England	-0.1%	-0.4%	+17.4%	+2.1%	-4.6%	+4.3%	+19%
Scotland	+4.3%	-7.6%	+31.5%	-8.3%	+17.3%	-7.6%	+26%
Wales	+3.6%	+11.9%	+1.3%	+20.6%	+1.5%	-6.9%	+34%
Northern Ireland	-10.0%	-5.0%	+23.0%	+13.8%	-10.2%	-2.7%	+4%

Note: Where the increase in average pre-tax income was below the DDRB recommendation the cell is shaded green

3.97 The DHSC said that a number of factors made it difficult to compare the level of earnings and gross income from one year to another. These included variation in hours worked, variation in the balance between NHS and private sector activity, the evolving nature of practice business models, the new methodology used to collect data, and the rise in practices becoming corporates or parts of corporates.

Earnings for associate dentists

3.98 In 2023-24, average income before tax for associate dentists was £66,700 in England, £80,700 in Scotland, £74,500 in Wales, and £65,500 in Northern Ireland. In England, average pre-tax incomes for associate dentists grew by 3.6 per cent over the year, in Wales average incomes grew by 2.6 per cent, in Scotland average incomes grew by 1.4 per cent, and in Northern Ireland average incomes fell by 2.6 per cent. The year-on-year change in England was the only statistically significant change.

Table 3.4: Associate dentists pre-tax income, by nation, 2023-24

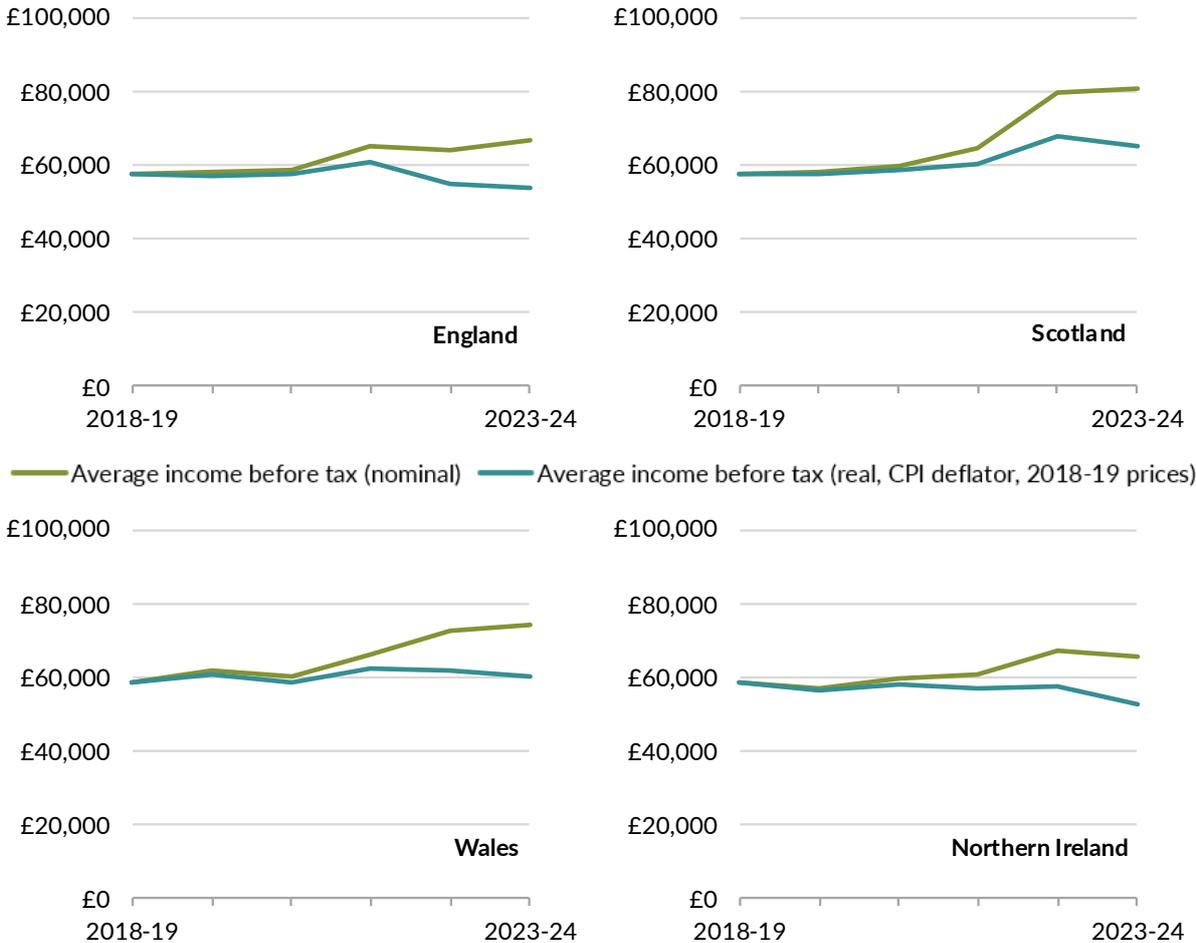
	England	Scotland	Wales	Northern Ireland
Mean (average)	£66,700	£80,700	£74,500	£65,500
Median	£60,600	£74,300	£68,800	£59,000
Lower quartile	£36,400	£52,800	£43,300	£39,400
Upper quartile	£87,200	£99,200	£97,000	£82,800

Source: NHS England.

3.99 The medium-term earnings path of associate dentists has been quite different across the nations. In real terms, adjusted by the CPI, associate dentists in Scotland saw average earnings growth of 13.7 per cent between 2018-19 and 2023-24. In Wales, real average earnings growth was 2.3 per cent over the period. In England and Northern Ireland, associate dentists saw falls in real average earnings between 2018-19 and 2023-24, of 6.5 per cent in England and 9.8 per cent in Northern Ireland.

3.100 Since 2018-19, compared to a cumulative DDRB uplift of 23 per cent, associate dentist average income growth has exceeded DDRB recommendations in Scotland (cumulative 46 per cent growth), Wales (28 per cent) and Northern Ireland (25 per cent), but fallen short in England (17 per cent).

Figure 3.9: Associate dentists, average pre-tax income, by nation, 2018-19 to 2023-24, nominal and adjusted by CPI



Source: OPRB calculations using data from NHS England and the ONS.

Table 3.5: Associate dentists changes to average pre-tax income compared with DDRB recommendations, by nation, 2018-19 to 2023-24

	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	Increase over the period
DDRB recommendation	2%	2.5%	2.8%	3%	4.5%	6%	23%
England	1.1%	0.9%	1.0%	10.6%	-0.9%	3.7%	+17%
Scotland	3.6%	1.6%	2.6%	7.7%	23.6%	1.4%	+46%
Wales	0.9%	5.3%	-2.9%	10.3%	9.5%	2.6%	+28%
Northern Ireland	12.2%	-2.6%	4.0%	2.0%	10.9%	-2.7%	+25%

Note: Where the increase in average pre-tax income was below the DDRB recommendation the cell is shaded green

3.101 The DHSC said that, while each year it strongly recommended that providing-performer dentists applied the uplift to their associate dentists' remuneration, it was unable to mandate that practices did so. As practices were private businesses, it fell to them to set employee and sub-contractor pay and conditions.

3.102 The BDA said that the long-term trend was of an extraordinary reduction in take home pay for both associates and practice owners across England, Scotland, Wales and Northern Ireland. It contrasted the sharp declines in the real earnings of NHS dentists

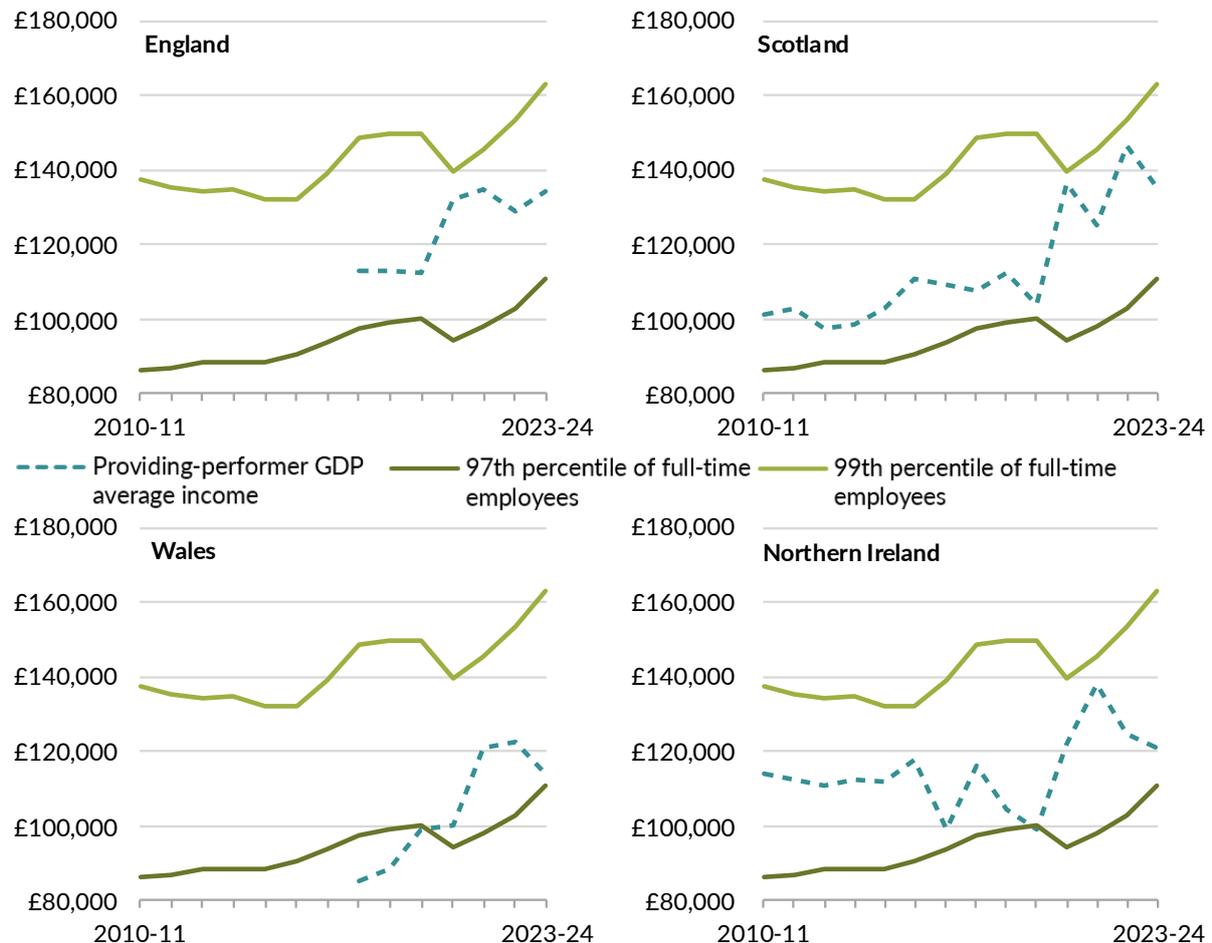
in recent years with the relative stability among GPs and said the evidence demonstrated a widening gap between dentistry and the rest of the NHS clinical workforce. The BDA said that, fundamentally, the sustained real-terms erosion of pay continued to impact recruitment and retention and directly undermined attempts to improve access to NHS dentistry.

3.103 In the BDA member survey, 20 per cent of practice owners (compared to 19 per cent in the previous year) and 40 per cent of associates (compared to 39 per cent in the previous year) agreed or strongly agreed that they were fairly remunerated for their work. Where practice owners and associates had a high NHS commitment, this dropped to 7 per cent and 29 per cent respectively.

Pay comparisons

3.104 Across all four nations, providing-performer GDP average incomes have generally tracked close to the top of the UK full-time earnings distribution. Average earnings have mostly remained between the 97th and 99th percentile across all four nations.

Figure 3.10: Average pre-tax income of providing-performer GDPs compared with the distribution of earnings of full-time UK employees, by nation, 2010-11 to 2023-24



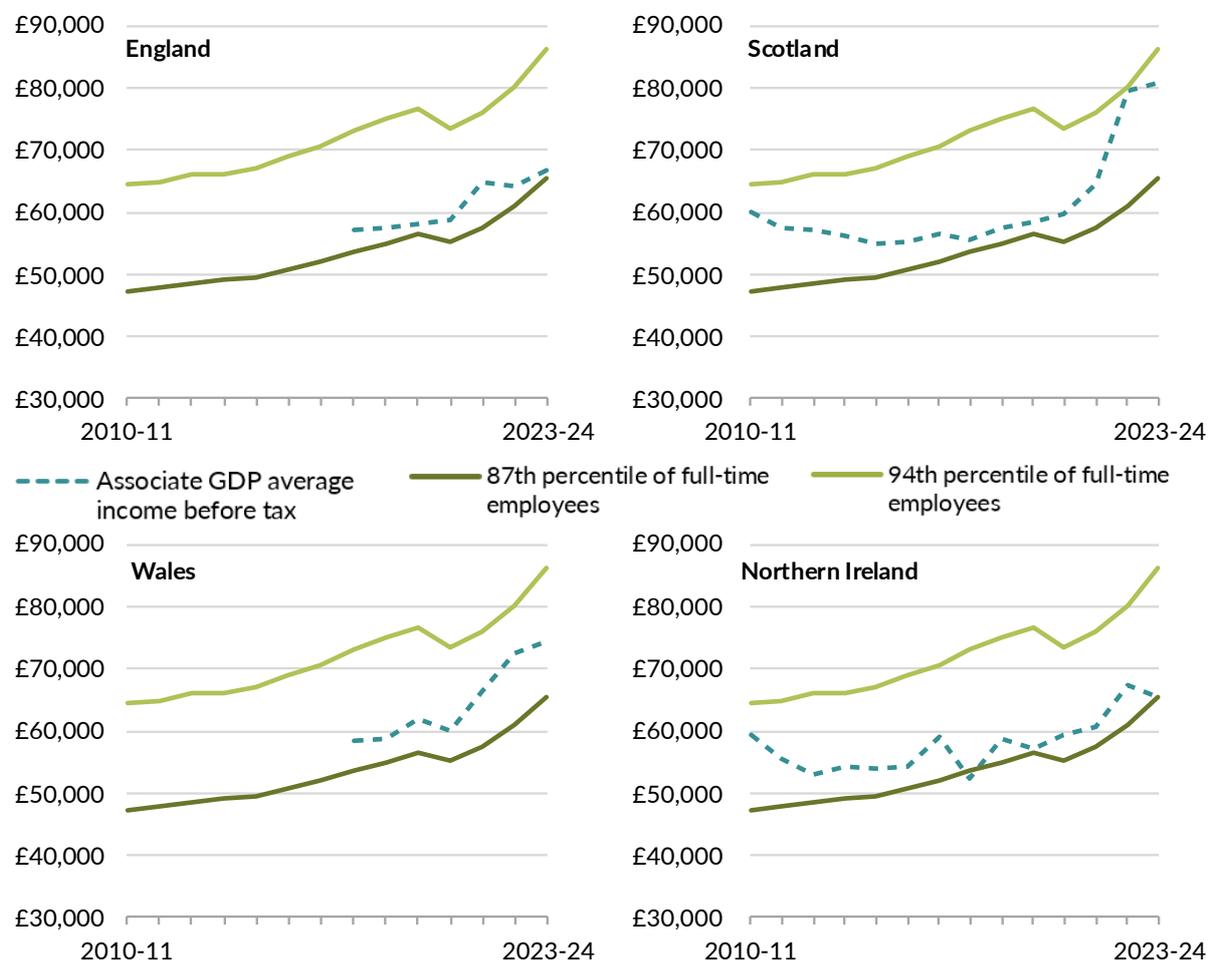
Source: OPRB calculations using data from NHS England and ONS.

Note: Dental earnings are not adjusted for working hours.

3.105 Across all four nations, associate GDP incomes have generally remained close to the upper end of the UK earnings distribution, tracking between the 87th and 94th percentiles over time. Average earnings for associate dentists in Scotland and Wales

have increased their relative position, while average earnings in England and Northern Ireland have remained close to the 88th and 87th percentile of all full-time earnings.

Figure 3.11: Average pre-tax income of associate GDPs compared with the distribution of earnings of full-time UK employees, by nation, 2010-11 to 2023-24



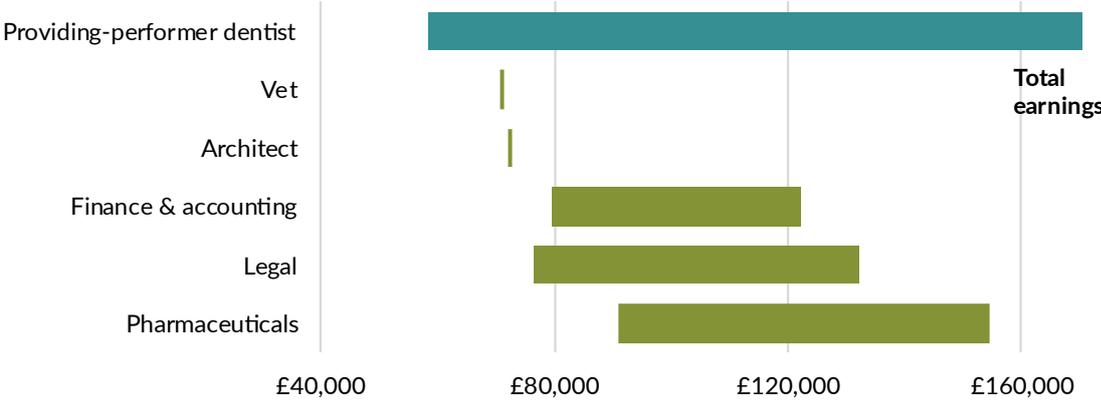
Source: OPRB calculations using data from NHS England and ONS.

Note: Dental earnings are not adjusted for working hours.

3.106 We commissioned work from Incomes Data Research (IDR) to identify roles which were broadly comparable to those in our remit group to inform pay comparisons. More detail is in appendix E. Our pay comparisons for dentists are limited to total earnings, and do not take account of working hours. Dentists also have a wide inter-quartile range of earnings, reflecting the variation in working hours and business types.

3.107 Focusing on median earnings for England, total earnings for providing-performer dentists are broadly in line with comparator professions. Median earnings for associate dentists are behind most comparators, in line with architects, and ahead of vets. Many associate dentists work less than full time, and this is reflected in the earnings data.

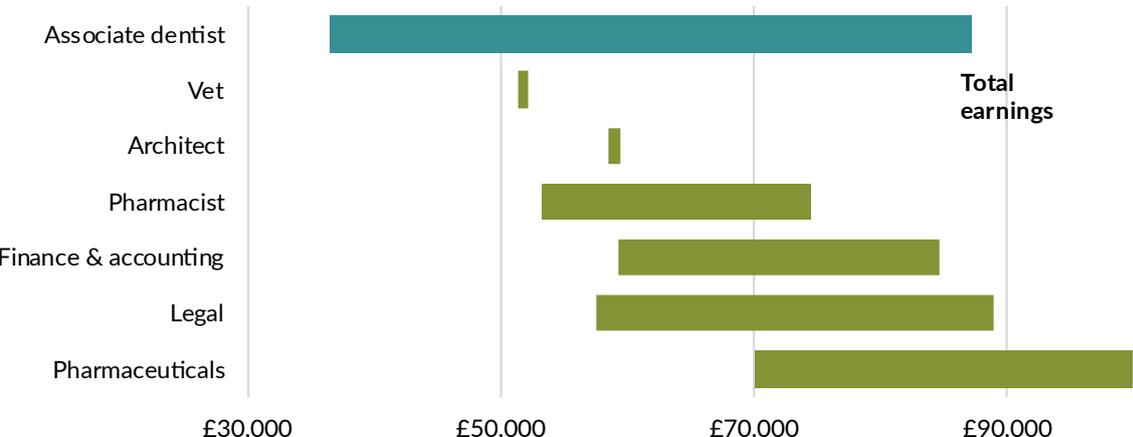
Figure 3.12: Median total earnings of providing-performer GDPs, England, and market comparators, 2025



Sources: Providing-performer dentist – dental earnings and expenses, 2023-24, median income before tax. Finance & accounting, legal, pharmaceuticals (R&D) – Korn Ferry level 19, interquartile range. Architect – Architects Earnings, principal architect in partnership I, less than 20 years' experience, London, median. Vet – SPVS 2025, Vet, 10-15 years qualified, median total remuneration.

Notes: Pay for comparator professions is on an FTE basis, while GDP earnings are on a headcount basis and are therefore lower than they would be on an FTE basis. GDP earnings are also from 2023-24, while comparator earnings are from 2025. See appendix E for more details.

Figure 3.13: Median total earnings of associate GDPs, England, and market comparators, 2025



Sources: Associate dentist – dental earnings and expenses, 2023-24, median income before tax. Finance & accounting, legal, pharmaceuticals (R&D) – Korn Ferry level 17, interquartile range. Pharmacist – IDR bespoke survey, pharmacy manager, interquartile range. Architect – Architects Earnings, private practice architect II, six or more years' experience, London, median. Vet – SPVS 2025, Vet, four years qualified, median total remuneration.

Notes: Pay for comparator professions is on an FTE basis, while GDP earnings are on a headcount basis and are therefore lower than they would be on an FTE basis. GDP earnings are also from 2023-24, while comparator earnings are from 2025. See appendix E for more details.

GDP earnings by gender

3.108 Across the nations, average earnings for female providing-performer dentists were between 9 and 14 per cent below the average for male dentists. For associate dentists, the differences in average earnings were greater, with female dentists earning 19 to 32 per cent less than male dentists on average. This will reflect lower working hours.

Table 3.6: Providing-performer dentists average pre-tax income, headcount, by gender and nation, 2018-19 to 2023-24

		2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
England	Male	£119,200	£119,300	£137,000	£143,200	£135,300	£140,600
	Female	£97,500	£96,100	£120,400	£115,800	£114,100	£121,100
	Difference	-18%	-19%	-12%	-19%	-16%	-14%
Scotland	Male	£124,300	£110,300	£145,000	£132,200	£155,600	£140,400
	Female	£90,500	£91,500	£122,000	£113,300	£134,300	£127,900
	Difference	-27%	-17%	-16%	-14%	-14%	-9%
Wales	Male	£91,000	£99,600	£101,800	£120,000	£121,200	£119,100
	Female	£81,500	£96,700	£95,700	£123,000	£126,000	£102,600
	Difference	-10%	-3%	-6%	+3%	+4%	-14%
Northern Ireland	Male	£113,600	£108,300	£131,500	£147,300	£133,900	£126,900
Ireland	Female	£85,000	£80,600	£100,800	£118,800	£104,800	£111,700
	Difference	-25%	-26%	-23%	-19%	-22%	-12%

Source: NHS England.

Notes: Does not adjust for working hours.

The differences quantify the gender pay gap as a percentage difference from the male earnings baseline. For example, a figure of -14 per cent signifies that female dentists earn 14 per cent less than their male counterparts in that category.

Table 3.7: Associate dentists average pre-tax income, headcount, by gender and nation, 2018-19 to 2023-24

		2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
England	Male	£67,800	£69,100	£68,100	£76,900	£76,000	£78,100
	Female	£50,100	£50,300	£52,100	£56,900	£56,800	£59,600
	Difference	-26%	-27%	-23%	-26%	-25%	-24%
Scotland	Male	£66,400	£67,600	£68,000	£75,100	£95,000	£93,500
	Female	£50,700	£52,000	£54,100	£56,800	£68,900	£72,400
	Difference	-24%	-23%	-20%	-24%	-27%	-23%
Wales	Male	£64,200	£71,300	£69,300	£76,600	£86,600	£84,100
	Female	£54,100	£54,900	£53,600	£59,200	£63,400	£68,000
	Difference	-16%	-23%	-23%	-23%	-27%	-19%
Northern Ireland	Male	£77,100	£71,100	£74,300	£74,300	£86,400	£83,500
Ireland	Female	£47,900	£48,900	£51,300	£54,200	£58,000	£56,900
	Difference	-38%	-31%	-31%	-27%	-33%	-32%

Source: NHS England.

Notes: Does not adjust for working hours.

The differences quantify the gender pay gap as a percentage difference from the male earnings baseline. For example, a figure of -24 per cent signifies that female dentists earn 24 per cent less than their male counterparts in that category.

Expenses

3.109 Pre-tax income figures are derived by deducting expenses from gross earnings.

Expenses include the cost of associate dentists, as well as other staff costs, premises, laboratory and equipment costs, debt interest payments, etc. For example, for

providing-performer dentists in England, the 2023-24 estimate of average pre-tax income (£134,400) results from average gross earnings (£469,500) less average expenses (£335,100). Expenses accounted for 71 per cent of gross earnings in England and Wales, 69 per cent in Scotland, and 68 per cent in Northern Ireland.

3.110 The expenses-to-earnings ratio has increased in England and Wales since 2018-19, indicating a growing share of earnings consumed by expenses. In contrast, Scotland saw a decrease of 1 percentage point and Northern Ireland saw a 0.7 percentage point decrease. Compared to 2022-23, the expenses-to-earnings ratio rose in all nations, with the largest increase in Scotland (+2.9 percentage points) and Wales (+2.8 percentage points).

Table 3.8: Providing-performer dentists gross earnings, expenses and pre-tax income, by nation, 2023-24

	England	Scotland	Wales	Northern Ireland
Gross earnings	£469,500	£433,300	£399,600	£380,400
Expenses	£335,100	£297,800	£285,500	£259,200
Income before tax (average)	£134,400	£135,500	£114,100	£121,200
Expenses as % of gross earnings	71.4%	68.7%	71.4%	68.1%

Source: NHS England.

3.111 The change in expenses may result from: a change in the price of inputs (i.e. hourly wage rates, equipment or energy costs); the need to use more/fewer inputs (as demand/activity changes); a change in the composition of the expenses base (e.g. greater use of higher-paid staff relative to lower-paid staff, or vice versa). It is likely to be a combination of these factors. Over time, the change in overall expenses each year shows a low correlation with CPI inflation, the GDP deflator, or measures of average earnings. The average expenses change also varies across nations.

3.112 The BDA said that, in the absence of appropriate remuneration, dentists were forced to bear the burden of substantial increases to the non-pay costs of NHS dentistry, as well as the increase to employer national insurance contributions. It estimated increases for 2024-25 of: 13.6 per cent for staff costs; 9.0 per cent for laboratory costs; 3.9 per cent for materials; and 4.1 per cent for other costs.

3.113 The ADG said the withdrawal of the new patient premium impacted practices as it was removed at the same time as national insurance and National Living Wage increases. The ADG estimated average 9.5 per cent annual payroll increases for high street dentistry. It estimated that lab costs increased by an average of 5.6 per cent, consumables by 5.7 per cent, energy/utility costs by 3.3 per cent and other overheads by 1.9 per cent. The ADG said this gave average year-on-year cost increases of 4.8 per cent.

3.114 The DHSC said it was conducting a research project to better understand the costs and pressures associated with running a dental practice in England. It said this would support its ambitions on dental reform by ensuring government had an objective and accurate understanding to inform policy development. It would also improve understanding around the sustainability of the current system. A survey closed on 16 June 2025, with around 500 responses. The DHSC said it was reviewing and analysing

these. The Department of Health in Northern Ireland had commissioned a GDS cost-of-service review.

3.115 The Scottish Government said that the matter of recognition of NHS dental expenses remained an area of contention between the trade union and Scottish Ministers and it recognised that this required attention. It said that it maintained a regular dialogue with BDA Scotland, however, in the absence of an agreed frame of reference on expenses this matter was likely to remain unresolved.

Motivation and morale

3.116 Last year we reported evidence from the dental working patterns survey, which showed that dentists were less positive about their jobs. This survey was not repeated for 2025.

3.117 The BDA conducted a survey of its members. This found that 56 per cent of practice owners and 42 per cent of associates reported low or very low morale in 2025, compared to 50 per cent and 38 per cent in the previous year. Where the relevant dentists held a high NHS commitment, 71 per cent of practice owners and 49 per cent of associates reported low or very low morale, compared to 65 per cent and 49 per cent in the previous year. Furthermore, 67 per cent of practice owners intended to either cease delivering NHS or Health Service dentistry entirely or reduce their commitment in the next 12 months.

3.118 The BDA survey found that 72 per cent of practice owners and 47 per cent of associates felt that their level of stress had increased over the last 12 months. When asked to pick which factors were causing stress, 92 per cent of practice owners chose increased practice costs, and 70 per cent chose staffing, recruitment, and retention issues. For associates, the two factors most frequently identified as causing stress were patient complaints and legal issues, and financial pressures specifically arising from the underfunding of NHS dentistry, at 62 per cent and 50 per cent respectively.

Community and Public Dental Services

3.119 The CDS in England, Wales and Northern Ireland and the PDS in Scotland provide general dental care to people who cannot be treated through practice-based GDPs. This includes those with particular dental needs, including vulnerable groups.

3.120 CDS/PDS dentists are salaried and are usually managed as NHS trust employees, or through community interest companies, with their own nationally agreed pay, terms and conditions. CDS and PDS dentists are often referred to as salaried dentists.

3.121 The ADG provided evidence from its CDS Community Interest Company (CIC). It employed 113 dentists, comprising 79 dentists, 27 senior dentists, 11 dental specialists, five dental consultants in special care or paediatric specialties, and 10 dentists in senior leadership/management roles, contributing as senior clinicians. It also had 10 funded foundation dentists.

3.122 In last year's report, we said there were still large evidence gaps in terms of understanding service delivery and workforce trends in the CDS and the PDS. The DHSC said that a new waiting list collection launched across CDS providers in August 2025.³⁵ This would provide:

³⁵ NHS Business Services Authority, *National Community Dental Service (CDS) Waiting List Collection*. <https://www.nhsbsa.nhs.uk/compass/national-community-dental-service-cds-waiting-list-collection>

- 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 the CDS.
- Data which could be used to support oral health needs assessments.

3.123 The DHSC said that work was also progressing on a set of national key performance indicators for the CDS.

Workforce

3.124 There were 640 dentists (headcount) working in community dentistry in England at 30 December 2024, an increase from 621 at 31 March 2024.

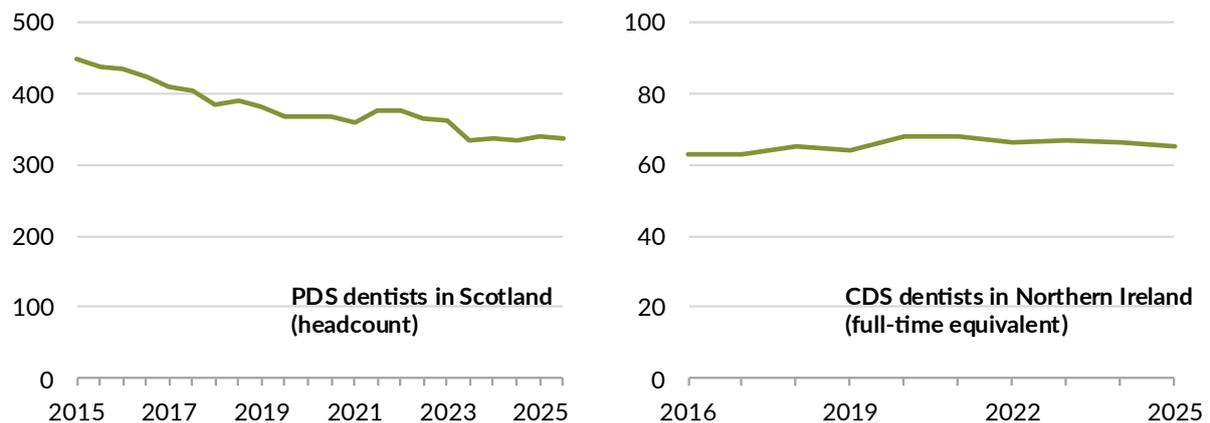
3.125 The BDA said that the CDS dentist headcount in England appeared to have almost halved over the course of a decade.

3.126 There were 336 dentists working in the PDS in Scotland in September 2025, largely unchanged from 334 in September 2024, but down from 438 in September 2015.

3.127 There were 85 dentists employed in the CDS in Northern Ireland in June 2025, equivalent to 65.4 FTE. This was broadly unchanged over the medium term. This included 38.5 FTE community dentists, 21.5 FTE senior community dentists, 0.4 FTE assistant community dental director, and 5.0 FTE community dental directors.

3.128 The Welsh Government said that a piece of work was being undertaken to review the coding used within ESR across NHS Wales for community dental staff.

Figure 3.14: PDS dentists in Scotland and CDS dentists in Northern Ireland, 2015 to 2025



Source: Scottish Government; Department of Health, Northern Ireland.

3.129 The BDA said that the declining capacity of the CDS/PDS workforce was deeply concerning because it was taking place against a wider backdrop of unmet need and increasing demand from the patient population the service was established to care for. This included patients who needed dental services such as general anaesthetic or sedation, adults and children with physical or learning disabilities, severe anxiety, Alzheimer’s, medical conditions, people who were housebound or lived in care homes, and people experiencing homelessness.

- 3.130 The BDA said that expansion of the CDS/PDS patient population was also, in part, a consequence of the wider access crisis facing the GDS. The lack of capacity had resulted in a very significant spillover of patients from NHS general dental practice across to the CDS.
- 3.131 The Scottish Government said it had committed to revision of available allowances to better support rural and island areas of Scotland where access to GDS might be more variable. It said that, where gaps existed in provision, routine dental care should be provided to the population by the PDS until such a time as rebalancing of care between the services could be achieved.

Recruitment and retention

- 3.132 There was a vacancy rate for CDS dentists in England of 11.0 per cent in December 2024, down from 13.4 per cent at March 2024. The DHSC noted that this was lower than the 19 per cent vacancy rate in high street dental practices. There were 55 leavers in the nine months to December 2024, implying an annual leaver rate of around 12 per cent.
- 3.133 NHS Employers said employers were experiencing persistent difficulties recruiting entry-level salaried dentists, particularly to band A roles. Despite national advertising efforts, many vacancies remained unfilled, highlighting concerns over the competitiveness of current pay structures and an NHS dentist career. In oral evidence, NHS Employers said the CDS entry level salary was too low and they struggled to recruit dentists, to the extent that they might terminate services in some areas.
- 3.134 The ADG said its CDS CIC faced significant recruitment and retention challenges, especially for dentists in rural and coastal areas. Workforce shortages were compounded by non-competitive pay and national training pathways that did not align with local needs. Financial pressures from contracts and difficulties covering specialist roles further impacted service delivery. The CDS CIC wanted more flexible, locally based specialist training and recruitment to support workforce stability and high-quality care.
- 3.135 The ADG said that turnover levels in dentist grades averaged approximately 13 per cent a year, nearly 50 per cent higher than the turnover for other roles. It was especially difficult to recruit to entry-level dental officer positions, and some geographies had felt a pressure to recruit at senior dental officer level.
- 3.136 Over the past 12 months, the CDS CIC had needed to recruit to fill 17 posts. To fill these, it had conducted 81 separate recruitment campaigns. Recruitment was particularly difficult in coastal and rural areas such as Norfolk & Waveney and Lincolnshire. Golden hello payments had been used, but their effect had been limited.
- 3.137 The CDC CIC had been unable to recruit for paediatric specialist vacancies and had also been unable to recruit for a special care consultant vacancy in the East Midlands. It said recruitment to these roles was vital to provide these complex services. Senior roles were also very difficult, if not impossible, to cover when maternity cover was required.
- 3.138 The Department of Health in Northern Ireland said that there was no access to agency staff to fill shortages, which meant clinical teams were frequently running under capacity. Community dental was especially affected by maternity leave, where it was challenging to recruit to a temporary post.

Pay and progression

3.139 The BDA said that current pay levels remained far below the level needed to support the CDS/PDS.

3.140 The ADG said that salaries were not competitive with wider remuneration levels across the dental sector. The CDS CIC believed it was essential to increase the salaried dentists’ pay scale.

3.141 The Department of Health in Northern Ireland said the starting salary for a community dental officer was attractive to early career dentists along with the other benefits of being employed – annual leave, sick pay, training allowance etc. It said that the ability to negotiate part-time working hours was also a significant benefit, as well as no requirement to provide on-call or weekend cover.

3.142 The Department said that the CDS pay scales for dentists in Northern Ireland were broadly aligned with those in England. However, an issue remained regarding progression to the next pay band. The current contract explicitly stated that CDS dentists could not be regraded into the specialist pay band. The Department said that community dentists felt there was limited opportunity for progression between the grades, so many dental officers who remained in the CDS felt they were stuck at the top of the pay scale with little or no opportunity for progression and reward for experience and hard work. The Department also acknowledged that there were very few, if any, opportunities for staff to access recognised training pathways within special care dentistry.

3.143 We included band A and band B CDS dentist in our pay comparability work this year. No earnings data are published for salaried dentists, so comparisons are limited to basic pay, using the published pay ranges.

3.144 The basic pay range for salaried dentist band A is in line with or ahead of comparator roles. The basic pay range for salaried dentist band B is ahead of most comparator roles.

Figure 3.15: Pay range for band A dentists, England, and market comparators, 2025



Source: Salaried dentist A – basic pay range. Finance & accounting, legal, pharmaceuticals (R&D) – Korn Ferry level 17. Pharmacy – IDR bespoke survey, pharmacist, interquartile range. Teacher – upper pay range.

Figure 3.16: Pay range for band B dentists, England, and market comparators, 2025



Source: Salaried dentist B – basic pay range. Finance & accounting, legal, pharmaceuticals (R&D) – Korn Ferry level 18. Teaching – deputy headteacher pay range.

Motivation, morale and wellbeing

3.145 The BDA shared evidence of deteriorating morale and high levels of stress among CDS/PDS dentists. It said that the deteriorating morale was, in large part, due to the overwhelming pressure placed on them as they attempted to scale down patient backlogs and keep up with the pace of demand. It said this was a direct consequence of the systemic underfunding of NHS dentistry over many years and a failure to increase the workforce in line with patient need.

3.146 The CDS CIC said that abuse and assaults from patients and carers were monitored closely, as many CDS patients had a wide range of neurodiverse conditions, and could react unpredictably in stressful situations.

3.147 NHS Employers said that abuse and violence continued to be a serious concern for salaried dentists. Many had reported experiencing both verbal and physical aggression from patients, often driven by frustration over limited access to care and long waiting times. These incidents could have a profound effect on dentists' health and wellbeing, with some professionals requiring time off work or choosing to leave the dental service entirely. Addressing this issue was key to safeguarding the workforce and ensuring the sustainability of NHS dental services.

3.148 The 2024 NHS staff survey for England showed improvement for salaried dentists across most indicators, following significant declines in the engagement and job satisfaction scores for salaried primary care dentists in 2023.

3.149 The Department of Health in Northern Ireland said that many felt the over-stretched CDS was struggling to meet the needs of the increasingly complex patients it served. Lack of career progression, training opportunities and access to specialist posts were also having a detrimental impact. There was deep concern about the rising workloads, shrinking workforce, and worsening morale, with the continued failure to address systemic workforce issues.

3.150 The Department said that staff were reporting an increase in workload challenges including waiting list pressures and the management of increasingly complex patients with a lack of efficient referral pathways and access to consultant-led services. Staff felt that they were firefighting with no opportunity to use their skills for prevention and patient-focused improvement regimes.

3.151 The Department said that a substantial increase in referrals from GDS had had a knock-on effect and put additional strain on staff with no corresponding increase in workforce. There was also reduced access to theatre time, which had led to increased waiting lists.

2025 recommendation

3.152 In our last report, we recommended that each government undertake a review of pay and progression for salaried dentists working in Community and Public Dental Services to assess whether the reward structure was appropriate to support recruitment, retention and service delivery. We set out responses to this below.

Our comments

Workforce and delivery

3.153 While some recovery in NHS dental activity is evidence, overall access has not returned to pre-pandemic levels. Between 38 and 55 per cent of adults in each nation are accessing an NHS dentist, and between 57 and 74 per cent of children.

3.154 The constraints lie in the dental workforce, the incentives in NHS dental contracts, and the overall funding for NHS dentistry. Governments have not made clear what their ambitions are for overall access to dentistry. The focus in England has been on urgent care, and using the existing under-spend in the dental budget, rather than expanded provision of basic dental care or restructuring of the underlying contract. Persistent under-delivery of contracted NHS services in England is indicative of both the lack of incentives in the underlying contract and the lack of dentists to deliver NHS work. The Welsh Government is implementing a reformed contract from April 2026, with a rebalanced set of incentives. The Department of Health in Northern Ireland is considering options for the long-term future of dental services. The Scottish Government implemented a significant increase in fees from 2023, which may have served to support NHS dentistry compared to the other nations.

3.155 The NHS Scotland Operational Improvement Plan recognised that there was an urgent need to look at the dental workforce to ensure there was continued capacity to meet demand into the future and support equitable access to services across Scotland. This is the case for all nations. Over the medium term, the dental workforce has only grown in Northern Ireland. Workforce planning for dentistry has been extremely limited, with workforce growth coming from international recruitment, without an expansion of undergraduate places, despite the significant under-provision of dentistry and the large and increasing number of people applying to study dentistry.

3.156 As well as policies to expand and incentivise NHS dentistry across the country, there needs to be a much better structure for dispersing dental provision to parts of the country with most need, in particular rural and remote areas. Data on the dental workforce remains poor, but there was a very high reported vacancy rate of 19 per cent in NHS high street dentistry in England in December 2024. In many areas this will be even higher. We have heard many reports of difficulties in recruiting associate dentists, and the recent golden hello policy seems to have had little impact. Such a policy may have a role in incentivising dentists to move to specific areas but will not improve the overall supply.

Earnings

- 3.157 In real terms, Wales is the only nation to have seen growth in the average incomes of providing-performer dentists over five years, of 4.2 per cent. Real average incomes of providing-performer dentists fell by 2.4 per cent in Scotland, 4.0 per cent in England, and 6.2 per cent in Northern Ireland between 2018-19 and 2023-24.
- 3.158 Associate dentists in Scotland have seen strong real terms average earnings growth, of 13.7 per cent between 2018-19 and 2023-24. In Wales, real average earnings growth for associate dentists was 2.3 per cent. In England and Northern Ireland, associate dentists saw falls in real average earnings between 2018-19 and 2023-24, of 6.5 per cent in England and 9.8 per cent in Northern Ireland.
- 3.159 The disconnect between our annual recommendations and actual income for dentists highlights the influence of other factors, such as fee levels, contract reform, activity levels, and local funding decisions. Nevertheless, the changes in GDP earnings relative to other parts of our remit group is noticeable.

Cost index

- 3.160 We recommended last year that the four governments work with dentists' representatives to develop an index of dental costs, to be used to determine the expenses element of dental contract uplifts in each nation. This followed on from strong evidence that expenses uplifts to dental contracts were not meeting the rising costs. This was driving the decreased attractiveness of NHS dentistry.
- 3.161 As we have made clear in past reports, we do not have the appropriate evidence base to make recommendations on the expenses uplift in primary care and this is not our role. This needs to be led by governments, informed by an assessment of typical costs.
- 3.162 The UK Government said it welcomed the recommendation to improve the evidence base on dental practice running costs, although it was not accepted. The DHSC was conducting a research project to better understand the costs and pressures associated with running a dental practice in England. It said this would support its ambitions on dental reform by ensuring government had an objective and accurate understanding to inform policy development. It would also improve understanding around the sustainability of the current system.
- 3.163 The UK Government said it used the GDP deflator to calculate uplifts to the expenses element of the dental contract, consistent with other primary care areas, including general practice and ophthalmology. It said there was a strong rationale for continuing to use the GDP deflator, but it would keep this under review.
- 3.164 The Department of Health in Northern Ireland is conducting a cost-of-service review which, along with the DHSC research, will form a useful evidence base. The BDA said that such an index was technically feasible. It said there was existing data from official sources, such as NHS dental earnings and expenses, ONS data, and industry reports.
- 3.165 In contrast, the Scottish Cabinet Secretary said in our remit letter than it was impractical to compile a detailed and meaningful index of typical expenses which accurately reflected the costs faced by contractors in Scotland.
- 3.166 In written evidence, the Scottish Government said it would like our recommendation on pay to include an assessment of the dental expenses position in Scotland. It said its

strategic focus was to maintain the positive engagement from the sector by ensuring that the comparative attractiveness of the new fees kept pace with the cost to deliver care and treatment. We do not consider it possible to achieve this without an evidence base on the costs of dentistry, as we have recommended.

3.167 Given the strong support from stakeholders in the sector, and the progress already made in England and Northern Ireland on establishing an evidence base on dentistry costs, we again recommend that the four governments work with dentists' representatives to develop an index of dental costs in each nation.

Community and Public Dental Services

3.168 Last year we recommended that each government should undertake a review of pay and progression for salaried dentists working in Community and Public Dental Services to assess whether the reward structure was appropriate to support recruitment, retention and service delivery. We said this should include whether pay ranges were positioned correctly, and whether there was a sufficiently attractive career path to attract and retain high quality dentists. We expected this to align with a broader workforce strategy which supported future service delivery and reviewed the overall workforce size and skill mix.

3.169 The BDA urged the four governments to accept our recommendation as soon as possible so that discussion and collaboration with stakeholders could begin. NHS Employers welcomed the recommendation and were waiting to see if the government accepted it. The ADG also welcomed the recommendation.

3.170 The UK Government said it recognised the vital role CDS dentists had in ensuring some of the most vulnerable members of society were able to access dental treatment and it would continue to consider the CDS as part of its long-term reform of the dental system. It said that pay scales for CDS dentists were comparable to other medical professionals, such as salaried GPs, with a common pay spine and competency-based progression. It said that the available workforce data did not show that CDS dentists were facing unique recruitment and retention issues. The Government therefore did not see a compelling case to undertake a review of salaried dentists in this setting at present; however, it would continue to monitor recruitment and retention in the CDS.

3.171 Our remit letter from the Cabinet Secretary for Health and Social Care in Scotland said it was important that the BDA was encouraged to take the lead in proposing plausible and sustainable solutions to a range of issues, including recruitment, retention, and overall job satisfaction within the PDS. The Scottish Government said that officials were in discussion with the BDA on the issues. NHS Employers in Scotland were investigating if there was scope to move PDS dentists on to the specialty doctor contract.

3.172 The Welsh Government said that consideration of our recommendation would take place in social partnership. It said there was a piece of work around gathering evidence on the specific issues in Wales, including the current pay structure, progression arrangements, and what this meant for recruitment and retention in the CDS. This would inform future options, along with service delivery models and affordability.

3.173 The Department of Health in Northern Ireland said it was considering the recommendation and was engaging with other UK nations and BDA Northern Ireland. The recommendation was discussed at a roundtable meeting in September 2025. In

oral evidence, the Department said that the messages from this were that the pay for the job was not the issue, it was the workload and the service configuration.

3.174 The Department said that, parallel to it considering the recommendation, the CDS would need to provide clear and robust data to determine whether the current reward structure was a barrier to recruitment, retention, or service delivery in Northern Ireland. The Department said that, consequently, a review might be premature and tenuous due to the lack of quality data.

3.175 There are still large evidence gaps in terms of understanding service delivery and workforce trends in the CDS and the PDS, and we agree with the Department of Health in Northern Ireland that any review needs to start with a clear evidence base. The lack of evidence is one of the reasons why a review is necessary, rather than a reason not to do it. The absence of a comprehensive evidence base for this workforce also makes our job of determining appropriate pay recommendations much more difficult.

3.176 Our visits highlighted substantial issues with workload and stress across the service. Both NHS Employers and the ADG also reported significant problems in the recruitment of band A dentists, and both said that starting salaries were too low. This was impacting service delivery. While the vacancy rate in the CDS may be lower than high street dentistry, it is still of concern, with dental vacancies having a severe impact in small teams. The band A starting salary should be considered as part of the broader review.

3.177 We are struck by the lack of government understanding and leadership of this vital service in our written and oral evidence, especially in England. This is in stark contrast to those responsible for front-line delivery. It is encouraging to see some engagement with CDS and PDS dentists in Scotland, Wales and Northern Ireland.

3.178 This is a neglected service under severe strain which is picking up the slack from the under-provision of high street dentistry. Again, we recommend that governments review pay and progression for salaried dentists working in Community and Public Dental Services to assess whether the reward structure is appropriate to support recruitment, retention and service delivery. This needs to start with a strong evidence base on service delivery and the current workforce.

3.179 We note that national CDS waiting list data collection has been introduced in England and is being collected monthly from August 2025. This has the potential to provide, for the first time, a consistent national picture of waiting times for assessment and treatment within the CDS. As this data becomes available, we would expect it to inform future assessments of service effectiveness, workforce capacity, and the alignment between demand, staffing levels and reward structures within the CDS. We would welcome timely publication of this data to support transparency and informed decision-making.

Specialty training

3.180 A specific issue has been highlighted to us around training for special care dentistry. Despite the importance of this specialty, and the small number of training places, places are being unfilled each year. This could be supported by a flexible pay premium. It has been raised with us that dentists in practice face a cut in pay if they return to specialty training, which is proving a barrier. We therefore advise that governments consider offering pay protection for dentists moving from practice into specialty training.

Chapter 4 General medical practitioners

- 4.1 This chapter considers general medical practitioners (GPs). General practice services are typically delivered by partnerships of GPs that own their practices and run them as private businesses, employing salaried GPs and other staff such as receptionists and healthcare professionals. Some practices are owned and operated by other NHS/HSC organisations, and GPs also work in other parts of the NHS/HSC, including out-of-hours services. Doctors become GPs after five years of postgraduate medical training, comprising the two-year foundation programme and three years' general practice training. Doctors in training are also discussed in chapters 5 and 6.
- 4.2 This chapter looks at trends in the general practice workforce, recruitment and retention, general practice training, developments in GP contracts in each nation, earnings and pay comparisons, and motivation, morale and wellbeing. Our comments on the data and evidence are at the end of the chapter.

Workforce

- 4.3 The qualified GP workforce has increased across all UK nations over the last year, continuing a longer-term trend of growth since 2016-17. This expansion has been driven by rising numbers of salaried GPs, while the number of GP partners or performers has either declined or remained stable. The number of GP locums has decreased, reflecting a gradual shift in workforce composition across general practice.
- 4.4 In December 2025, there were 37,638 regular full-time equivalent (FTE) GPs in England, including those in training. This was 0.4 per cent lower than a year earlier but 10.0 per cent higher than five years earlier. There were 28,195 qualified permanent FTE GPs (excluding those in training) in England in December 2025, 2.1 per cent higher than a year earlier and 4.2 per cent higher than five years earlier.³⁶
- 4.5 There has been a difference in the growth of GP partners and salaried GPs.³⁷ In December 2025, there were 15,254 FTE qualified permanent partner GPs in England, a fall of 2.9 per cent over the year and a fall of 12.7 per cent over five years. In December 2025, there were 12,632 FTE qualified permanent salaried GPs, an increase of 8.8 per cent over the year and an increase of 35.0 per cent over five years.

Table 4.1: GPs, England, December 2025

	Headcount	Annual growth	FTE	Annual growth
All regular GPs	48,491	1.5%	37,638	-0.4%
Qualified permanent GPs	38,802	3.6%	28,195	2.1%
Partner GPs	17,974	-2.4%	15,254	-2.9%
Salaried GPs	20,324	9.5%	12,632	8.8%
GP retainers	733	3.7%	309	4.7%
GPs in training	9,848	-6.4%	9,442	-7.1%
Locum GPs	1,356	-0.7%	582	-0.9%

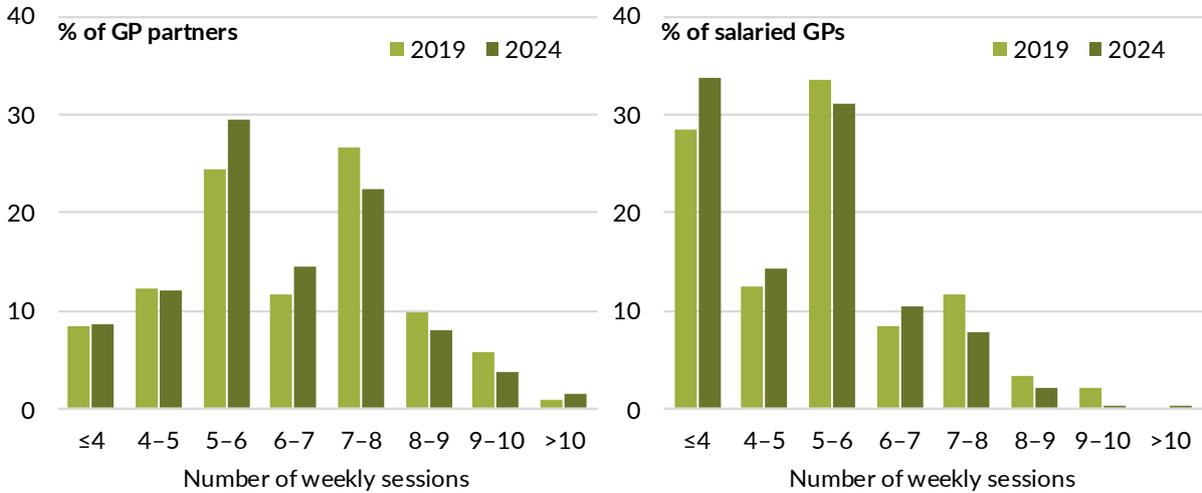
Source: NHS England.

³⁶ Regular GPs includes all GPs except locums. Qualified permanent GPs includes all GPs except locums and GPs in training.

³⁷ Partner GPs are called performers in Scotland and principals in Northern Ireland. They are all also referred to as contractor GPs.

- 4.6 On average, GP partners work longer hours than salaried GPs. GP partners had a participation rate (the ratio of FTE to headcount) of 0.85 at December 2025, similar to 0.86 in December 2020. Salaried GPs had a participation rate of 0.62 in December 2025, down from 0.64 in December 2020. Declining participation rates and the shift to salaried GPs means it takes a greater number of headcount GPs to generate the same number of FTE GPs.
- 4.7 The 2024 GP Worklife Survey in England showed that working patterns varied notably between GP partners and salaried GPs. Among partners, the most common working pattern was five to six sessions per week, while for salaried GPs it was four or fewer sessions. Partners were more likely to work longer hours, with 36 per cent working seven or more sessions, compared to just 11 per cent of salaried GPs.³⁸

Figure 4.1: Weekly sessions worked by GPs, England, 2024



Source: GP Worklife Survey, 2024.

Note: A contracted GP session is 4 hours 10 minutes.

- 4.8 The number of FTE locum GPs in England continued to fall, by 0.9 per cent over the year to December 2025, and by 40.7 per cent over five years.
- 4.9 There were 3,657 FTE qualified GPs in Scotland in September 2025, an increase of 3.7 per cent over the year, and fall of 0.6 per cent since 2019. The number of FTE salaried GPs in Scotland grew by 15.4 per cent in the year to September 2025, while the number of FTE GP performers fell by 0.7 per cent. Performer GPs in Scotland had an average 0.83 full-time equivalence in September 2025, while salaried GPs had an average 0.70 full-time equivalence.
- 4.10 In the General Practice Workforce Survey, 87 per cent of practices in Scotland reported the use of locums in 2025, similar to the previous two surveys. The total number of whole-time equivalent locum posts filled was 260, down by 25.2 per cent from the previous year.

³⁸ The number of sessions reported in the Worklife Survey is not directly comparable to FTE participation rates, as FTE is calculated from total weekly hours relative to a 37.5-hour full-time week, whereas a 'session' is a variable measure of clinical time and does not capture additional administrative or managerial work undertaken by GPs.

Table 4.2: GPs, Scotland, September 2025

	Headcount	Annual growth	FTE	Annual growth
All qualified GPs	4,643	2.8%	3,657	3.7%
Performers	3,071	-1.1%	2,557	-0.7%
Salaried	1,518	11.6%	1,070	15.4%
Retainees	54	5.9%	31	23.6%
Registrars	798	5.1%	-	-

Source: NHS Education for Scotland, NHS Scotland Workforce

Notes: Retainees are qualified GPs on the performers list with caring responsibilities which prevent them committing to a more substantive GP post. Data on full-time equivalent GP registrars is not available.

4.11 In June 2025, there were 1,893 FTE regular GPs employed in Wales, 0.8 per cent more than a year earlier, and 0.9 per cent higher than December 2021. GP partners in Wales had an average 0.74 full-time equivalence in June 2025, while salaried GPs had an average 0.60 full-time equivalence.

Table 4.3: GPs, Wales, June 2025

	Headcount	Annual growth	FTE	Annual growth
All regular GPs	2,651	3.2%	1,893	0.8%
Qualified permanent GPs	2,157	2.9%	1,476	0.9%
Partner GPs	1,353	-1.2%	999	-3.5%
Salaried GPs	780	11.4%	467	11.8%
GP retainers	28	-6.7%	11	-4.6%
GPs in training	490	4.3%	417	0.8%
Locum GPs	470	-14.7%	96	-32.6%

Source: StatsWales.

4.12 The Welsh Government said there were 2,332 GPs on the all-Wales locum register at the end of June 2025, an increase of 236 since June 2024. An average of 408-487 worked as GP locums each month. In June 2025, this amounted to almost 3,000 shifts.

4.13 In 2025, there were 1,468 qualified GPs in Northern Ireland, 1.0 per cent higher than a year earlier and 7.6 per cent higher than five years earlier. The headcount number of principal GPs fell by 2.2 per cent over the year and by 5.1 per cent over five years. The headcount number of salaried GPs increased by 10.8 per cent over the year and by 94.4 per cent over five years. There were 575 locum GPs in Northern Ireland at March 2025, an increase from 540 in 2024.

Table 4.4: GPs, Northern Ireland, 2025

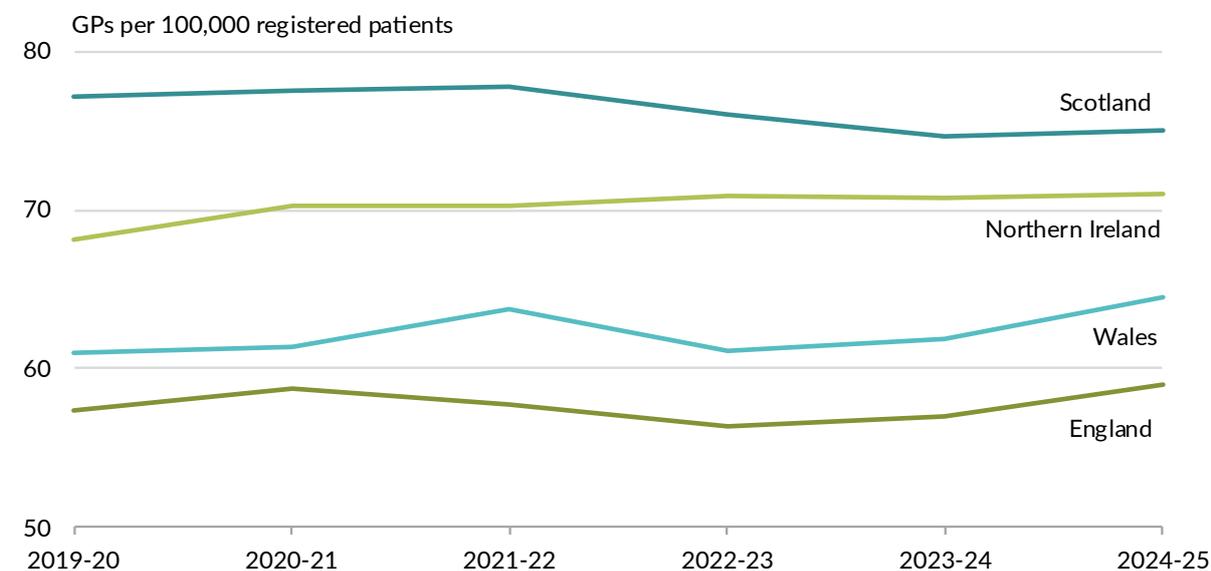
	Headcount	Annual growth
All qualified GPs	1,468	1.0
Principals	1,104	-2.2%
Salaried	348	10.8%
Retainers	16	45.5%
GP locums	575	6.5%

Source: Department of Health, Northern Ireland.

4.14 In 2024-25, the number of GPs per 100,000 registered patients was: 75.0 in Scotland; 71.0 in Northern Ireland; 64.5 in Wales; and 57.0 in England. The ratio showed an

increase in England and Wales in 2024-25 and was broadly unchanged in Scotland and Northern Ireland.³⁹

Figure 4.2: GPs (headcount) per 100,000 registered patients, by nation, 2019-20 to 2024-25

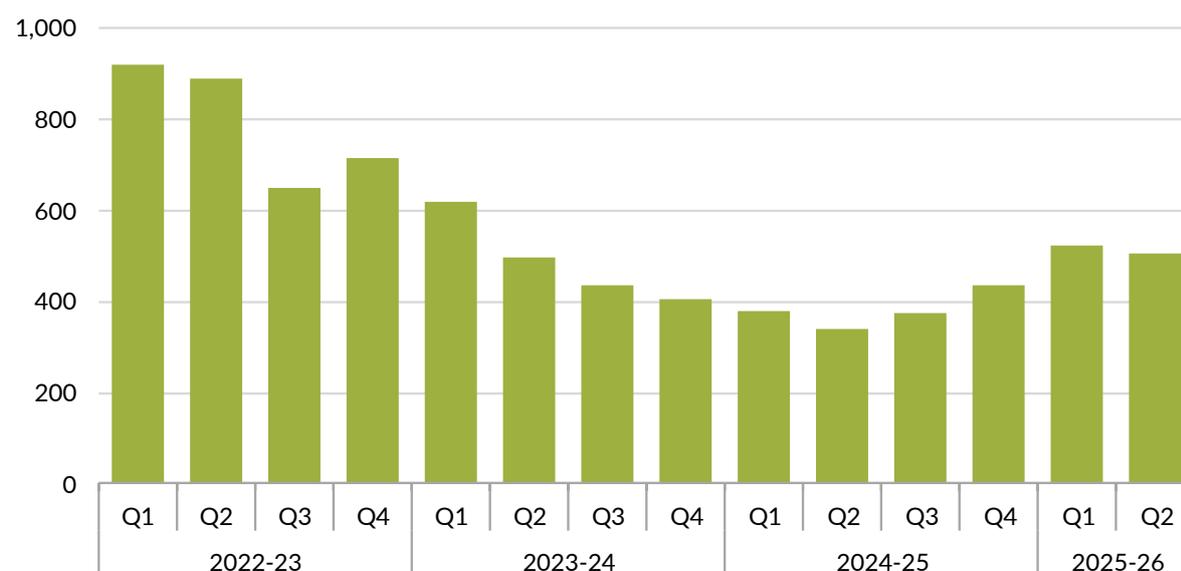


Source: General Medical Services for Northern Ireland, Family Practitioner Services Information Unit.

Recruitment and retention

4.15 NHS England published information on GP job adverts for the first time in December 2025. This identified jobs advertised by or on behalf of general practices on the NHS Jobs platform for GP partners, salaried GPs, locums, and roles funded through the Additional Roles Reimbursement Scheme (ARRS). This showed that GP job adverts fell sharply in 2023-24 but began to rise again from the middle of 2024-25, with recent quarters showing a clear recovery from the low levels seen in 2023-24.

Figure 4.3: Advertised FTE jobs for general practitioners, England, 2022-23 to 2025-26



Source: NHS England.

³⁹ This takes no account of any differences between nations in working patterns or in how services are delivered.

- 4.16 The number of GP job adverts increased from 341 in 2024-25 Q2 to 504 in 2025-26 Q2, an increase of 47.9 per cent. The number of GP job adverts was still much lower than the 892 adverts recorded in 2022-23 Q2.
- 4.17 The DHSC said there had been £82 million of additional funding for the ARRS in 2024-25 to enable the recruitment of 1,000 recently qualified GPs (up to two years post Certificate of Completion of Training (CCT)). It said that this continued in 2025-26, with total funding for the ARRS uplifted by £188 million for 2025-26, which was included in the contract funding. It said that, from April 2025, the ARRS had become more flexible to allow Primary Care Networks (PCNs) to respond better to local workforce needs, with fewer restrictions on the number and type of staff covered and the inclusion of practice nurses in the scheme. The two funding pots – for recently qualified GPs and for other direct patient care staff – had been combined into one to enable PCNs to utilise the entire pot as flexibly as possible.
- 4.18 The latest NHS data showed that 3,073 GPs had been claimed for through the ARRS between 1 October 2024 and 31 December 2025.⁴⁰ Provisional data showed that GPs claimed for under the ARRS were delivering 1,416.2 FTE in November 2025.
- 4.19 In the 2024 GP Worklife Survey, 29 per cent of GPs in England reported a high or considerable intention to leave direct patient care within five years. While this overall figure was unchanged since 2019, the proportion had increased among GPs under 50 (from 11 per cent to 15 per cent) and declined among those aged 50 and over (from 62 per cent to 55 per cent). The most common factors that GPs said would make them more likely to stay were reduced working hours (67 per cent), better remuneration (65 per cent), and improved physical working conditions (61 per cent). Recognition for good work (49 per cent) and greater autonomy (41 per cent) were also frequently cited.
- 4.20 In the GP Worklife Survey, 62 per cent of GPs in England in 2024 reported doing non-GP work for either the NHS or outside it. Nearly half (49 per cent) undertook non-GP work for the NHS, while 23 per cent did so outside the NHS. The most common types of non-GP work were research (46 per cent), GP training (43 per cent), and working as a prison doctor (39 per cent). Other frequently reported roles included medical education (28 per cent), GP appraisal (20 per cent), and management roles in PCNs (17 per cent). The DHSC said it did not collect data on the proportion of doctors providing private GP services.
- 4.21 In the 2025 General Practice Workforce Survey in Scotland, 14.4 per cent of GP practices reported that they had vacant GP sessions in the year to 31 March 2025, down from 22.1 per cent in the previous year. The overall vacancy rate was 3.8 per cent in 2024-25, down from 7.6 per cent in 2023-24. The vacancy rate ranged across health boards from 0.8 per cent in Forth Valley to 15.5 per cent in Highland.
- 4.22 The 2024 GP Recruitment and Retention Action Plan in Scotland set out 20 actions, including increasing the number of GP specialty training placements, improving the fellowship programme for early career GPs, and reviewing and developing the retention initiatives to support GPs to remain in practice. The Scottish Government said there had been good progress in a number of areas including improvements to workforce data, guidance on visa requirements, and leadership training for GPs who might be

⁴⁰ *Primary Care Workforce recruited through the Additional Roles Reimbursement Scheme (ARRS).*

<https://digital.nhs.uk/data-and-information/publications/statistical/mi-primary-care-workforce-recruited-through-the-additional-roles-reimbursement-scheme-arrs>

considering entering partnership. The Scottish Government had a commitment to increase the number of GPs by 800 by 2027.

- 4.23 National Education for Scotland launched a new GP Retain and Sustain scheme to support GPs who were at risk of leaving the profession. The Scottish Government was working with health boards to expand the GP fellowship schemes to support early career GPs to transition into the workforce. Existing early career fellowships were available to provide opportunities for GPs to develop the skills and experience to work in island and rural settings as well as areas of deprivation. The Centre for Workforce Supply and the National Centre for Remote and Rural Health and Care were developing a sustained model of direct support that would provide rural and island health and social care employers with the help they needed to improve recruitment success.⁴¹
- 4.24 The Scottish Government said it incentivised GPs to take up harder-to-fill posts, mainly in rural and deprived areas, through the golden hello scheme, which offered a bursary of up to £10,000. Golden hellos could also be paid to new GP performers if the local health board believed the practice was experiencing significant difficulties around recruitment and retention.
- 4.25 The Scottish Government said that the longer-term reduction in the number of GP partners reflected a broader trend towards fewer and larger practices incorporating multi-disciplinary teams to provide a wider range of services. It said it recognised that becoming a partner could present particular challenges and required the development of new skills. It had funded a new Royal College of General Practitioners (RCGP) project 'First5 to Partnership' with an aim to support the future leaders of general practice. It was also working with National Education for Scotland to expand the 'Preparing for GP Partnership' course to include all GPs and not just those in the first five years of practice.
- 4.26 The Scottish Government said that seniority payments rewarded experienced GPs and were made to the practice for payment to individual GPs. Payments were worth £600 a year after six years, £5,129 a year after 21 years, £10,258 a year after 36 years and £13,900 a year after 47 years. The annual paybill for seniority payments to GPs was £15.9 million in 2024-25, unchanged from the previous year.
- 4.27 The Welsh Government said that the Partnership Premium Scheme was introduced in 2019 as an incentive for GPs to take up partner roles, with payments made based on clinical sessions undertaken. There were around 900 quarterly claimants across the core and higher schemes in March 2025, with around 400 in the frozen seniority scheme. Quarterly payments for GP partners were around £1.6 million; annual payments for 2024-25 totalled £6.4 million. Annual payments to non-GP partners for 2024-25 totalled £0.4 million.
- 4.28 The Department of Health in Northern Ireland reported 176 GP leavers in 2024-25, down from 211 in 2023-24, but up from 96 in 2019-20.
- 4.29 The Department said that initiatives to support the GP workforce included the Attract, Recruit, Retain scheme which supported the recruitment of GPs in hard-to-recruit areas. GP practices could apply for a number of packages under the scheme including a golden hello, relocation costs, recruitment costs, management costs, reimbursement

⁴¹ Scotland Deanery, *Supporting Our Remote and Rural GP Workforce*. <https://www.scotlanddeanery.nhs.scot/news-events/supporting-our-remote-and-rural-gp-workforce/>

costs for applying to the Northern Ireland performers list, and funding for international GPs. Since its establishment in January 2023, 87 GP practices had applied and received approval in principle for funding under the scheme; 54 practices had applied and received final approval for payment in respect of a recruited GP.

- 4.30 The Department said it did not hold information on GP vacancies in Northern Ireland or on the number of GP practitioners who delivered private primary medical services in addition to services under the General Medical Services (GMS) contract.
- 4.31 The Department said that salaried GPs working in hospital environments were employed by HSC trusts to deliver general medical services to specific patient groups, often in intermediate care or specialist clinics within secondary care. Their role typically included providing generalist medical care to inpatients who did not require consultant-led specialist input, supporting discharge planning, and bridging the interface between primary and secondary care.
- 4.32 The British Medical Association (BMA) said that unemployment and under-employment were increasingly prevalent among sessional GPs. Its Sessional GP Committee undertook a survey of members at the beginning of 2025. It received 1,682 individual responses, with most respondents (85 per cent) working or seeking work in England:
- 15 per cent of respondents said they could not find any GP work.
 - A further 56 per cent said they would like to work more hours as a GP in the NHS than they currently were.
 - On average, respondents wanted to work nine more hours a week than they were currently able to.
- 4.33 The BMA said in oral evidence that under-doctored areas continued to struggle to attract GPs. In other areas, new GPs could not secure the opportunities they expected. Jobs existed, but not in the places where new GPs were able or prepared to work. The BMA said that, after years of struggling to recruit GPs, many practices had reorganised their workforce around ARRS-funded roles. In some regions this had created an over-reliance on non-GP roles, displacing investment in substantive GP posts.
- 4.34 Recent work by the Nuffield Trust looked at why there were unemployed and under-employed GPs in England.⁴² It pointed to the massive growth of other allied health professionals working in general practice, driven by ARRS funding. The Nuffield Trust said that this was not intended to replace GPs, but the significant numbers recruited, and the absence of cost to practices, meant that at least some substitution seemed likely. The Nuffield Trust also said there was a significant risk that allowing employment of GPs under the ARRS was worsening the GP recruitment crisis as there was little incentive for GP partnerships to employ salaried GPs directly at practice level when they could access ARRS GPs for free.
- 4.35 The Nuffield Trust said there was some merit in the argument that years of constrained practice funding may have limited the ability of GP surgeries to afford new recruits. However, it noted that the major funding uplift in 2025-26 did not appear to have increased direct GP employment by practices, suggesting that partners may be relying on ARRS GPs rather than making practice-based posts available. It also pointed to the rise in GP partner income and said that arguments that GP partners could not find GPs

⁴² Nuffield Trust, *Why does England have unemployed GPs when patients can't get GP appointments?*
<https://www.nuffieldtrust.org.uk/resource/why-does-england-have-unemployed-gps-when-patients-can-t-get-gp-appointments>

to hire, or could not afford to employ them in practices, sat at odds with the available evidence.

- 4.36 The Nuffield Trust concluded that the factors that led to GP unemployment were different from those now driving it. It said that, initially, under-employment of GPs likely did result from over a decade of constrained funding in general practice. It said that allowing GP employment under the ARRS solved an immediate crisis in the summer of 2024, but it was now causing problems, with many GP partnerships relying on staff recruited through the ARRS (now including GPs), rather than recruiting directly at practice level. Limited availability of practice-level GP jobs was likely driving early career GPs to ARRS roles.
- 4.37 The RCGP said in November 2025 that GPs were willing and able to work more hours but were constrained by a shortage of suitable opportunities, especially without having to move themselves and their families across the country.⁴³ It said it was essential that GPs were supported to move into under-served or hard-to-recruit areas, for example, through the reintroduction of a targeted enhanced recruitment scheme or a similar initiative.
- 4.38 A survey of 493 practice managers by the RCGP found that more than half of respondents (61 per cent) said their practice would need to expand its GP workforce over the next 12 months to meet patient need. Most respondents (92 per cent) identified the lack of funding in general practice as a major barrier to recruiting more GPs, while 83 per cent highlighted the 2025 rise in employer national insurance contributions as a key barrier to workforce expansion. Workforce growth was also hampered by the limitations of general practice premises. Many practices lacked the physical space and capacity to accommodate multidisciplinary teams or receive new trainees.

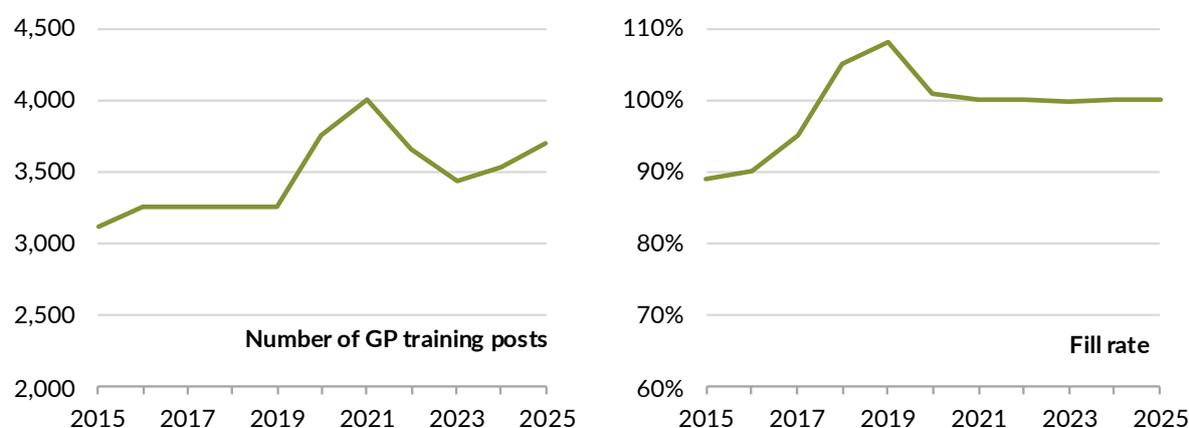
General practice training

- 4.39 There has been strong growth over the medium term in the number of GP trainees in England, with headcount growth of 35.5 per cent between December 2020 and December 2025. There was a fall over the latest year, of 6.4 per cent, which may reflect an increase in the numbers completing GP training from earlier larger intakes. Around half, 51.0 per cent, of GPs in training had gained their primary medical qualification in the UK in December 2025, down from 65.2 per cent in December 2020, with most international medical graduates (IMGs) coming from countries outside the EEA.
- 4.40 The DHSC said that 4,000 GP specialty training places were filled in 2024 across the recruitment rounds. An additional 250 places were available from September 2025, bringing the total to 4,250. It noted that the 10-year health plan committed to train thousands more GPs in the coming years.
- 4.41 Data on training posts in England show that there were 3,695 general practice ST1 roles being recruited for in round 1 in 2025. The fill rate (number of acceptances as a

⁴³ Royal College of General Practitioners, *GP practices need more GPs but can't afford them, College warns.* <https://www.rcgp.org.uk/News/gp-recruitment-letter-health-secretary>

proportion of posts) increased from 87 per cent in 2014 to 100 per cent or more since 2018.⁴⁴

Figure 4.4: General practice ST1 posts and fill rates, England, 2015 to 2025



Source: Office for the Pay Review Bodies (OPRB) calculations using NHS England data.

- 4.42 The DHSC said that a one-off payment of £20,000 had previously been offered 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 were in under-doctored or deprived areas under the Targeted Enhanced Recruitment Scheme (TERS). From 2025, the DHSC and NHS England agreed to stop the scheme due to record numbers of applicants applying, including in areas where take up had been historically low. The DHSC said it would monitor the continued impact of removing TERS payments on application rates including to those areas previously targeted by the scheme. In oral evidence, the DHSC said that there were other approaches to this issue – it was trying to increase training places and training capacity in areas that had under-recruitment. It said that the TERS may have helped to recruit people in the past, but there was no evidence that TERS payments kept the GP in the area once they finished their training.
- 4.43 The BMA said in oral evidence that the removal of the TERS risked undermining recruitment and retention in deprived areas. It said that the TERS was a genuine recruitment incentive which encouraged applicants to consider under-served areas. While posts were being filled now, it did not mean that doctors would remain in the area once they had completed training.
- 4.44 The Scottish Government said that recruitment to general practice specialty training had been successful in recent years, with 99 per cent of advertised posts filled in 2024 and 100 per cent of posts in 2023. Since 2022, 100 additional GP specialty training posts had been created. The Scottish Government said it was working with partners to better understand challenges and opportunities in relation to training capacity in primary care across Scotland. A stakeholder working group was to produce a comprehensive report by early 2026 to include an assessment of the current capacity and a forecast of future capacity requirements.
- 4.45 The Welsh Government said that recruitment into GP training posts had historically been challenging. Before 2019, Wales was not achieving its baseline target of 136 GP

⁴⁴ This does not include Scotland, Wales and Northern Ireland which is why the number of training place posts is less than the 4,250 mentioned above.

training places a year. However, the current recruitment target of 160 new GP trainees each year continued to be achieved, with 160 trainees recruited in 2024.

- 4.46 Financial incentives for GP training were introduced in Wales in 2017. The targeted incentive scheme provides £20,000 to GP trainees who take up a training post in north Wales (three training schemes – Bangor, Dyffryn Clwyd and Wrexham), Ceredigion, Pembrokeshire and Powys. These training schemes historically had a trend of low fill rates – less than 75 per cent over a five-year period. The scheme was extended to Carmarthenshire from August 2023. Trainees receive £10,000 on commencing their training, with the second payment made after they complete one year of practice in the incentivised region. The Welsh Government said that an independent review of the GP training incentive scheme was to be undertaken later in 2025.
- 4.47 The Department of Health said that the number of GP training places in Northern Ireland increased from 111 in 2021 to 121 in 2022 and had remained at this level since. All posts were filled in 2023-24 and 2024-25 across two cohorts commencing in August and February. It was anticipated that this would be the case for the 2025-26 academic year, with 115 doctors offered training places in August 2025 and further recruitment planned for February 2026 to complete the full intake of 121. All the training places in the Northern Ireland GP scheme could be filled through the national recruitment process.
- 4.48 The Department had worked with key stakeholders to increase the exposure of undergraduates to general practice, encourage more GP trainees, and ensure that there were sufficient GP training practices to meet demand and support GPs in training. There was also an expansion in general practice posts within the foundation programme to facilitate doctors who wished to gain experience in general practice.
- 4.49 Increasing numbers of GP trainees were international graduates and required visa sponsorship to remain in Northern Ireland. The Department said this created challenges due to the short three-year training period. Of the 475 trainees currently in the GP training programme, 184 (39 per cent) undertook their primary medical qualification outside the UK.
- 4.50 Retention of GPs post-CCT in the GMS workforce in Northern Ireland had been examined, with data showing that, while the retention rate for doctors with a UK medical degree was over 90 per cent, the rate for IMGs was around 70 per cent. While some IMG doctors relocated to other parts of the UK and continued to work as GPs there, others left the UK completely. Data on what countries they relocated to was limited; however, it was known that a proportion moved to work in the Republic of Ireland and Canada.
- 4.51 A survey from the RCGP found that 66 per cent (103) of 156 final year GP registrars (ST3s) who had looked for work, found it difficult.⁴⁵ Of those who said they had not been able to find work yet (79 ST3 GPs), 70 per cent (56) said that there were not enough suitable jobs anywhere in the country, and 65 per cent (51) were considering leaving the UK to find work in the future.

⁴⁵ Royal College of General Practitioners, *GP practices need more GPs but can't afford them, College warns.* <https://www.rcgp.org.uk/News/gp-recruitment-letter-health-secretary>

Access to GP services and general practice sustainability

4.52 There were around 1.47 million appointments with general practices in England every working weekday in December 2025, up by 4.0 per cent from December 2024 and by 22.8 per cent from December 2021. The number of daily appointments each working weekday with a GP (as opposed to other health professionals) rose by 3.1 per cent from December 2024 to December 2025, to a daily average of 651,000, up by 10.6 per cent since December 2021. The proportion of all general practice appointments that were with GPs was 44.3 per cent in December 2025, marginally down from 44.7 per cent in June 2024 and more significantly down from 49.2 per cent in December 2021.

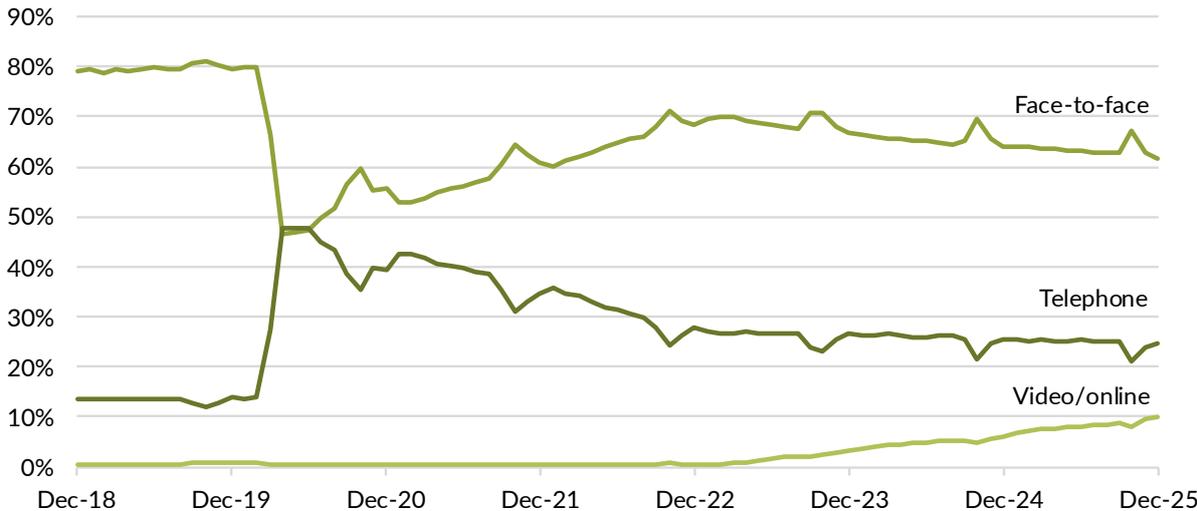
Figure 4.5: Number of appointments per working weekday in general practice, England, 2021 to 2025



Source: NHS England, Appointments in General Practice.

Note: Appointment volumes are influenced by factors other than the number of working weekdays. The data is adjusted for working weekdays in the month, which helps standardise comparisons across months, but underlying daily activity still varies due to seasonal demand, staff availability, appointment mix, and practice-level operational factors. As a result, “appointments per working weekday” will fluctuate month-to-month even after adjusting for working days.

Figure 4.6: Type of GP appointment, England, 2018 to 2025



Source: NHS England, Appointments in General Practice.

Note: Some of the less recent data is taken from previous publications and may have been revised since. Unknown and home visits are not included – they represented less than 5 per cent of appointments in December 2025.

- 4.53 There was a fall in the proportion of appointments that were face-to-face, to 61.5 per cent in December 2025, down from 64.0 per cent in December 2024 and from 79.1 per cent in December 2018. There was an increase in the proportion of online/video appointments, to 10.1 per cent of appointments in December 2025, up from 5.9 per cent in December 2024 and from 0.5 per cent in December 2018. The proportion of telephone appointments fell from 25.5 per cent in December 2024 to 24.7 per cent in December 2025.
- 4.54 The number of open GP practices in England continued to fall, to 6,210 in December 2025, down 0.7 per cent over the year and down 11.4 per cent since December 2018.
- 4.55 The 2025 GP Patient Survey in England showed a modest improvement in patient satisfaction and access to GP services. The proportion of respondents reporting they were satisfied with their GP practice increased slightly, from 74 per cent in 2024 to 75 per cent in 2025.
- 4.56 At 1 July 2025, there were 885 GP practices in Scotland. The number of practices in Scotland decreased by 10.9 per cent, from 994 practices in 2013. The average size of a Scottish GP practice was 6,822 registered patients in 2025, with practice size ranging from under 200 patients for practices in remote locations or those which addressed specific health needs (e.g. patients with challenging behaviours or homelessness), to practices of over 20,000 patients in densely populated urban areas.
- 4.57 The Welsh Government said that access to GP services remained a key public concern and a government priority. Over 360,000 appointments were undertaken in general practices each week, and around 1.5 million every month, representing almost half the population of Wales.
- 4.58 The Welsh Government said that, despite the significant financial resource provided, the long-term sustainability of GMS in Wales remained an ongoing concern. It said it had targeted investment in supplementary services which GPs could receive funding for in addition to the global sum, providing new income streams to support sustainability and embed reform.
- 4.59 The number of GP practices in Wales was 370 on 31 March 2025, four fewer than the year before and 13 fewer than March 2023. The Welsh Government said that contract hand backs and mergers meant there were fewer practices overall, with each typically serving a larger number of patients. This reflected a gradual move away from very small or low-partner practices and towards larger, more sustainable models that could offer a wider range of services from a single location. The Welsh Government said this suggested greater sustainability for practices.
- 4.60 The Welsh Government said that, if a contract was not in place, the local health board could manage a general practice. On 31 March 2025, there were 24 local health board managed practices, one fewer than the year before. These practices employed 77 FTE fully qualified GPs and 417 FTE wider practice staff.
- 4.61 The Welsh Government said that an increasing number of GPs and potential GPs saw the model of practice partnerships as owner-occupiers of premises as being a barrier to continuing to be or becoming a GP. It was working to update the Premises Cost Directions to support investment in GMS facilities across Wales which it said could ultimately improve sustainability and the safety of patients and staff in GP practices.

- 4.62 The BMA said that general practice in Wales was under severe and sustained pressure, driven by chronic underfunding, growing workload, and workforce shortages. It said that financial erosion had led to pay stagnation for GP partners, difficulty in recruiting and retaining staff, and a widespread sense of instability across the sector.
- 4.63 Northern Ireland had 305 active GP practices at 31 March 2025, a reduction of seven practices since 2024 and 45 practices (12.9 per cent) since 2014. The number of GP practices per 100,000 population was 14.8, a decrease of 2.6 per cent from 2024 (15.2 per 100,000 at March 2024) and a 14.5 per cent decrease since 2017.
- 4.64 The Department of Health in Northern Ireland said it had been working with GP federations to explore how they could play a role in the longer-term sustainability of GMS, including moving away from the locum-reliant model that had been in place in some trust-run practices, and implementing a more sustainable salaried GP model.
- 4.65 The Department said that, with ongoing challenges with GP retention and recruitment across Northern Ireland, multi-disciplinary teams were key in helping to meet rising demand. During 2024-25, over 342,000 additional consultations were delivered in general practice settings by multi-disciplinary teams. It was estimated that the multi-disciplinary team programme could provide around a million consultations each year in general practice. Feedback from senior GPs in existing multi-disciplinary team areas indicated that these roles had been critical in stabilising GP services in these areas and averting further practice closures.

GP contracts in England

- 4.66 The 10-year health plan for England said that the status quo of small, independent general practices was struggling to deal with population ageing and rising need. It said that, without economies of scale, many dedicated GPs were finding it difficult to cope with rising workloads. This was causing chronic stress and mental illness.
- 4.67 The 10-year health plan said that, where the traditional GP partnership model was working well it should continue, but an alternative for GPs would be created. Two new contracts for general practice would be rolled out from 2026, to encourage and allow GPs to work over larger geographies and lead new neighbourhood providers.
- 4.68 The first new contract would create single neighbourhood providers that delivered enhanced services for groups with similar needs over a single neighbourhood (around 50,000 people). The 10-year health plan said that, in many areas, the existing PCN footprint was well set up as a springboard for this type of working. The second new contract would create multi neighbourhood providers (250,000+ people). These larger providers would deliver care that required working across several different neighbourhoods (e.g. end of life care).
- 4.69 The DHSC said that these new contracts would exist alongside the current GMS contract. The government had also committed to working with the General Practice Committee (GPC) for England on reform of the GMS contract within this parliamentary cycle. The DHSC said it would also review the Carr-Hill formula to ensure that resources were targeted where they were most needed.
- 4.70 The 10-year health plan also said that GP capacity would be freed up by the use of technology to cut unnecessary administrative and clerical work. Ambient voice technology (AI scribes), digital triage and the Single Patient Record would end the need for tasks such as clinical note taking, letter drafting and manual data entry. It estimated

that saving 90 seconds on each appointment would generate over 2,000 full time equivalent worth of GP capacity.

- 4.71 The BMA said that, under the 10-year health plan, there would be a growing salaried GP workforce, and most GPs would be working for new neighbourhood providers. It pointed out that the ARRS was the first version of neighbourhood general practice.
- 4.72 The BMA said that pay parity with consultants would be a key element of a salaried GP service and that, if GPs were to become centrally employed by the NHS through neighbourhood providers, the terms and conditions of consultants should be applied to these GPs over time. It said that adopting a 10 programmed activities contract, with job plans which carved out clinical and non-clinical time, allocated supervision of resident doctors and other healthcare professionals, and protected continued professional development time, might support greater job satisfaction for GPs.

Contract uplift

- 4.73 The DHSC said that the GP contract uplift initially announced for 2025-26 was £889 million, which assumed pay growth of 2.8 per cent. An additional £80 million was made available as part of the introduction of the advice and guidance service. The DHSC said that the acceptance of our recommendation resulted in a further uplift of £122 million, giving an overall funding increase for general practice of £1,092 million in 2025-26.
- 4.74 The DHSC said that the government usually provided an increase to core funding for GP practices to allow the pay uplift to be passed on to salaried and contractor GPs. It said that the additional funding also allowed general practice contractors to implement pay rises for other general practice staff in line with the uplift.
- 4.75 The BMA said that the GP contract uplift for 2025-26 in England, totalling 9.7 per cent or £1.2 billion at August 2025, was a welcome and urgently needed investment that had helped stabilise general practice in England, bringing total investment in the GP contract from £12.3 billion to £13.5 billion. It said these uplifts must be seen in the context of additional cost pressures and growing patient demand.

GP contracts in Scotland

- 4.76 The Scottish Government said it implemented the DDRB recommendation to uplift GP pay net of expenses by 4 per cent for 2025-26. In total, GP contract funding was increased by £46 million. This included a 4.25 per cent uplift to practice staff expenses (in line with the Agenda for Change uplift), and a 4.5 per cent uplift to wider practice expenses. This included £6.4 million additional funding to cover population growth.
- 4.77 The Scottish Government said it remained committed to progressing phase two of the 2018 GP contract, which included exploring direct reimbursement of practice expenses.
- 4.78 In October 2025, the Scottish Government announced additional recurrent funding for general practice, of £98 million in 2026-27, £183 million in 2027-28, and £249 million in 2028-29.⁴⁶

⁴⁶ Scottish Government, *£531 million investment in General Practice*. <https://www.gov.scot/news/531-million-investment-in-general-practice/>

GP contracts in Wales

- 4.79 The Welsh Government announced an uplift to the GP contract for 2025-26 in December 2025, with increased funding of £37.9 million and the continuation of £4 million capacity funding.⁴⁷ This included:
- A 4 per cent pay uplift (£15.9 million) for GP partners and practice staff.
 - A 1.77 per cent uplift (£2 million) for practice expenses.
 - £20 million additional funding.
- 4.80 The Welsh Government said this guaranteed a 5.8 per cent recurrent funding uplift for the GMS contract from 2026-27. It also announced that a review of the allocation formula of the GMS contract would be undertaken.
- 4.81 The Welsh Government said an ambitious primary care contract reform programme was underway to drive contractual changes to deliver improved services. An established principle was that annual uplifts were linked to progress with contract reform.
- 4.82 GPC Wales had provided evidence to the Senedd Cymru Health and Social Care Committee inquiry into the Future of General Practice.⁴⁸ This included the GPC Wales recommendation that the Welsh Government must consider reforms to the GMS contract annual negotiation process to ensure fair remuneration for GP partners, salaried GPs, and practice staff by instilling a number of principles:
- Dissociation of the annual GP and staff pay awards from wider contractual change.
 - Transfer of work into GMS necessitates transfer of resource.
 - Pay awards to be enabled and protected each year by a sufficient expense uplift, as per the expectations of the DDRB.
 - An ongoing commitment for an index-linked and ringfenced uplift to expenses, and a population growth factor to adjust global sum for local practice populations.

GP contracts in Northern Ireland

- 4.83 The Department of Health in Northern Ireland said that a 4 per cent uplift to GP earnings had been imposed, together with a 4 per cent uplift for staff expenses and a 4.1 per cent uplift for other non-staff expenses.
- 4.84 The Department said that GP practices were required to provide assurance that the funding for staff expenses was used for this purpose and that staff received the full benefit of this uplift. It said that pay uplifts for salaried GPs were an arrangement between the contractor and the salaried GP.

Earnings for contractor GPs

- 4.85 Earnings data for contractor (partner/principal) GPs and salaried GPs comes from His Majesty's Revenue and Customs (HMRC) and the most recent data available is for 2023-24. In 2023-24, average taxable income for contractor GPs increased by 13.2 per cent in England, 7.0 per cent in Scotland, 3.9 per cent in Wales and 5.0 per cent in Northern Ireland.

⁴⁷ Welsh Government, *Written Statement: General Medical Services Contract Reform for 2025-26*. <https://www.gov.wales/written-statement-general-medical-services-contract-reform-2025-26>

⁴⁸ Welsh Parliament, *Inquiry launched into the Future of General Practice in Wales*. <https://senedd.wales/senedd-now/news/inquiry-launched-into-the-future-of-general-practice-in-wales/>

4.86 In 2023-24, pre-tax incomes of contractor GPs in England were higher than in the other nations. Median pre-tax incomes in Scotland, Wales and Northern Ireland were between £108,100 and £121,200, compared with £141,700 in England.

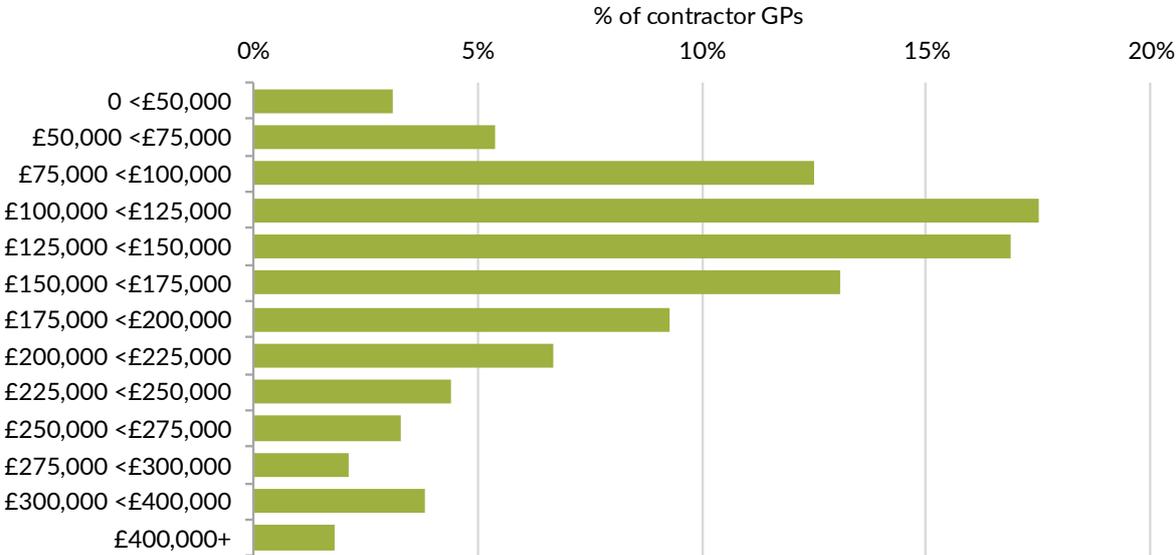
Table 4.5: Contractor GPs pre-tax income, by nation, 2023-24

	England	Scotland	Wales	Northern Ireland
Mean	£158,700	£128,300	£119,800	£113,800
Median	£141,700	£121,200	£113,600	£108,100

Source: NHS England.

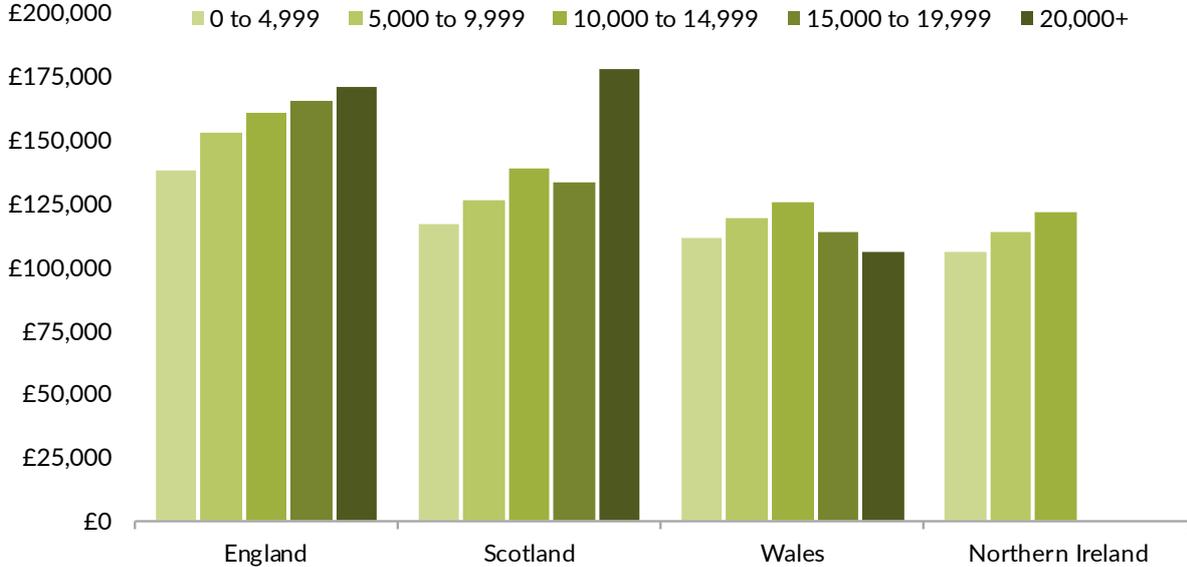
Note: Pre-tax income is gross earnings minus expenses. Income is on a headcount basis, i.e. no adjustment is made for working hours.

Figure 4.7: Distribution of contractor GPs pre-tax income, England, 2023-24



Source: NHS England.

Figure 4.8: Distribution of contractor GPs pre-tax income, by practice size (number of registered patients) and nation, 2023-24



Source: NHS England.

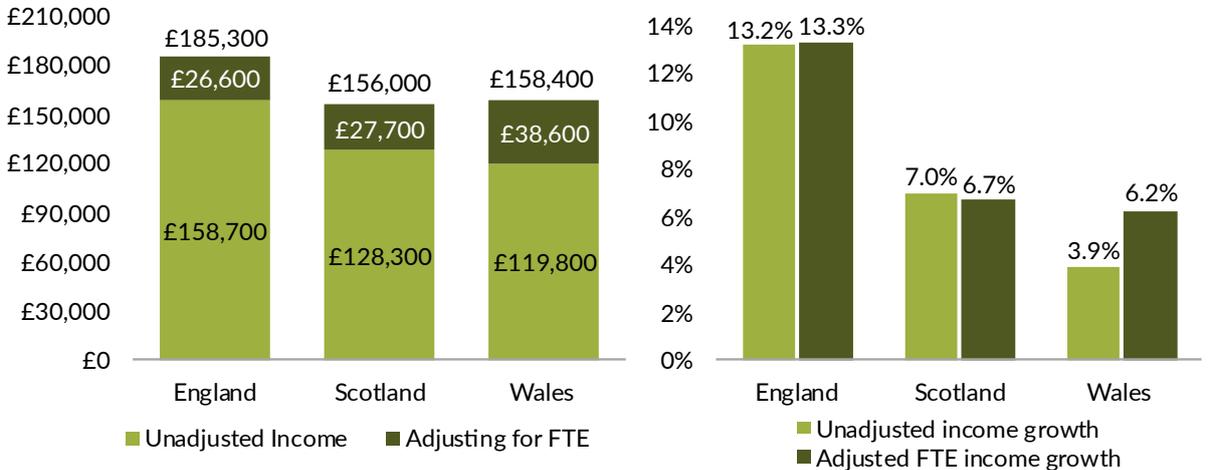
4.87 Contractor GP incomes showed substantial variation within each nation. In England, 31.4 per cent of contractor GPs had pre-tax income above £175,000 in 2023-24. This compared to 11.8 per cent of contractor GPs in Scotland and 6.6 per cent in Northern Ireland. In England, 22.1 per cent of contractor GPs had pre-tax income above £200,000, compared to 6.2 per cent in Wales. In England, 11.0 per cent of contractor GPs had pre-tax income above £250,000.

4.88 Contractor GPs in rural practices had higher pre-tax incomes than urban practices, by 4 per cent in England and Northern Ireland, and by 6 per cent in Wales. There was no difference in Scotland. In England, Scotland and Northern Ireland, contractor GP pre-tax income increased with practice size.

4.89 The pre-tax income estimates are on a headcount basis and take no account of hours worked. The number of FTE contractor GPs in England over 2023-24 was 0.856 of the headcount number of contractor GPs, slightly down from 0.857 a year earlier. Applying this ratio to the average income estimates gives an estimated FTE mean pre-tax income for contractor GPs in England in 2023-24 of £185,300 rather than £158,700 on a headcount basis, a 13.3 per cent increase from 2022-23.

4.90 Applying full-time equivalent adjustments to the pre-tax income estimates for Scotland and Wales gives adjusted mean FTE contractor incomes of £156,000 and £158,400 respectively in 2023-24. These figures represent growth of 6.7 per cent in Scotland and 6.2 per cent in Wales. Contractor GPs in Wales are more likely to work part time, and therefore the adjustment from headcount to FTE results in a larger differential compared with England and Scotland.

Figure 4.9: Unadjusted and FTE adjusted average pre-tax income for contractor GPs and annual growth, England, Scotland, Wales, 2023-24



Source: OPRB calculations. GP FTE is not available for Northern Ireland so an adjustment cannot be applied. It should be noted that the adjustment from headcount to full-time-equivalent is based on NHS hours worked only, while the pre-tax income estimates capture total income from both NHS and private work.

4.91 In nominal terms, contractor GP income has increased across all UK nations since 2012-13, by 51.0 per cent in England, 44.5 per cent in Scotland, 31.6 per cent in Wales and 23.4 per cent in Northern Ireland.

4.92 We have data on GP incomes since 2012-13. In real terms (adjusted for the consumer prices index (CPI)), contractor GP income has grown by 10.9 per cent in England and 6.1 per cent in Scotland since 2012-13 but declined by 3.3 per cent in Wales and by 9.3 per cent in Northern Ireland.

Figure 4.10: Contractor GPs average pre-tax income, nominal and adjusted by CPI, by nation, 2012-13 to 2023-24



Source: NHS England.

Note: Income is on a headcount basis, i.e. no adjustment is made for working hours.

4.93 The DHSC said in oral evidence that the increase in partner earnings in 2023-24 was unexpectedly high. The reasons for this were thought to be:

- Increases in unconditional income streams, e.g. capacity and access funding.
- List growth inflation of £62 million, with practice size list growth above population growth, which drove global sum payments.
- A discrepancy between partner and salaried earnings growth, with practices only passing on 4.3 per cent of the 6 per cent uplift.
- Falls in the number of GP partners, so there were fewer to share the profits.
- A notable increase in the proportion of partners who earned over £225,000, from 8.6 per cent in 2022-23 to 15.4 per cent in 2023-24.

4.94 The Welsh Government said that the fall in real terms average earnings for GP partners, for the third consecutive year, reflected the sustainability challenges. It said it underlined a growing disparity between employed and risk-bearing GPs, with potential implications for the attractiveness of partnership roles.

4.95 The BMA said that underfunded contract uplifts in Wales meant that the DDRB recommendation for GP partner pay could not be realised.

4.96 We recommended a 6.0 per cent uplift for contractor GPs for 2023-24. Earnings growth for contractor GPs each year does not align with our recommendation. Average pre-tax incomes for contractor GPs generally grew by more than the DDRB recommendation between 2016-17 and 2021-22 in England and Scotland and were broadly in line in Wales and Northern Ireland. Each of the four nations had different measures in place to mitigate the impacts of COVID-19 and varied the extent to which GP contractors were involved with and reimbursed for providing vaccination programmes. This affected earnings growth in the period from 2020-21 to 2022-23.

Table 4.6: GP contractors' changes to average pre-tax income compared with DDRB recommendations, by nation, 2016-17 to 2023-24

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	Increase over the period
DDRB recommendation	1.0%	1.0%	2.0%	2.5%	2.8%	3.0%	4.5%	6.0%	25%
England	4.5%	3.5%	3.4%	3.8%	16.6%	8.0%	-8.6%	13.2%	51%
Scotland	1.5%	2.5%	8.8%	4.7%	8.8%	3.6%	0.4%	6.9%	43%
Wales	3.3%	3.4%	6.4%	2.4%	12.6%	-5.4%	-0.5%	3.9%	28%
Northern Ireland	-1.6%	3.2%	-1.2%	7.9%	12.4%	2.7%	-5.8%	5.1%	24%

Note: From 2019-20 to 2023-24, GP contractors were outside the DDRB remit and covered by a multi-year agreement.

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

Earnings for salaried GPs

4.97 Earnings data for salaried GPs comes from HMRC and the most recent data available is for 2023-24. In 2023-24, average pre-tax income for salaried GPs grew by 4.3 per cent in England, by 2.3 per cent in Scotland, by 8.7 per cent in Wales, and by 9.3 per cent in Northern Ireland. Earnings for salaried GPs showed much less variation by nation than contractor GPs.

Table 4.7: Salaried GPs pre-tax income, by nation, 2023-24

	England	Scotland	Wales	Northern Ireland
Mean	72,200	76,500	77,800	69,000
Median	67,900	70,200	69,500	66,800

Source: NHS England.

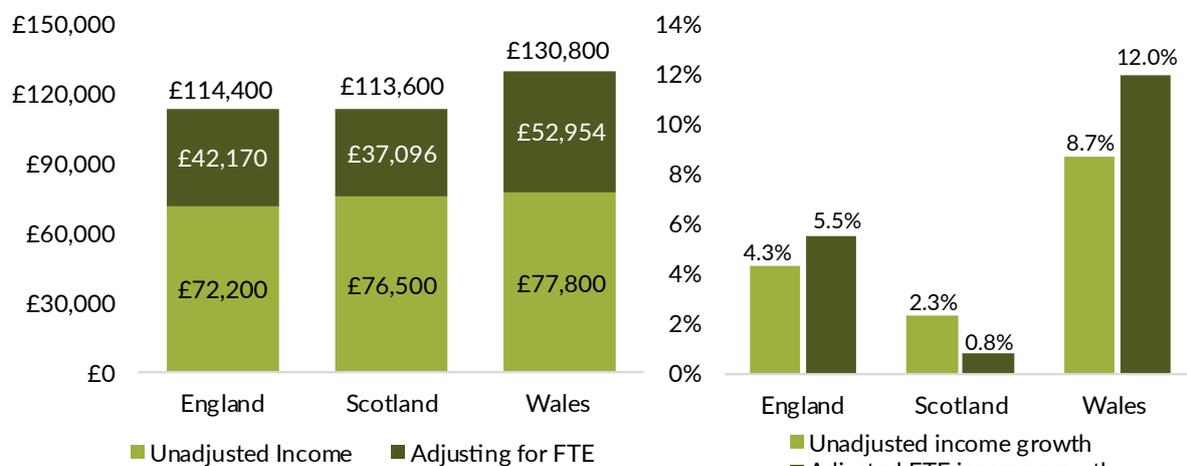
Note: Pre-tax income is gross earnings minus expenses. Income is on a headcount basis, i.e. no adjustment is made for working hours.

4.98 The pre-tax income estimates are on a headcount basis and do not take account of hours worked. The number of FTE salaried GPs in England in 2023-24 was 0.631 of the headcount number, down from 0.638 in 2022-23. Applying this ratio to average income gives an estimated FTE mean pre-tax income for salaried GPs in England of £114,400, rather than £72,200 on a headcount basis, a 5.5 per cent increase from 2022-23.

4.99 Adjusting the pre-tax income estimates for salaried GPs for full-time equivalence gives adjusted mean FTE incomes of £113,600 in Scotland and £130,800 in Wales in 2023-24. This indicates annual growth of 0.8 per cent in Scotland and 12.0 per cent in Wales.

Salaried GPs in Wales showed the largest differential following FTE adjustment, reflecting a higher prevalence of part-time working than in England or Scotland.

Figure 4.11: Unadjusted and FTE-adjusted average pre-tax income for salaried GPs and annual growth, England, Scotland, Wales, 2023-24



Source: OPRB calculations. GP FTE is not available for Northern Ireland so an adjustment cannot be applied.

Figure 4.12: Salaried GPs average pre-tax income, nominal and adjusted by CPI, by nation, 2012-13 to 2023-24



Source: NHS England.

Note: Income is on a headcount basis, i.e. no adjustment is made for working hours.

4.100 In nominal terms, mean salaried GP income has increased across all UK nations since 2012-13, by 43.8 per cent in Wales, 41.1 per cent in Scotland and 27.6 per cent in England. Average salaried GP income in Northern Ireland has increased by 45.9 per cent since 2015-16.

4.101 In real terms (adjusted for CPI), salaried GP income has increased since 2012-13 by 5.6 per cent in Wales and by 3.7 per cent in Scotland but declined by 6.4 per cent in England. In Northern Ireland, real average salaried GP income has increased by 10.9 per cent since 2015-16.

4.102 For salaried GPs, most earnings come from employment, making up between 76 and 87 per cent of gross income across the four nations. Pre-tax income from employment has grown faster than total income, as self-employment earnings (from locum, out of hours, private work etc) have remained stable or declined. Most expenses are linked to self-employment, with self-employed work accounting for over 70 per cent of total expenses in all nations.

Table 4.8: Salaried GPs earnings and expenses, self-employed and employment earnings, by nation, 2023-24

	Income measure	England	Scotland	Wales	Northern Ireland
Gross earnings	Total	£82,400	£83,500	£83,500	£76,900
	Employed	£62,800	£67,900	£72,900	£63,200
	Self employed	£19,600	£15,600	£10,700	£13,700
	Employed as % of total	76%	81%	87%	82%
Expenses	Total	£10,200	£7,100	£5,800	£7,900
	Employed	£1,000	£1,000	£1,300	£2,400
	Self employed	£9,200	£6,100	£4,500	£5,500
	Employed as % of total	10%	14%	22%	30%
Pre-tax income (gross earnings minus expenses)	Total	£72,200	£76,500	£77,800	£69,000
	Employed	£61,800	£66,900	£71,600	£60,800
	Self employed	£10,400	£9,500	£6,100	£8,200
	Employed as % of total	85%	87%	92%	88%
Pre-tax income, change between 2022-23 and 2023-24	Total	4.3%	2.3%	8.7%	9.3%
	Employed	5.3%	2.8%	9.6%	9.0%
	Self employed	-1.0%	-1.0%	-3.2%	12.3%

Source: NHS England.

Pay uplifts for salaried staff

4.103 We recommended a 6.0 per cent increase to the minimum and maximum of the salaried GP salary range for 2023-24 in each nation. The growth in salaried GP average income in England and Scotland has been close to the total DDRB recommendation of 25 per cent since 2016-17. Northern Ireland and Wales have seen higher growth, of 46 per cent and 50 per cent respectively.

Table 4.9: Salaried GPs' changes to average pre-tax income compared with DDRB recommendations, by nation, 2016-17 to 2023-24,

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	Increase over the period
DDRB recommendation	1.0%	1.0%	2.0%	2.5%	2.8%	3.0%	4.5%	6.0%	25%
England	1.3%	3.2%	3.8%	5.0%	2.0%	4.8%	1.8%	4.3%	29%
Scotland	6.9%	1.8%	3.5%	1.2%	9.7%	-0.6%	3.9%	2.4%	32%
Wales	3.9%	-3.0%	12.1%	4.1%	8.1%	7.2%	1.6%	8.8%	50%
Northern Ireland	16.9%	2.5%	-2.8%	2.5%	8.5%	-4.4%	7.7%	9.4%	46%

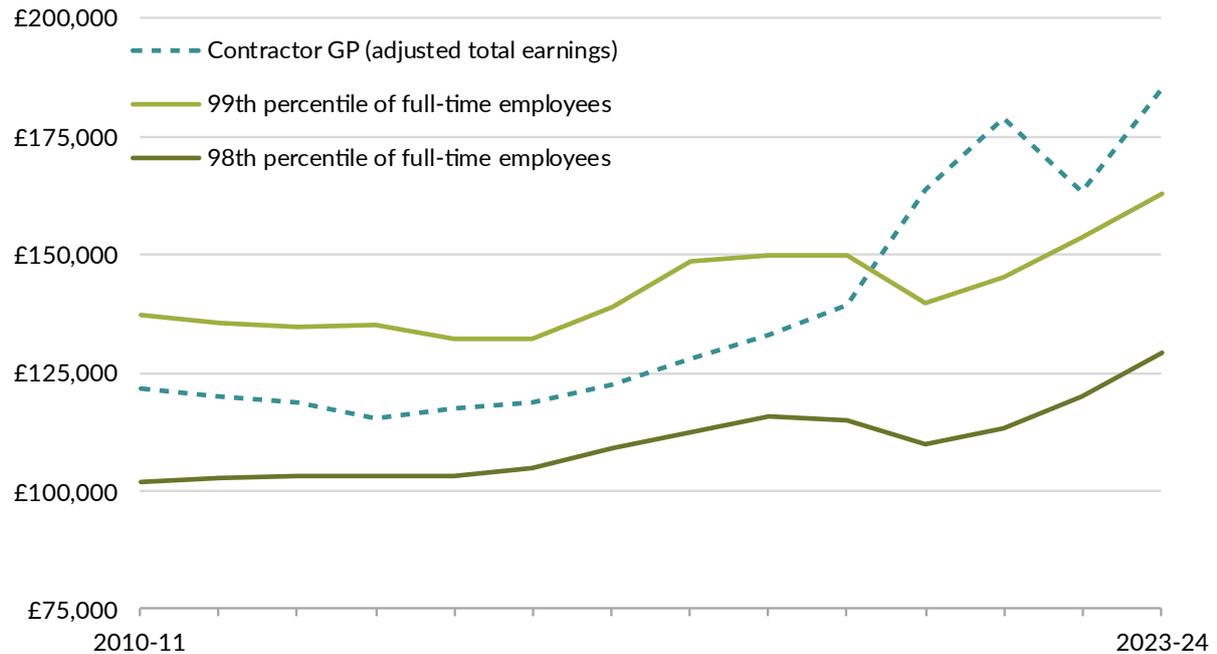
Note: The cell is shaded green when average income grew by less than the DDRB recommendation.

- 4.104 The Sessional GPs Committee said it heard reports each year about practices failing to pass on the DDRB's recommended uplift, despite the salaried GP being entitled to the pay award in their employment contract. Practices reported that they were unable to pass on the uplift in full due to insufficient funding.
- 4.105 The BMA said that there needed to be greater accountability on behalf of practices in passing on the DDRB uplift to their salaried GP employees. It said it was increasingly frustrating that the change in employed earnings of salaried GPs was consistently below the recommended uplift. It said that failure to pass on the uplift in full meant that salaried GPs fell further behind their secondary care colleagues.
- 4.106 The BMA noted that the GMS contract in Wales required practices to provide confirmation to their local health board that they had passed on the DDRB uplift to practice staff, or the practices risked having the funding for the staff pay award within the global sum clawed back. A similar mechanism existed in Northern Ireland, where practices were required to provide assurance that staff received the full benefit of the DDRB uplift. Where practices did not fully implement the uplift, the funds would be recovered.
- 4.107 The BMA said that, in Wales and Northern Ireland, where a recovery mechanism existed, salaried GPs on average received at least the DDRB uplift. In England and Scotland, where no clawback mechanism existed, salaried GPs did not receive the DDRB uplift. It said it was imperative that the UK and Scottish Governments introduced a recovery mechanism which ensured that practices used the funding provided as intended, for staff pay uplifts.
- 4.108 The Royal College of Nursing (RCN) wrote to us in October to say that its survey of members employed in general practice in February 2025 showed that three in 10 respondents in England reported receiving no pay rise in 2024-25. Fewer than one in five (18.9 per cent) had received the full 6 per cent uplift. The RCN said that a third of respondents employed directly by practices in Scotland reported receiving either no award or an increase below 5 per cent, despite a centrally funded 5.5 per cent uplift.
- 4.109 The DHSC said that the salary element of the maximum reimbursement amount that PCNs could claim for GPs through the ARRS was increased from £73,113 in 2024-25 (the bottom of the salaried GP pay range) to £82,418 (the lower quartile of the salaried GP pay range, an uplift of £9,305). The DHSC said this reflected that some GPs would be entering their second year in the scheme. This amount was subsequently increased to £85,715 following our 2025 recommendation.

Pay comparability

4.110 After adjusting for full-time equivalence, estimated average earnings per FTE for contractor GPs in England were between the 98th and 99th percentiles of all full-time employee earnings between 2010-11 and 2019-20, but moved above the 99th percentile in 2020-21, and have remained above since then. In Scotland and Wales, estimated average earnings per FTE for contractor GPs were between the 98th and 99th percentiles in 2023-24. FTE earnings data for Northern Ireland is not available.

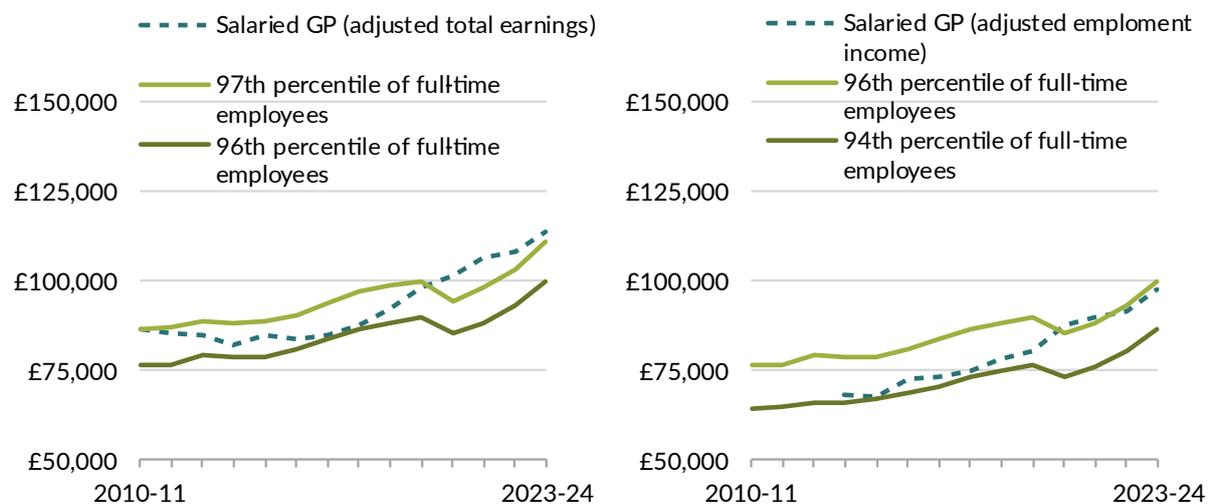
Figure 4.13: Average FTE earnings of contractor GPs, England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2023-24



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

Note: GP earnings are adjusted for full-time equivalence.

Figure 4.14: Average FTE earnings of salaried GPs, England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2023-24

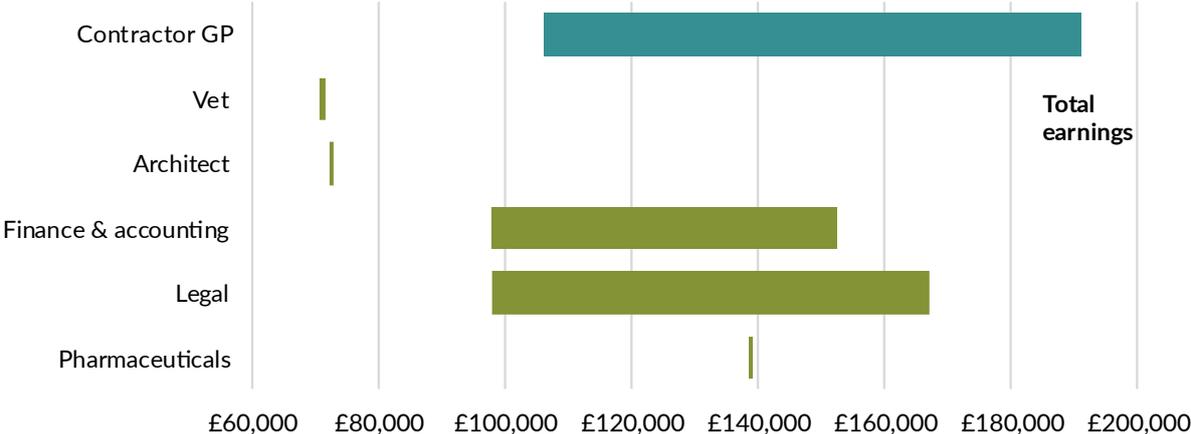


Source: OPRB analysis of data from NHS England and ONS.

Note: GP earnings are adjusted for full-time equivalence.

4.111 Average full-time equivalent earnings for salaried GPs in England (including employment and self-employment income) were at the 97th percentile of UK average full-time earnings in 2010-11. This fell to the 96th percentile for much of the following decade before returning to the 97th percentile in 2019-20. In Scotland, estimated average earnings per FTE for salaried GPs were between the 97th and 98th percentiles in 2023-24. In Wales, estimated average earnings per FTE for salaried GPs were just above the 98th percentile. FTE earnings data for Northern Ireland is not available.

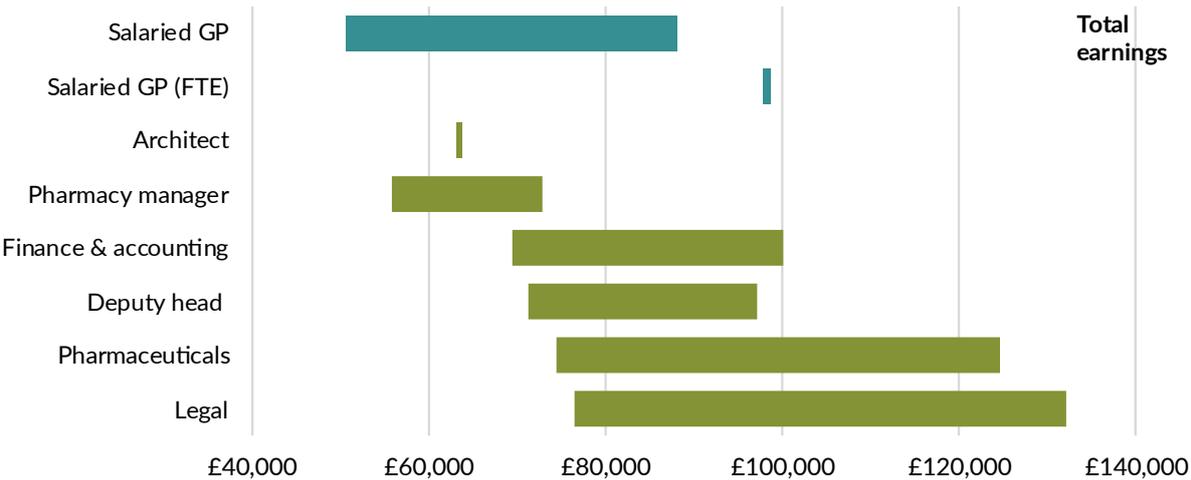
Figure 4.15: Total earnings of contractor GPs, England, and market comparators, 2025



Sources: GP earnings and expenses, interquartile range of pre-tax income. Finance & accounting, legal, pharmaceuticals (R&D) – Korn Ferry level 20, interquartile range. Architect – Architects Earnings, principal in partnership I, less than 20 years’ experience, London, median. Vet – SPVS 2025, Vet, 10 to 15 years’ qualified, median.

Notes: Pay for comparator professions is on an FTE basis, while contractor GP earnings are on a headcount basis and are therefore lower than they would be on an FTE basis. GP earnings are from 2023-24, while comparator earnings are from 2025. See appendix E for more details.

Figure 4.16: Median total earnings of salaried GPs, England, and market comparators, 2025



Sources: GP earnings and expenses, inter-quartile range of pre-tax income and average pre-tax income from employment only adjusted for average full-time equivalence. Finance & accounting, legal, pharmaceuticals (R&D) – Korn Ferry level 18, interquartile range. Pharmacy – IDR bespoke survey, pharmacy manager, interquartile range. Architect – Architects Earnings, private practice associate, London (median). Teaching – deputy head pay range. Vet – SPVS 2025, Vet, seven years qualified (median).

Notes: Pay for comparator professions is on an FTE basis, while GP earnings are on both a headcount basis and an FTE basis. The FTE adjustment (0.631) uses average earnings from employment only. GP earnings are from 2023-24, while comparator earnings are from 2025. See appendix E for more details.

4.112 Estimated FTE average earnings for salaried GPs from employment only were above the 94th percentile of all full-time employee earnings in 2013-14, the first year data broken down in this way were available, and have been at around the 96th percentile since 2020-21.

4.113 Comparisons for GPs with other professions focus on total earnings. Contractor GP earnings are ahead of all comparator roles. This is without adjusting for full-time equivalence.

4.114 Earnings for salaried GPs are behind or in line with comparator roles. When an adjustment is made for full-time equivalence, salaried GP earnings are in line with or ahead of comparators.

GP earnings by gender

4.115 Average pre-tax incomes of female contractor GPs were lower than those of male contractor GPs in each nation in 2023-24, by 22 per cent in Northern Ireland, 21 per cent in Wales, 19 per cent in Scotland and 18 per cent in England. The income gap narrowed over time in England, Scotland and Northern Ireland but remained the same in Wales. This data does not adjust for differences in working hours.

Table 4.10: Contractor GPs average pre-tax income, by gender and nation, 2017-18 to 2023-24

		2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
England	Male	£125,600	£130,000	£134,300	£156,100	£168,100	£153,700	£173,900
	Female	£97,300	£101,200	£106,400	£125,200	£136,300	£124,800	£142,100
	Difference	-23%	-22%	-21%	-20%	-19%	-19%	-18%
Scotland	Male	£107,800	£117,200	£120,800	£131,400	£135,900	£135,000	£144,200
	Female	£80,800	£88,700	£94,400	£103,200	£107,300	£108,600	£116,700
	Difference	-25%	-24%	-22%	-21%	-21%	-20%	-19%
Wales	Male	£111,000	£118,800	£122,300	£135,600	£130,400	£129,400	£134,800
	Female	£87,700	£93,300	£96,100	£109,100	£103,200	£102,900	£106,300
	Difference	-21%	-21%	-21%	-20%	-21%	-20%	-21%
Northern Ireland	Male	£107,900	£104,500	£113,800	£126,500	£128,900	£124,100	£130,500
	Female	£79,600	£81,400	£87,400	£100,000	£103,300	£96,000	£101,300
	Difference	-26%	-22%	-23%	-21%	-20%	-23%	-22%

Source: OPRB analysis of data from NHS England.

Note: Does not adjust for working hours.

The differences quantify the gender pay gap as a percentage difference from the male earnings baseline. For example, a figure of -18 per cent signifies that female doctors earn 18 per cent less than their male counterparts in that category.

4.116 Average pre-tax incomes of female salaried GPs were also lower than those of male salaried GPs in each nation in 2023-24, by 27 per cent in Northern Ireland and Wales, 23 per cent in Scotland, and 21 per cent in England. The income gap narrowed since 2017-18 in England, Scotland and Northern Ireland but increased over the same period in Wales. This data does not adjust for differences in working hours.

Table 4.11: Salaried GPs average pre-tax income, by gender and nation, 2017-18 to 2023-24

		2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
England	Male	£75,100	£76,900	£79,800	£81,100	£83,100	£83,800	£85,300
	Female	£52,600	£55,000	£58,000	£59,200	£62,500	£63,700	£67,000
	Difference	-30%	-28%	-27%	-27%	-25%	-24%	-21%
Scotland	Male	£85,200	£85,900	£85,400	£93,000	£89,200	£92,300	£92,500
	Female	£55,800	£57,000	£58,600	£65,000	£66,900	£69,600	£71,500
	Difference	-35%	-34%	-31%	-30%	-25%	-25%	-23%
Wales	Male	£62,800	£68,200	£72,800	£80,500	£84,300	£95,100	£95,800
	Female	£49,200	£55,700	£57,800	£61,100	£65,400	£64,400	£69,900
	Difference	-22%	-18%	-21%	-24%	-22%	-32%	-27%
Northern Ireland	Male	£92,900	-	£70,100	£85,100	£83,500	£83,900	£87,400
Ireland	Female	£51,800	£51,500	£53,900	£55,400	£52,300	£59,200	£63,600
	Difference	-44%	-	-23%	-35%	-37%	-29%	-27%

Source: OPRB analysis of data from NHS England.

Note: Does not adjust for working hours.

The differences quantify the gender pay gap as a percentage difference from the male earnings baseline. For example, a figure of -21 per cent signifies that female doctors earn 21 per cent less than their male counterparts in that category.

Expenses

4.117 In 2023-24, expenses accounted for: 72 per cent of gross earnings for contractor GPs in England; 69 per cent in Wales; 59 per cent in Northern Ireland; and 58 per cent in Scotland. The different funding arrangements for GMS across the four nations will account for some of the differences in gross earnings and expenses. Expenses increased over the year, by 17 per cent in England, 15 per cent in Wales, 14 per cent in Scotland and 7 per cent in Northern Ireland. Employee costs were the largest single category, accounting for between 59 per cent (Northern Ireland) and 73 per cent (Scotland) of all expenses.

Table 4.12: Contractor GPs average gross earnings, expenses and pre-tax income, 2023-24

	England	Scotland	Wales	Northern Ireland
Average gross earnings	£575,900	£306,600	£381,400	£274,300
Average expenses	£417,200	£178,300	£261,600	£160,500
Average income before tax	£158,700	£128,300	£119,800	£113,800
Expenses as % of gross earnings	72%	58%	69%	59%

Source: NHS England.

4.118 In England, average gross expenses for contractor GPs increased by 17 per cent (£62,000) in 2023-24 compared with the previous year, representing the largest annual increase in the series, which begins in 2012-13. Despite this, contractor GPs in England experienced an increase in income before tax, reflecting a 16 per cent (£80,500) increase in gross earnings over the year. Across all four nations, while expenses rose sharply, the increase in gross earnings was sufficient to more than offset higher costs, resulting in higher income before tax.

4.119 The Welsh Government said that the main drivers of the 15 per cent increase in costs in 2023-24 were: staff costs, rising 15.3 per cent, reflecting both the mandated

replication of GP pay uplifts for all staff and statutory minimum wage increases; interest costs, which grew by 68 per cent in the year, as practices faced significantly higher borrowing and mortgage repayments during the interest rate spike; premises costs, up 12 per cent, with inflationary pressures in utilities, insurance, and maintenance; fuel and travel costs, up 14 per cent, reflecting wider energy price volatility; and other operating costs (supplies, contracted services) also growing faster than general inflation.

4.120 The Welsh Government said that, with over two-thirds of contract income consumed by expenses, and with partners personally liable for financial risks, practices had limited scope to absorb further external pressures. It said that the combination of rising costs and falling real-terms income highlighted the growing sustainability challenge in Wales.

Motivation, morale and wellbeing

4.121 In the 2024 GP Worklife Survey in England, 58 per cent of GPs reported being satisfied with their job. Overall job satisfaction had remained stable since 2019, but there were declines in satisfaction with pay and with the opportunity for GPs to use their abilities.

4.122 The most prevalent job stressors were increasing workloads and managing patients waiting for hospital treatment, with 81 per cent of respondents reporting considerable or high pressure in both these areas. Job stress levels had eased in most areas since 2019, with notable reductions in pressure related to increasing workloads and long working hours. However, stress linked to adverse publicity in the media had increased.

4.123 The DHSC said that 33 ICSs participated in the second year of the general practice staff survey in 2024, and nearly 25 per cent of practices in those systems shared staff lists. This created a survey sample of more than 1,700 organisations and 46,849 individuals, 38 per cent of whom completed the survey. The DHSC said it expected the sample size and response rate to grow. Results for the general practice staff survey were not publicly available, but the DHSC shared some findings.

4.124 The DHSC said that the average staff engagement score for doctors 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. Overall, 63.4 per cent of doctors in GP practices were satisfied with recognition for good work. Trainee GPs had the highest score in this area, at 76.1 per cent, and locums had the lowest score, at 52.8 per cent.

4.125 In total, 53.2 per cent of all doctors working in general practice were satisfied with their level of pay. Locums had the greatest levels of satisfaction with pay, at 59.7 per cent, and trainee GPs had the lowest satisfaction with pay, at 39.0 per cent.

4.126 The GPC Wales Workforce, Workload and Wellbeing survey from April 2025 showed that nearly nine out of 10 GPs (88 per cent) expressed concerns for their personal wellbeing due to workload, with 89 per cent believing that patient care was occasionally (50 per cent) or routinely (39 per cent) compromised as a result. In addition, 70 per cent of survey respondents were very worried about costs such as employer national insurance contributions and statutory wage increases. Around 95 per cent were worried about the impact of workload on their practice's sustainability.

Our comments

GP workforce

- 4.127 There has been some growth in the GP workforce over the last year, but this is concentrated among salaried GPs, with the number of GP partners falling. The workforce growth is substantially below that seen in secondary care. However, it has enabled the number of GPs per 100,000 registered patients to improve in England and Wales over the last two years. This has been stable in Scotland and Northern Ireland, but at a notably higher ratio.
- 4.128 There has undoubtedly been a substantial shift in the GP labour market over the last two years. Information published by NHS England on GP job vacancies is a valuable addition to the evidence base, especially in the light of concerns about lack of GP jobs. It would be helpful to break this data down further; for example by type of GP role i.e. partner/salaried/locum, or the number of sessions available. The number of GP job adverts in England increased in 2025-26, but to only just over half of the level seen in 2022-23. The GP vacancy rate halved in Scotland between 2023-24 and 2024-25. The evidence indicates that GP practices in England have been using funding from the ARRS to recruit GPs since 2024 rather than using core funding.
- 4.129 The evidence of under-employment among recently qualified GPs, despite overall workforce growth, indicates that workforce planning for general practice requires much greater consideration, including the appropriate skill mix in general practice and the best way of funding this.
- 4.130 On our visits we have seen good examples of GPs working in secondary care. Parties need to consider whether the very different pay systems for GPs and for doctors in secondary care are suitable for supporting this kind of work. Furthermore, the proposed move to care in the community, and large-scale neighbourhood contracts, may require a different type of pay structure, with more direct employment of GPs, and with GPs and consultants working together.
- 4.131 Despite workforce growth and the expansion of GP training, there are still concerns about the recruitment and retention of GPs in rural, remote and deprived areas. Work has been done on this in Scotland, with initiatives including fellowship programmes, retention initiatives, leadership training, and golden hellos, which could be used by other nations. The current review of the effectiveness of financial incentives in supporting GP recruitment and retention in Scotland will be valuable.

GP earnings and expenses

- 4.132 The earnings and expenses position of GPs varies significantly across the nations. In the most recent year, to 2023-24, GP contractors saw increases in average pre-tax incomes of between 3.9 per cent in Wales and 13.2 per cent in England. These outcomes reflect many different factors, such as contract funding, costs, service provision, and the population of practices, with a shift to larger practices. Our pay recommendation is only one small part of this and has a limited impact on the out-turn in earnings growth. Average earnings growth for salaried GPs in 2023-24 also showed a wide range, from 2.3 per cent in Scotland to 9.3 per cent in Northern Ireland.
- 4.133 Last year we recommended that the four governments work with GPs' representatives to develop an index of general practice costs. We said that this index should then be used to determine the expenses element of the GP contract uplift in each nation. An

effective uplift mechanism, related to the actual costs of general practice, is necessary to ensure both the sustainability of services and value for money. Our comments on this are set out in chapter 1, and we will continue to keep it under review.

Chapter 5 HCCHS workforce issues

- 5.1 Hospital and Community Health Service (HCCHS) doctors and dentists are those directly employed by NHS trusts and foundation trusts in England, NHS boards in Scotland, health boards in Wales, and HSC trusts in Northern Ireland. This includes resident doctors and dentists,⁴⁹ specialty, associate specialist and specialist (SAS) doctors and dentists, and consultants, as well as doctors and dentists employed on local contracts. Salaried dentists working in the Community Dental Services or Public Dental Services, most of whom are also part of the HCCHS workforce, are discussed in chapter 3.
- 5.2 This chapter looks at trends in the HCCHS medical and dental workforce, recruitment and retention indicators, training, flexible pay premia, and motivation and morale. Our comments on the data and evidence are at the end of the chapter. Chapter 6 looks at developments for specific parts of the HCCHS workforce.

Workforce

- 5.3 The full-time equivalent (FTE) medical and dental HCCHS workforce has shown strong recent growth, increasing by between 3.4 per cent (in Scotland) and 4.7 per cent (in Northern Ireland) over the last year. This follows on from consistent workforce growth over the last five years, by between 15.7 per cent (in Scotland) and 24.4 per cent (in England).

Table 5.1: HCCHS doctors and dentists, by nation, FTE, 2025

	England	Scotland	Wales	Northern Ireland
Total	153,619	16,672	8,886	5,218
<i>Annual change</i>	+4.3%	+3.4%	+3.7%	+4.7%
<i>Five-year change</i>	+24.4%	+15.7%	+23.2%	+15.9%
Resident doctors	78,330	7,325	4,607	2,294
<i>Annual change</i>	+4.2%	+4.5%	+3.0%	+6.1%
<i>Five-year change</i>	+28.2%	+15.8%	+28.0%	+14.3%
SAS doctors and dentists	13,143	1,312	1,054	632
<i>Annual change</i>	+6.5%	+3.6%	+6.5%	+2.2%
<i>Five-year change</i>	+32.6%	+8.9%	+31.1%	+20.0%
Consultants	60,585	6,308	3,131	2,071
<i>Annual change</i>	+4.0%	+2.0%	+4.0%	+2.9%
<i>Five-year change</i>	+18.6%	+10.6%	+16.0%	+14.8%

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

Notes: Data for England is from November 2025. Data for Scotland is from September 2025. Data for Wales is from September 2025. Data for Northern Ireland is from March 2025 as the workforce breakdown is only published once a year. Figures may not sum to total as "other" categories are excluded from the table.

- 5.4 Participation rates among the HCCHS workforce in England (the ratio of FTE to headcount) remained high, at 93 per cent in 2025 (95 per cent for men and 91 per cent for women), one percentage point lower than in 2015. This indicates that there has not been a large increase in part-time working.

⁴⁹ This group encompasses foundation doctors and dentists, core and specialty trainees, and locally employed doctors/resident doctors not in training on equivalent national contracts.

Table 5.2: Participation rates of HCHS doctors and dentists, England, November 2025

	Participation rate (ratio of FTE to headcount)			Percentage point change Since 2015		
	All	Male	Female	All	Male	Female
All HCHS doctors	93%	95%	91%	-1%	-1%	0%
Consultant	92%	94%	90%	-3%	-3%	-1%
Associate specialist	89%	93%	83%	0%	-1%	3%
Specialty doctor	89%	94%	83%	4%	3%	7%
Staff grade	92%	94%	90%	8%	4%	16%
Specialty registrar	95%	97%	92%	-2%	-2%	-1%
Core training	97%	98%	96%	-1%	-1%	-2%
Foundation doctor year 2	99%	99%	98%	-1%	-1%	-1%
Foundation doctor year 1	99%	99%	99%	0%	0%	0%
Hospital practitioner/ clinical assistant	37%	38%	36%	9%	11%	8%
Other and local grades	61%	61%	62%	-4%	-1%	-5%

Source: NHS England

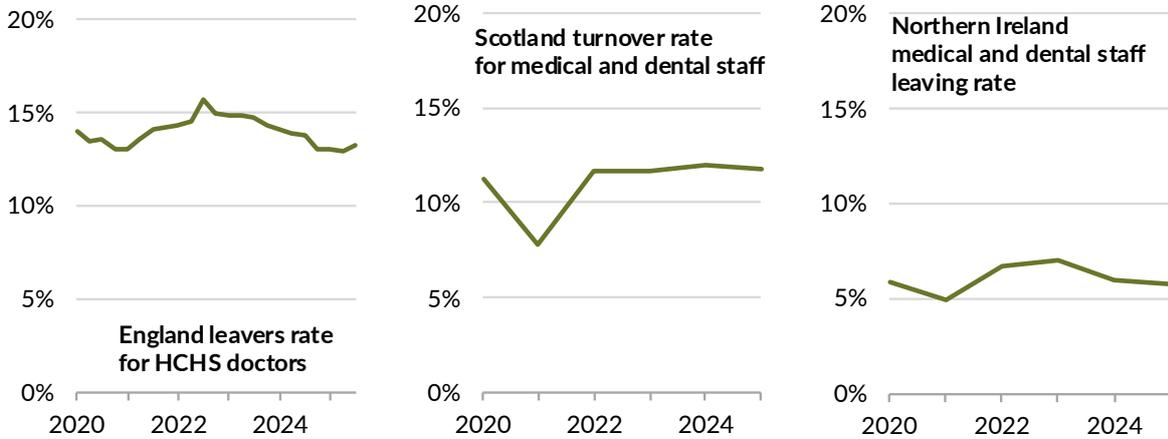
Notes: Data for 2015 for men and women are from September 2015.

5.5 The Department of Health and Social Care (DHSC) noted that medical workforce growth in 2024-25 remained significantly above the non-medical workforce. It expected slower workforce growth over the next couple of years. It said the growth in medical workforce in 2024-25 was driven mainly by increased numbers of domestically trained doctors, while the number of internationally recruited doctors remained similar to the 2023-24 level.

Recruitment and retention

5.6 Turnover rates for medical and dental staff fell in England over the last year, were broadly stable in Scotland and Northern Ireland, and rose in Wales.

Figure 5.1: Leaving/turnover rates for medical and dental staff, England, Scotland and Northern Ireland, 2020 to 2025



Source: NHS England; NHS Education for Scotland; Department for Health, Northern Ireland.

Note: The leaving rate for Northern Ireland excludes resident doctors.

- 5.7 The leaving rate for all hospital and dental staff in England was 13.2 per cent in the year to September 2025, down from 13.8 per cent a year earlier.⁵⁰ The stability index, which measures the percentage of staff employed at both the start and end of the period, was 86.5 per cent in September 2025, up from 85.9 per cent a year earlier.
- 5.8 The leaving rate for consultants in England was 4.2 per cent in the year to September 2025, down from 4.5 per cent a year earlier, and the lowest rate for over a decade. The leaving rate for specialists/associate specialists was 5.2 per cent in the year to September 2025, up from 4.0 per cent a year earlier. The leaving rate for specialty doctors was 6.1 per cent in the year to September 2025, down from 7.3 per cent a year earlier, and the lowest rate for over a decade.
- 5.9 Leaving rates for HCHS doctors in England did not show significant variation by region, ranging from 11.9 per cent in the South East to 13.9 per cent in the in the year to September 2025.

Figure 5.2: Leaving rates, consultants, specialists and specialty doctors, England, 2020 to 2025



Source: NHS England.

- 5.10 The turnover rate for medical and dental staff overall in Scotland has been broadly stable over the last three years, at 11.8 per cent in 2024-25, compared to 12.0 per cent in 2023-24. The turnover rate for consultants in Scotland was 4.5 per cent in 2024-25, compared to 4.3 per cent in 2023-24. The turnover rate for SAS doctors in Scotland was 9.3 per cent in 2024-25, down from 10.9 per cent in 2023-24.
- 5.11 The turnover rate for medical and dental staff in Wales was 12.3 per cent in March 2025, up from 11.1 per cent in March 2024. The turnover rate in the year to March 2025 was 3.3 per cent for consultants and 10.5 per cent for SAS doctors.
- 5.12 The leaving rate for medical and dental staff (excluding resident doctors) in Northern Ireland was 5.7 per cent in the year to March 2025, down from 6.0 per cent in March 2024. Consultants in Northern Ireland had a leaving rate of 4.4 per cent in the year to March 2025, down from 5.3 per cent in March 2024, and broadly unchanged from the rate of 4.3 per cent in March 2019. SAS doctors had a leaving rate of 7.8 per cent in

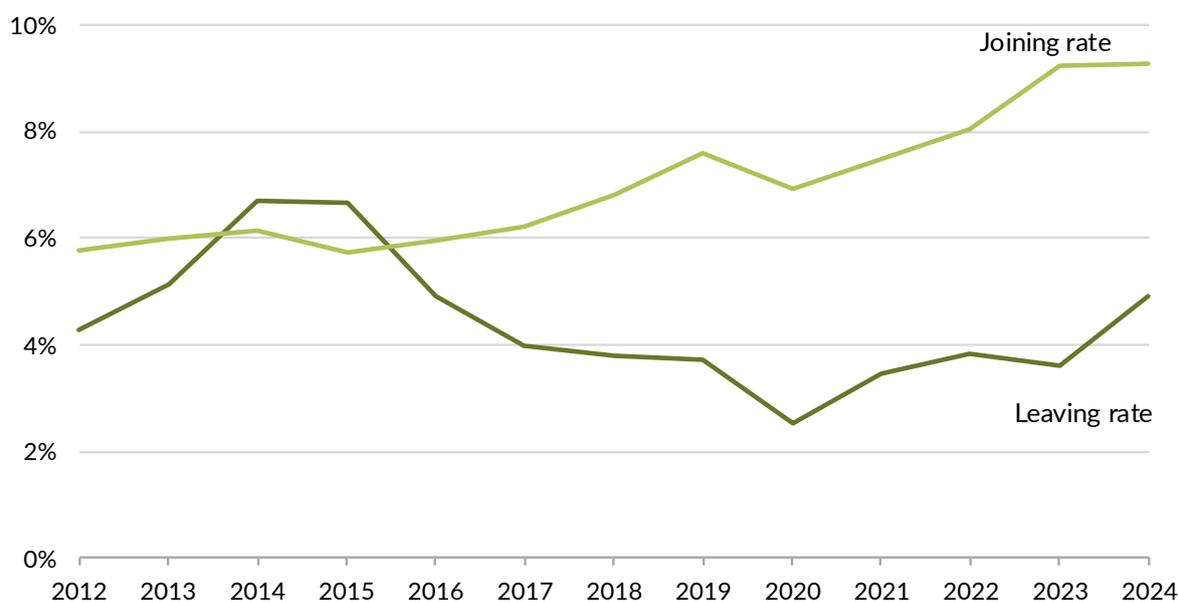
⁵⁰ Some resident doctors are counted as a leaver and a joiner when they move from one training grade/contract to the next. This means that the overall leaving rate likely overstates the 'real' flows. The outflow rates for specialty doctors, associate specialists and consultants are not affected by this issue.

the year to March 2025, up from 5.4 per cent in March 2024, and broadly unchanged from the rate of 7.5 per cent in March 2019.

5.13 The General Medical Council (GMC) register indicates the overall size of the UK medical workforce. In 2024, there were 328,129 licensed doctors, an increase of 4.6 per cent over the year and 26.1 per cent over five years. The number of licensed specialists on the GMC register increased by 2.9 per cent over the year and by 11.3 per cent over five years. The number of doctors in training increased by 4.7 per cent over the year and by 23.0 per cent over five years. The number of licensed doctors who were on neither the general practitioner (GP) nor specialist register and were not in training increased by 8.0 per cent over the year and by 48.3 per cent over five years. This group includes SAS and locally employed doctors.

5.14 In 2024, 4.9 per cent of the workforce left the GMC register, up from 3.6 per cent in 2023. The GMC said this increase was mostly driven by non-UK primary medical qualification (PMQ) doctors who had never connected to a designated body and were therefore unlikely to have ever worked in the UK. However, there was also an increase in the rate of licensed and designated body connected doctors leaving the register, from 3.2 per cent in 2023 to 3.6 per cent in 2024. The proportion of doctors leaving to practise abroad among those on the GP/specialist register or in training was around 0.5 per cent.

Figure 5.3: Leaver and joiner rates from the GMC register, UK, 2012 to 2024



Source: GMC.

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

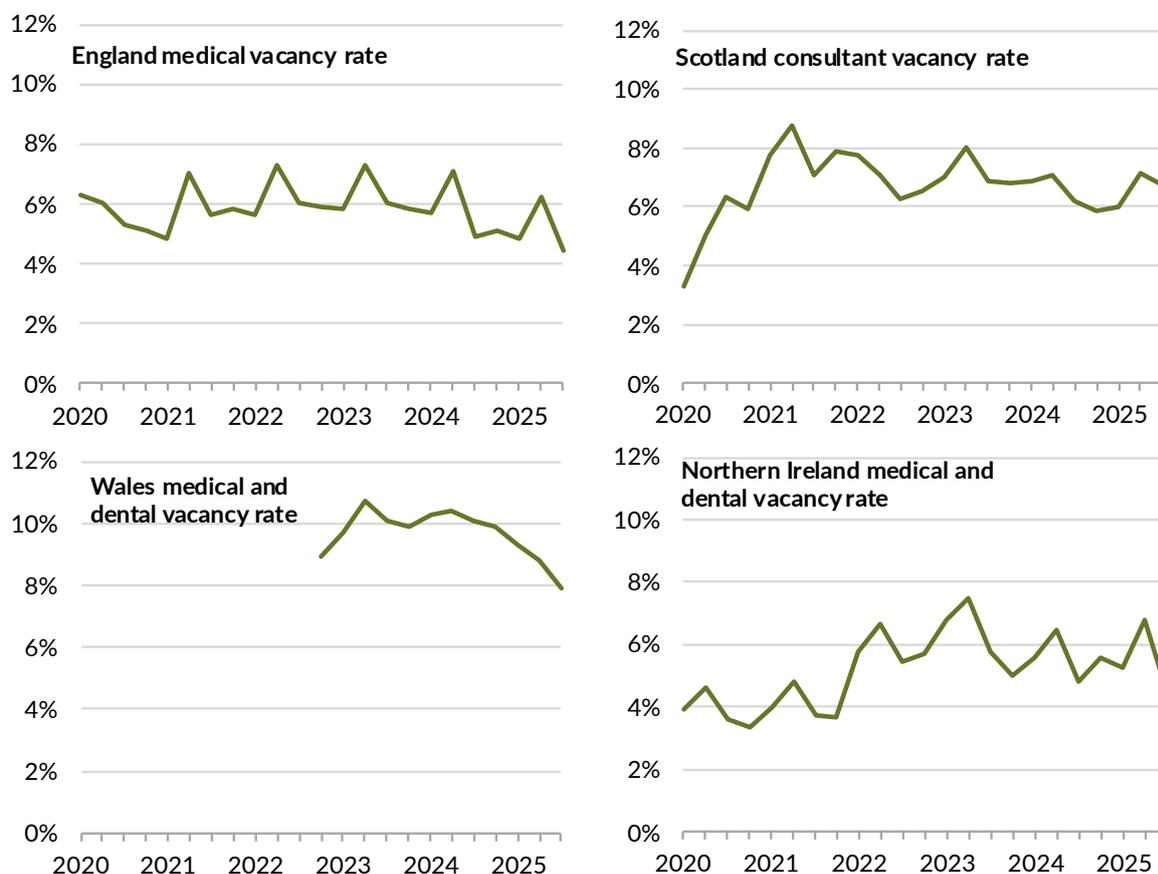
Vacancies

5.15 Medical vacancies fell in England and Wales over the last year, were broadly stable in Northern Ireland, and rose in Scotland.

5.16 There were 7,248 medical vacancies in England in the second quarter of 2025-26, a reduction from 7,777 a year earlier. The medical vacancy rate in England was 4.4 per cent in the second quarter of 2025-26, a reduction from 4.9 per cent a year earlier, and

the lowest rate since the series began in 2017-18. Across the regions, medical vacancy rates ranged from 2.8 per cent in the North East and Yorkshire to 6.7 per cent in the Midlands.

Figure 5.4: Medical and dental vacancy rates, by nation, 2020 to 2025



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

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

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

- 5.17 There were 447 consultant vacancies in Scotland in September 2025, an increase from 398 a year earlier. The consultant vacancy rate in Scotland was 6.7 per cent in September 2025, an increase from 6.2 per cent a year earlier. The consultant vacancy rate was particularly high in mental health specialties.
- 5.18 There were 414 medical and dental vacancies (excluding trainees) in Wales in September 2025, a decrease from 522 a year earlier. The medical and dental vacancy rate in Wales was 7.9 per cent in September 2025, down from 10.1 per cent a year earlier.
- 5.19 There were 287 medical and dental vacancies in Northern Ireland in September 2025, similar to the 290 figure in September 2024. The medical and dental vacancy rate in Northern Ireland was 4.5 per cent in September 2025, a small decrease from 4.8 per cent a year earlier.
- 5.20 The DHSC noted that vacancy rates for medical staff had remained relatively steady over the past three years at around 5 to 6 per cent. It said it was difficult to disentangle the different factors driving vacancy rates. In particular, it was not clear what the

'natural' level of vacancies would be as people also moved between roles, sectors, or retired.

- 5.21 NHS Employers said that, while medical and dental vacancies had reached their lowest levels in recent years, many employers continued to face persistent challenges in recruiting and retaining staff in areas affected by national shortages. Consultant vacancies, although reduced to around 2 per cent in some organisations, remained challenging to fill in specialties such as emergency medicine, gastroenterology, pathology, and ophthalmology. Smaller trusts and those located outside London reported difficulties attracting candidates due to geographic isolation, high living costs and competition from larger institutions.
- 5.22 NHS Employers said that financial constraints, limited training pathways, and evolving workforce expectations, particularly around pay and career progression, also contributed to ongoing recruitment pressures. Some organisations were exploring alternative staffing models, including expanding roles for SAS doctors and specialists, to address gaps and support long-term workforce sustainability.
- 5.23 The British Medical Association (BMA) said that deficiencies in the way secondary care medical vacancies in England were recorded were likely to underestimate the true shortfall of staffing. It said that vacancies were recorded inconsistently and with varying definitions. It said that vacancy data was not a reliable indicator of shortages if staffing establishments did not accurately reflect staffing need. It was possible that the vacancy rate was being artificially deflated, whereby vacancies were dropped because employers were not advertising posts, rather than because posts were filled.
- 5.24 The Scottish Government noted that consultant vacancies had increased by 12 per cent (49.6 whole time equivalent) over the year, while establishment had increased by 185.5 whole time equivalent. It suggested that new posts had been created due to the expansion of services.
- 5.25 The Welsh Government said the high medical and dental vacancy rate highlighted ongoing recruitment and retention challenges within key clinical specialties. It said that addressing these vacancies was critical for improving service resilience and reducing workload pressures. Efforts to improve retention, streamline recruitment, and expand training pipelines would be central to future workforce planning.
- 5.26 The BMA said that the continued high vacancy rate in Wales was leading to increased pressure being placed on the existing workforce, with 66 per cent of doctors reporting that they were working beyond their rostered hours at least once a week.
- 5.27 The HCSA said that Wales faced persistent recruitment and retention issues, particularly in rural and hard-to-staff areas. It said that limited specialty training opportunities and rota gaps exacerbated these pressures, impacting patient care and increasing stress for doctors.
- 5.28 The Department of Health in Northern Ireland said that, despite sustained and proactive recruitment efforts, vacancy rates remained high, creating significant operational pressures across the system. Trusts had highlighted acute shortages across all specialty groupings, which intensified workloads and stress levels. The highest number of reported consultant vacancies in March 2025 were in psychiatry and radiology. Among SAS roles, the highest number of vacancies were in emergency medicine.

- 5.29 The Department said that staff shortages were having a profound impact on service delivery and staff wellbeing and also risked compromising the quality and consistency of patient care. Increased workloads, especially in emergency and acute settings, were contributing to: rising stress levels and burnout; increased sickness absence and attrition; lower morale and a ripple effect across teams; and a higher risk of errors and compromised patient safety.
- 5.30 Mental health services were particularly affected, with multiple trusts facing consultant vacancies. The Department said this threatened the sustainability of services and led to longer waiting times, delayed interventions, and increased pressure on emergency departments. Staff reported feeling demotivated and exhausted, with concerns about the impact on patient care and their own mental health.
- 5.31 The Department said there was a shortage of available trained consultants in Northern Ireland. This had been impacted by lower pay rates/different terms and conditions in Northern Ireland compared to Republic of Ireland and wider UK. Consultant vacancies were influenced by sub-optimal workforce planning, competition from other UK regions offering higher pay, and cross-border employment in the Republic of Ireland and the private sector.
- 5.32 The Western Trust in particular had experienced significant challenges, compounded by the geographical location and rurality of the trust. As well as being far from Belfast, where many clinicians preferred to practise, it competed with the Health Service Executive (HSE) in the Republic of Ireland for medical and dental staff.
- 5.33 The Department said that, with imaginative team job planning, SAS doctors, particularly those with advanced skills, could fill vacant consultant posts and help reduce waiting lists. It said that roles must be attractive, with career development opportunities and varied clinical activity. The Department was developing guidance to support trusts in recruiting specialists.
- 5.34 The Department of Health said in oral evidence that there was not one single thing that would address the issues with consultant vacancies; a holistic approach was needed, through recruitment from outside, retention of existing staff, and doing things differently.

Recruitment and retention initiatives

- 5.35 The DHSC said there might be cases where organisations struggled to recruit specific types of staff using national terms and conditions and the pay system included flexibilities such as recruitment and retention premia to help alleviate such issues. It said these flexibilities were rarely used, with earnings data suggesting that less than 0.5 per cent of the medical workforce received this kind of payment.
- 5.36 NHS Employers said in oral evidence that recruitment to less favourable areas was an issue. They said this would be critical when looking to community-based care, and how doctors and dentists could be attracted to these areas. Recruitment difficulties to rural areas could lead to services being lost, such as intensive care. Joint posts across hospitals had been created to help cover posts that were difficult to recruit to and make them more attractive.
- 5.37 The Hospital Consultants and Specialists Association (HCSA) said it advocated for a shift in focus to attracting doctors to work in certain locations rather than forcing. It said that 61 per cent of respondents to its 2025 survey said that the offer of certain

incentives would encourage them to work in a geographical area: 97 per cent cited financial incentives other than accommodation; more than four in five said free or subsidised accommodation; over 40 per cent cited fewer service delivery demands; a third mentioned greater space for teaching in their work schedule; and another third mentioned greater space for research in their work schedule.

- 5.38 The Scottish Government said that recruitment and retention in psychiatry remained a challenge, noting that other UK nations were facing similar issues. This was raised on both our visits to Scotland this round, with unfilled vacancies leading to substantial agency and locum costs.
- 5.39 A psychiatry recruitment and retention working group was established in 2023, and the Scottish Government said it had already delivered a number of initiatives and improvements to psychiatry training. The working group's report was published in June 2025 and set out recommendations for both the training and education of psychiatrists and how to recruit, support and retain the psychiatric workforce in NHS Scotland.⁵¹ Retention challenges were considered as critical by the working group. These challenges were underpinned by increasing demands upon psychiatric services in NHS Scotland, cultural attitudes, high workforce vacancy rates, and an increased reliance on locum psychiatrists, particularly under-qualified consultant locums, to fill vacant positions.
- 5.40 The working group made a large number of recommendations including:
- Considering whether targeted incentives might be necessary to retain existing trainees or encourage those at the early stages of their career to pursue a career in psychiatry.
 - Recognising the need for additional higher psychiatry training places.
 - Prioritising psychiatry when moving to whole time equivalency recruitment to account for less-than-full-time training.
 - Developing a robust evidence base and business case for additional targeted incentives to aid retention of psychiatrists in rural areas and areas of severe urban deprivation.
- 5.41 On our visit to NHS Western Isles, significant gaps in the medical workforce were highlighted, with around half of posts covered by locums at a high cost. Psychiatry was a particular problem. The remote island allowance (£1,400) was considered to be very valuable, but not enough to enable recruitment and retention or to compensate for the additional travel costs of living/working on the island. We would note, however, the very positive experiences reported by resident doctors working in the Western Isles, most of whom had relocated as part of their training rotation.
- 5.42 The Welsh Government said that the challenge of recruiting to particular specialties needed to be addressed through workforce planning, recruitment initiatives, and changing the way roles were designed. It did not wish to consider the use of targeted pay until it had evaluated the impact of some of its wider measures designed to address the underlying causes of recruitment challenges.
- 5.43 In oral evidence, the Welsh Government highlighted specific recruitment issues in North and West Wales. It said that many resident doctors chose to become a locally employed doctor in the area where they trained, such as London, which trained more

⁵¹ Scottish Government, *Psychiatry Recruitment and Retention Working Group: final report*.
<https://www.gov.scot/publications/psychiatry-recruitment-retention-working-group-final-report/>

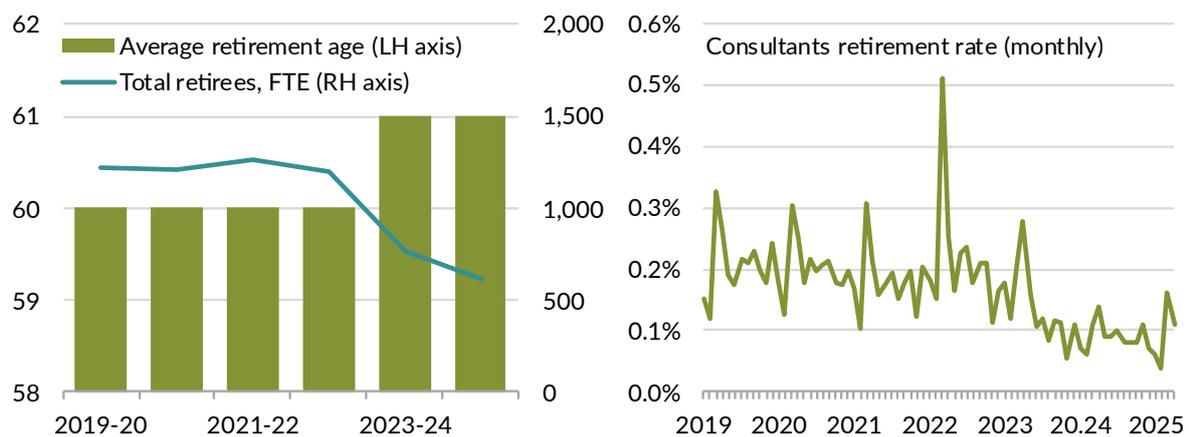
doctors than it needed, rather than move to west or north Wales. It was trying to recruit internationally to Betsi Cadwaladr and Hywel Dda health boards for relatively senior doctors who could be supported through the portfolio pathway and on to the specialist register.

- 5.44 The Department of Health in Northern Ireland said that recruitment and retention premia, equal to a one-off payment of 10 per cent of the starting salary, were offered by HSC organisations to attract and retain consultants in roles where market pressures or workforce shortages made recruitment or retention particularly challenging.
- 5.45 In light of the ongoing challenges affecting the psychiatry workforce in Northern Ireland, and pending the outcome of a wider review, the Department had introduced an interim recruitment and retention premium specifically for psychiatry, permitting an increase of up to 20 per cent to attract suitable specialists to the current vacancies, with a further option of extending up to 30 per cent. The Department gave details of 11 recruitment exercises, mostly for psychiatry, that included a recruitment and retention premium. Six with a 10 per cent recruitment and retention premium had been unsuccessful; one with a 10 per cent premium was in progress, and four with a 20 per cent premium were in progress. In oral evidence, the Department noted that the recruitment and retention premia were only available to consultants coming from outside the HSC, to avoid destabilising the consultant workforce.

Consultant retirements

- 5.46 Data for England have shown a steady fall in the number of consultant retirements over the last two years, from 1,202 in 2022-23 to 617 in 2024-25, with the average age of retirement increasing from 60 to 61. The retirement rate fell from 2.3 per cent in 2022-23 to 1.1 per cent in 2024-25.

Figure 5.5: Average retirement age, total retirees, and retirement rate, consultants in England, 2019 to 2024

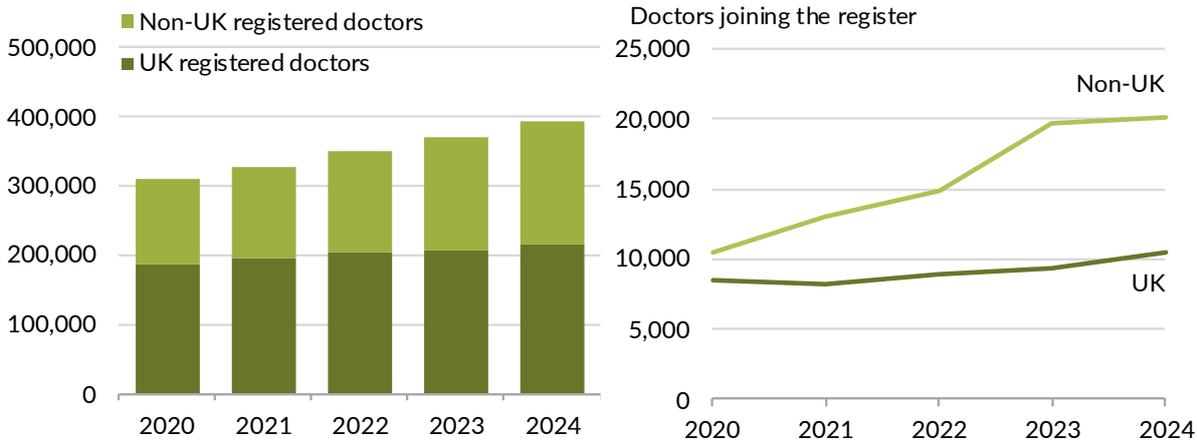


Source: DHSC.

International recruitment

- 5.47 In 2024, 66 per cent of joiners to the GMC register were non-UK graduates, down from 68 per cent in 2023 but up from 39 per cent in 2015. The number of UK graduate joiners increased by 11 per cent from 2023 to 2024, while the number of non-UK joiners increased by only 2 per cent (compared to 32 per cent between 2022 and 2023). Non-UK graduates made up 45 per cent of those on the medical register in 2024, up from 36 per cent in 2015.

Figure 5.6: Registered doctors and joiners to the GMC register by region of primary medical qualification, UK, 2020 to 2024



Source: GMC.

5.48 The number of health and care worker visas granted for doctors increased from 5,808 visas in 2021, to 8,853 visas in 2023. There was a fall to 7,450 visas in 2024 and to 6,240 in 2025. In 2025, doctors were most likely to come from India, Nigeria, Pakistan, Malaysia and Egypt.

5.49 In England, the proportion of the secondary care medical and dental workforce with a non-UK nationality increased from 28.4 per cent in September 2020 to 36.4 per cent in September 2025. The proportion of staff with a non-UK nationality varied by grade: 23.9 per cent of foundation year 1; 30.3 per cent of foundation year 2; 58.4 per cent of core trainees; 43.8 per cent of registrars; 58.7 per cent of specialty doctors; 42.2 per cent of specialists/associate specialists; and 22.6 per cent of consultants. The most common non-UK nationalities were Indian, Pakistani, Egyptian and Nigerian.

5.50 In Wales, 58.7 per cent of the medical and dental workforce had a UK nationality in September 2025, 4.8 per cent had a European Union (EU) nationality, 24.1 per cent had a non-EU nationality and 12.3 per cent had an unknown nationality.

5.51 NHS Employers said that the policy environment on international recruitment had shifted considerably over the past year. They pointed to rising salary thresholds, restricted visa routes, and broader immigration reforms, outlined in the 10-year health plan and the immigration white paper, which together posed significant challenges to sustaining international recruitment. These measures had led to a decline in health and care visa grants and impacted trust-grade and locally employed roles, which had traditionally provided entry points for international medical graduates.

5.52 The Welsh Government highlighted a number of barriers to international recruitment:

- Accommodation and school places – there were ongoing difficulties for international recruits finding housing and suitable schools, which was often navigated without structured support.
- Pastoral support – there was feedback that integration support was inconsistent; mentorship was offered with peers but could be enhanced.
- Visa complexity – visa application processes had become increasingly complex with limited Home Office guidance, complicating conversations and planning.

- Sponsorship cost increases – recent Home Office fee increases for Certificates of Sponsorship would have a direct financial impact on health boards’ recruitment budgets.
- Starting salary and incremental credit – while previous experience was assessed for incremental credit prior to contract, this process could still be a point of contention or confusion.

5.53 The Department of Health in Northern Ireland commissioned the Government Actuary’s Department (GAD) to examine the differences between the Sláintecare public only consultant contract in the Republic of Ireland and the consultant contract used within Northern Ireland’s HSC system. The report highlighted key structural and operational differences, including remuneration models, clinical governance, and workforce planning implications. The Department said that the findings were expected to inform future policy decisions on consultant contract reform within HSC. Basic pay for a consultant was €231,215 to €277,736⁵² for a 37-hour week from 1 March 2025 under Sláintecare, compared to £110,681 to £145,517 for a 40-hour week after the implementation of the 2025 uplift in Northern Ireland.

5.54 The Department of Health said that there was anecdotal, but not empirical, data to show that the higher medical and dental salaries in the HSE were leading to a number of doctors across HSC resigning and taking up posts in Ireland.

5.55 The Department of Health said that individual HSC trusts undertook their own international medical recruitment to meet their workforce needs. HSC trusts reported a total of 188 overseas doctors who started employment between April 2023 to March 2024, with a further 132 starting employment between April 2024 to March 2025. The doctors were recruited through a mixture of direct applications and bespoke international medical projects (at Western Trust and Southern Trust). The Department said that individual HSC trusts had well-established international medical recruitment teams and there were currently no concerns that they would be able to continue attracting international doctors to work in Northern Ireland.

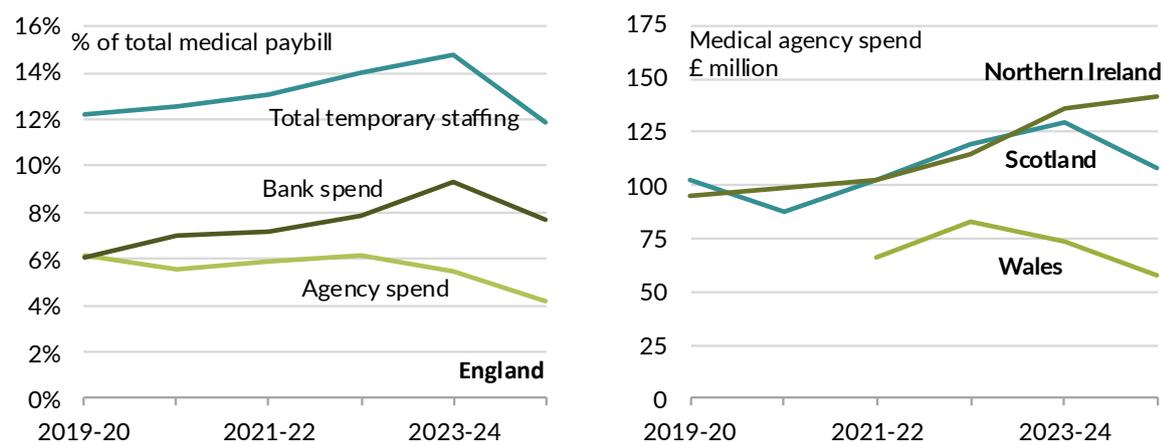
Use of temporary staffing

5.56 There has been a commitment to reduce spend on temporary staffing across all nations. Expenditure on temporary medical staffing fell in England, Scotland and Wales over the year to 2024-25, but continued to increase in Northern Ireland.

5.57 In England, total expenditure on temporary medical staffing reduced by 11 per cent (£334 million) in 2024-25 compared to 2023-24, with falls in both agency and bank staffing. Bank medical staffing costs fell by 9 per cent (from £1.92 billion to £1.76 billion), and bank staff as a proportion of the overall medical paybill fell from 9.3 per cent to 7.7 per cent. Agency medical staff costs fell by 15 per cent (from £1.13 billion to 0.96 billion), and agency staff as a proportion of the overall medical paybill fell from 5.5 per cent to 4.2 per cent.

⁵² Converting from €231,215 - €277,736 to pounds sterling using an exchange rate of €1 = £0.8738, gives a value of £202,036 - £242,686. This does not capture any purchasing power differences. See appendix F for further comparisons.

Figure 5.7: Temporary medical staffing spend, by nation, 2019-20 to 2024-25



Source: DHSC; Scottish Government; Welsh Government; Department of Health, Northern Ireland.

Note: Northern Ireland includes locum spend.

- 5.58 The DHSC said that the NHS still had bank and agency locum rates that were significantly out of line with substantive pay rates. The 10-year health plan stated that agency staffing in the NHS would be eliminated by the end of this parliament. The DHSC said that this would take a concerted effort to transition agency workers to staff banks. The NHS planning guidance stated that trusts should reduce their agency spend by 30 per cent and their bank spend by 10 per cent in the 2025-26 financial year.
- 5.59 NHS Employers noted that trusts were required to develop plans to shift from agency staffing to bank staffing, as the latter offered better value and continuity of care. Trusts also needed to ensure that bank rates were competitive but not higher than average agency rates, and they should evaluate these regularly against local market conditions.
- 5.60 NHS Employers said that the BMA had reintroduced rate cards for consultants and SAS doctors in May 2025, which had previously been withdrawn as part of the 2024 pay agreements. These set out minimum recommended pay for extra-contractual work. While employers had reported that they did not reflect these rate cards when setting pay for extra-contractual work, some reported having to escalate rates during strike days or in exceptional circumstances to maintain service continuity. Employers had raised concerns that doctors were increasingly using the rate cards to request higher pay for internal locum shifts, even where local pay governance and affordability constraints did not support such increases. NHS Employers said this had strained local industrial relations and added pressure on already stretched budgets, particularly in organisations facing significant financial challenges.
- 5.61 Medical agency spend in Scotland decreased by 16.7 per cent from £129.6 million in 2023-24 to £108.0 million in 2024-25. The Scottish Government said that, while the use of temporary staff would always be needed in NHS Scotland, its aim was to limit agency use as much as possible, with more shifts being filled either by substantive staff or through NHS board staff banks. Most territorial health boards had reduced agency spend over the year except Shetland, Western Isles, Ayrshire & Arran and Forth Valley. The health boards with the highest agency spend in 2024-25 were Grampian (£18.5 million), Highland (£15.6 million), and Fife (£14.5 million). These were also the health boards with the highest spend in the previous year.
- 5.62 The agreements with both consultants and SAS doctors in Scotland in 2024 included commitments to discussions to agree a national rate for internal short-term cover to

improve continuity of care and help alleviate agency and locum spend. Negotiations on a national rate for short-term cover were ongoing.

- 5.63 The Welsh Government said that all NHS organisations were required to implement a control framework in their organisations with robust scrutiny of agency deployment and concerted action to encourage people to work for the NHS bank or in substantive NHS employment. Agency spend on medical and dental staff made up 3.2 per cent of total pay in 2024-25, but this varied by health board, from 0.1 per cent to 32.3 per cent (in Powys).
- 5.64 Overall NHS Wales agency spend was reduced by 33.7 per cent (£88.3 million) between 2023-24 and 2024-25, with medical and dental agency spend down by 22.0 per cent (16.2 million). The Welsh Government said this was significant progress, but there was potential for further savings in future years. As part of the planning framework, organisations were required to reduce agency spend by an additional 30 per cent in 2025-26. NHS organisations were forecasting a reduction of around £88.3 million in their agency spend in 2025-26.
- 5.65 NHS Wales Employers said that variation in pay rates across health boards and specialties could create inequities when recruiting ad hoc locum cover. This disparity could leave doctors feeling undervalued when asked to take on emergency cover.
- 5.66 An employer's reference group had been established to develop all-Wales rates with key objectives to be finalised but likely to be:
- Implement national rates to address the current pay inequities across medical specialties and NHS organisations in Wales.
 - Reduce reliance on costly agency locums and transform the temporary staffing landscape by encouraging internal staff to take on additional shifts.
 - Resolve inconsistencies in backfill/waiting list initiative rates, including variations in sessional multipliers across health boards, to establish a more standardised approach.
- 5.67 The Department of Health in Northern Ireland said that agency/locum costs had increased substantially over the last 10 years, from £76 million in 2014-15 to £382 million in 2024-25 across the whole HSC. The Department said this was not sustainable. Medical and dental agency/locum expenditure totalled £141.9 million in 2024-25, a rise of 4.3 per cent from £136.1 million in 2023-24 and 16.0 per cent of the medical and dental paybill.
- 5.68 The Department of Health said that HSC trusts increasingly relied on locum doctors as well as agency staff to mitigate workforce gaps. The Department said that, while these temporary solutions provided short-term relief, they came with notable drawbacks. Trusts consistently reported that locum arrangements lacked the continuity, stability, and integration offered by substantive staff. Moreover, locum and agency services were significantly more costly, placing additional strain on already stretched budgets.
- 5.69 The Department said that the recruitment of locum doctors presented its own set of challenges, particularly due to Northern Ireland's geographical separation from the rest of the UK. This limited the pool of available candidates and meant that most locums were either existing HSC doctors working additional hours or individuals choosing to do locum work exclusively. The Department said that the attractive nature of locum engagements also continued to drive doctors away from rotational training schemes,

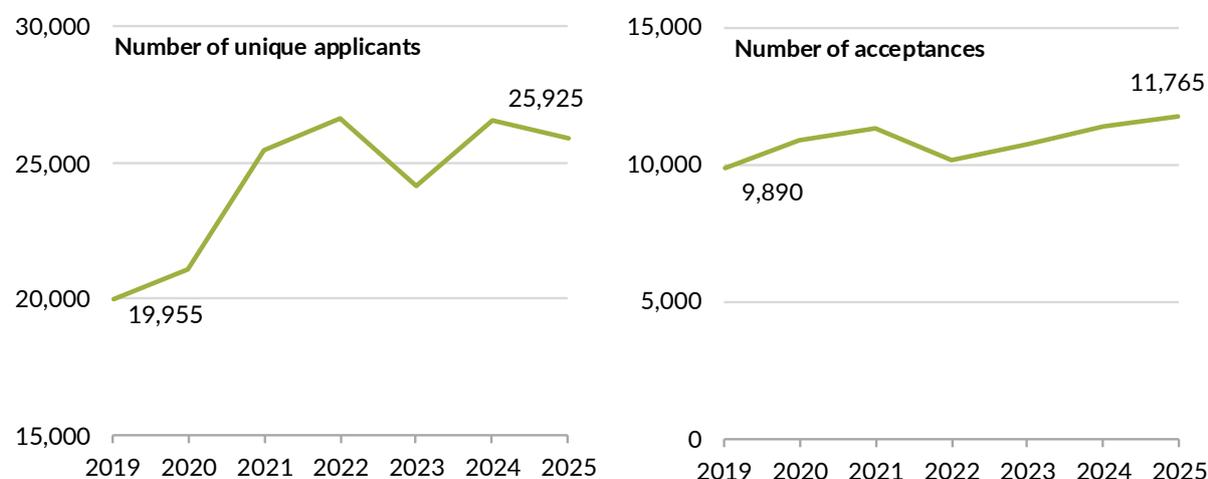
particularly after foundation year 2. A new medical and dental locum framework was planned to be in place by the end of 2025.

5.70 The Department of Health said in oral evidence that it was doing a system-wide piece of work to get control of locum expenditure through increasing training places and creating more sustainable rotas. It might look more to SAS doctors to fill some of the vacancies or to other professions to deliver services in a different way.

Undergraduate medical training

5.71 There were 25,925 applicants to study medicine in 2025, a decrease of 2.5 per cent from 2024. In 2025, the number of applicants was 29.9 per cent higher than in 2019. The acceptance rate increased from 42.8 per cent in 2024 to 45.4 per cent in 2025; acceptance rates remained lower than 2019, when they were 49.6 per cent.

Figure 5.8: Number of applicants and acceptances for medicine degrees, UK, 2019 to 2025



Source: UCAS. Acceptance rate is defined as the number of acceptances as a proportion of the number of unique applicants.

5.72 The DHSC said that the number of funded undergraduate medical school places in England was 8,230 for the 2025-26 academic year (an increase of 350 on 2024-25).

5.73 The Scottish Government had approved a medical undergraduate intake of 1,417 for 2025-26. It said this was unchanged on 2024-25, but a 67 per cent increase compared to the 2015-16 intake of 848.

Postgraduate medical training

Foundation training

5.74 The DHSC said that all 10,634 eligible applicants for the 2025 Foundation Programme were allocated to a foundation school, with 84 per cent of those applicants getting their first preference of location. The DHSC said this was an improvement on 2024, when 9,702 applicants were placed and 75 per cent got their first preference. The DHSC said that the higher proportion of first-preference placements and the more even distribution of overseas applicants had resulted in a more consistent withdrawal rate across the country and reduced vacancy hotspots in less popular regions and trusts.

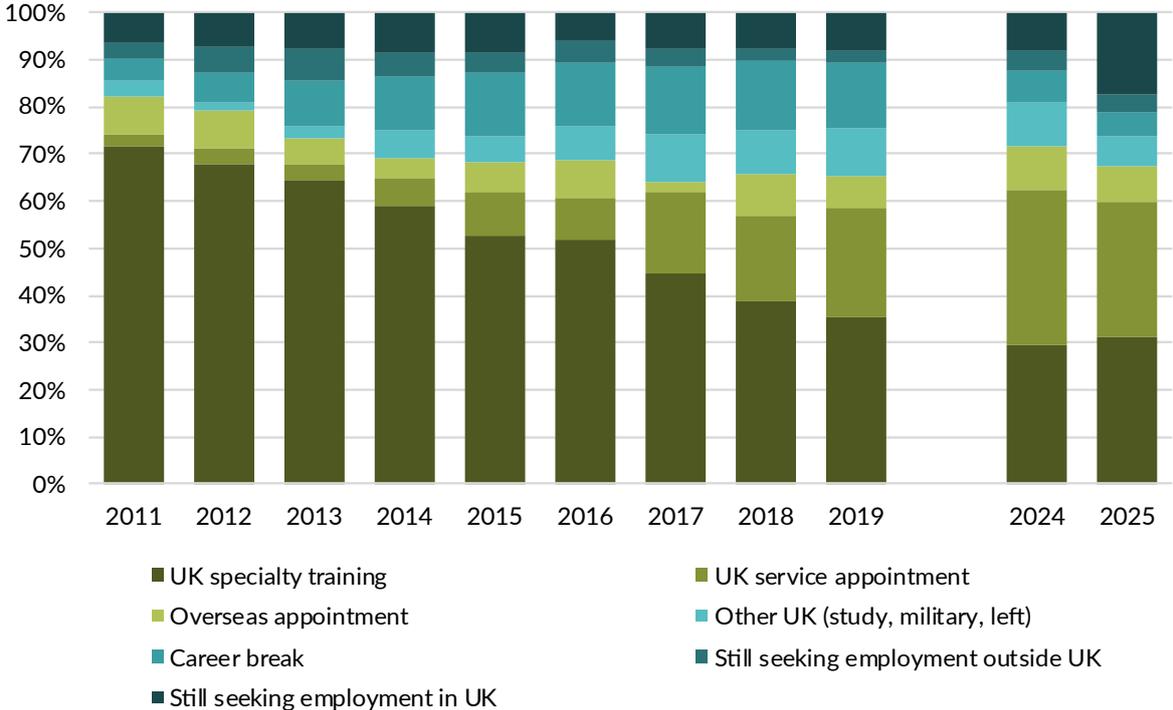
5.75 The DHSC said that applications to the Foundation Programme had increased substantially over recent years. It said this had been fed in part by immigration rule

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 did not receive government funding. The total number of applicants grew from 7,963 in 2020 to 11,205 in 2025.

- 5.76 The Scottish Government said it had funded increases to foundation training places to match the increased output of Scottish medical schools. There were 1,101 foundation year 1 posts for 2025 in Scotland, compared to 1,002 in 2024.
- 5.77 The Welsh Government said the fill rate for foundation training was 100 per cent. Due to withdrawals prior to commencing training, there was a vacancy rate at the start of the 2025-2026 academic year of 3.6 per cent (16 out of 450 posts).
- 5.78 The Department of Health said that the number of foundation places in Northern Ireland increased from 259 in 2022, to 294 in 2023 and 2024, and to 363 in 2025. Of these, 359 posts were filled at August 2025. It said that the expansion in 2023 was to meet university output locally. There had been a further expansion from August 2025 of 70 places to meet the first graduates from the University of Ulster medical school. This would continue to be an estimated 70 graduates a year.
- 5.79 The Department said that the Northern Ireland Medical and Dental Training Agency (NIMDTA) was reviewing the 2025 recruitment process to consider approaches for 2026. It said the expansion to the foundation programme had facilitated the rotation of more trainees through less popular specialties and might increase the interest in pursuing these as a career.
- 5.80 In the foundation year 2 career destinations survey, 31 per cent of foundation doctors were moving into specialty training in the UK.⁵³ This was largely unchanged from 30 per cent in 2024, but down from 72 per cent in 2011. In 2025, 29 per cent of foundation doctors were taking a UK service appointment, down from 33 per cent in 2024, but up from just 2 per cent in 2011. The proportion of foundation doctors that were still seeking employment in the UK was 17 per cent, up from 9 per cent in 2024, and from 6 per cent in 2011.
- 5.81 The Department of Health said that the numbers of foundation year 2s in Northern Ireland entering specialty training immediately following foundation training remained low. Data from the Single Lead Employer indicated that 8.05 per cent of foundation year 2s who completed in August 2024 entered GP or specialty training in Northern Ireland.

⁵³ UK Foundation Programme, *Reports*. <https://foundationprogramme.nhs.uk/resources/reports/>
Reporting on career destinations after foundation training was paused between 2020 and 2023, creating a gap in the long-term trend data. Reports for 2024 and 2025 are based on survey responses from a subset of doctors rather than a full census and use a different methodology. As a result, the figures are less granular and not directly comparable with the historic series. The 2025 survey ran from 16 June to 14 August.

Figure 5.9: Career destinations for foundation year 2 doctors immediately after completing their training, UK, 2011 to 2025



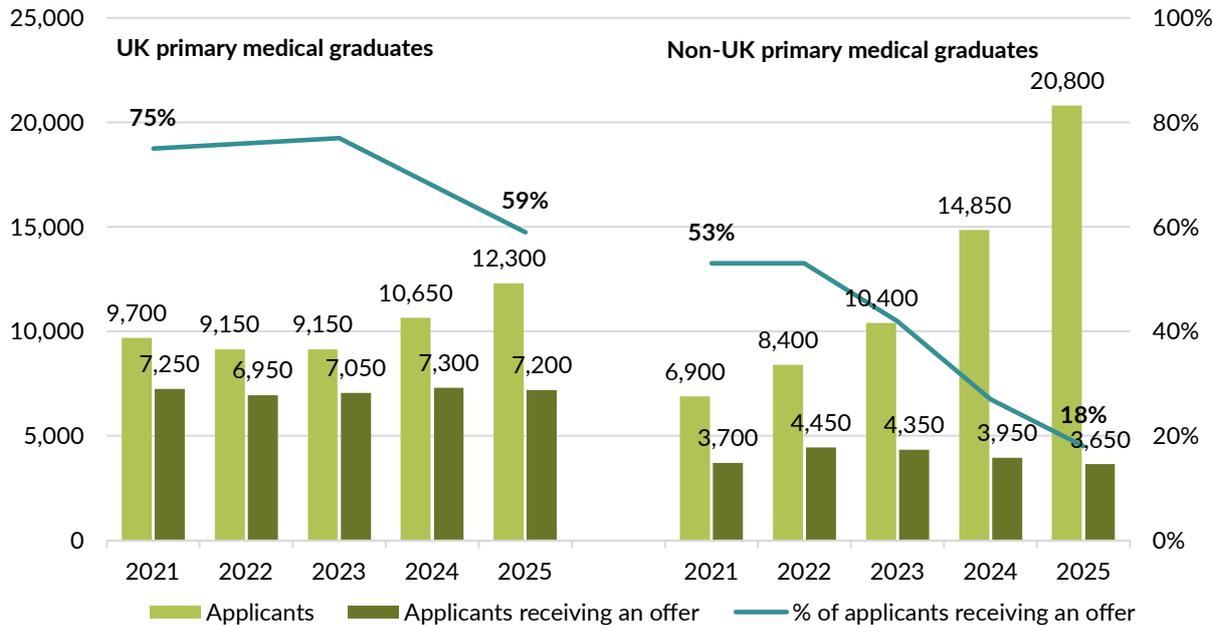
Source: UK Foundation Programme.

Notes: Reporting on career destinations after foundation training was paused between 2020 and 2023, creating a gap in the data. Reports covering 2024 and 2025 are based on survey responses from a subset of doctors rather than a full census and use a different methodology. As a result, the figures are less granular and not directly comparable with the historic series.

Core and specialty training

- 5.82 Since 2021, the number of individuals applying to core/specialty training posts in round 1 (CT1/ST1) has risen substantially (up 99 per cent), with particularly strong growth in 2025 compared to 2024 (up 30 per cent). Most of this increase has come from doctors with non-UK qualifications.
- 5.83 The number of individuals applying to CT1/ST1 training posts with a UK PMQ increased from 9,700 in 2021 to 12,300 in 2025 (a 27 per cent rise), including a 15 per cent increase in the latest year (from 10,650 in 2024). Individuals applying with a non-UK PMQ increased from 6,900 in 2021 to 20,800 in 2025 (an increase of 201 per cent), including a 40 per cent rise in the most recent year (from 14,850 in 2024).
- 5.84 The number of individuals receiving at least one offer for CT1/ST1 training decreased by 1 per cent from 10,950 in 2021 to 10,850 in 2025. The overall proportion of applicants receiving an offer for ST1/CT1 training posts fell sharply, from 66 per cent in 2021 to 33 per cent in 2025. Most of this decline occurred in the last two years, with the rate falling from 58 per cent in 2023 to 33 per cent in 2025.
- 5.85 For UK PMQ applicants, the proportion receiving an offer decreased from 75 per cent in 2021 to 59 per cent in 2025, with a notable fall in the most recent year (from 68 per cent in 2024). For non-UK PMQ applicants, the proportion receiving an offer declined from 53 per cent in 2021 to 18 per cent in 2025, including a sharp drop from 27 per cent in 2024.

Figure 5.10: CT1/ST1 recruitment outcomes for UK primary medical graduates, 2021 to 2025

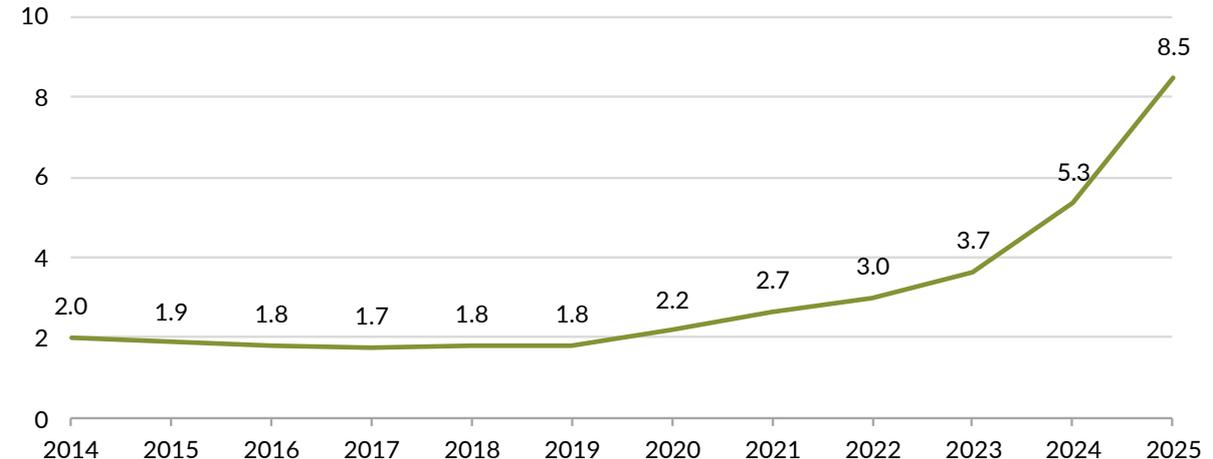


Source: Internal round 1 data from NHS England and DHSC.

Notes: Excludes non-medical applicants to public health medicine. There may be discrepancies with other released statistics due to ongoing work to clean the data and refine the analysis. UK and non-UK applicants may not sum to the number of total applicants due to data rounding.

5.86 Competition has increased overall, with the average across specialties rising from 2.0 applications per post in 2014 to 8.5 in 2025, including a large jump in the most recent year, from 5.3 in 2024. Competition ratios are based on total applications divided by available posts; applications are not unique because individuals may apply to multiple specialties.

Figure 5.11: Average competition ratio for CT1/ST1 training posts, UK, 2014 to 2025

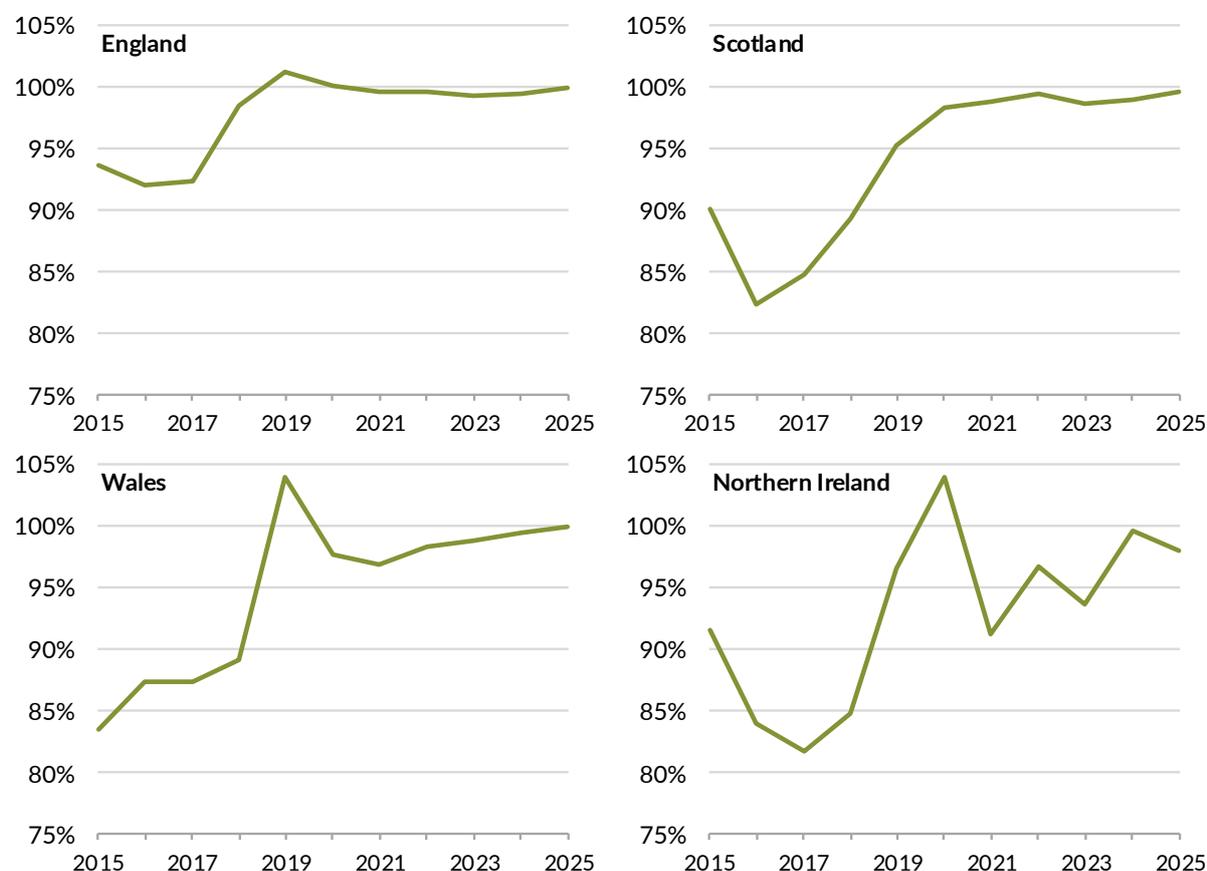


Source: Internal OPRB calculations using NHS England data on competition ratios in medical specialty recruitment.

Note: Individuals can make multiple applications meaning the number of applications does not equal the number of individuals applying. The chart shows the number of applications.

5.87 Fill rates for CT1/ST1 posts have increased steadily since 2014, reaching very high levels across all nations in 2025. England and Wales achieved full recruitment in 2025, with Scotland close to full and Northern Ireland slightly lower.

Figure 5.12: CT1/ST1 fill rate, by nation, 2015 to 2025



Source: Internal OPRB calculations using NHS England data on fill rates in medical specialty recruitment.

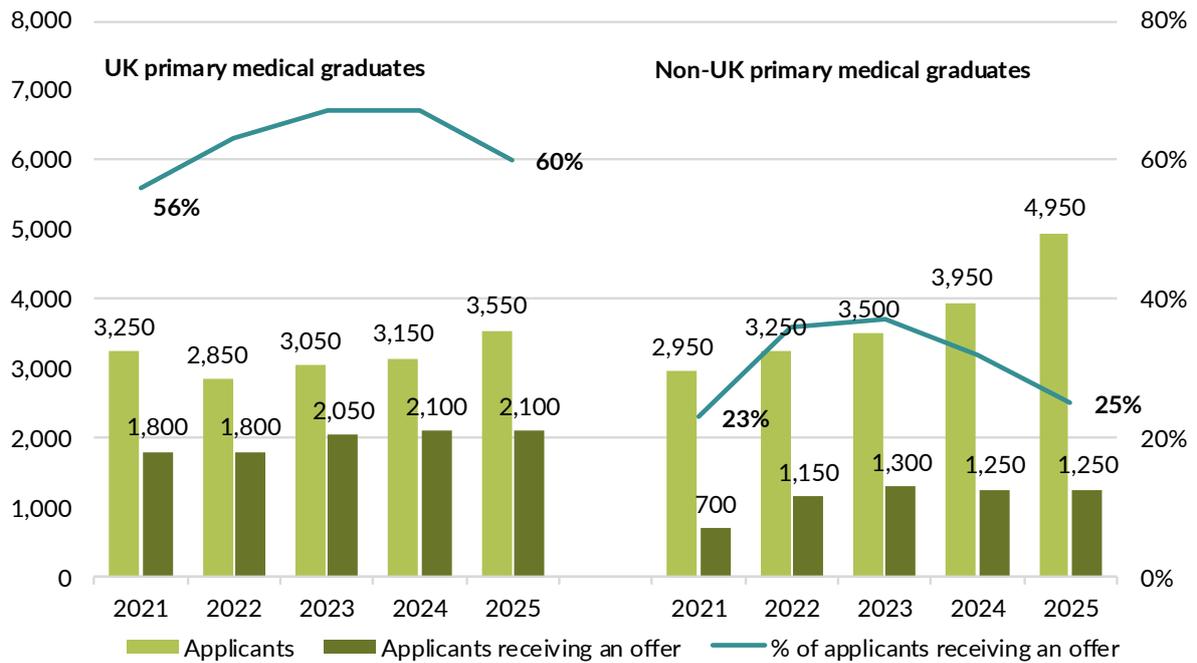
Notes: These figures include all four UK nations but only cover specialties that were advertised in England in 2025. Specialties that did not recruit in England in 2025, because they were advertised only in another nation or did not recruit that year, are not included. As a result, specialty coverage varies between years and nations, and the figures should be interpreted as indicative rather than comprehensive.

5.88 The total number of individuals applying to ST3/ST4 training posts increased by 37 per cent over the last four years, rising from 6,200 in 2021 to 8,500 in 2025. Growth was strongest in the latest year, with a 20 per cent increase from 7,100 in 2024 to 8,500 in 2025.

5.89 The number of individuals applying with a UK PMQ increased from 3,250 in 2021 to 3,550 in 2025 (a 9 per cent rise), including a 13 per cent increase in the latest year. Individuals applying with a non-UK PMQ increased from 2,950 in 2021 to 4,950 in 2025 (a 68 per cent rise), with a 25 per cent increase in the most recent year (from 3,950).

5.90 The number of individual applicants receiving offers for ST3/ST4 posts increased from 2,500 in 2021 to 3,350 in 2025. The overall offer rate was 40 per cent in 2021, 48 per cent in 2024, and 40 per cent in 2025. For UK-qualified doctors, the rate was 56 per cent in 2021, 67 per cent in 2024, and 60 per cent in 2025. For non-UK qualified doctors, the rate was 23 per cent in 2021, 32 per cent in 2024, and 25 per cent in 2025.

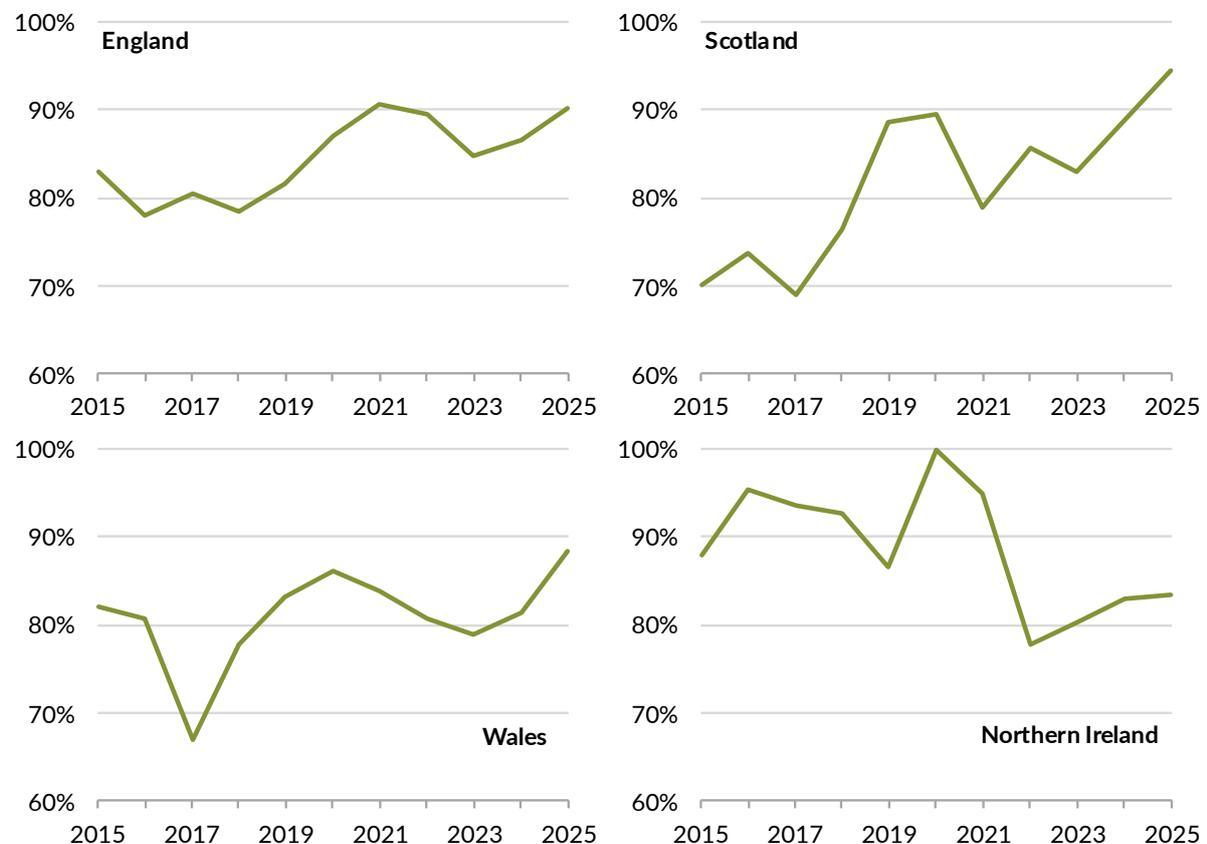
Figure 5.13: ST3/ST4 recruitment outcomes, UK, 2021 to 2025



Source: Internal round 2 data from NHS England and DHSC.

Notes: There may be discrepancies with other released statistics due to ongoing work to clean the data and refine the analysis. UK and non-UK applicants may not sum to the number of total applicants due to data rounding.

Figure 5.14: ST3/ST4 fill rate, by nation, 2015 to 2025



Source: Internal OPRB calculations using NHS England data on fill rates in medical specialty recruitment.

Notes: Missing data for Scotland in 2024. The number of posts in the devolved nations are relatively small so fill rates are subject to higher levels of volatility.

- 5.91 The number of applications to posts at ST3/ST4 increased from 1.86 applications per post in 2016 to 2.87 in 2024, and then to 3.51 in 2025. The ratios are based on total applications divided by available posts, and applications are not unique because individuals may apply to multiple specialties.
- 5.92 In England, the fill rate for ST3 and ST4 posts in England was 90.3 per cent in 2025, up from 86.5 per cent in 2024 and slightly below the 90.6 per cent recorded in 2021. The 2025 rate was 9.5 percentage points higher than 2014 (80.8 per cent),
- 5.93 In Wales, the ST3/ST4 fill rate reached 88.3 per cent in 2025, up from 81.4 per cent in 2024 and above the 83.8 per cent rate in 2021. This represents an increase of 8.3 percentage points compared to 2014 (80.0 per cent).
- 5.94 In Scotland, the fill rate for ST3 and ST4 posts was 94.6 per cent in 2025, up from 83.1 per cent in 2023 and 66.7 per cent in 2014.
- 5.95 In Northern Ireland, the fill rate for ST3 and ST4 posts was 83.3 per cent in 2025, an increase from 82.9 per cent in 2024 but below the 95.0 per cent recorded in 2021. The 2025 rate was 10.7 percentage points lower than 2014 (94.0 per cent).
- 5.96 Certain specialties show low fill rates across most regions despite attracting applicants nationally. This suggests that factors such as location preferences, eligibility requirements, and selection processes may be limiting recruitment.
- 5.97 The Scottish Government said it undertook annual reviews of the number of specialty training places needed to meet anticipated future service demand and consultant need and had funded hundreds of additional specialty training places since 2014, including 47 new specialty training places in 2025. It said that planning for the future medical workforce was complex as it needed to make assumptions about population needs, future service delivery models, training capacity, workforce demographics, global mobility of the medical workforce, individual working and training patterns, and geographic preferences.
- 5.98 The Scottish Government said that it noted stakeholder concerns around UK doctors struggling to obtain specialty training places in recent recruitment rounds. It said it would work with National Education for Scotland (NES) to provide greater transparency on recruitment data including competition ratios, existing training vacancies, and the location of training posts to resident doctors in Scotland.
- 5.99 The Welsh Government said there were some notable improvements in 2025 in specialties where fill rates had previously been a concern, including psychiatry and obstetrics and gynaecology. Wales continued to experience challenges recruiting to clinical oncology, geriatric medicine, and genito-urinary medicine programmes. The Welsh Government said this was mirrored across the UK and it was working to explore options to enhance recruitment in these areas.
- 5.100 The Strategic Mental Health Workforce Plan for Health and Social Care set an ambition to increase the number of commissioned training places in Wales, including eight additional core psychiatry training places each year from 2022 to 2025. The fill rate for core psychiatry training programmes had improved, with a 100 per cent fill rate in 2025. Higher specialty training recruitment had increased over the last three years, and from August 2025 there would only be one vacancy in higher training in Wales.

- 5.101 The Welsh Government said that nine higher psychiatry trainees achieved their Certificate of Completion of Training (CCT) during 2024. Of those nine, seven had taken up consultant posts within NHS Wales, either substantively or as a locum. In 2025, eight higher trainees would complete their training. The majority had either taken up a consultant post or intended to do so.
- 5.102 The recent agreement with resident doctors in Wales included a commitment to a working group to investigate the existence, location, and causes of bottlenecks within training programmes. The focus would be on understanding where these bottlenecks occurred and why they arose. Where bottlenecks were identified, the group would work with the Welsh Government to explore options for increasing training posts in the affected areas, ensuring that training capacity met service and workforce needs.
- 5.103 The overall number of vacant training (foundation and specialty) posts in Northern Ireland was 182 in 2025, 9 per cent of posts. The Department of Health in Northern Ireland said that there had been record numbers of applicants to specialty training programmes for 2025 and the resource to deliver recruitment was not sufficient with the continual increases. It said that applicant behaviour was changing, with applicants making more applications in a bid to secure a training programme. In addition, as applicants could apply from anywhere in the world, it was impossible to predict the number of applications. It said there were ongoing discussions across the four nation governments on this.
- 5.104 The Department of Health said that national processes often did not appear to work well for Northern Ireland applicants, and those who were appointed often decided not to take up a post in Northern Ireland. NIMDTA locally recruited to around 40 training programmes and where possible moved to deliver local recruitment where it was anticipated this would improve fill rates. This was becoming increasingly challenging with the number of applications received. Conversely, some specialties did not attract local applicants and national recruitment often provided better fill rates.
- 5.105 The Department said that Northern Ireland was reliant on the attraction of doctors who had qualified outside Northern Ireland to fill training programmes and provide healthcare service. In August 2021, there were 181 trainees requiring visa sponsorship, including 61 new trainees. This increased to 369 in August 2024, which included 188 new trainees. At September 2025, there were 426 trainees requiring visa sponsorship. Of these, the most common nationalities were Nigerian (72), Indian (67) and Pakistani (66).
- 5.106 The Department said that any increase in specialty training posts would be subject to available funding and in line with workforce planning. Confirmation was received in May 2025 of an expansion of 11 posts across medical specialty training programmes. The Department said there had been a trial of over-recruitment into a medical specialty training programme. This would continue for the 2025 intake, with 17 additional doctors across four trusts.
- 5.107 The DHSC said that the increasing competition for training posts had led to bottlenecks and limited development opportunities for many doctors. It said there were two reasons for this bottleneck. Firstly, while the number of undergraduate medical places had expanded, there had not been a commensurate expansion in specialty places – places did increase but at a lower rate than the undergraduate expansion. Secondly, the 2020 decision to end the Resident Labour Market Test meant that international medical graduates were now applying on equal terms with UK medical graduates for

specialty training roles. This resulted in an increase in the number of applications and applicants.

5.108 The DHSC acknowledged the impact bottlenecks had had on individuals and said it was committed to enabling UK graduates to continue their training within the NHS. It would therefore work to prioritise UK medical graduates for foundation training and to prioritise UK medical graduates and other doctors who had worked in the NHS for a significant period for specialty training. In addition, 1,000 new specialty training posts would be created over the next three years with a focus on specialties where there was greatest need.

5.109 The BMA said that years of inadequate workforce planning by successive governments had resulted in a shortage of specialty training posts, leaving many doctors unable to progress in their careers. It said that the mismatch between workforce need and available training or consultant roles had left many doctors in limbo, delaying or derailing their professional development. It said that persistent training bottlenecks added an incentive to leave the profession, particularly to go overseas where smoother routes to career fulfilment were readily available.

5.110 The HCSA said that the increase in competition ratios for training places was a national crisis, with resident doctors unable to see a career pathway in the health service. Nine in 10 HCSA resident doctors surveyed in May 2025 were concerned about increasing competition ratios for training places and the potential impact on their careers.

5.111 The HCSA said that this job insecurity was demoralising and would push early-career doctors out of the health service. It noted that the bar to gain an interview was far higher, requiring resident doctors to produce more portfolio work, at a time when service demands absorbed their capacity. The HCSA said that robust workforce planning must be carried out urgently, with targeted increases in training places at every stage. It said that government plans to increase specialty places by 1,000 were insufficient to address the current crisis.

5.112 The UK Government offer to resident doctors in December 2025 included emergency legislation for UK and Republic of Ireland medical graduates and doctors who had worked in the NHS for a significant period of time to be prioritised for specialty training. It also included the introduction 4,000 more specialty training places over the next three years, with 1,000 of these brought forward to this year. The BMA said that these would have been existing locally employed doctor jobs converted to specialty training posts.

5.113 The Medical Training (Prioritisation) Act 2026 has now been passed. The Act introduces prioritisation for foundation and specialty training places for graduates of UK medical schools, and for certain international medical graduates, including those with experience of working as a doctor in the NHS. The government has stated that the Act is intended to respond to increased competition for postgraduate medical training places and help ensure a sustainable medical workforce in the NHS.⁵⁴

Review of medical training

5.114 NHS England announced a review of postgraduate medical training in February 2025. A Phase 1 diagnostic report was published in October, designed to identify major

⁵⁴ *Medical Training (Prioritisation) Bill: impact statement*. <https://www.gov.uk/government/publications/impact-statement-medical-training-prioritisation-bill/medical-training-prioritisation-bill-impact-statement>

concerns and areas where the system was working well.⁵⁵ It said that the level of concern about current medical training was now clearly substantial.

- 5.115 The report concluded that, although many aspects of postgraduate training worked well, the current model did not always serve the professional development needs of doctors or meet the population and patient health needs for the future. It recommended that a reform of postgraduate medical education and training was undertaken as a matter of urgency.
- 5.116 The report said that the current bottlenecks in training did not benefit anyone; while some competition had always been a necessary part of medical training and career progression, especially in the most popular disciplines, the current ratios were making sensible career planning and assessment very difficult.
- 5.117 The report said that changes in 2019 to the shortage occupation list to include doctors had resulted in significant increases in the numbers of overseas medical graduates applying for UK training posts. Coupled with the incremental growth in the number of medical degree places in England, this had resulted in marked increases in the numbers of applications for the majority of core and specialty training programmes. Higher competition ratios had driven candidates to apply for more than one and in some cases multiple programmes, further driving up competition.
- 5.118 The report said that, from a service perspective, in the short term this may have been beneficial as many specialty training programmes now had fill rates of 100 per cent. However, it noted that some specialties, such as clinical and medical oncology and genito-urinary medicine, still had significant underfill, and programmes outside the major urban areas were considered less popular by applicants, reducing the likelihood of recruiting to posts in remote, rural and coastal localities.
- 5.119 The report recommended that addressing bottlenecks at all points in training and development should be considered urgently. It said this would have to include consideration of the right ratio between new international graduate entrants to medicine in the UK and those who were already working and training in the NHS, taking into account workforce need.
- 5.120 The recent agreement with resident doctors in Wales included a commitment to review the Code of Practice for Postgraduate Medical Training and create a Wales-specific equivalent.
- 5.121 The Department of Health in Northern Ireland provided evidence on progress to enhance the quality of medical education; 50 per cent of trainees reported accessing at least one hour of self-development time a week or the equivalent (one afternoon a month).

Flexible training

- 5.122 The Scottish Government said it recognised the impact of less-than-full-time training and had funded a number of additional training posts in impacted specialties to work towards addressing this. It was continuing to work with stakeholders to explore sustainable solutions through future workforce planning, taking account of current service and training need, supervision, and future trained workforce requirements. Its

⁵⁵ NHS England, *The Medical Training Review: Phase 1 diagnostic report*. <https://www.england.nhs.uk/long-read/the-medical-training-review-phase-1-diagnostic-report/>

intention was to simplify funding arrangements for whole time equivalency adjustment and review post allocation to ensure an equitable distribution across specialties and regions.

- 5.123 It also continued to work with NES to streamline selection and recruitment processes, improve flexibilities within medical training to assist movement into and through specialties, and offer out of programme opportunities so that trainees could undertake clinical training/experience, research, or take a career break.
- 5.124 The Welsh Government said there had been a substantial growth in resident doctors wishing to train on a less-than-full-time basis. Overall, 5 per cent of foundation doctors in Wales were training less than full time; 50 per cent of GP resident doctors were training less than full time; and 34 per cent of resident doctors in secondary care were training less than full time, up from 15 per cent in 2020 and 29 per cent in 2024. The Welsh Government said there had been a notable increase in uptake among male residents and early-career doctors. There was a growing preference for 80 per cent whole-time-equivalent working patterns, with wellbeing, commuting, and rota intensity cited as key drivers.
- 5.125 The Department of Health said that 17.6 per cent of medical trainees worked less than full time in Northern Ireland. This had reduced from October 2024, when 24 per cent (411) were working less than full time. Median hours for those working less than full time were 32 a week (i.e. 0.8 FTE). The Department said there were growing gaps within training rotas due to the number of those working less than full time and those with restrictions on their duties. These gaps had traditionally been filled with locum doctors and there had been a move to recruit clinical fellows to provide more stable and cost-effective cover. Vacancies in training grades impacted on the other trainees in that team due to rota gaps, daytime service to cover, and consequent loss of time for training opportunities.

Flexible pay premia

- 5.126 Flexible pay premia were introduced with the resident doctors' contract in England in 2016. The purpose was both to reduce pay differences that might occur between specialties (general practice and oral-maxillofacial surgery), and to incentivise recruitment into underfilled specialties (psychiatry, emergency medicine and, from 2018, histopathology). An academic pay premium is also paid to doctors who have completed a higher degree and returned to training. Since their introduction, flexible pay premia have been increased in line with the main uplift for resident doctors.
- 5.127 In our 2025 report, we recommended that the government review flexible pay premia to assess their value for money and effectiveness. We said that, given the very high fill rates at core training, there was limited evidence to support their continued payment. There was also little evidence that payments were correctly targeted within higher levels of training.
- 5.128 As set out above, we continue to see very high fill rates for CT1/ST1 training posts and increasing fill rates for higher training levels.
- 5.129 NHS Employers said there was clear support from employers for a review of flexible pay premia, particularly those covering hard-to-fill specialties. They said that, since the implementation of the 2016 contract, neither flexible pay premia nor the hard-to-fill specialties had been reviewed, raising questions about whether the listed specialties

were still considered to be the most difficult to recruit to. They noted that the list of hard-to-fill specialties was maintained by NHS England.

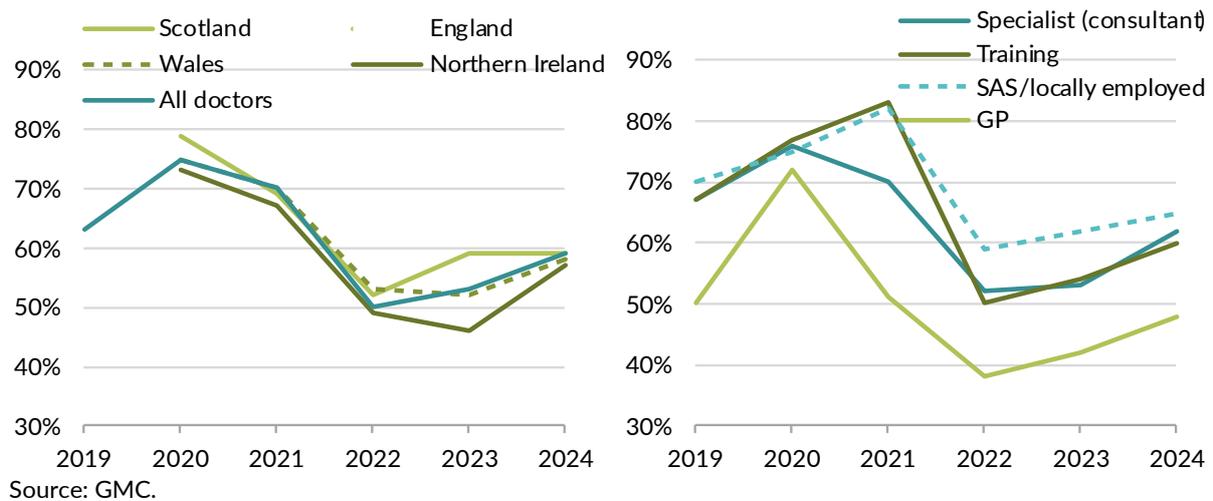
- 5.130 In oral evidence, NHS Employers said that the review of flexible pay premia had not commenced partly due to the dispute. The Minister of State for Health (Secondary Care) also said that flexible pay premia could not be considered while the industrial dispute was ongoing.
- 5.131 The BMA noted with concern our recommendation to review flexible pay premia, particularly as this was made following commentary on the current very high fill rates. It said this had caused significant concern among members working in these specialties that these premia may be removed.
- 5.132 The BMA acknowledged that the system was not perfect but said it provided a useful function in reducing the financial disincentive to doctors undertaking an academic career and it should not be removed until a better, workable alternative could be put in place. The BMA said that the academic flexible pay premium was to address the financial penalty associated with the elongated nature of academic training and, in particular, the time taken out of programme to undertake the required PhD, which delayed pay progression and appointment to a consultant or equivalent post. Its intention was to address pay disparities which would discourage early career doctors from entering this field. The BMA said it had previously called for the academic flexible pay premium to reflect better the loss of earnings arising from the time out of programme. It called on the government to fund an improved academic pay premium to both NHS and university employers.
- 5.133 In oral evidence, BMA resident doctors said that competition ratios needed to normalise back to 2017 to 2020 levels. They said that changes in flexible pay premia now, during the acute jobs crisis, would not be reflective of the position in a year or two.
- 5.134 The Royal College of Emergency Medicine wrote to us in October, specifically on the issue of the flexible pay premium in emergency medicine, which is paid to trainees at ST4-ST6. It highlighted the low fill rates over a sustained period, the relatively low competition ratio, the high level of weekend working, and the high risk of burnout in emergency medicine. It said that emergency medicine was not only a hard-to-fill specialty, but also a uniquely difficult one in which to sustain a career without additional support. It highlighted that less-than-full-time training had become essential to workforce sustainability, and the flexible pay premium had made this possible for many emergency medicine trainees. It said that emergency medicine was a uniquely challenging specialty and that any removal or reduction in the flexible pay premium would seriously damage the sustainability of the emergency medicine workforce, worsen morale, and ultimately compromise patient care.
- 5.135 The recently agreed new contract in Wales included a pay premium to resident doctors on general practice training programmes, paid at a rate of 30 per cent of point 1 of the registrar scale. The premium would only be paid to GP registrars when they were working on a general practice placement.
- 5.136 A pay premium would also be paid to resident doctors undertaking higher training in oral and maxillo-facial surgery to recognise the requirement to complete undergraduate degrees and foundation programmes in both medicine and dentistry. The premium would be paid at a rate of 8.6 per cent of point 1 of the registrar scale. The agreement

said that the purpose of this was to compensate for the longer length of training and the impact of this on pay progression; it was not a recruitment premium, nor specific targeting of a hard-to-fill specialty.

Motivation and morale

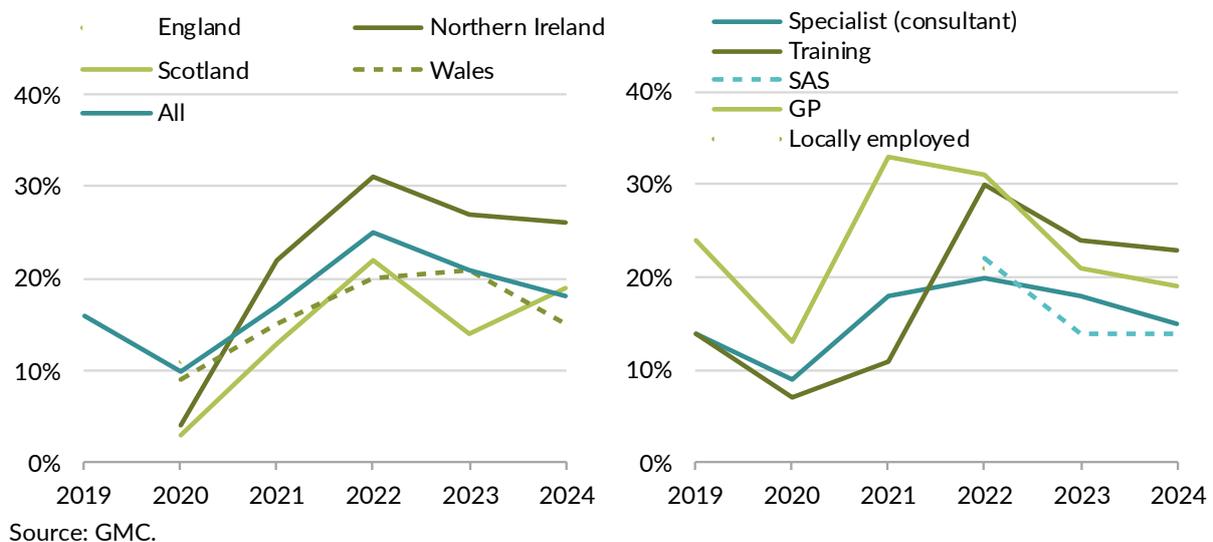
5.137 In the GMC's 2024 Barometer survey, a higher proportion of doctors were satisfied with their day-to-day work than in 2023. However, satisfaction in 2024 was still lower than in 2019 and 2020. England had the highest satisfaction, while Northern Ireland remained the lowest, though it had improved the most over the latest year.

Figure 5.15: Doctors satisfied with their day-to-day work, by nation and group, 2019 to 2024



5.138 In 2024, fewer doctors were at high risk of burnout or took time off for stress compared to 2023. Despite this improvement, burnout and stress-related absence were still more common than in 2019. Doctors in training and those in Northern Ireland were most affected. Northern Ireland continued to have the highest risk of burnout, and unlike other nations, Scotland saw an increase over the latest year.

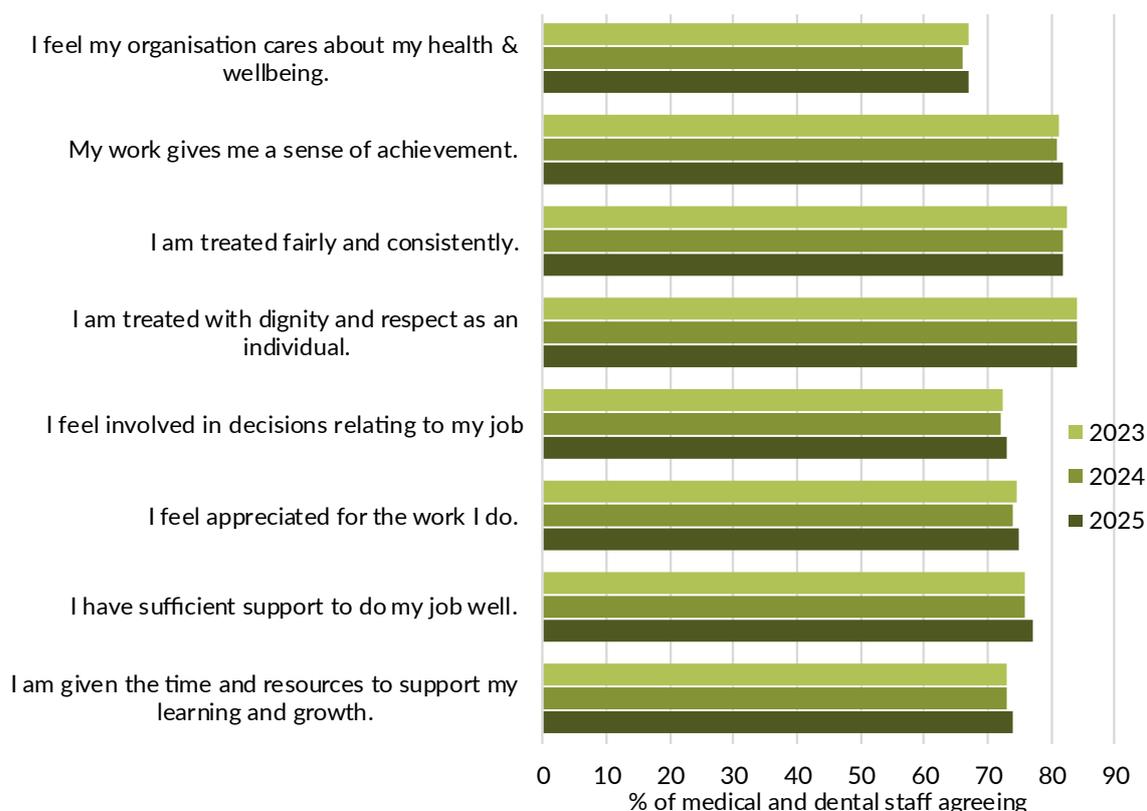
Figure 5.16: Doctors at high risk of burnout, by nation and group, 2019 to 2024



5.139 The 2025 NHS staff survey for England was not published in time for us to consider. The 2024 survey showed better results for medical and dental staff than in both 2022 and 2023. However, the results for 2024 generally remained worse than those recorded in 2020.

5.140 In Scotland, the Health & Social Care Staff Experience Survey 2025 showed a consistent picture for medical and dental staff.⁵⁶ In 2025, 82 per cent of medical and dental staff said their work gave them a sense of achievement, compared to 81 per cent in 2023 and 2024. In 2025, 82 per cent of medical and dental staff said they were treated fairly and consistently, unchanged from 2023 and 2024. In 2025, 75 per cent of medical and dental staff felt appreciated for the work they did, compared to 74 per cent in 2024 and 75 per cent in 2023.

Figure 5.17: Medical and dental staff experience, Scotland, 2023 to 2025



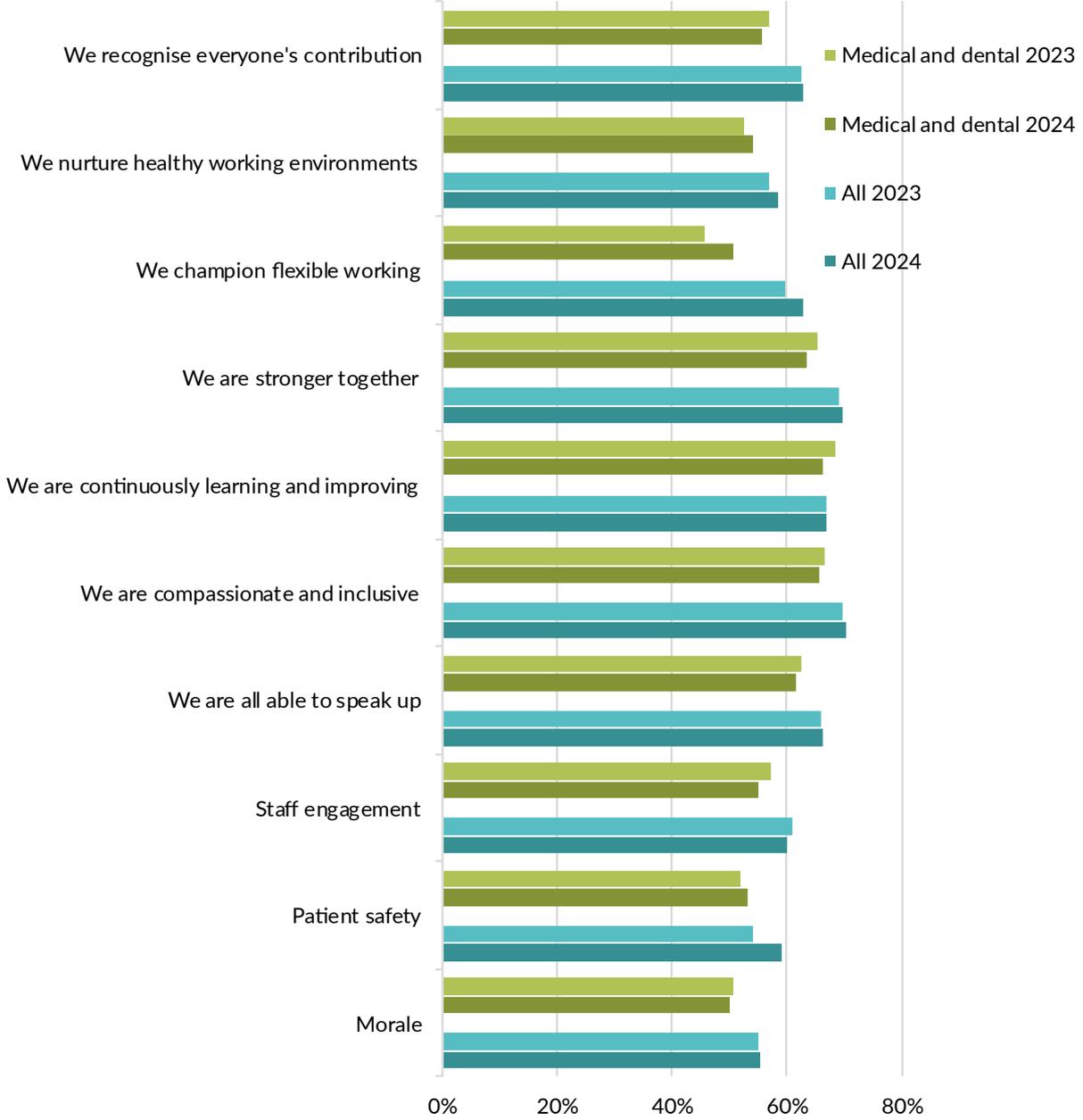
Source: iMatter Health & Social Care Staff Experience Survey 2023 to 2025.

5.141 NHS Wales shared results from its staff survey for medical and dental staff for the first time. Overall, 1,620 medical and dental staff responded in 2024. On the whole, medical and dental staff had less positive results than the workforce as a whole. Scores for morale and staff engagement for medical and dental staff saw small falls between 2023 and 2024: the proportion of medical and dental staff reporting positive staff engagement fell from 57.2 per cent in 2023 to 54.9 per cent in 2024; and the proportion of medical and dental staff reporting positive morale fell from 50.7 per cent in 2023 to 50.0 per cent in 2024.

5.142 There is no HSC-wide staff survey for Northern Ireland.

⁵⁶ Scottish Government, *iMatter Health & Social Care Staff Experience Survey 2025*.
<https://www.gov.scot/publications/imatter-health-social-care-staff-experience-survey-2025/documents/>

Figure 5.18: Medical and dental positivity scores from the NHS Wales staff survey, 2023 and 2024



Source: NHS Wales.

Our comments

Recruitment and retention

5.143 The overall trend appears to be improvement in recruitment and retention across the secondary care medical and dental workforce, as evidenced by the growing workforce, improved retention, falling vacancies and a lower proportion of consultants retiring each year. This is despite overall increasing demand and the creation of new roles in some areas. High and increasing training fill rates suggest this will continue in the medium term. Undergraduate applications for medicine remain strong, indicating that it remains an attractive profession. Lower retirement rates indicate a positive trend of retaining the most experienced consultants in the NHS.

- 5.144 There are, however, ongoing recruitment and retention challenges within some clinical specialties and in rural, remote and coastal areas. It is clear that, where vacancies persist, they have a substantial impact on service delivery, lead to high agency and locum costs, and intensify workloads and stress levels among other staff.
- 5.145 Given the overall reduction in vacancies for medical staff, we would encourage employers to understand better why vacancies persist, in which areas and specialties, whether these are national or local issues, and what levers might resolve them. National-level strategies, linked to workforce planning, are likely to be most effective.
- 5.146 Employers have highlighted a number of strategies to address specific recruitment and retention issues: the use of advanced SAS doctors to cover consultant vacancies; international recruitment; joint posts across hospitals; redesign of roles; and recruitment and retention premia. The latter are most likely to be effective where recruitment issues are local rather than national. The recent psychiatry working group in Scotland provides a helpful example of how solutions are likely to be multifaceted, encompassing expanded training places, and targeted retention incentives.

Flexible pay premia

- 5.147 Last year we recommended that the UK Government review flexible pay premia in England to assess their value for money and effectiveness. We said that, given the very high fill rates at core training, there was limited evidence to support their continued payment. There was also little evidence that payments were correctly targeted within higher levels of training or applied consistently across specialties.
- 5.148 Since then, we continue to see very high fill rates for CT1/ST1 training posts and increasing fill rates at higher training levels. The case for a review of flexible pay premia for value for money and effectiveness has increased. Giving different reward for different specialties at the same level of training needs to be fully justified, and we cannot support the continuation of the current payments without a review. We would expect any changes to be for future recruitment and to not impact those currently in training posts with a flexible pay premium.
- 5.149 The Royal College of Emergency Medicine has set out a strong case for the continued payment of the flexible pay premium for higher training in emergency medicine. This level of evidence should be provided for each specialty. It may be the case that recruitment to other specialties could be supported by the introduction of a flexible pay premium.
- 5.150 We set out the responses to our recommendation in chapter 1 and our view that the requirement for such a review remains.

Payment for additional work

- 5.151 Improved recruitment and retention are further evidenced by the reduction in spend on temporary medical staffing in England, Wales and Scotland. As well as substantial cost savings through a shift to direct/permanent employment, this is likely to improve the quality of care.
- 5.152 On our visits, management frequently raised with us the challenging issues around out-of-hours payments, including the time and goodwill that negotiating them locally takes up. A number of senior leaders highlighted the need for a consistent national rate for out-of-hours work. There are plans to establish national rates for short-term cover in

both Scotland and Wales, and for a medical and dental locum framework in Northern Ireland. These are likely to deliver significant system benefits. This might form part of the reform of the consultant contract, which we discuss further in chapter 6.

5.153 The desire for consultants to stop on-call work towards the end of their career was also raised with us across a number of discussion groups. A revised consultant contract might recognise that different consultants have different requirements for work-life balance and develop a framework to support this.

Motivation and morale

5.154 Staff survey data show an overall improvement in motivation, morale, engagement and wellbeing over the latest year, from a low point in 2022, but not to the levels seen before the pandemic. The staff survey in Scotland indicates broad stability, while the survey for Wales shows a small fall.

5.155 It is very positive to have received evidence from the NHS staff survey in Wales for medical and dental staff this year. We continue to lack evidence on motivation, morale and wellbeing among our remit group in Northern Ireland. As we said last year, this is important in improving the effectiveness of the workforce and we hope it can be addressed.

5.156 The impact that poor working conditions were having on motivation, morale and wellbeing was highlighted to us on our visits. For example, we heard of major problems with very poor facilities for those working out of hours, including working in cars and sleeping on desks or floors, and that this unacceptable environment affected the willingness to work on call. We understand that the ongoing industrial dispute in England is indicative of a broader dissatisfaction with both medical careers and day-to-day working life. Investment in working facilities and arrangements is likely to be cost effective in terms of the improvement to motivation, wellbeing and commitment.

Less-than-full-time working

5.157 The workforce data indicate only a small change in the participation rates of HCHS doctors and dentists in England, of one percentage point between 2015 and 2025. This is in significant contrast to what we have heard on visits, which is of widespread less-than-full time working, especially among doctors in core and specialty training. While this supported wellbeing, management reported less-than-full-time working led to gaps in rotas, falling disproportionately on specific areas, such as emergency medicine and obstetrics. There was a particular impact for on-call working, which tended to reduce more than basic hours. It was also hard to plan for over the long term, as it was so variable. These patterns do not show clearly in the workforce statistics because participation is measured using contracted hours, with 1.0 FTE based on 37.5 hours per week, and therefore the workforce data do not capture the majority of changes in on-call or out-of-hours commitments, where most reductions occur.

5.158 It would be helpful for employers to share their understanding of the extent of less-than-full-time working, the impact this is having on service delivery and the workforce, and how it can best be managed.

Chapter 6 HCHS workforce groups

6.1 This chapter looks at developments for specific parts of the Hospital and Community Health Services (HCHS) workforce – resident doctors, local employed doctors, specialty, associate specialist and specialist (SAS) doctors, and consultants. Our comments on the data and evidence are at the end of the chapter. Issues around the workforce, recruitment and retention, training, and motivation and morale were discussed in chapter 5.

Resident doctors

6.2 Resident doctors in England have been in dispute since April 2025 and took 15 days of strike action over three weeks in July, November and December 2025.

6.3 Resident doctors and dentists in Scotland are outside our remit. They have a two-year agreement with headline pay increases of 4.25 per cent in 2025 and 3.75 per cent in 2026 as well as accelerated pay progression. This includes a commitment to contract reform, including a pay review mechanism for future financial years. The British Medical Association (BMA) has estimated the agreement to be worth 9.9 per cent on average in 2025-26 and 9.4 per cent in 2026-27, including the additional pay progression.

Contract reform

6.4 Agreement was reached at the end of 2025 on a new pay framework for resident doctors in Wales. The Welsh Government said the current contract was over 20 years old and did not reflect safe and modern working practices, educational and training needs, or optimal service delivery. It said the new contract would end up with improved outcomes for patients, the service, and doctors/dentists.

6.5 The agreed aims of the negotiations were:

- To improve the recruitment, retention, motivation, and engagement of resident doctors and dentists in order to make Wales the preferred destination for medical and dental training.
- To ensure high-quality care by enabling employers and staff to meet shared responsibilities to patients, while maintaining competitiveness with other UK and international training programmes.
- To develop an equitable and progressive pay structure aligned with skills, experience, and Welsh Government longer term commitments to pay restoration.
- To provide clear entitlements to protected study time, modernise terms and conditions to support wellbeing and patient safety, and ensure affordability and return on investment in line with A Healthier Wales and the Workforce Strategy.

6.6 The new pay scale has seven pay points, based on a 40-hour week. The agreement said that it would add up to 4 per cent to the resident doctor paybill. The aims of the new pay structure were to:

- Create a simple to understand pay system.
- Move to an hours-based model of pay, where each hour of work has a defined value.
- Reduce the number of pay points and frontload pay to reduce the gender pay gap, support early career earnings, and improve pension outlook.
- Redistribute some out-of-hours pay, currently within banding supplements, into basic pay to reduce variations in pay across rotations and improve pension outlook.

- Ensure established flexible training pathways are supported and appropriately remunerated.
- Ensure the pay system does not discriminate against protected groups.

Table 6.1: Pay scales for resident doctors in Wales from August 2026

	Year	Old spine		New spine
F1	1	£35,390	1	£40,000
	2	£37,487		
	3	£39,587		
F2	1	£43,466	1	£50,000
	2	£46,192		
	3	£48,915		
Registrar (post foundation)	1	£46,324	1	£55,000
	2	£49,046		
	3	£52,853	2	£62,000
	4	£55,157		
	5	£57,929		
	6	£60,706	3	£68,000
	7	£63,482		
	8	£66,259		
	9	£69,034		
	10	£71,814	5	£78,000

Note: Does not include any uplift from 1 April 2026.

- 6.7 There is a single pay point each for foundation year 1 and foundation year 2. There is then a scale for registrar level with standard progression every two years. The agreement said that all residents would receive a higher level of basic pay than before, with more of it earlier in their career. It also meant that pay progressed in larger, less frequent amounts after foundation year 2. The framework covers locally employed doctors who work on rotas alongside resident doctors.
- 6.8 Pay progression between spinal points 2 and 3 of the registrar scale will be known as 'enhanced pay progression'. It will require a resident to have four years total equivalent experience following completion of their foundation programme, of which two years must be in a formal training programme (including dental core training) or equivalent.
- 6.9 The new contract replaces the old banding system and pays additional hours of work in the resident doctor's job plan (i.e. rostered hours) at an hourly rate of 1/40th of full-time basic pay, up to a maximum of an average 48 hours a week. Core hours will be between 07:00 and 19:00, Monday to Friday, unchanged from the 2002 contract. An enhancement of 50 per cent of the hourly basic rate will be paid for hours worked between 19:00 and 07:00 Monday to Friday, and any hours worked on a Saturday, Sunday or Bank Holiday. On call will be paid an availability rate of 50 per cent of the basic hourly rate.
- 6.10 The new contract introduces limits on working hours, designed to ensure that rotas are safe for both patient and resident doctor, sustainable, and provide a higher quality of work-life balance than the old contract.
- 6.11 The existing contract will be closed to new entrants from 1 August 2026, and existing resident doctors transferred to the new contract over a two-year period from this time.

The agreement said that the pay scales would be considered in the usual manner by the Welsh Government for an uplift alongside all other medical pay scales following the publication of the DDRB recommendations for 2026-27, i.e. prior to implementation, and in subsequent years.

- 6.12 In the agreement reached in January 2025, the Department of Health and BMA Northern Ireland committed to enter into contract reform discussions. The Department said that, since June 2025, parties had been engaged in discussions to identify key areas of agreement and prioritise themes to guide the upcoming negotiations. The Northern Ireland Resident Doctors Committee said that, while formal negotiations had yet to commence, initial planning meetings were constructive and collaborative. It said it had been assured that a mandate from the Minister would be forthcoming to enable formal negotiations to begin and this would include a pay envelope.

Working lives

- 6.13 The 10-year health plan for England said that the experience of doctors working in the NHS, particularly resident doctors, had deteriorated significantly in recent years. It said that under previous governments they had felt devalued and defeated by a loss of autonomy, by the difficulty securing postgraduate training, and by the NHS' refusal to modernise its employment practices. It said that they had gone unheard and had left for other industries and other countries.
- 6.14 NHS Employers said that, while pay remained a point of contention for resident doctors, employers acknowledged that dissatisfaction also stemmed from issues such as training capacity, rotational disruption, and working conditions.
- 6.15 NHS England published a 10-point plan to improve resident doctors' working lives in August 2025.⁵⁷ It said that the 75,000 resident doctors working across the NHS were the backbone of the service, but too often they were let down on basic issues such as payroll errors, poor rota management, lack of access to rest facilities and hot food, and unnecessarily repeating training. It said that, while some progress had been made, it had been too slow, and many still faced unfair and inconsistent working conditions. The Plan said that resident doctors were different from other staff because they provided care while training in different parts of the NHS, which meant they moved employer regularly for several years.
- 6.16 The 10-point plan proposed:
- Improving workplace wellbeing for resident doctors, including access to mess facilities, rest areas and lockers in all hospitals and 24/7 access to hot meals and cold snacks.
 - Ensuring that resident doctors receive their work schedules at least eight weeks in advance and detailed rotas no later than six weeks before the rotation begins.
 - Being able to take annual leave in a fair and equitable way.
 - A senior named lead for resident doctors' issues in each trust.
 - A reduction in payroll errors.
 - No unnecessary repetition of statutory or mandatory training.
 - Implementation of the new process for exception reporting to ensure resident doctors are being fairly compensated for the additional hours they are required to work, and to support the safety of their working hours.

⁵⁷ NHS England, 10 Point Plan to improve resident doctors' working lives. <https://www.england.nhs.uk/long-read/10-point-plan-to-improve-resident-doctors-working-lives/>

- Prompter reimbursement of course-related expenses.
 - Reducing the impact of rotations.
 - Expanding the lead employer model.
- 6.17 NHS England said that every NHS organisation was required to act across all 10 areas within 12 weeks. Progress needed to be reported to boards and, where actions were not met, a formal explanation and corrective measures should be provided. The outcomes should be included in annual reports to demonstrate accountability and progress.
- 6.18 From autumn 2025, NHS England said it would publish new data and information on:
- Trusts delivering access to the basics – lockers, rest facilities, hot meals, on-call parking spaces.
 - The delivery of eight-week work schedules and six-week rota notice on rotations.
 - The number of payroll errors.
 - Self/preferential e-rostering.
 - The percentage of trusts delivering board level reporting of issues.
 - Changes to the way in which annual leave could be taken.
- 6.19 NHS Employers said the 10-point plan represented a significant operational and cultural shift for NHS trusts. They said that trusts would need to allocate resources to upgrade facilities, improve HR systems, and support more consistent training and payroll processes. These changes were expected to enhance staff morale, reduce burnout, and improve retention, ultimately benefiting patient care.
- 6.20 NHS Employers said that concerns existed regarding the short implementation timescales, the introduction of new reporting roles, and the lack of clarity surrounding funding and delivery capacity. In particular, NHS Employers highlighted the critical role of medical workforce teams in sustaining workforce reforms and improving doctors' working lives, which could be undermined by cuts to corporate service costs.
- 6.21 The Hospital Consultants and Specialists Association (HCSA) said it was too early to assess the success of the 10-point plan for resident doctors. It had presented the Secretary of State with a list of actions to restore dignity to resident doctors and improve attrition rates. This included:
- A multi-year agreement to restore the value of resident doctor pay.
 - Reform of the medical training system.
 - Reforms to limit rotational training.
 - Support for resident doctors' accommodation and relocation costs.
 - Advanced notification of rotations and enforceable rota notice periods.
 - Access to parking, lockers, rest facilities, showers, secure bike storage, hot meals and safe sleeping rooms.
 - IT investment to secure accurate payroll and HR systems.
 - Coverage of non-salary expenses essential to work, including workplace parking and DBS checks.
 - Funded postgraduate exams and training portfolio costs.
 - Equitable access to meaningful teaching, protected training time, and funded study leave.
 - Innovative training models.
 - Enhanced pastoral support.
 - A commitment that non-medical roles were used to support and not replace doctors and did not impair medical training.

- 6.22 The BMA said that any fix to workplace issues was highly complex, often requiring contractual negotiations and implementation at every level. It said this could be time consuming and expensive. In contrast, adjustments to pay were relatively simple and could be implemented swiftly.
- 6.23 The BMA said that resident doctors were overwhelmed by an increasingly unsustainable workload and deteriorating working conditions. It said that constraints on hospital spending meant that employers felt unable to escalate rates other than to cover the most safety-critical shortages, meaning that the other doctors on the shift had to cover for absent or non-existent colleagues, with worsened doctor-patient ratios and higher risk of errors compounding the risk of burnout.
- 6.24 The HCSA said that resident doctors faced unique costs not reflected in comparator groups, including the additional costs that came from moving rental accommodation through rotational training, training fees and exams. It also highlighted the significant financial burden of student loans on resident doctors impacting their long-term financial security and career satisfaction.
- 6.25 The Scottish Government said that, while rotational training could have a range of benefits, it recognised that in some circumstances it could have negative impacts on resident doctors. Measures were in place, through National Education for Scotland, to support the health and wellbeing of resident doctors in training including the improvement of placement distribution to ensure more stable and less disruptive rotations, focus on resilience and support including access to flexible working arrangements, and the provision of a trainee development and wellbeing service.
- 6.26 The recent agreement with resident doctors in Wales included commitments to working groups on: transferring resident doctors to the Agenda for Change expenses system; clarifying mandatory courses and establishing automatic approval processes; developing alternatives to rota monitoring and suspending rota monitoring during transition; and implementation of a new role of Guardian of Safe and Flexible Training.
- 6.27 The Department of Health said that all medical and dental trainees in Northern Ireland were employed by a single lead employer. It said this had reduced payroll errors and onboarding issues and had received overwhelmingly positive feedback. The Department said there remained issues in releasing rotas on time. It said that notable progress was being made in a number of trusts on improving the provision of rest and on-call facilities for doctors in training.
- 6.28 The BMA resident doctors committee in Northern Ireland said that progress on implementing the recommendations to improve the experience of doctors in training in Northern Ireland had stalled.⁵⁸

Pay and earnings

- 6.29 Basic pay scales for resident doctors vary across the nations, reflecting the different contracts. Additional payments also vary, which will affect earnings. Under the 2016 contract, resident doctors in England receive pay for additional hours at plain time (i.e.

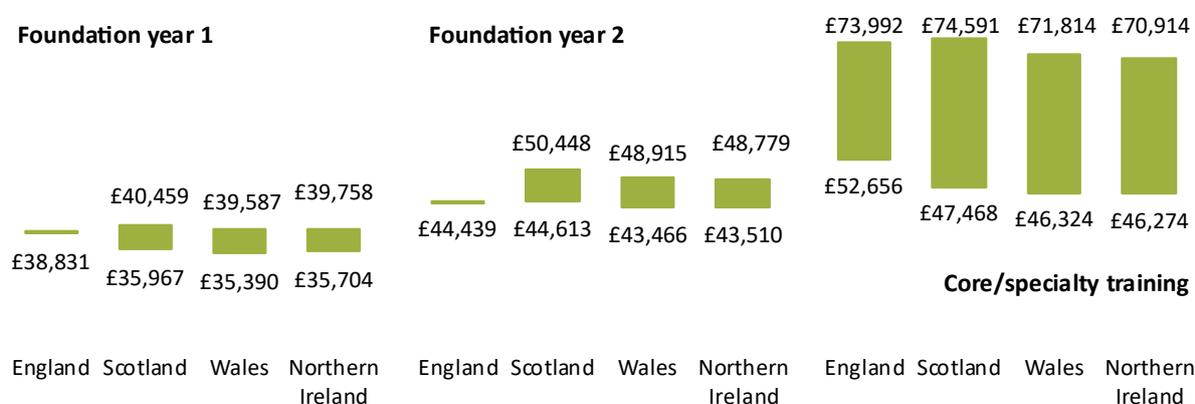
⁵⁸ These were outlined in our 2025 report: an initial one hour a week self-development time; fair and timely rota design; improved provision of rest and on-call facilities; a trial of over-recruitment into a medical specialty training programme; active support of less-than-full-time training across all medical training programmes; and a transparent methodology for the review of the current distribution of medical training posts across Northern Ireland (starting with psychiatry) including a review into rotational training.

1/40th of basic pay), up to a maximum of 48 hours worked. There are a number of other payments:

- An enhancement of 37 per cent for hours worked at unsociable times i.e. between 9pm and 7am on a weekday.
- A 3 to 15 per cent allowance for weekend working.
- An 8 per cent on-call allowance.
- Flexible pay premia, worth £3,390 to £11,118, for some training programmes.

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

Figure 6.1: Resident doctor pay scales, by nation, 2025-26



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

Note: Under the 2025 agreement in Scotland, foundation year 1 doctors will be on a minimum salary of £38,215.

6.31 There are separate earnings data for foundation year 1, foundation year 2, core trainees and registrars in England. In the year to November 2025:

- Average earnings per head for foundation year 1 were £45,938, 11.7 per cent higher than a year earlier. Basic pay increased by 13.0 per cent over the year, while non-basic pay increased by 7.2 per cent. Non-basic pay made up 21.1 per cent (£9,677) of foundation year 1 average earnings per head.
- Average earnings per head for foundation year 2 were £53,855, 7.9 per cent higher than a year earlier. Basic pay increased by 8.9 per cent over the year, while non-basic pay increased by 4.8 per cent. Non-basic pay made up 23.5 per cent (£12,679) of foundation year 2 average earnings per head.
- Average earnings per head for core trainees were £68,698, 6.8 per cent higher than a year earlier. Basic pay increased by 8.4 per cent over the year, while non-basic pay increased by 1.8 per cent. Non-basic pay made up 23.2 per cent (£15,920) of core trainee average earnings per head.
- Average earnings per head for registrars were £76,945, 6.7 per cent higher than a year earlier. Basic pay increased by 8.7 per cent over the year, while non-basic pay increased by 0.9 per cent. Non-basic pay made up 23.8 per cent (£18,303) of registrar average earnings per head.

6.32 In 2024-25, average total pay per full-time equivalent (FTE) for resident doctors (covering foundation doctors, specialty training and clinical fellows) in Scotland was £87,798, 9.3 per cent higher than in 2023-24. Basic pay increased by 8.3 per cent over the year. Non-basic pay made up 46 per cent of FTE earnings.

6.33 In 2024-25, average total pay per FTE for doctors in training grades in Wales was £64,445. Average total earnings per head were £60,369. Non-basic pay made up 20 per cent (£13,149) of FTE earnings.

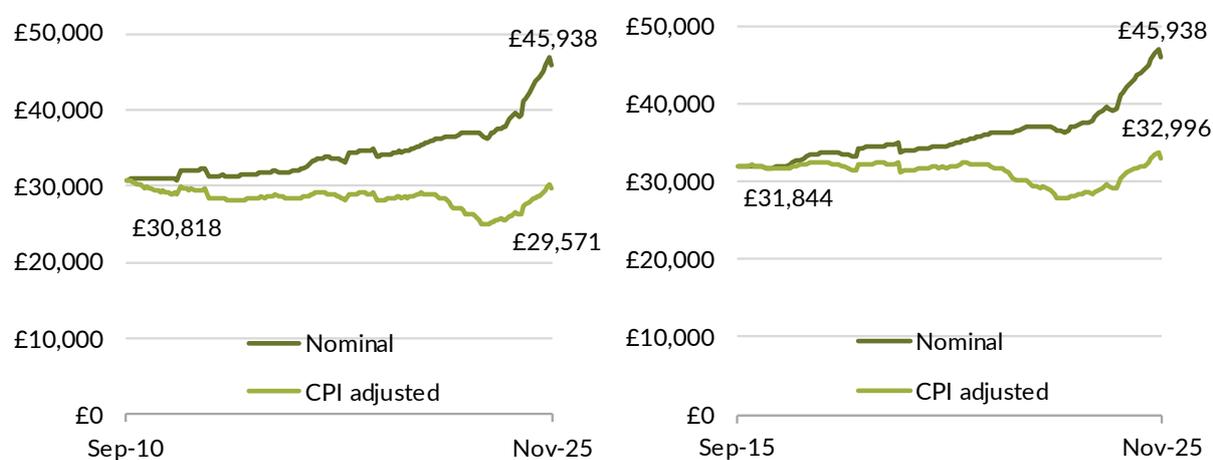
6.34 In Northern Ireland, earnings at May 2025 were:

- Foundation year 1: £29,578 average FTE unbanded (i.e. basic); £48,863 banded (i.e. total).
- Foundation year 2: £36,431 average FTE unbanded; £53,262 banded.
- Core training: £43,713 FTE unbanded; £67,405 banded.
- Specialty training: £49,232 FTE unbanded; £73,682 banded.

Earnings over time

6.35 We only have earnings data over time for England. In nominal terms, average earnings per head for foundation year 1 doctors in England increased from £30,818 in September 2010 to £45,938 in November 2025, an increase of 49.1 per cent. In real terms, after adjusting for the consumer prices index (CPI), average earnings per head for foundation year 1 doctors decreased from £30,818 in September 2010 to £29,571 in November 2025, a reduction of 4.0 per cent. Using the CPI including owner occupiers' housing costs (CPIH) gives a reduction of 3.3 per cent.

Figure 6.2: Foundation year 1, average earnings per person, nominal and CPI adjusted, England, September 2010/September 2015 to November 2025



Source: Office for the Pay Review Bodies (OPRB) analysis of NHS England and Office for National Statistics (ONS) data.

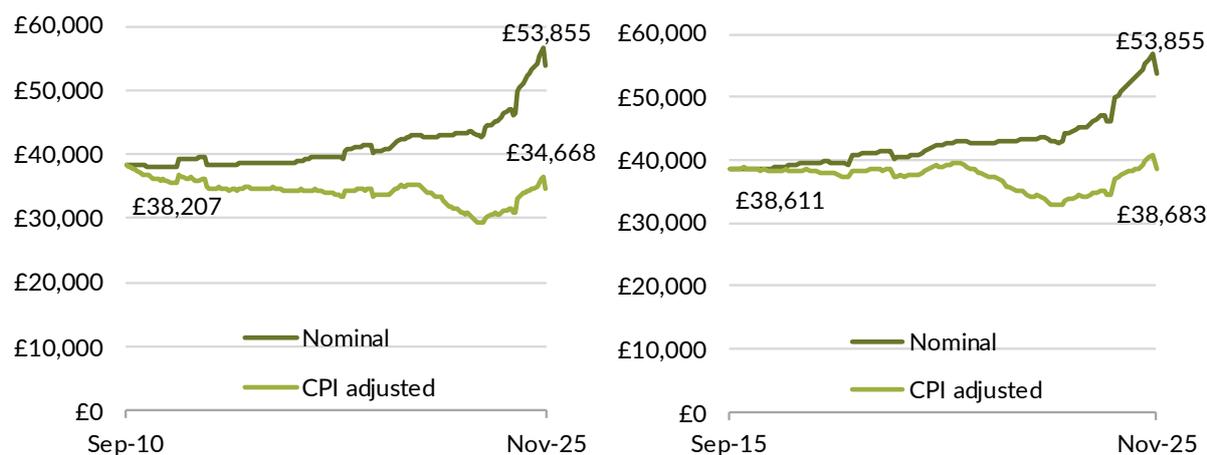
6.36 In nominal terms, average earnings per head for foundation year 1 doctors increased from £31,844 in September 2015 to £45,938 in November 2025, an increase of 44.3 per cent. In real terms, after adjusting for CPI, average earnings per head for foundation year 1 doctors increased from £31,844 in September 2015 to £32,996 in November 2025, an increase of 3.6 per cent. Using CPIH gives an increase of 3.7 per cent.

6.37 In nominal terms, average earnings per head for foundation year 2 doctors in England increased from £38,207 in September 2010 to £53,855 in November 2025, an increase of 41.0 per cent. In real terms, after adjusting for CPI, average earnings per head for

foundation year 2 doctors decreased from £38,207 in September 2010 to £34,668 in November 2025, a reduction of 9.3 per cent. Using CPIH gives a reduction of 8.6 per cent.

6.38 In nominal terms, average earnings per head for foundation year 2 doctors increased from £38,611 in September 2015 to £53,855 in November 2025, an increase of 39.5 per cent. In real terms, after adjusting for CPI, average earnings per head for foundation year 2 doctors increased from £38,611 in September 2015 to £38,683 in November 2025, an increase of 0.2 per cent. Using CPIH gives an increase of 0.3 per cent.

Figure 6.3: Foundation year 2, average earnings per person, nominal and CPI adjusted, England, September 2010/September 2015 to November 2025



Source: OPRB analysis of NHS England and ONS data.

Figure 6.4: Core training, average earnings per person, nominal and CPI adjusted, England, September 2010/September 2015 to November 2025



Source: OPRB analysis of NHS England and ONS data.

6.39 In nominal terms, average earnings per head for doctors in core training in England increased from £46,713 in September 2010 to £68,698 in November 2025, an increase of 47.1 per cent. In real terms, after adjusting for CPI, average earnings per head for doctors in core training decreased from £46,713 in September 2010 to £44,223 in November 2025, a reduction of 5.3 per cent. Using CPIH gives a reduction of 4.6 per cent.

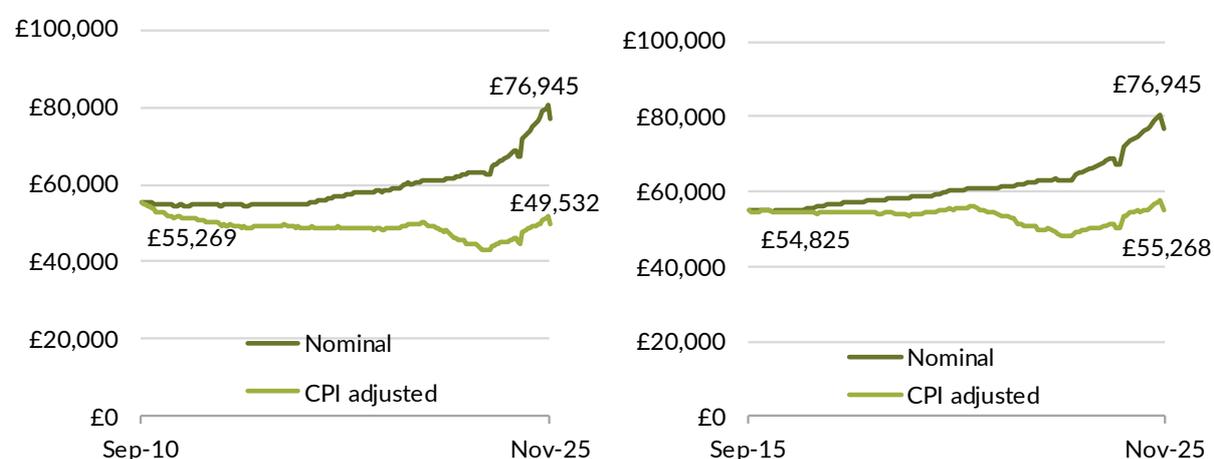
6.40 In nominal terms, average earnings per head for doctors in core training increased from £46,680 in September 2015 to £68,968 in November 2025, an increase of 47.2 per

cent. In real terms, after adjusting for CPI, average earnings per head for doctors in core training increased from £46,680 in September 2015 to £49,344 in November 2025, an increase of 5.7 per cent. Using CPIH gives an increase of 5.8 per cent.

6.41 In nominal terms, average earnings per head for registrars in England increased from £55,269 in September 2010 to £76,945 in November 2025, an increase of 39.2 per cent. In real terms, after adjusting for CPI, average earnings per head for registrars decreased from £55,269 in September 2010 to £49,532 in November 2025, a reduction of 10.4 per cent. Using CPIH gives a reduction of 9.7 per cent.

6.42 In nominal terms, average earnings per head for registrars increased from £54,825 in September 2015 to £76,945 in November 2025, representing an increase of 40.3 per cent. In real terms, after adjusting for CPI, average earnings per head for registrars increased from £54,825 in September 2015 to £55,268 in November 2025, an increase of 0.8 per cent. Using CPIH gives an increase of 0.9 per cent.

Figure 6.5: Registrars, average earnings per person, nominal and CPI adjusted, England, September 2010/September 2015 to November 2025



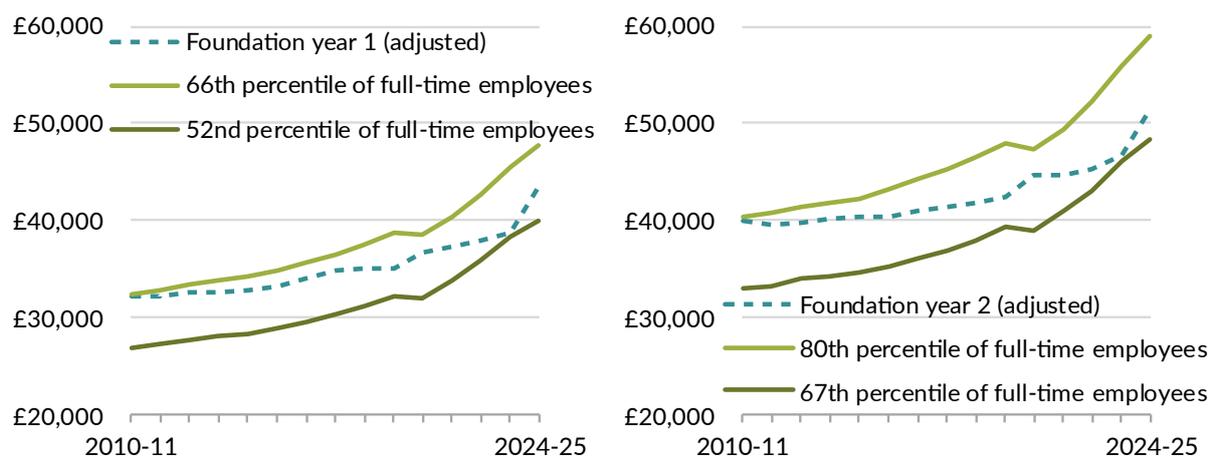
Source: OPRB analysis of NHS England and ONS data.

Pay comparability

6.43 Average FTE earnings for foundation year 1 doctors moved from the 65th percentile of UK average full-time earnings in 2010-11 to the 52nd percentile in 2023-24, with an increase to the 58th percentile in 2024-25. Average FTE earnings for foundation year 2 doctors declined from the 79th percentile of UK average full-time earnings in 2010-11 to the 67th percentile in 2023-24, with an increase to the 71st percentile in 2024-25.

6.44 Average FTE earnings for doctors in core training declined from the 87th percentile of UK average full-time earnings in 2010-11 to the 83rd percentile in 2023-24, with an increase to the 85th percentile in 2024-25.

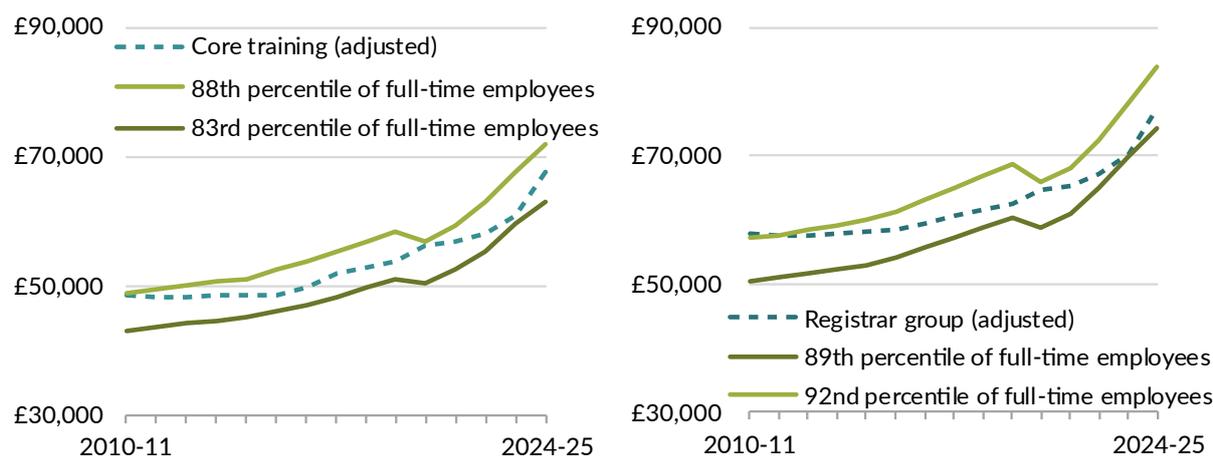
Figure 6.6: Average total FTE earnings for foundation doctors, England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2024-25



Source: OPRB analysis of NHS England and Annual Survey of Hours and Earnings (ASHE) data.

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

Figure 6.7: Average total FTE earnings for doctors in core training and registrars, England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2024-25



Source: OPRB analysis of NHS England and ASHE data.

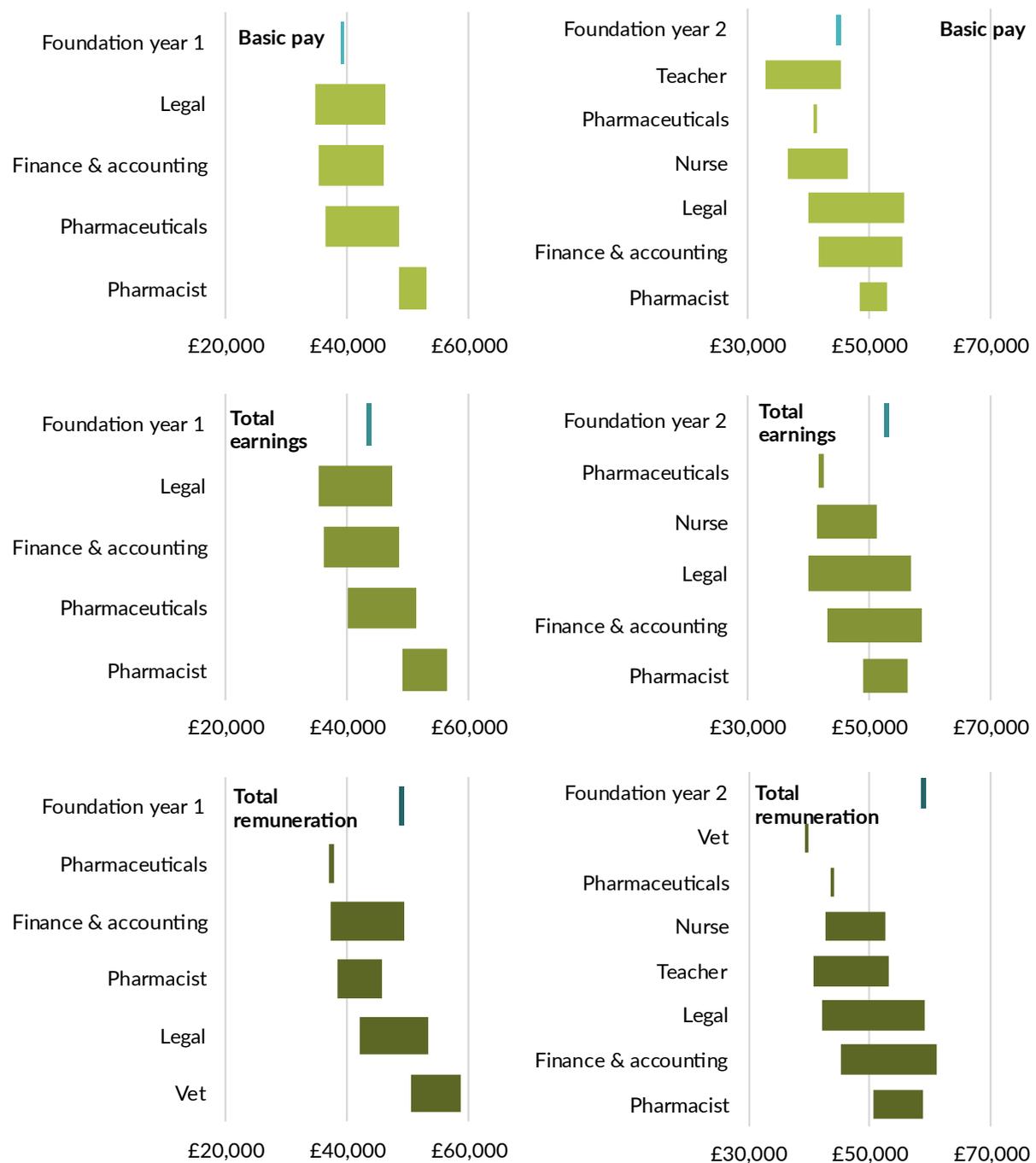
Note: Earnings for doctors are average annual basic pay per FTE, added to average non-basic pay per head, adjusted by a factor that reflects the ratio between FTE and headcount estimates of basic pay.

6.45 Average FTE earnings for registrars were slightly above the 92nd percentile of UK average full-time earnings in 2010-11. By 2023-24, this had moved to the 89th percentile, with an increase to the 90th percentile in 2024-25.

6.46 We commissioned work from Incomes Data Research (IDR) to identify roles which were broadly comparable to those in our remit group to inform pay comparisons. More detail is in appendix E. These pay comparisons indicate that basic pay for foundation year 1 doctors is in line with or below comparator roles. Total earnings are broadly in line with comparator roles. Total remuneration is either in line with or ahead of the comparators.

6.47 Basic pay for foundation year 2 doctors is broadly in line with comparator roles. Total earnings are either in line with or ahead of the comparators. Total remuneration is above all comparators.

Figure 6.8: Pay for foundation doctors, England, and market comparators, 2025



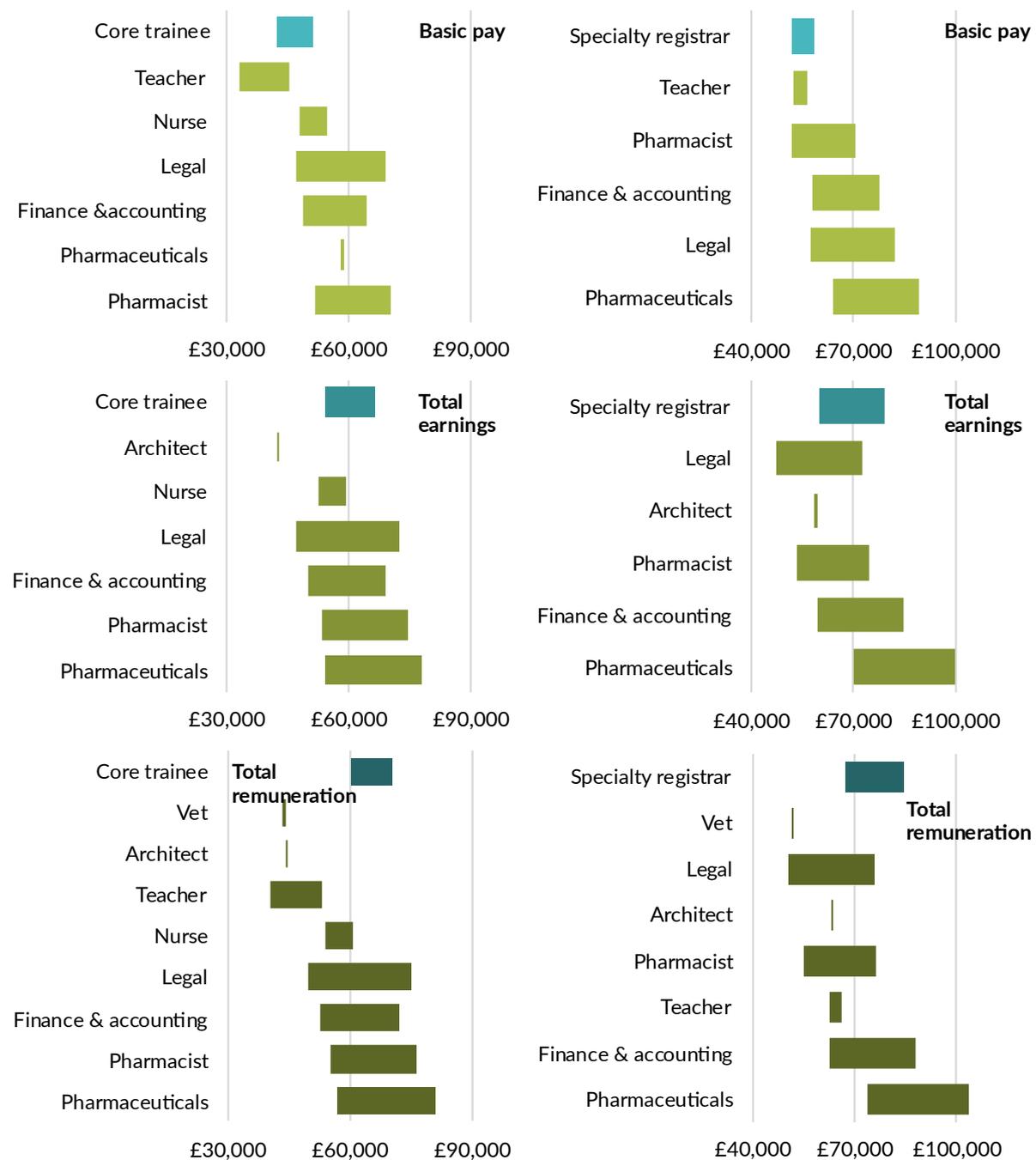
Sources: Foundation year 1 – basic rate/average earnings. Finance & accounting, legal, pharmaceuticals (R&D) – Korn Ferry, level 14, interquartile range. Pharmacy – IDR bespoke survey, newly qualified pharmacist, interquartile range. Vet – SPVS 2025, vet, less than one year qualified, median.

Foundation year 2, basic rate/average earnings. Finance & accounting, legal, pharmaceuticals (R&D) – Korn Ferry, level 15, interquartile range. Pharmacy – IDR bespoke survey, newly qualified pharmacist, interquartile range. Nurse – AfC band 6; Teacher – main pay scale. Vet – SPVS 2025, vet, one year qualified, median.

6.48 Basic pay for core trainee doctors is below or in line with the comparator roles. Total earnings are broadly in line with the comparators, while total remuneration is in line with or ahead of comparator roles.

6.49 Basic pay for specialty registrar doctors is below all comparator roles. Both total earnings and total remuneration are in line with or ahead of comparator roles.

Figure 6.9: Pay for core trainee and registrar, England, and market comparators, 2025



Source: Core trainee – Interquartile range of CT1-2, NHS Digital. Finance & accounting, legal, pharmaceuticals (R&D) – Korn Ferry level 16, interquartile range. Pharmacist – IDR bespoke survey, pharmacist, interquartile range; Nurse – AfC band 7; Architect – Architect Earnings, private practice architect I, less than five years' experience, London, median. Teacher – main pay scale. Vet – SPVS 2025, vet, two years qualified, median.

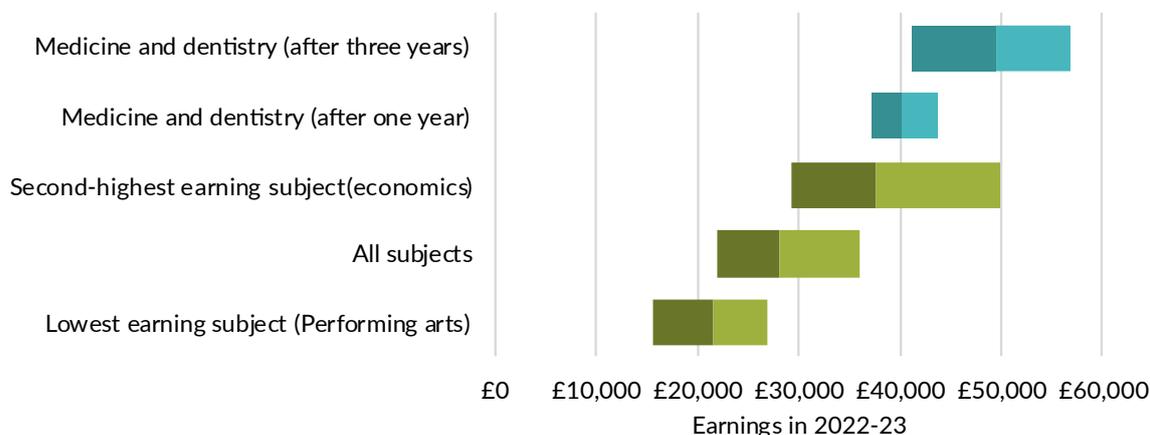
Specialty registrar – Interquartile range of ST3-5, NHS Digital. Finance & accounting, legal, pharmaceuticals (R&D) – Korn Ferry, level 17, interquartile range. Pharmacist – IDR bespoke survey, pharmacist, interquartile range. Architect – Architect Earnings, private practice architect II, six or more years' experience, London, median. Teacher – upper pay scale. Vet – SPVS 2025, vet, four years qualified, median.

Note: The registrar role is job evaluated at the entry point (ST3), while earnings are for all specialty registrars, which will span more than one job level. This means that earnings for registrar may be overstated relative to market comparators.

6.50 Longitudinal Education Outcomes (LEO) data show that, in 2022–23, median earnings for medicine and dentistry graduates one year after graduation (£40,200) were

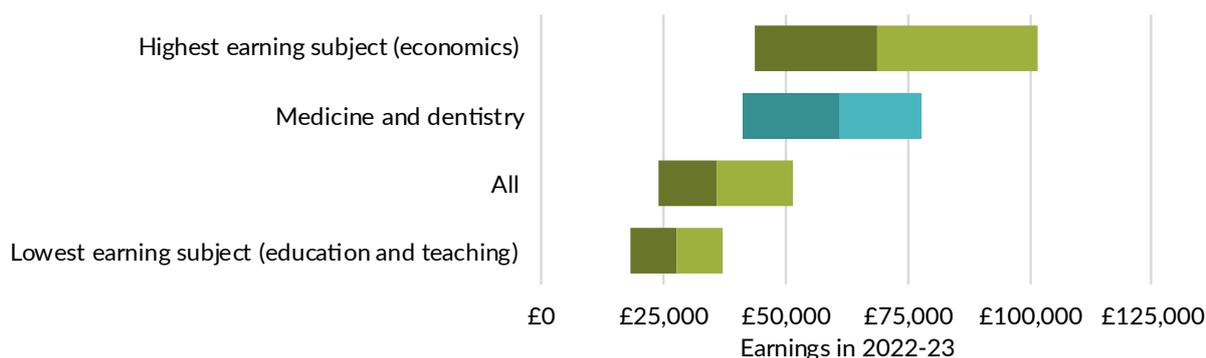
substantially higher than those for any other subject. Median earnings for medical and dental graduates remained the highest three years after graduation (£49,600) and five years after graduation (£53,300). Ten years after graduation, median earnings for those who studied medicine or dentistry (£61,000) continued to exceed those for all other subjects except economics (£68,600).

Figure 6.10: Earnings three years after graduation, 2022-23



Source: Longitudinal Education Outcomes.

Figure 6.11: Earnings 10 years after graduation, 2022-23



Source: Longitudinal Education Outcomes.

6.51 The LEO data also showed higher rates of sustained employment among medicine and dentistry graduates than most other subjects:

- One year after graduation, medicine and dentistry had 88.6 per cent of graduates in sustained employment, joint third highest alongside education and teaching, and behind nursing and midwifery (94.6 per cent) and allied health (90.3 per cent). These were well above the all-subject average of 82.8 per cent.
- Three years after graduation, medicine and dentistry had 92.2 per cent of graduates in sustained employment, the second highest of any subject group, just behind nursing and midwifery at 93.3 per cent. Both were well above the all-subject average of 85.7 per cent.
- Five years after graduation, medicine and dentistry had 91.9 per cent of graduates in sustained employment, just behind nursing and midwifery at 92.2 per cent, and well above the all-subject average of 86.6 per cent.
- Ten years after graduation, medicine and dentistry had 88.2 per cent of graduates in sustained employment, among the highest, but below nursing and midwifery (89.3 per cent), veterinary sciences (88.9 per cent) and sport and exercise sciences (88.5 per cent); all were above all the subject average of 85.1 per cent.

6.52 International comparisons indicate that pay at resident doctor level was higher in Australia, lower in New Zealand, and at a similar level in the Republic of Ireland. See appendix F for more details.

Pay progression

6.53 The Department of Health and Social Care (DHSC) highlighted the extent of pay progression for doctors. Within-grade pay progression was worth 91 per cent for resident doctors, 61 per cent for specialty doctors, and 33 per cent for consultants in England. Basic pay progression was worth 275 per cent from foundation year 1 to the maximum of the consultant scale (£38,831 to £145,478).

6.54 The DHSC provided 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, split according to the individual's grade in March 2025. The median increase in basic pay per FTE over the 10-year period was 67.5 per cent (5.3 per cent a year) while one quarter of the workforce experienced an annual increase of over 10 per cent a year, generally 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 per cent (4.7 per cent a year) while the increase for those who had moved grades, mainly entering the consultant grades, was over 10 per cent a year.

Table 6.2: Change in basic pay per FTE for HCHS staff employed in both March 2015 and March 2025, England

	Count	25th percentile earnings growth (annualised growth)	Median earnings growth (annualised growth)	75th percentile earnings growth (annualised growth)
Consultant	50,500	55.0 per cent 4.5 per cent	65.2 per cent 5.1 per cent	189.5 per cent 11.2 per cent
Associate specialist	2,000	44.4 per cent 3.7 per cent	54.4 per cent 4.4 per cent	81.9 per cent 6.2 per cent
Specialty doctor	3,500	50.1 per cent 4.1 per cent	77.7 per cent 5.9 per cent	118.5 per cent 8.1 per cent
Specialty registrar	1,000	104.7 per cent 7.4 per cent	134.7 per cent 8.9 per cent	173.1 per cent 10.6 per cent
Core training	6,100	86.2 per cent 6.4 per cent	120.5 per cent 8.2 per cent	176.4 per cent 10.7 per cent
All medical staff	64,100	55.0 per cent 4.5 per cent	67.5 per cent 5.3 per cent	147.3 per cent 9.5 per cent
CPI		36.9 per cent 3.2 per cent	36.9 per cent 3.2 per cent	36.9 per cent 3.2 per cent

Source: OPRB analysis of data from DHSC and ONS.

Locally employed doctors

6.55 Locally employed doctors are employed by an NHS trust or health board under locally determined contracts. They have various titles, such as trust grade, clinical fellow, foundation year 3 or staff grade. Posts are often temporary and most commonly at a level equivalent to core training, although roles can range from foundation to consultant level. This group are not in a formal training or development programme.

- 6.56 General Medical Council (GMC) data indicate that there were 38,394 licensed locally employed doctors in England and Wales in 2024. This was up by 4.2 per cent over the year and by 66.1 per cent over five years. More than two thirds (69 per cent) of locally employed doctors had a non-UK primary medical qualification.
- 6.57 The DHSC estimated there were 14,763 doctors in 'trust grades', which could alternatively be described as locally employed doctors, in England in 2024-25, an increase of 4,987 (51 per cent) from two years' earlier. This represented an increase from 7 to 10 per cent of the medical workforce.
- 6.58 The Welsh Government said that locally employed doctors made up a significant proportion (13 per cent FTE) of the medical and dental workforce in Wales. There were 1,185 (1,159 FTE) locally employed doctors in Wales in March 2025. NHS Wales provided a breakdown by specialty, with the most common areas being general medicine (269 FTE including locums), trauma and orthopaedic surgery (127 FTE), and emergency medicine (123 FTE).
- 6.59 In Scotland, there were 964 whole-time equivalent resident doctors without a national training number in September 2025, an increase of 2.5 per cent over the year and 40.4 per cent over five years. This was 5.8 per cent of the medical and dental secondary care workforce in Scotland. These doctors are on national terms and conditions.
- 6.60 We do not have data on the number of locally employed doctors in Northern Ireland. Southern Trust had 74.5 locally appointed resident doctors at April 2025, around 9 per cent of the trust's overall medical and dental workforce.

Terms and conditions

- 6.61 The GMC said that 76 per cent of locally employed doctors in England and Wales in 2024 were on fixed-term contracts. A further 12 per cent were on bank contracts only and 3 per cent in locum employment only. Just 9 per cent were on permanent contracts.
- 6.62 NHS Employers said that most locally employed doctors in England were employed on terms mirroring the 2016 resident doctor contract although some trusts continued to use the 2002 contract. They said that employers continued to support the principles of equal pay for work of equal value and had expressed that a standard template contract, rather than a separate pay scale, would help standardise the employment of locally employed doctors. This could encourage the adoption of recommended elements (such as the MT01-MT05 nodal points⁵⁹) without overly restricting employers. It would also allow employers to retain sufficient freedom to create local terms for more senior roles, such as post Certificate of Completion of Training (CCT) fellows.
- 6.63 NHS Employers said it was essential to ensure that any agreed framework remained sufficiently flexible for employers to implement locally. Employers had expressed concern that a template containing elements that a trust could not – or did not wish to – offer would create additional employment relations challenges.
- 6.64 A process was in development in England to allow locally employed doctors who had been carrying out a role comparable to a SAS doctor the option to move to a permanent SAS contract.

⁵⁹ Equivalent to the five nodal points on the resident doctor contract.

- 6.65 The BMA said that locally employed doctors were often treated as an invisible workforce, that they were vulnerable to exploitation, and could occupy positions of profound insecurity. In particular, it highlighted:
- Doctors on back-to-back fixed-term contracts as short as three months, or with brief gaps before re-engagement to avoid continuous employment.
 - Individuals being released from their current contracts and re-engaged on worse terms.
 - Employers opting out of pay uplifts.
 - Unclear definitions leading to locally employed doctors being placed on erroneous contracts (e.g. SAS-level locally employed doctors working on resident doctor-level pay scales).
 - The use of 'trust consultant' contracts with poorer terms.
- 6.66 The HCSA said that locally employed doctors continued to face significant challenges around pay, progression, and recognition. It noted the issues affecting locally employed doctors highlighted by the GMC and the SAS Collective:
- Lack of standardised contracts and pay parity, leaving locally employed doctors vulnerable to inconsistent terms and conditions across trusts.
 - Limited access to professional development and training opportunities which restricted career progression and created a two-tier system within the medical workforce.
 - Job insecurity and exclusion from national agreements, meaning locally employed doctors often missed out on benefits such as pay uplifts.
 - Cultural and structural barriers, with locally employed doctors frequently reporting feeling undervalued and disconnected from the wider medical team.
- 6.67 The HCSA said it advocated implementing a mirror pay scale and addressing the systemic issues impacting locally employed doctors. It said that, without reform, locally employed doctors would continue to experience disadvantage, which risked exacerbating workforce shortages and undermining retention efforts.
- 6.68 NHS Wales Employers said that locally employed doctors operated under terms and conditions that mirrored those of resident doctors and were included in the implementation plan to transition to the new terms and conditions. The recent agreement with resident doctors in Wales included a commitment to the development of a clear and consistent process for locally employed doctors to secure permanent employment on the specialty doctor terms, subject to eligibility. It said this recognised the mutual benefits for both doctors and employers, supporting career development for doctors while providing workforce stability and funding continuity for organisations.
- 6.69 The Department of Health in Northern Ireland said that discussions had started between the four nations to develop a regional framework for locally employed doctors. The Department was preparing a scoping paper to enhance its understanding of locally employed doctors.

Data issues

- 6.70 The DHSC noted that it was difficult to gain a completely accurate picture of the numbers of locally employed doctors due to the different electronic staff record codes used by employers for these staff.
- 6.71 NHS Employers said that employers were reporting that they had a good understanding of their locally employed doctor workforce and could easily provide this

data. NHS Employers said that the pay codes MT01-05 should be used for locally employed doctors employed on terms that mirrored the 2016 national contract. Previously, locally employed doctors on closed grades (for example the MN37 pay code) had been hard to differentiate from doctors in training under pay protection arrangements. They said that, as the number of doctors in training eligible for pay protection continued to decrease, this should become less of an issue. They said that challenges would remain where employers had created a local code (for example, for doctors working on truly bespoke terms), but it was expected this number should be relatively small and easily identifiable at the trust level.

- 6.72 The BMA said that employers should be compelled to share information on the distribution of locally employed doctors across the NHS and the terms and conditions these doctors were engaged on.
- 6.73 Across NHS Wales, over 150 different job titles were in use for locally employed doctors at May 2024. A standardised list of nine core job titles for the electronic staff record was formally approved. The recoding of locally employed doctor roles was completed in March 2025. NHS Wales Employers said this enabled more consistent and comprehensive analysis of the terms and conditions of employment for locally employed doctors across Wales and supported improved workforce planning and reporting.
- 6.74 BMA Wales said that the next steps as part of this workstream were for employers to undertake a comprehensive review of the local terms and conditions of service under which locally employed doctors were being employed in Wales, with an analysis of the discrepancies this identified. Following that, it was agreed that work would be undertaken on the feasibility of transitioning locally employed doctors to appropriate nationally agreed contracts.

Locally employed doctor roles

- 6.75 The DHSC said that locally employed posts were likely to be occupied by doctors who had stepped out of formal training, many of whom would return to training when the time was right. It said this arrangement allowed flexibility for doctors to continue to provide service to the NHS and build their experience while taking a pause from training. This benefited employers who could maintain retention of experienced doctors, which ultimately benefited patients.
- 6.76 The DHSC said the increase in locally employed doctors would become concerning 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. It did not believe these circumstances were the case.
- 6.77 NHS Employers said that most locally employed doctors performed roles similar to doctors in training, working similar patterns, and often working on the same rotas. Locally employed doctors could also be found in more specialised roles such as teaching fellows, post-CCT fellows, or associate specialists.
- 6.78 For employers, factors driving the increasing number of locally employed doctors included: vacancies in training allocations; the need to expand rota numbers to maintain compliance with national terms; and increasing workload pressures. Generally, employers viewed the increasing numbers of locally employed doctors as neither a

positive nor a negative but simply a consequence of the changing pressures on the service.

- 6.79 NHS Employers said that several aspects made employing a locally employed doctor attractive. Employers had greater control over working patterns, which ensured a more consistent and engaged workforce, as there was no requirement to rotate. For doctors, a locally employed post might be an opportunity to step out of training temporarily or a necessity due to their inability to gain access to a desired training programme. Post-foundation locally employed doctor posts (often referred to as foundation year 3) were particularly attractive as a means to gain additional skills before entering core and higher training programmes.
- 6.80 NHS Wales Employers said locally employed doctors had been instrumental in supporting vacancies and accommodating the rise in less-than-full-time resident doctors in training. Some locally employed doctors took part in non-training rotations across health boards, and some were on the portfolio pathway.

Support and development

- 6.81 NHS Employers said there was growing recognition of the need for better educational and career support for locally employed doctors. They said that access to training was inconsistent, mainly because posts were trust-funded without designated training budgets. Some employers offered support voluntarily, but this varied between trusts. This could take the form of supporting progression into SAS roles, extended induction periods for international recruits, study leave and budget, or educational supervision. NHS Employers said there remained some inconsistencies between trusts with things such as access to clinical supervision and exception reporting not being delivered consistently.
- 6.82 The DHSC pointed to the NHS England Blueprint for Change which contained actions trusts could take to improve opportunities for progression, skills development, induction and access to educational opportunities for locally employed doctors.⁶⁰
- 6.83 The BMA said that the commitment in the 2024 England SAS deal to undertake a piece of work to determine how locally employed doctors could be better supported to progress in their careers, including a better understanding of the locally employed doctor workforce, had not yet been actioned properly. The BMA said it needed engagement from individual employers.
- 6.84 The offer to resident doctors in England in November and December included the introduction of an alternative core training programme to support locally employed doctors to transfer into postgraduate training.

SAS doctors and dentists

- 6.85 The SAS group covers specialty doctors and dentists, specialists, and a range of closed grades, most notably associate specialist. SAS doctors in England, Scotland, Wales and Northern Ireland all received our 4 per cent recommended pay uplift from 1 April 2025. The additional pay agreements in 2024 largely resolved the issues where the open specialty doctor pay scales had pay points below the 2008 closed pay scales and where

⁶⁰ NHS England, *Supporting locally employed doctors: Blueprint for Change*. <https://www.hee.nhs.uk/our-work/doctors-training/supporting-locally-employed-doctors-blueprint-change>

the top of the 2008 specialty doctor pay scale was above the bottom of the 2021 specialist pay scale.

- 6.86 The pay scale for the specialist grade is now the same in all nations. The pay scale for specialty doctors on the new contract is the same in England and Northern Ireland. The pay scale minimum in Wales is slightly (0.9 per cent) higher, while the minimum in Scotland is 4.3 per cent higher. The maximum is the same in England, Wales and Northern Ireland, while the Scotland pay scale maximum is slightly (0.8 per cent) higher.
- 6.87 The DHSC said that 67 per cent of specialty doctors in England were on the 2021 contract in May 2025, an increase from 54 per cent in May 2024. The DHSC said it recognised that there were likely to be reasons beyond pay which discouraged specialty doctors from transferring to the new contract, for example lack of understanding of the benefits, or inefficiencies in the transfer process.
- 6.88 NHS Employers had issued guidance to support employers in managing transitions to the new contract effectively.⁶¹ They said that, while the increase in the proportion of SAS doctors on the new contracts marked a positive shift, disparities between the 2008 and 2021 contracts remained, particularly across six pay points, which could affect long-term career progression and remuneration.
- 6.89 The BMA said that the different definitions of premium time work continued to discourage specialty doctors from adopting the 2021 terms. It said the extension of plain time had taken on a symbolic importance. It also added a degree of complexity when SAS doctors considered if they would be better off on the 2021 pay scales. The BMA said this disparity felt unfair to new SAS doctors and noted that consultants had a 7pm weekday start to premium time.
- 6.90 The BMA noted that Scotland never introduced the plain time extension for its SAS doctors, and the Welsh Government reversed it as part of their 2024 pay deal with SAS doctors. It said that the cost of reversing plain time would be minimal but would send out a clear message regarding SAS doctors' value.
- 6.91 In Wales, the proportion of specialty doctors on the 2021 contract increased from 61 per cent in May 2024 to 72 per cent in May 2025.

Specialist roles

- 6.92 The DHSC said the intention behind opening the specialist grade, as part of the multi-year agreement in 2021, was to provide career progression opportunities for skilled and experienced SAS doctors. It said specialist posts were created by employers where there was a service need for expert clinical decision makers in a specialised area, and the posts were filled through fair and open recruitment.
- 6.93 The DHSC said that the number of specialists had been steadily increasing, by around 33 a month, to just over 1,600 specialist doctors in May 2025. It recognised concerns raised by the BMA that specialist roles were being created at a slower rate than had been anticipated.
- 6.94 NHS Employers said that, despite perceptions of limited specialist role creation, actual figures exceeded initial forecasts by around 12 per cent. They said that structural,

⁶¹ NHS Employers, *Guidance for SAS transfer to 2021 contracts*.
<https://www.nhsemployers.org/publications/guidance-sas-transfer-2021-contracts>

financial, and cultural barriers continued to hinder widespread adoption. Employers were being encouraged to consider specialists as part of strategic workforce planning, especially given consultant recruitment challenges. Resources such as the specialist hub and joint guidance aimed to support implementation and promote the value of specialist roles.

- 6.95 As part of the 2024 agreement in England, research was commissioned to understand why specialist roles were not being created. NHS Employers said this pointed to a range of structural, organisational, financial and cultural barriers. Key challenges included a lack of managerial buy in, unclear eligibility criteria and progression pathways, and the financial reluctance to pay more for work already being undertaken by specialty doctors. Trusts often prioritised consultant appointments with some viewing the specialist role as a less valuable alternative. The report highlighted that an absence of standardised job descriptions, inconsistent internal processes, and limited strategic workforce planning had hindered implementation. The research recommendations were being considered by the SAS deal implementation group.
- 6.96 The BMA said that the NHS was failing to fully tap into the potential of the SAS cohort. It said that access to specialist roles remained one of the key concerns facing SAS doctors. Many specialty doctors felt halted in their career progression, and unable to access a grade that reflected their skills, knowledge and experience.
- 6.97 The BMA said that specialists were autonomous workers, and expanding this senior grade could help tackle waiting lists and relieve pressures on the broader workforce. It said that thousands of specialty doctors had the 12+ years' experience required to become specialists. It said that the creation of specialist posts remained purely at employers' discretion, and they had not been given the means to expand them.
- 6.98 The BMA said that the best way to ensure a pathway to specialist roles, as set out in the 10-year health plan, was through a mechanism that assessed specialty doctors and recognised them as specialists when they met the criteria for the grade. It said that the simplest way to do this would be through a single pay spine, where doctors could progress (providing they met eligibility requirements) without needing to apply for competitive positions.
- 6.99 The HCSA said that measures introduced following the 2024 negotiations to support SAS progression had not produced tangible outcomes. It said that the limited availability of specialist posts and insufficient support in the workplace for professional development remained key obstacles. It said that genuine cultural change would only be achieved through ring-fenced funding for specialist posts and consequences for employers who failed to uprate SAS doctors already working at that level.
- 6.100 Following the 2024 agreement, a policy was developed in Scotland whereby a specialty doctor/dentist who could demonstrate that they possessed and had been applying the skills and experience which met the capability framework requirements for the specialist grade, and where there was a service need for a specific specialist post, would progress to the specialist grade.⁶² A minimum of 10 years' work since obtaining a primary qualification and a minimum of six years in an SAS grade was required.

⁶² Scottish Government, *Policy for the Career Progression/Regrading of Specialty Doctor/Dentist to Specialist Grade*. <https://www.publications.scot.nhs.uk/files/pcs2025-dd-02.pdf>

- 6.101 The BMA said that this policy should help ensure senior specialty doctors had their level of working recognised in the absence of new specialist roles being created, which employers had been very slow to do. The BMA drew attention to the very small pay difference (£895) between the top of the specialty doctor pay scale and the bottom of the specialist scale in Scotland. It said that this differential did not adequately reflect the increased responsibility and level of autonomy of a specialist.
- 6.102 The number of specialist doctors on the 2021 contract in Wales increased from 37 in May 2023 to 71 in May 2024 and 93 in May 2025. The number of associate specialists on the old contract fell from 163 to 138 over this period.
- 6.103 The Welsh Government said there was a specialty doctor to specialist career progression regrading policy. If a specialty doctor could demonstrate that they possessed and had been applying the skills, experience and met the capability framework requirements for the specialist grade, and the grade was required against service need, they would automatically progress to the specialist grade.
- 6.104 The Department of Health said there were 38 specialist and 60 associate specialists in Northern Ireland in June 2025. It said that encouraging greater adoption of the specialist grade would be key to strengthening the senior medical workforce across the HSC. The Department said the specialist role was highly sought after by experienced specialty doctors and aided recruitment, retention and job satisfaction. A survey conducted by the Northern Ireland Medical and Dental Training Agency (NIMDTA) identified the main barriers to specialist posts as lack of funding and lack of awareness of the specialist post.
- 6.105 The BMA said that, in Northern Ireland, despite the best intentions of the 2021 contract and the agreement on non-pay asks in 2024, there had been no meaningful increase in specialist posts. It said that associate specialists/specialists made up only 14 per cent of the SAS cohort in Northern Ireland in 2024, compared to 28 per cent in 2010.

SAS development and recognition

- 6.106 The 10-year health plan for England said that specialty, associate specialist and specialist doctors were an invaluable part of the NHS team. It said that specialists were senior decision makers who had important generalist skills and could work autonomously in clinics in community settings including those areas with the most severe shortages. The Government said it would work with stakeholders to ensure a more streamlined and predictable pathway was in place for experienced specialty doctors to develop and operate at a specialist level. It would also work with the GMC to ensure a more streamlined pathway was in place for experienced doctors to obtain the registration to become a consultant.
- 6.107 NHS Employers said that work continued on the outstanding items of the 2024 agreement which included the promotion of job planning and a joint piece of work with the objective of helping SAS doctors to progress through the portfolio pathway. It published SAS development guidance in October 2025.⁶³ This said that employers should assist and support SAS doctors in meeting the requirements of a portfolio pathway application. This could include secondment opportunities, support when sitting exams, or arranging for the applicant to be released from their post to undertake

⁶³ NHS Employers, *SAS development guidance*. <https://www.nhsemployers.org/publications/sas-development-guidance>

top-up training. It also said that SAS doctors should be encouraged to apply for non-clinical roles, such as leadership or appraiser, and provided with training as appropriate. It said that SAS doctors were underutilised in these positions and efforts should be made to ensure that the NHS was both recognising and fully tapping into the skills and expertise of this cohort.

6.108 NHS Employers said that initiatives such as SAS Week, the SAS advocate role, and increased access to leadership opportunities, were helping to elevate the profile of SAS doctors. There was an increased focus on SAS doctors undertaking leadership roles with more trusts advertising the positions and offering these to both the consultant and SAS workforce.

6.109 The HCSA said that SAS doctors endured structural and cultural barriers that restricted their professional development and recognition. It said that the majority of SAS doctors reported an intention to move beyond their current role, either by promotion to a specialist post, entering the portfolio pathway route to become a consultant, or re-entering a training programme.

6.110 The BMA highlighted an issue of invisibility, with colleagues simply not recognising SAS doctors' roles. It said that the threat of ill treatment, and the intersectional potential for different forms of discrimination to interact with and exacerbate one another, presented a significant equalities concern.

Earnings

6.111 In the year to November 2025:

- Average earnings per head for specialty doctors in England were £86,837, 2.3 per cent higher than a year earlier. Basic pay increased by 6.0 per cent over the year, while non-basic pay fell by 14.9 per cent. Non-basic pay made up 14.8 per cent (£12,869) of specialty doctor average earnings per head.
- Average earnings per head for specialist/associate specialist doctors in England were £114,710, 2.3 per cent higher than a year earlier. Basic pay increased by 5.4 per cent over the year, while non-basic pay fell by 11.6 per cent. Non-basic pay made up 15.8 per cent (£18,086) of specialist/associate specialist average earnings per head.

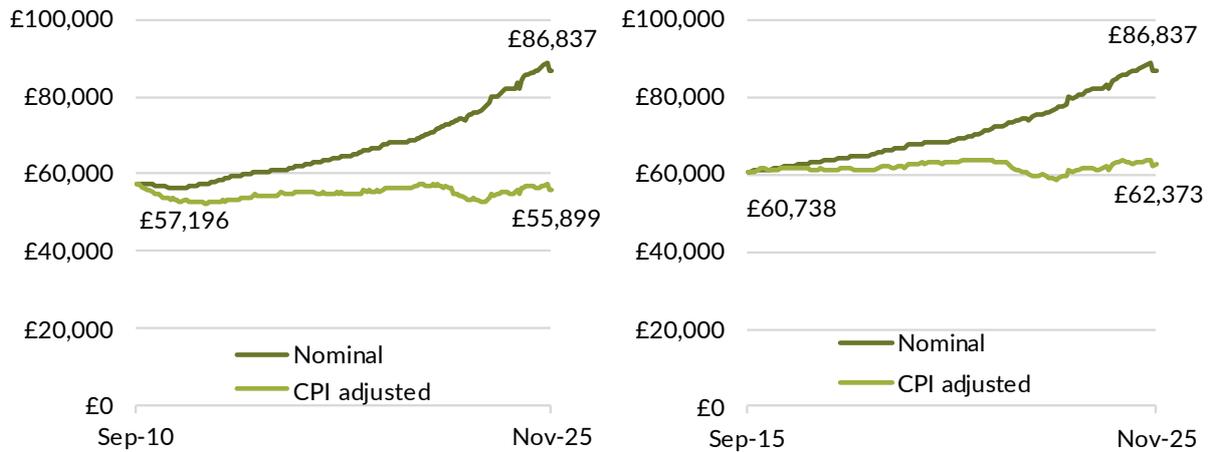
6.112 In 2024-25, average total pay per FTE for SAS doctors (including specialty doctors and associate specialists) in Scotland was £101,372, 3.6 per cent higher than 2023-24. Basic FTE pay increased by 3.5 per cent over the year. Non-basic pay made up 16 per cent of FTE earnings.

6.113 In 2024-25, average total pay per FTE for SAS doctors in Wales was £101,257. Non-basic pay made up 13 per cent of FTE earnings. Annual pay per head was £89,281 in 2024-25.

Earnings over time

6.114 In nominal terms, average earnings per head for specialty doctors in England increased from £57,196 in September 2010 to £86,837 in November 2025, an increase of 51.8 per cent. In real terms, after adjusting for CPI, average earnings per head for specialty doctors decreased from £57,196 in September 2010 to £55,899 in November 2025, a reduction of 2.3 per cent. Using CPIH gives a reduction of 1.5 per cent.

Figure 6.12: Specialty doctors, average earnings per person, nominal and CPI adjusted, England, September 2010/September 2015 to November 2025

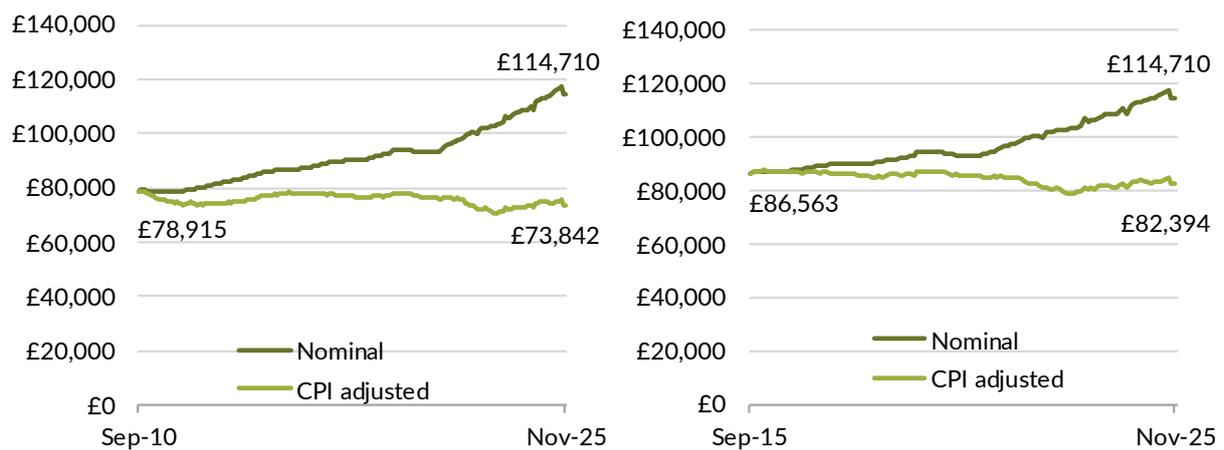


Source: OPRB analysis of NHS England and ONS data.

6.115 In nominal terms, average earnings per head for specialty doctors increased from £60,778 in September 2015 to £86,837 in November 2025, an increase of 42.9 per cent. In real terms, after adjusting for CPI, average earnings per head for specialty doctors increased from £60,778 in September 2015 to £62,373 in November 2025, an increase of 2.6 per cent. Using CPIH gives an increase of 2.7 per cent.

6.116 In nominal terms, average earnings per head for specialists/associate specialists in England increased from £78,915 in September 2010 to £114,710 in November 2025, an increase of 45.4 per cent. In real terms, after adjusting for CPI, average earnings per head for specialists/associate specialists decreased from £78,915 in September 2010 to £73,842 in November 2025, a reduction of 6.4 per cent. Using CPIH gives a reduction of 5.7 per cent.

Figure 6.13: Specialists/associate specialists, average earnings per person, nominal and CPI adjusted, England, September 2010/September 2015 to November 2025



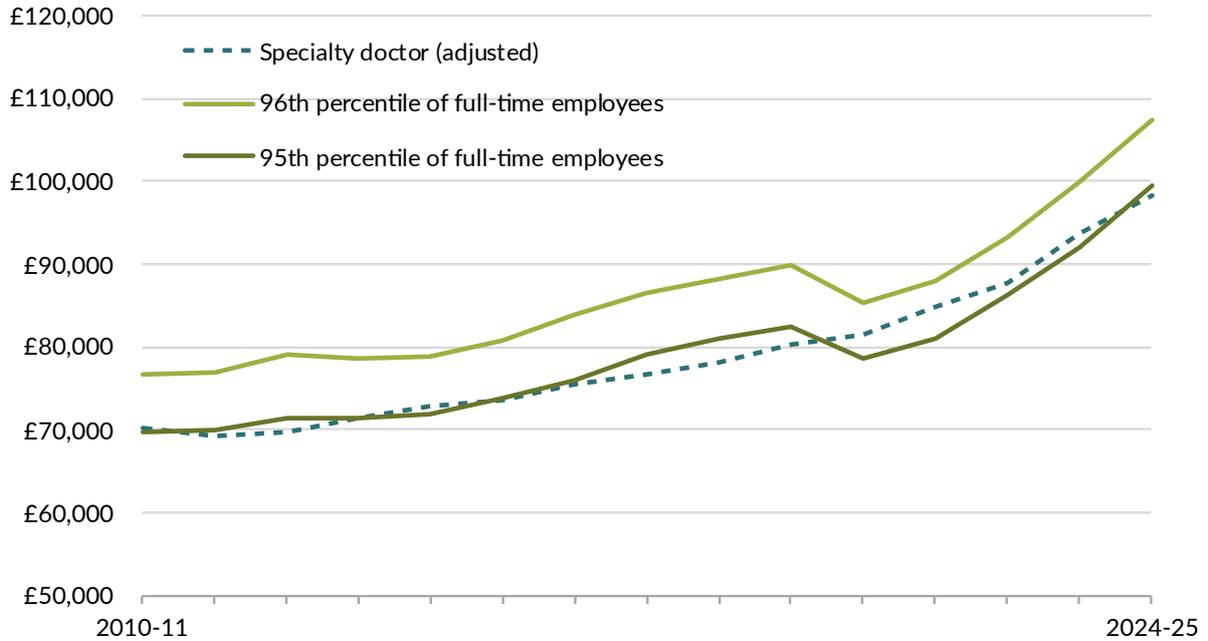
Source: OPRB analysis of NHS England and ONS data.

6.117 In nominal terms, average earnings per head for specialists/associate specialists increased from £86,563 in September 2015 to £114,653 in November 2025, an increase of 32.5 per cent. In real terms, after adjusting for CPI, average earnings per head for associate specialists decreased from £86,563 in September 2015 to £82,394 in November 2025, a reduction of 4.8 per cent. Using CPIH gives a reduction of 4.7 per cent. This fall is likely to be linked to the move to new contracts.

Pay comparability

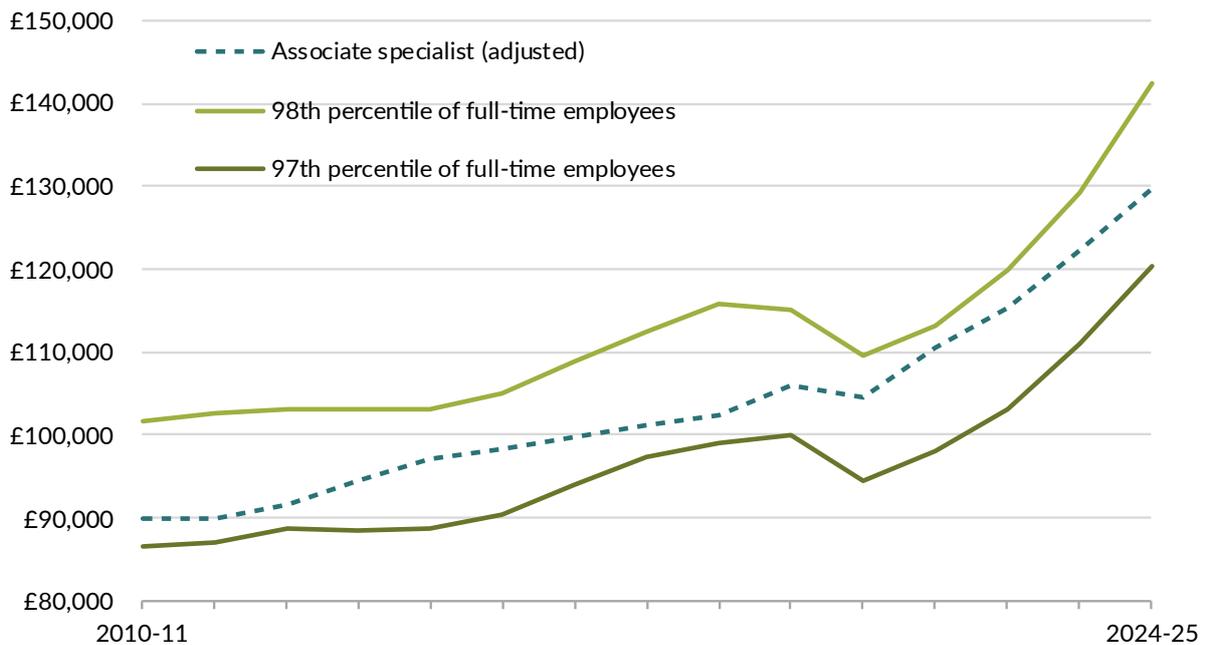
6.118 Average FTE earnings for specialty doctors have remained close to the 95th percentile of UK average full-time earnings since 2010-11. Average FTE earnings for specialists/associate specialists remained between the 97th and 98th percentile of UK average full-time earnings from 2010-11 to 2024-25.

Figure 6.14: Average total FTE earnings for specialty doctors, England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2024-25



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

Figure 6.15: Average total FTE earnings for associate specialists/specialists, England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2024-25



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

6.119 Basic pay, total earnings, and total remuneration for both specialty doctors and specialists are in line with or above comparator roles in each case.

Figure 6.16: Pay for specialty and specialist doctors, England, and market comparators, 2025



Sources: Specialty doctor – interquartile range, NHS Digital. Finance & accounting, legal, pharmaceuticals (R&D) – Korn Ferry, level 17, interquartile range. Pharmacy – IDR bespoke survey, pharmacy manager, interquartile range. Architect – Architect Earnings, private practice associate, London, median. Teacher – deputy head pay range. Vet – SPVS 2025, vet, five years qualified, median.

Specialist – Interquartile range for specialist/associate specialist, NHS Digital. Finance & accounting, legal, pharmaceuticals (R&D) – Korn Ferry level 19, interquartile range. Pharmacy – IDR bespoke survey, senior pharmacy manager/pharmacy manager, interquartile range. Architect – Architect Earnings, private practice associate, London, median. Teacher – deputy head pay range. Vet – SPVS 2025, vet, 10 to 15 years qualified, median.

Consultants

6.120 Several parties indicated that reform of the consultant contract could be beneficial. NHS Employers said that the 2003 contract no longer reflected the realities of modern working patterns. Consultants commonly operated under a range of flexible working arrangements, including annualised and hybrid job plans, alongside the take up of pension flexibilities. These developments highlighted the need for a new and modernised contractual framework that better supported contemporary, adaptable ways of working. NHS Employers said in oral evidence that significant reform of the consultant pay structure would bring long-term benefits to the workforce and was needed to meet the needs of the long-term workforce plan.

6.121 Employers had identified several areas of the consultant contract as requiring review:

- Ambiguity around job planning processes.
- Calculation of annual leave.
- Lack of clear definitions, for example for emergency work and premium time.
- On-call rotas and categorisation.
- The ability to deploy staff to meet seven-day working ambitions.

6.122 NHS Employers said that the continued deployment of staff to support seven-day working arrangements required a balance between service needs and contractual rights. Consultants were currently not required to undertake non-emergency work outside 7am to 7pm or on weekends unless mutually agreed in their job plan. This had led to challenges for employers to deploy staff to meet service needs.

6.123 NHS Employers said in oral evidence that the current consultant contract was inflexible and did not give the scope to deliver the clinical care now required. It needed review and reform and there needed to be a mandate to do this. To ensure efficiencies in job planning, it needed to reduce the need for waiting list initiatives, extra-contractual work, and agency work. Plain time needed to be changed from 7pm to 9pm, in line with other contracts, and the opt out for emergency work needed to be removed. The current contract also made it hard to support hospitals that consultants were not recruited to but were in the same trust

6.124 The DHSC said in oral evidence that it was in the process of reinstating the joint negotiating committee for consultants, which had not been in place since 2015, and which would provide a formal forum to discuss contract reform.

6.125 The HCSA said that, under the 10-year health plan, consultants would play a critical leadership role in integrated neighbourhood teams – shaping clinical pathways, ensuring robust clinical governance, and mentoring multi-disciplinary staff to maintain high standards of care. It said that success depended on granting consultants meaningful influence over service design and resourcing, to prevent further strain on an already pressured workforce and to secure sustainable improvements in patient outcomes.

6.126 The Scottish Government said it had taken forward discussions on the balance of different elements of the job plan for consultants to facilitate attractive employment opportunities within NHS Scotland and to enable retention of the existing workforce, which was part of the 2024 consultants pay agreement. The BMA said that the discussions on job planning had concluded, with confirmation that consultant posts should not be advertised as 9:1.

6.127 As part of the 2024 agreement for consultants in Wales, it was agreed that work would be undertaken to address job planning and recruitment, aiming to ensure consistency and efficiency across NHS Wales. A working group had been established to work towards an all-Wales job planning policy to include consultants and SAS doctors.

6.128 In oral evidence, the Welsh Government said that, as part of the 2024 agreement, there was a commitment to begin scoping consultant contract reform, but it had not had the capacity to start this due to resident doctors' contract reform.

6.129 A task and finish group had begun to review locum consultants in Wales who had been in post over 12 months and look at a process to move them into substantive contracts. This would link into a similar workstream for locally employed doctors.

6.130 The Department of Health in Northern Ireland said in oral evidence that, once contract reform for resident doctors was complete, it would discuss the opportunity for consultant contract reform. There would be a focus on flexibility, work-life balance and job satisfaction. It was setting up a new forum with employers and the BMA to drive forward work plans and enhance working lives. The long-term goal for consultants was to move to a seven-day service. The Department said it would also like a more flexible system around locality, with consultants working across trusts.

Earnings

6.131 Under 2025-26 pay scales for consultants:

- Scotland has the highest minimum salary at £111,430, 1.6 per cent higher than the lowest minimum of £109,725 in England.
- Wales has the highest maximum salary at £160,951, 10.6 per cent higher than the lowest maximum of £145,478 in England. This follows the 2024 pay agreement in Wales, which made commitment awards part of the main pay scale.
- Maximum pay for a consultant in Scotland, with discretionary points, is £178,016.

6.132 Consultants' pay in all four nations was increased by 4 per cent from 1 April 2025, in line with our recommendation. Discretionary points in Scotland were also increased by 4 per cent.

6.133 In the year to November 2025, average earnings per head for consultants in England were £145,683, 0.8 per cent higher than a year earlier. Basic pay increased by 5.7 per cent over the year, while non-basic pay fell by 15.6 per cent. Non-basic pay made up 19.2 per cent (£27,983) of consultants' average earnings per head.

6.134 In 2024-25, average total pay per FTE for consultants in Scotland was £164,110, 9.3 per cent higher than 2023-24. Basic pay increased by 6.1 per cent. Non-basic pay made up 28 per cent of FTE earnings.

6.135 In 2024-25, average annual total pay per FTE for consultants in Wales was £148,216. Non-basic pay made up 9 per cent of total pay. Annual basic pay per head was £134,403 in 2024-25.

6.136 The BMA said that, as a result of the 2024 deal in England, the consultant pay scale still contained an anomaly at pay threshold 2, which was split between pay point 2a (for those with three years completed as a consultant) and 2b (for those with four years completed). It said this additional pay point was never intended to be permanent, and

no pay progression review meeting was required for progression from pay point 2a. Its expectation was that pay point 2a would be uplifted to bring it in line with 2b.

6.137 The BMA said that higher Scottish income tax rates had a significant impact on take home pay, particularly for senior doctors. It said that, although base salaries for consultants were slightly higher in Scotland, a consultant at a similar pay point in England would have around £3,500 to £5,000 more take home pay.

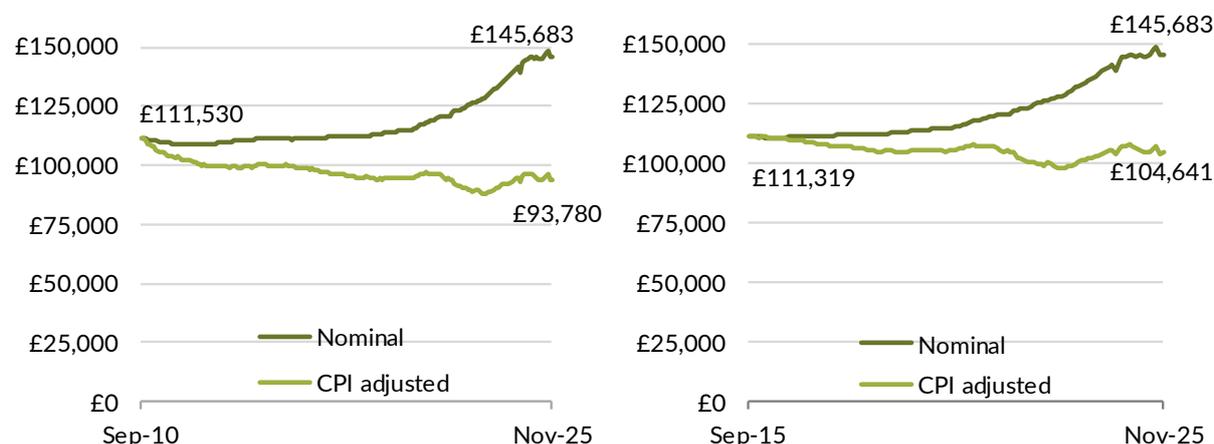
6.138 On our visits to Scotland for this round, consultants reported experiencing a significant drop in pay when moving from registrar roles, due to the drop in banding payments.

Earnings over time

6.139 In nominal terms, average earnings per head for consultants in England increased from £111,530 in September 2010 to £145,683 in November 2025, an increase of 30.6 per cent. In real terms, after adjusting for CPI, average earnings per head for consultants decreased from £111,530 in September 2010 to £93,780 in November 2025, a reduction of 15.9 per cent. Using CPIH gives a reduction of 15.3 per cent.

6.140 Much of this real-terms reduction reflects changes in the composition of pay, with non-basic earnings falling more sharply than basic pay over the period. In real terms, basic earnings per head fell by 7.7 per cent between 2010 and 2025, while non-basic earnings fell by 38.8 per cent. This was driven by a substantial decline in the average value of medical awards, which fell by around 78.5 per cent in real terms, and by a fall of around 20.8 per cent in additional activity payments. These reductions are likely attributable to contractual/policy reforms and local arrangements as well as activity levels.

Figure 6.17: Consultants, average earnings per person, nominal and CPI adjusted, England, September 2010/September 2015 to November 2025



Source: OPRB analysis of NHS England and ONS data.

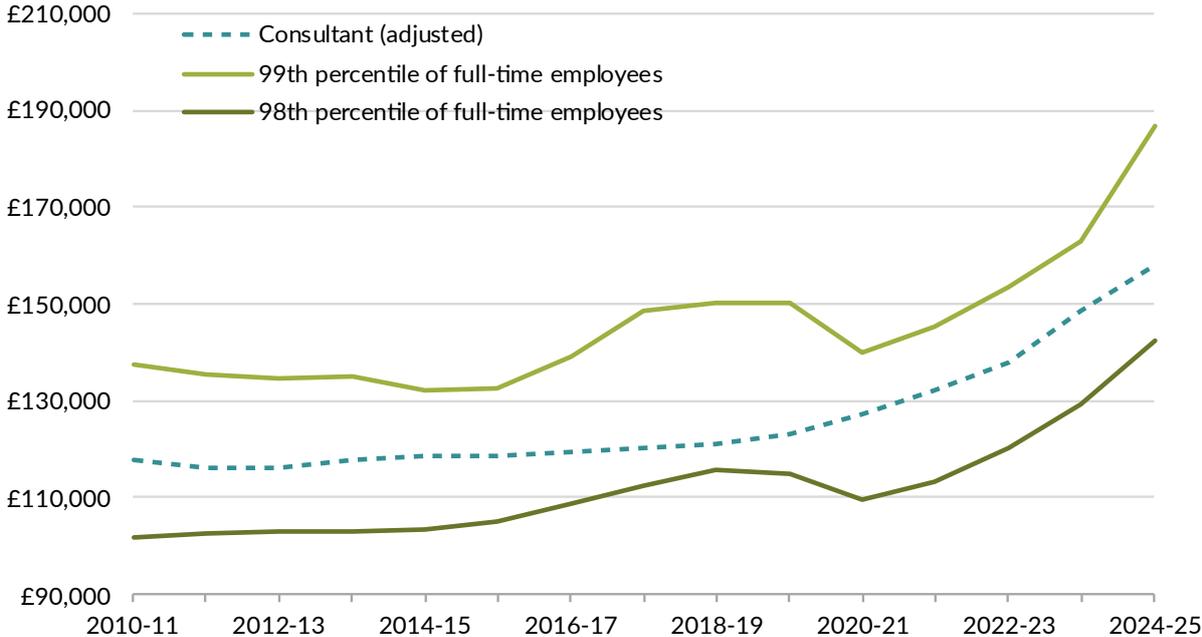
6.141 In nominal terms, average earnings per head for consultants increased from £111,319 in September 2015 to £145,532 in November 2025, an increase of 30.9 per cent. In real terms, after adjusting for CPI, average earnings per head for consultants decreased from £111,319 in September 2015 to £104,641 in November 2025, a reduction of 6.0 per cent. Using CPIH gives a reduction of 5.9 per cent.

Pay comparability

6.142 Average FTE earnings for consultants have remained between the 98th and 99th percentile of UK average full-time earnings between 2010-11 and 2024-25.

6.143 Basic pay for consultants is in line with or behind comparator roles. Total earnings are broadly in line with the comparators. Total remuneration is in line with or ahead of comparator roles.

Figure 6.18: Average total FTE earnings for consultants, England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2024-25



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

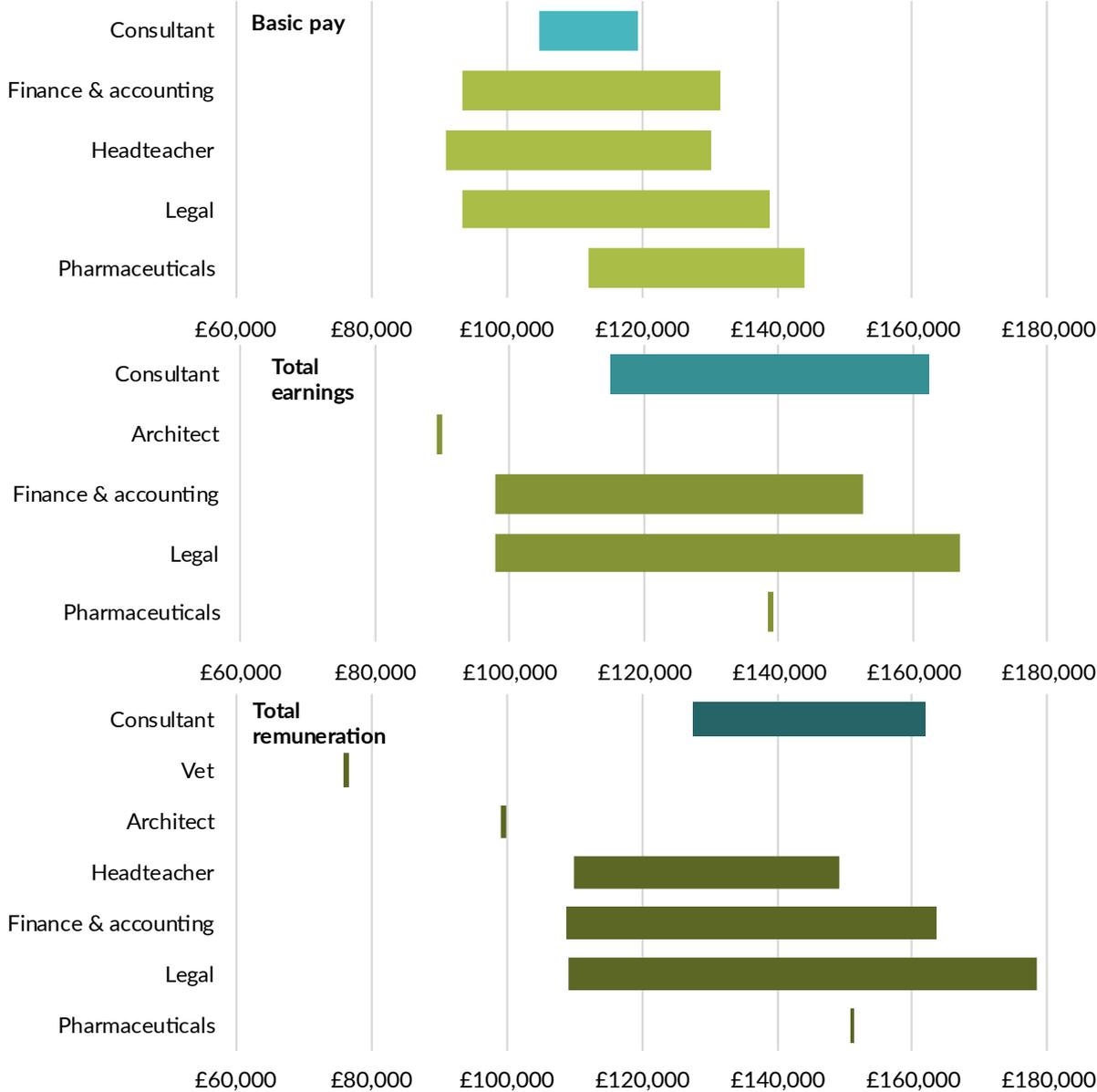
International pay comparisons

6.144 International pay comparisons are set out in more detail in appendix F. Organisation for Economic Co-operation and Development (OECD) data showed that pay for consultants in the UK was above countries such as Belgium, Denmark, New Zealand, Spain, Norway and Sweden, while the Netherlands, Germany, and the Republic of Ireland offered higher levels of pay. Information for Australia, Canada and US was not available in the OECD dataset.

6.145 Consultant pay in Australia was generally much higher than in England, with some states offering significantly more. The national average for consultants in Australia was well above the level found in England, and the highest-paying states showed an even greater gap.

6.146 When compared to England, pay bands for doctors in New Zealand were generally lower in senior positions. Consultants in the Republic of Ireland had much higher pay scales than their counterparts in England and Northern Ireland.

Figure 6.19: Pay for consultants, England, and market comparators, 2025



Source: Consultant - interquartile range, NHS Digital. Finance & accounting, legal, pharmaceuticals (R&D) – Korn Ferry level 20, interquartile range. Architect – Architect Earnings, principal in partnership II, 20 or more years' experience, London, median. Teacher – headteacher pay range, band 7. Vet – SPVS 2025, Vet, 20+ years qualified, median.

Consultant award schemes

- 6.147 The four nations are in different positions on the payment on consultant awards. National clinical impact awards are in payment in England and Wales. The local clinical excellence award scheme was ended in England in 2024, with the funding moved into basic pay. The DHSC noted that around 10,000 consultants (20 per cent of the workforce) retained an old local clinical excellence award.
- 6.148 The Scottish Government has for some years not sought recommendations from the DDRB on discretionary points or discretionary awards. While both had been frozen in value since 2010, discretionary points were increased in the 2024 pay agreement with consultants and again by 4 per cent in 2025 in line with the main pay uplift for consultants.

6.149 Commitment awards in Wales, which were additional discretionary pay points at the top of the pay scale for consultants, were made part of the main pay scale in 2024.

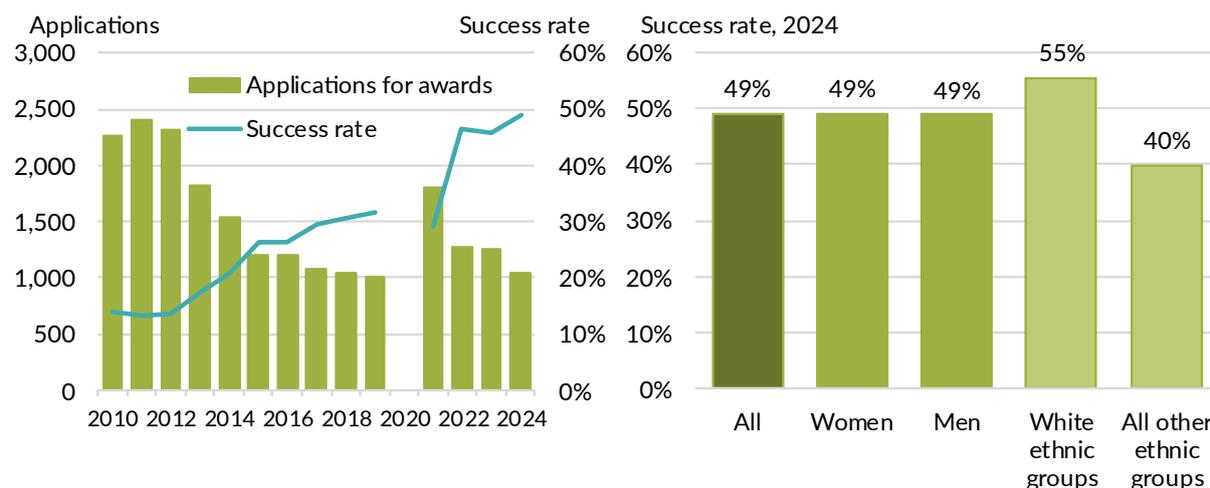
6.150 There are no active consultant award schemes in Northern Ireland, although some existing awards continue to be paid.

National clinical impact awards in England and Wales

6.151 National clinical impact awards were introduced from April 2022 for consultants in England and Wales. Up to 600 new awards are available in England each year and 37 in Wales. They are worth £20,000 (national 1), £30,000 (national 2) or £40,000 (national 3) a year, as well as a £10,000 (national 0) award in Wales. Awards are non-pensionable and held for five years.

6.152 The total cost of awards in England in 2024-25 was £105.5 million, down from £110.8 million in 2023-24. This included £9.9 million of new awards granted in 2024. The Advisory Committee on Clinical Impact Awards (ACCIA) annual report for the 2024 round said that national clinical impact awards continued to recognise and reward senior clinicians delivering impact to the NHS at a national level.⁶⁴

Figure 6.20: Applications and success rates for new national clinical impact awards, England and Wales, 2010 to 2024



Source: ACCIA.

6.153 In 2024, there were a total of 1,051 applications for new awards: 978 in England and 73 in Wales. A total of 514 new awards were granted, 477 in England and 37 in Wales, resulting in an overall success rate of 48.8 per cent in England and 50.7 per cent in Wales. Most new awards – 82.7 per cent – were given to applicants with no previous award, up from 50.9 per cent in 2023. In England, there was a significant increase in the proportion of national 3 awards given to applicants with no prior award – 51.5 per cent in 2024 compared with 6.3 per cent in 2023.

6.154 The ACCIA said the decrease in application numbers for 2024 was slightly disappointing. It said that, with a renewed plan for advertising the scheme, it had seen an increase in application numbers in the 2025 awards round. In addition, there would

⁶⁴ UK Government, *Advisory Committee on Clinical Impact Awards: annual report for the 2024 awards round*. <https://www.gov.uk/government/publications/accia-annual-report-for-the-2024-awards-round/advisory-committee-on-clinical-impact-awards-annual-report-for-the-2024-awards-round>

be re-applications from many award holders who last applied in the 2021 awards round.

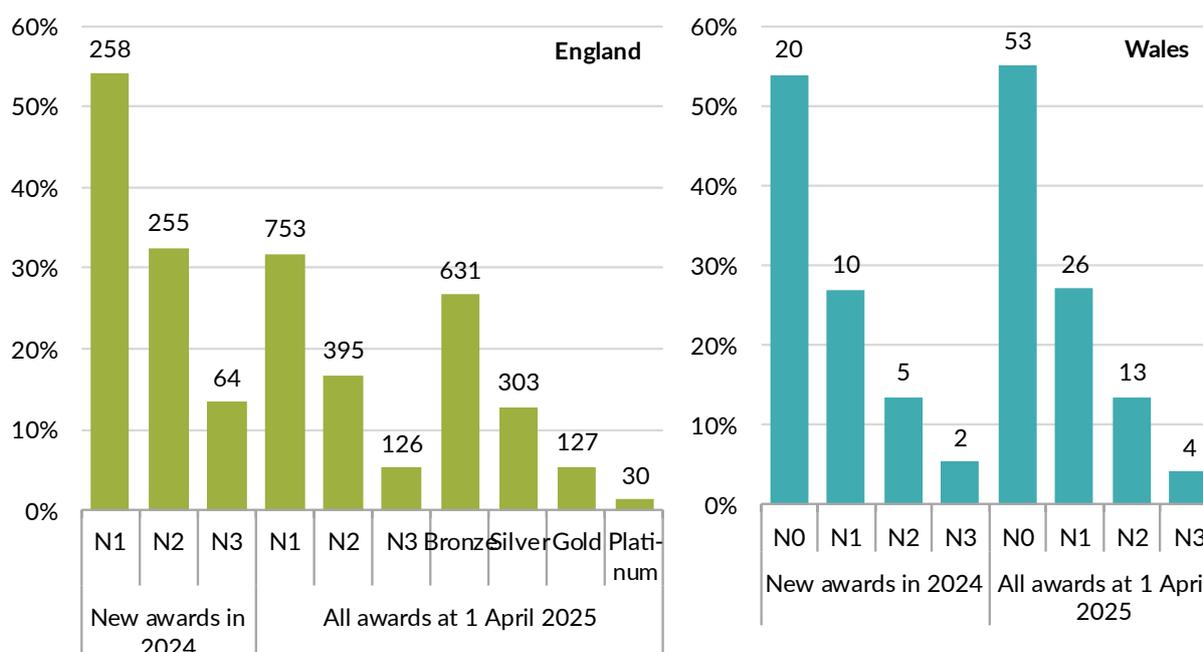
6.155 The ACCIA said that it received 37.1 per cent of applications from women and 62.1 per cent of applications from men in 2024, representing a 3.6 percentage point increase in the share of applications from women from 2023. In total, 61.1 per cent of awards granted were to men (down by 6.1 percentage points) and 37.2 per cent to women (up by 7.2 percentage points). There was a fall in applicants identifying as other or preferring not to say. The success rate was 48.8 per cent for men and 49.0 per cent for women. Previously, men had been more successful than women, with a 6.9 per cent gap in 2023.

6.156 The ACCIA noted that there was still an under-representation of women in application rates when compared to the wider consultant population. It said that, although it had seen a positive increase in applications from women, there was still more to be done to encourage and support women to apply.

6.157 Of the total applications in 2024, 56.0 per cent were from white ethnic groups, 41.6 per cent of applications were from all other ethnic groups combined, and 2.4 per cent came from those who did not specify their ethnicity. The success rate among white ethnic groups was 55.3 per cent, compared to 39.8 per cent for all other ethnic groups. The ACCIA said there was an over-representation of white ethnic groups, both in applications and in success rates, but that the proportion of applications received was now more reflective of the consultant workforce. However, it said the disparity in success rates continued to be of concern.

6.158 The proportion of applicants declaring a disability was higher than the wider consultant workforce (3.6 per cent of applicants compared to 2.3 per cent of the consultant workforce), with a slightly higher success rate (50.0 per cent).

Figure 6.21: Distribution and number of national awards, England and Wales, 2024-25



Source: ACCIA.

- 6.159 The ACCIA said that, in the 2024 awards round, four people granted a national clinical impact award declined the award after application outcomes had been announced, stating that they wanted to retain their local clinical excellence award for financial reasons. This was down from 12 in 2023.
- 6.160 The DHSC said that national clinical impact awards were 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 delivered contracted out NHS services. Examples of recognised work had included nationwide treatment pathway changes and reviews, research that had fundamentally changed national and international guidelines, and introduction of new therapies that had positively impacted patients globally. Award holders had also served as role models and mentors for other clinicians, providing training and mentorship.
- 6.161 NHS Employers reported that national clinical impact awards were placing a significant administrative burden on organisations. Organisations generally reported no measurable impact at the service level from consultants holding the awards. They said that application numbers remained low, and many respondents noted minimal or no engagement with the awards.
- 6.162 In oral evidence, NHS Employers said there had been mixed feedback on clinical impact awards, with some organisations reporting value but many more that did not. They thought there should be a more considered review.
- 6.163 In oral evidence, the Welsh Government said that its assessment of clinical impact awards was focused on accessibility and equality, and there had been improvements across all the diversity categories – gender, ethnicity, disability – in terms of successful awards each year since their introduction. It said that, in terms of the impact on service delivery, the evaluation was fairly limited.
- 6.164 Last year we recommended a £500-£2,000 increase in the value of national clinical impact awards. This was the first increase in their value. This recommendation was accepted in both England and Wales.
- 6.165 The DHSC asked us to not make further recommendations on award values until it could fully understand the impact of the uplifts. It said that contractual transition arrangements for legacy award holders meant that the impact of uplifts to national clinical impact awards was not felt by all award holders, but this position would change over time.
- 6.166 The BMA welcomed the recommendation to uplift the values of national clinical impact awards. However, it said that the recommended uplifts felt tokenistic and fell far short of addressing the significant losses incurred by the removal of the previous scheme.
- 6.167 The BMA's UK Consultants Committee said it still had outstanding concerns about previous changes to the national clinical excellence award scheme: the lower value of the national awards; their non-pensionable status; and the inability of consultants to hold a national award concurrently with a local award. It said these represented a significant decrease in the lifetime remuneration for the most talented and experienced consultants and impeded the NHS from being able to attract and retain the best and brightest.

6.168 It said that, if the ACCIA maintained its position of forcing holders of pre-2018 local clinical excellence awards to give these up to apply for national clinical impact awards, then up to 50 per cent of the consultant workforce would not have an incentive to access an excellence award scheme as it was financially disadvantageous to relinquish a consolidated, pensionable local award for a non-consolidated, non-pensionable national award. It said this disincentive to access new awards would have a negative impact on both consultant morale and motivation.

6.169 In oral evidence, the HCSA said that there was limited evidence that clinical impact awards improved outcomes, as they focused on additional activities rather than clinical commitments or service needs. Instead, they should be linked to local and national NHS operational priorities.

Discretionary points and distinction awards in Scotland

6.170 The Scottish Government said it remained the position that no new distinction awards had been made in Scotland as these did not align with its progressive pay principles. There were consultants who received awards prior to the freeze who were still in receipt.

6.171 The Scottish Government said that the availability of new discretionary points continued to increase in line with the number of consultants in post. Distinction points were increased in value from £3,204 to £3,600 as part of the 2024 consultant agreement. The Scottish Government said that the increase in the value of discretionary points [in 2024] ensured that Scotland continued to offer a competitive pay package for consultants. It was not seeking any recommendations from DDRB on distinction awards or discretionary points.

6.172 BMA Scotland asked that the DDRB recommendation for consultant pay applied to discretionary points in Scotland. It said this was consistent with the application of the uplift by Scottish Government in both 2024-25 and 2025-26 and should now be considered the norm. In oral evidence, BMA consultants said there were divided opinions on discretionary points across consultants in Scotland. They were a very welcome amount of money and many consultants liked them. There was a working group starting in January to look at discretionary points.

6.173 On our visits to Scottish health boards this year, consultants told us that, while the recent uplifts in discretionary points were welcomed, the system did not feel fair, especially for those working part time, and could contribute to the gender pay gap. There were limited incentives to continue the commitment once a discretionary point had been awarded. It was thought that they did not lead to an improvement in quality and that there should be a better way of recognising extra work. There were also reported difficulties with managing the local distribution of discretionary points fairly.

6.174 In oral evidence, the Scottish Government said that there was no evidence that discretionary points enhanced service delivery. There had been no change or deterioration in service since distinction awards were closed. There were also concerns about the equality of discretionary points.

Clinical excellence awards in Northern Ireland

6.175 The Department of Health in Northern Ireland noted that the clinical excellence award scheme had been on pause for a number of years, with no new awards being made. Existing awards continued to be paid where applicable. The Department had engaged

with key stakeholders including the BMA and trusts to elicit their views and preferences to inform the development of a revised scheme for rewarding high performance in the medical field.

6.176 The draft scheme was subject to a 12-week consultation from November 2023 to February 2024. The proposals were to broaden access to the scheme, make the application process fairer and more inclusive, and to change the application process. The Department was considering the responses to the consultation. It had drawn on learning from the clinical impact awards scheme operating in England and Wales to inform its approach.

6.177 The Department said the overall aim was to introduce a new scheme in Northern Ireland which was affordable and modernised the arrangements for making awards, which then rewarded the highest performing consultants who went over and above the standards expected of them. The decision on whether to implement the proposal (or any other arrangement) would be a matter for a Minister.

6.178 In oral evidence, the Department of Health in Northern Ireland said it had been working with the BMA on the consultation on clinical excellence awards last year. It said that, with the current industrial relations and work pressures, this had paused but it wanted to prioritise this work. There was a mixed review to the consultation, and the Department was near to a final response.

6.179 The BMA was concerned about there having been no local and national clinical excellence award rounds in Northern Ireland for many years and the long-delayed response to a consultation on a new scheme.

Our comments

Resident doctors

6.180 We set out in our report last year how we continued to see high levels of dissatisfaction among resident doctors with their working lives. These concerns were widespread, from unhappiness with the immediate working environment, such as a lack of facilities for hot food or rest, to the need to regularly relocate to enable training progression, with the associated cost and disruption, and rising apprehension around job security and access to training places. We were also concerned to hear the ongoing high emotional toll of working as a resident doctor, and of the considerable impact on personal and family lives.

6.181 The commitments made by NHS England and NHS Employers both through the review of medical training and the 10-point plan to improve resident doctors' working lives are welcome. As we said last year, investment in working facilities and arrangements for resident doctors is likely to be cost effective in terms of the improvement to motivation, wellbeing and commitment. However, from our visits we understand that resident doctors are yet to see material improvement, and there is scepticism about the extent to which the commitments will be implemented.

6.182 NHS England has said that progress will be reported and data published on meeting targets. We believe this is vital, not only to ensure that commitments are delivered, but to demonstrate and communicate progress to resident doctors.

6.183 The proportion of applicants receiving an offer for specialty training has significantly reduced over the last two years, causing substantial concerns among those looking for

a training place. We heard on our visits how doctors in foundation training were spending considerable amounts of time supporting their portfolios and applications for specialty training.

- 6.184 As with the last two years, the pay and industrial relations environment is evolving as we make our recommendations. Talks with resident doctors in England over the pay and jobs dispute are ongoing. The Bill to prioritise medical training places for graduates of UK medical schools is progressing through Parliament.
- 6.185 Basic pay scales for resident doctors across the four nations are fairly similar, and total earnings are at comparable levels in England, Wales and Northern Ireland. Contractual differences deliver much higher average earnings for resident doctors in Scotland. Earnings growth for resident doctors has been strong over the last year.
- 6.186 A new contract has been agreed for resident doctors in Wales. While the structure is similar to the current contract in England, pay rates are higher and it will constitute an average 4 per cent paybill increase, in addition to our pay recommendation. Implementation will not start until August 2026, and the Welsh Government has confirmed it wishes our pay recommendation for 2026-27 to apply to pay rates under both the old and new contracts.
- 6.187 Data for England show real terms growth for both basic and total earnings for all grades of resident doctor since both 2015 and 2019. Since 2010, there has been real terms growth in basic pay for most resident doctor grades but falls in total earnings in real terms. These are likely to have been affected by contractual changes and changes in working hours over the period. However, few current resident doctors would have been employed since 2010.
- 6.188 Resident doctors in England have declined in their position within the overall earnings distribution over the longer term but have seen improvement in the latest year of data, for 2024-25, particularly among foundation doctors. We expect the relative position of resident doctors to have further improved given the higher pay uplift in 2025, and the strong recent earnings growth.
- 6.189 Pay comparisons are made for England. As noted above, basic pay for resident doctors is similar across the nations, but total earnings in Scotland are notably higher. Basic pay for doctors in both foundation year 1 and foundation year 2 is broadly in line with comparable roles, and for doctors in core training and specialty registrars is typically behind comparator roles. However, the comparison with external roles indicates that total earnings for all resident doctor groups are in line with, or ahead of comparators, and total remuneration (including pensions) is ahead of comparators for all resident doctor groups.
- 6.190 Earnings for medical and dental graduates are consistently higher than other graduates. More so than comparator professions, doctors and dentists in training typically experience very strong in-role pay progression and structured pathways for promotion over their career.

Locally employed doctors

- 6.191 In our 2025 report, we recommended that governments consider a separate pay framework for locally employed doctors. This was in recognition of the disparate and opaque terms and conditions currently in use across the nations, the fact that these doctors were not in training programmes, and that they were working across broader

equivalent grades than just resident doctors. Without a clear pay framework, it is difficult to ensure equal pay with doctors on national contracts doing equivalent work. The high representation of those with a non-UK PMQ among the locally employed doctor workforce suggests a significant risk of pay discrimination without a framework to ensure equal pay.

- 6.192 The locally employed doctor workforce is large and growing. This is at the same time as very limited growth of training posts. The rapid growth in locally employed doctors has been made through local decision making and has not been part of a wider workforce strategy.
- 6.193 If accepted, our recommendation would have necessitated government and employers review locally employed doctors across all levels, improve the evidence base, ensure fairness and consistency, and develop a rationale and guidance for their employment. Any framework would need to recognise both the differences from and similarities with doctors in training and should be linked to workforce planning.
- 6.194 As well as supporting equal pay, a review and rationalisation of the range of locally employed doctor roles could enhance support for this group, help avoid discriminatory practices, and enable better understanding of progression and development both within role and to other roles, how these doctors contribute to service delivery, and how these doctors fit into a coherent future workforce strategy.
- 6.195 The evidence on the roles undertaken by locally employed doctors and their pay remains limited. The ability to identify these doctors in the payroll data in England and Northern Ireland in particular is poor. The gap between the GMC estimate of locally employed doctors in England and Wales and the estimate from the Welsh Government and the DHSC (which only counts five nodal points) is around 20,000.
- 6.196 The BMA has said that employers should be compelled to share information on the distribution of locally employed doctors across the NHS and the terms and conditions these doctors were engaged on. We would support and encourage this.
- 6.197 The BMA said it did not support a separate pay scale for locally employed doctors as this opened the possibility of creating an 'underclass' grade, further entrenched the perceived otherness of locally employed doctors, and threatened worse pay for them. We expect that any pay framework for locally employed doctors ensures equal pay for equivalent work with doctors on national contracts, which is one of the main drivers for our recommendation.
- 6.198 The UK Government said it could not accept the recommendation on locally employed doctors at this time due to the need for further work to better understand this growing part of the workforce. It said it recognised the key role locally employed doctors played in service delivery, and the challenges they faced. It said its priority would be to improve the data on locally employed doctors to increase its understanding of the needs of this workforce. Once this work was complete, it would re-assess the case for a separate pay framework.
- 6.199 In Scotland, doctors in these roles are already on national terms and conditions. We note the significant recent growth in this workforce. It would be helpful to understand why this workforce has expanded rapidly over the last five years, while the number of doctors in training has seen far less growth.

- 6.200 The new contract for resident doctors in Wales encompasses locally employed doctors at this level. NHS Wales has made a significant improvement in harmonising over 150 job titles for locally employed doctors to nine core job titles. This helpfully demonstrates the disparate use of locally employed doctors, and we hope to see better data on the locally employed workforce in Wales in future. This workforce makes up a large proportion (13 per cent) of the medical and dental workforce in Wales. As with Scotland, it would be helpful to have a greater understanding of the drivers of this workforce growth.
- 6.201 The Department of Health in Northern Ireland said it was undertaking a scoping exercise to better understand the specific needs and circumstances of locally employed doctors. This would inform a full and considered response to our recommendation. In oral evidence, the Department said that standardised arrangements for doctors without a training number could strengthen the locally employed doctor role and help to reduce locum staffing.
- 6.202 Both the BMA and the HCSA have raised substantial concerns about the detrimental treatment of local employed doctors, including poorer terms and conditions and job insecurity. A very high proportion (estimated at over 90 per cent by the GMC) are on fixed-term contracts. There has been some recognition of, but limited progress, on support and development for locally employed doctors. For example, the recent offer made to resident doctors in England looked to convert existing locally employed doctor roles into specialty training posts and to introduce an alternative core training programme. There are commitments in both England and Wales to develop mechanisms to move locally employed doctors onto specialty doctor contracts.
- 6.203 The Scottish Government, NHS Wales Employers, and NHS Employers have pointed to the use of mirror contracts for locally employed doctors. This serves the purpose of a separate pay structure in terms of ensuring consistency of both pay and broader terms and conditions for similar roles. It would be helpful to have greater understanding and transparency about what this means in practice – where there are similarities and differences from the national contracts which are mirrored. Unlike national contracts, locally employed doctors do not have guaranteed training and development, are fixed term, do not have structured progression, and there is no requirement to rotate.

SAS doctors and dentists

- 6.204 The evidence this year for SAS doctors focused on career progression and the creation of specialist roles. Mechanisms to regrade specialty doctors to specialist roles have been recently agreed in both Wales and Scotland. The 10-year health plan in England said the government would work with stakeholders to ensure a more streamlined and predictable pathway for experienced specialty doctors to develop and operate at a specialist level. This would be very valuable to the specialty doctor cohort.
- 6.205 There is still evidence that specialty doctor and specialist roles, and the distinction both between them and with consultants, is not well understood. We would hope future workforce planning communicates this clearly, as well as setting out when each role is most appropriate to enable service delivery.
- 6.206 We also continued to hear concerns on our visits in England and Northern Ireland about the perceived unfairness of differences in premium pay between the old and new contracts for specialty doctors. We understand that this was agreed as part of a rebalancing of terms and conditions, and it would be helpful for employers to continue to communicate to individuals if they would be better off moving to the new contract.

6.207 Basic pay scales for SAS doctors are similar across all nations and the data that we have indicate that earnings are also similar. While our pay comparability work for this group is based on England, due to the lack of longer-term data for the other nations, we expect the current picture to be similar.

6.208 Specialty doctors have seen real terms increases in basic pay and total earnings since 2015 and increases in basic pay since 2019 with little change in total earnings. Going back to 2010 shows small real terms falls in basic pay. Specialist doctors have seen more consistent real terms falls in total earnings, albeit with little change in basic pay since 2015 and 2019. This is linked to the move to the new contract and falls in working hours.

6.209 Specialty doctors and specialists have largely maintained their position in the earnings distribution over time. The pay comparability work shows pay for both specialty doctors and specialists is in line with or ahead of comparators on all measures.

Consultants

6.210 There is a case for significant investment in the consultant contract to enhance service delivery. The current contract is over 20 years old and does not meet the needs of the modern NHS. In particular, it needs to better enable flexible working – across the working week, across localities, and across types of clinical activity, and between primary, secondary and community care – in response to the evolving needs of the NHS. This might require higher basic pay along with broader commitments to flexible working, with less reliance on incentivising additional hours. All four nations are currently at the beginning of this process. We would expect contract discussions to address the appropriate rate and extent of pay progression for consultants, and resolve anomalies created by the 2023 agreement in England, as highlighted by the BMA.

6.211 There is variation across the nations for basic pay for consultants, especially in terms of maximum basic pay. Total average earnings for consultants are similar in England and Wales, but higher in Scotland. While growth in basic pay for consultants in England over the last year has been in line with the pay uplift, there have been large falls in non-basic pay, of 16 per cent, driven by falls in medical awards and local payments.

6.212 Since 2015 and 2019, consultants in England have seen real terms growth in basic pay, but real terms falls in total earnings, likely driven by changes to clinical excellence awards. Since 2010, consultants have seen real terms falls in both basic and total earnings. Despite this, consultants have maintained their position at the 98th percentile of the earnings distribution. Comparisons with other professions indicate that, while basic pay for consultants is behind or in line with comparators, total earnings and total remuneration are in line with or ahead of comparators.

Consultant award schemes

6.213 Last year we recommended an increase in the value of national clinical impact awards in England and Wales from 1 April 2025. This was accepted by the UK and Welsh Governments. The UK Government said it acknowledged that national clinical impact awards were an important means of recognising and rewarding the significant impact consultants had on the NHS at a national level, specifically through activity that was over and above their contractual obligations.

6.214 We will continue to keep consultant award schemes under review. We would like future reviews to be better informed by evidence on the effectiveness of these awards,

that they are driving health outcomes that would not have been otherwise achieved, and that they are not a cause of pay inequality in the consultant workforce.

6.215 We note that less than 4 per cent of consultants in England and Wales are holders of national clinical impact awards and less than 2 per cent apply for an award each year. By contrast, the DHSC report that around 10,000 consultants (20 per cent of the workforce) retain their old local clinical excellence awards.

6.216 The current evidence base gives a mixed picture on clinical impact awards and raises a number of questions that need to be addressed. The DHSC said that recognised work had included nationwide treatment pathway changes and reviews, research that had fundamentally changed national and international guidelines, and introduction of new therapies that had positively impacted patients globally. NHS Employers, however, said that organisations generally reported no measurable impact at the service level from consultants holding the awards. They said that application numbers remained low, and many respondents noted minimal or no engagement with the awards. The HCSA said that there was limited evidence that clinical impact awards improved outcomes, as they focused on additional activities rather than clinical commitments or service needs and suggested they should be linked to local and national NHS operational priorities. The Welsh Government said it had not evaluated the impact of clinical impact awards on service delivery. There is not an active national consultant award scheme in either Scotland or Northern Ireland, and there has not been a reported detrimental impact on outcomes.

Chapter 7 Looking forward

- 7.1 This chapter gives a forward look on policy issues for our next round, reflects on our methodology and process, and sets out specific requests for data and evidence to support our future work.

Timing of the pay round

- 7.2 As set out in chapter 1, we have again been able to move our report submission earlier this year. We expect this will result in the earlier receipt of the pay uplift by members of our remit group. Further progress to move the pay round forward depends on us receiving earlier written and oral evidence. For the next round, we hope to receive our remit letters from governments in summer 2026, and written evidence by the start of September, in order that oral evidence sessions can be completed in the autumn.
- 7.3 We also stress the importance of a timely response to our recommendations. Delays this year not only held up our process, and subsequent pay awards, but also the necessary reforms which we recommended.
- 7.4 We address a great breadth of issues in our work, across both primary and secondary care, and are committed to a full and detailed consideration of the evidence. This process takes time and needs to be built into a realistic schedule. We also undertake a valuable visit programme between pay rounds. Many of our parties spend considerable time and resource consulting with their members to provide us with high quality evidence and we do not wish to compromise this. We would again stress that the timetable needs to be agreed across all the parties to our process.

Workforce planning

- 7.5 A refreshed workforce plan for the NHS in England is expected in spring 2026. Many of the issues that have been raised with us can be addressed through effective workforce planning. We hope to see far more detailed planning on how doctors in training can be best matched to future healthcare needs, in terms of specialties and locality. There also needs to be efforts from health education bodies to align the expectations of doctors in the early parts of their career with the overall needs of the NHS in terms of where, and in which specialties, training places are needed.
- 7.6 A refreshed workforce plan will need to be costed, so that appropriate prioritisation can be given to the areas that will deliver the greatest improvements in healthcare outcomes. This will support improvements in productivity. Progress has already been made in reducing expensive agency and locum spend. The workforce plan should recognise the different needs of different parts of the workforce as part of the delivery of the ambitions of the 10-year plan and articulate a reward strategy in support of this transition.
- 7.7 National pay structures require flexible and agile levers to deal with specific issues. Governments have made clear that they wish to address these issues locally. However, the evidence does not indicate that this is being done in a systematic or effective way. We would like to see all NHS employers have a far deeper and evidence-based understanding of where specific recruitment and retention issues lie, both in terms of locality and specialty, the impact these are having on service delivery, the cost of temporary staff, and the effect on colleagues. This should be accompanied by a review of the levers and tools that might support specific recruitment and retention issues which can be integrated into workforce plans.

- 7.8 The evidence of under-employment among recently qualified GPs, despite overall workforce growth, indicates that workforce planning for general practice requires much greater consideration, including the appropriate skill mix in general practice and the best way of funding this. Furthermore, the proposed move to care in the community, and large-scale neighbourhood contracts, may require a different type of pay structure, with more direct employment and GPs and consultants working together. Lessons may be learnt from the good examples of GPs already working in secondary care.
- 7.9 There also needs to be significantly more attention paid to workforce planning for dentistry. This has been extremely limited to date, with workforce growth coming from international recruitment, without an expansion of undergraduate places, despite the significant under-provision of dentistry and the large and increasing number of people applying to study dentistry

Locally employed doctors

- 7.10 Last year we recommended that governments consider a separate pay framework for locally employed doctors. The Scottish Government has told us that all doctors are on national terms and conditions and has provided data on the number of resident doctors without a national training number. NHS Wales has made significant progress on identifying and rationalising locally employed doctors in the payroll. The new agreement for resident doctors in Wales encompasses locally employed doctors.
- 7.11 The Department of Health in Northern Ireland said it was undertaking a scoping exercise to better understand the specific needs and circumstances of locally employed doctors. The UK Government said its priority would be to improve data collection on locally employed doctors and increase its understanding of the needs of this workforce.
- 7.12 Evidence on the number, roles, and terms and conditions of locally employed doctors in England is poor, despite General Medical Council estimates that this group number close to 37,000 in England. Both the British Medical Association (BMA) and the Hospital Consultants and Specialists Association (HCSA) have raised substantial concerns with us about the poor treatment of locally employed doctors. The 2024 agreement for specialty, associate specialist and specialist (SAS) doctors in England included a joint piece of work to determine how locally employed doctors can be better supported to progress in their careers. It is disappointing that this has not come to fruition, and we hope to see progress in the coming months.
- 7.13 We would like to see substantially improved data on the locally employed doctor workforce in England in particular. NHS Employers have indicated that this is achievable and would be a first step to support this large and growing part of the medical workforce. We request that the UK and Northern Ireland governments share the conclusions of their scoping exercises with us as soon as they are available.

Medical training and resident doctors' working lives

- 7.14 The commitments made by NHS England and NHS Employers both through the review of medical training and the 10-point plan to improve resident doctors' working lives, are welcome. NHS England has said that progress will be reported and data published on meeting targets. We believe this is vital, not only to ensure that commitments are delivered, but to demonstrate and communicate progress to resident doctors. Investment in working facilities and arrangements for resident doctors is likely to be cost effective in terms of the improvement to motivation, wellbeing and commitment.

- 7.15 In light of the issues highlighted by resident doctors around career progression and training places, and the significant investment that is made in their training, we strongly urge the health education bodies to track the progress of UK medical graduates through employment and training on a longitudinal basis. This would better inform understanding of progression through training, bottlenecks, time spent out of training, career breaks, unemployment, transitions into locally employed or locum roles, and movements into and out of UK practice, including overseas moves.
- 7.16 The Government has introduced legislation to prioritise medical training places for foundation and specialty training for graduates of UK medical schools and, from 2027, for doctors with significant NHS experience. The government has stated that the Act is intended to respond to increased competition for postgraduate medical training places and help ensure a sustainable medical workforce in the NHS. As this policy is implemented, we would welcome evidence on how prioritisation affects progression through training, time out of training, and aligns with workforce planning across specialties and locations.

Flexible pay premia

- 7.17 In chapter 1 we outlined the ongoing need for the government to review flexible pay premia in England to assess their value for money and effectiveness. This should be linked to a clear picture on future training place requirements from a refreshed workforce plan and feed into future contract negotiations. We would expect any changes to be for future recruitment and to not impact those currently in training posts with a flexible pay premium.
- 7.18 This is not a difficult or resource intensive task. The Royal College of Emergency Medicine has set out a strong case for the continued payment of the flexible pay premium for higher training in emergency medicine. This level of evidence should be compiled for each specialty. It may be the case that recruitment to other specialties could be supported by the introduction of a flexible pay premium, such as special care dentistry.

Clinical impact awards

- 7.19 We consider it appropriate to review clinical impact awards periodically rather than every year. We would like future reviews to be better informed by evidence on the effectiveness of these awards, that they are driving health outcomes that would not have been otherwise achieved, and that they are not a cause of pay inequality in the consultant workforce.
- 7.20 The current evidence base gives a mixed picture on these issues and raises a number of questions that need to be addressed. In particular, we would like evidence that clinical impact awards are the best use of this part of the consultant paybill. We note that there is not an active national consultant award scheme in either Scotland or Northern Ireland, without any reported detrimental impact on outcomes. We would like the UK and Welsh Governments to consider a more in-depth review of clinical impact awards. This might form part of wider discussions on contractual reform for consultants.
- 7.21 The 10-year health plan said that providers would be given new flexibilities to make additional financial payments to clinical teams that had consistently high clinical outcomes and excellent patient feedback or were significantly improving care. This is an interesting development, with a potentially valuable link to local delivery, which can

be gainfully explored. We would value more consideration of how this might work in practice.

London weighting and wider locality issues

7.22 The BMA has asked us to review London weighting. The current payment is £2,162 a year and it has not been changed since 2005.⁶⁵ There is also a payment of £602 for resident staff, although it is not clear that this is still in use. As we understand it, this payment is not made to general dental practitioners working in London but is paid to dentists in the Community Dental Services (CDS).

7.23 To fully assess London weighting we need a far stronger evidence base, a shared understanding of the purpose of London weighting, and better data on local labour markets and regional costs to consider the issue fully. As with flexible pay premia, paying differently for the same job requires robust justification. We are happy to review this, alongside a broader review of locality issues including the position of remote, rural and coastal areas, so we ask parties to submit evidence on all these matters next year.

Community and Public Dental Services

7.24 There are still significant areas where the evidence base on the CDS and Public Dental Service (PDS) can be improved, particularly in England. This is key to understanding the effectiveness of the overall service. As well as trends in the workforce over time, and evidence on recruitment and retention, we would like to see the distribution of dentists across pay bands, and data on earnings and working hours. We have recommended that the overall reward structure for CDS and PDS dentists is reviewed. We agree with the Department of Health in Northern Ireland that any review needs to start with a clear evidence base. The lack of evidence is one of the reasons why a review is necessary, rather than a reason not to do it.

7.25 National CDS waiting list data collection has been introduced in England and is being collected monthly from August 2025. This has the potential to provide, for the first time, a consistent national picture of waiting times for assessment and treatment within the CDS. As this information becomes available, we would expect it to inform future assessments of service effectiveness, workforce capacity, and the alignment between demand, staffing levels and reward structures within the CDS. We would welcome timely publication of this data to support transparency and informed decision-making.

NHS staff surveys

7.26 Due to the earlier timing of our round, we have not been able to consider the results of the 2025 NHS staff survey in England. We expect this to be the case in future rounds, and so we are keen to consider alternative survey data.

7.27 It is very positive to have received evidence from the NHS staff survey in Wales for medical and dental staff this year. We continue to lack evidence on motivation, morale and wellbeing among our remit group in Northern Ireland. As we said last year, this is

⁶⁵ In our 2006 report, we said:

There is no basis, on labour market grounds, for increasing the current level of payment and indeed, there is an argument for removing it completely. We recognise however that its immediate removal could create considerable problems in morale and motivation terms. We therefore recommend that supplements for London weighting should remain at their existing levels for 2006-07. Unless the evidence in future years indicates that labour market conditions in London have changed, we do not intend to revisit this decision.

important in improving the effectiveness of the workforce and we hope it can be addressed.

- 7.28 The DHSC said that 33 Integrated Care Systems participated in the second year of the general practice staff survey in 2024, and nearly 25 per cent of practices in those systems shared staff lists. This is a valuable development which we hope can be extended across the sector and the results published in future.

Primary care workforce

- 7.29 The dental working patterns survey was published in April 2024 for the first time in four years. This survey provided useful information on dentists' working hours, the proportion of time spent on NHS and private work, and measures of motivation and morale. We would welcome this survey being updated and published regularly, so that it can inform our future reports. The dental workforce survey was published for the second time in July 2025, providing useful information on vacancies, joiners and leavers. We hope this survey will be continued each year.
- 7.30 Information published by NHS England on general practitioner (GP) job vacancies is a valuable addition to the evidence base, especially in the light of concerns about lack of GP jobs. It would be helpful to break this data down further – for example by type of GP role, or the number of sessions available.

Workforce equalities

- 7.31 It is again disappointing not to see consistent and clear information on the extent of the gender pay gap in the medical and dental workforces across all nations. It is also disappointing that the DHSC has not provided an update on the work of the Gender Pay Gap in Medicine Implementation Panel.
- 7.32 The Scottish Government is providing this information, and we would like to see the other nations taking a similar approach. Some individual trusts publish detailed reports that highlight substantial gender pay gaps among the consultant workforce, driven by legacy clinical excellence awards. This reporting is important in understanding the problems of the current pay system and the impact of reforms to pay structures.
- 7.33 We would like to see progress on gender, ethnicity and disability pay gaps across the medical and dental workforce groups. Without full reporting on these issues, it is hard for us to meet our terms of reference to consider the legal obligations on the NHS, including anti-discrimination legislation.
- 7.34 NHS England said it had asked all lead employers of resident doctors in training to report annually on ethnicity and gender pay gaps. This is positive, although we see no reason why it should not apply to all medical and dental workforce groups.
- 7.35 The NHS Race and Health Observatory has commissioned a review of ethnicity pay gaps across the NHS in England. This is long overdue, and we look forward to seeing the findings, in particular to understand how ethnicity pay gaps interact with nationality in the medical and dental workforce, and how they relate to structural reward issues, such as progression or access to additional pay.
- 7.36 The 10-year health plan said that the Department for Education would publish data on the background of university entrants, starting with medicine. The DHSC also said that, from 2025, NHS workforce systems, as well as annual national workforce surveys,

would capture socio-economic background information. These are very positive developments, and we look forward to receiving this evidence. They will also support the UK Government in meeting its commitment to widening participation in medicine.

Pay comparability

7.37 We have reviewed our approach to pay comparability, in the light of our revised terms of reference. Full details are set out in appendices E and F. This includes a commissioned review from Incomes Data Research (IDR), which is published alongside this report.⁶⁶ This work develops a framework for comparing the earnings of doctors and dentists with other roles, which will be updated each year and can be adjusted in response to developments in external roles or sources of data. Parties are invited to comment on this reviewed and revised approach, which can be developed in future years.

Future data and evidence requirements

7.38 In addition to the issues covered above, there are a number of specific areas where we would welcome data and evidence from the parties. This is in addition to what we normally receive.

Table 7.1: Further data requirements

Area	Data requests
Context	<ul style="list-style-type: none"> • Gender pay gaps for the secondary care workforce by grade. • Ethnicity pay gaps for the secondary care workforce by grade. • Disability pay gaps for the secondary care workforce by grade. • Affordability in the context of wider health spending pressures.
Secondary care workforce	<ul style="list-style-type: none"> • Data on the motivation and morale of the HSC medical and dental workforce in Northern Ireland. • Average working hours for the main workforce groups. • The average number of programmed activities and supporting professional activities worked by consultants. • The number of doctors on local contracts. • Average earnings by workforce group in Northern Ireland.
Career progression and training pathways	<ul style="list-style-type: none"> • Longitudinal data linking training, workforce and registration records to track doctors' and dentists' progression from training into employment, including time spent out of training and post-training outcomes.
Primary care workforce	<ul style="list-style-type: none"> • Leavers and joiners, and turnover in the GP workforce. • Number of dentists, grades, working hours, and earnings in the CDS and PDS. • Leavers and joiners, turnover and vacancies in the CDS and PDS. • NHS staff survey results for GP practices.

⁶⁶ <https://www.gov.uk/government/organisations/review-body-on-doctors-and-dentists-remuneration>

Appendix A Remit letters



*From the Rt Hon Wes Streeting MP
Secretary of State for Health and Social Care*

*39 Victoria Street
London
SW1H 0EU*

22 July 2025

Dear Mr Hoble,

RE: DDRB Remit Letter

I would firstly like to welcome you as the new chair of the Review Body for Doctors' and Dentists' Remuneration (DDRDB) starting on 1 August. I am looking forward to engaging with you in due course and to the leadership you will bring to the process.

I would also like to offer my thanks to the DDRB for their work over the past year on the 2025 to 2026 report. I appreciate the independent, expert advice and valuable contribution that the DDRB makes. I am still considering the further non-headline pay recommendations made in that report and will respond to these as soon as possible.

I write to you now to formally commence the 2026 to 2027 pay round.

On 3 July we published our [10 Year Health Plan for England: fit for the future](#). This plan seeks to make 3 big shifts from hospital to community, sickness to prevention, and analogue to digital, and sets the context for the pay round. A valued, motivated and skilled NHS workforce is essential to delivering our plan, which is why we will publish a 10 Year Workforce Plan to create a more empowered workforce ready to deliver a transformed service. To support this, we are taking steps to address the legitimate concerns that doctors have raised about their working conditions. As a first step for resident doctors, over the next 3 years we will create 1,000 new training posts and will prioritise UK medical graduates. We have already made progress on improving working lives, including developing a new exception reporting process to improve safe working and undertaking a review into how we make the rotational element of training less disruptive to the personal lives of resident doctors. This government has also worked closely with the unions to implement the consultant deal and is continuing its work implementing the Specialist and Associate Specialist (SAS) deal that was agreed last year.

We were pleased to be able to accept your recommendations for 2025 to 2026 pay awards. However, it came in above the figures we set out as affordable within evidence. Over the past few months, we have identified how extra funds will be freed up by cutting duplication and waste, and through abolishing NHS England, and reshaping and reducing Integrated Care Board (ICB) costs by 50% to empower NHS staff and deliver better care for patients. As the Spending Review confirmed, all pay must be funded from departmental budgets and there will be no additional funding available for pay settlements. My department's evidence will set out the funds available to the Department of Health and Social Care (DHSC) for 2026 to 2027, following the Spending Review last month, as well as the recruitment and retention context alongside, earnings data and our plan for building an NHS fit for the future.

We know that public sector workers delivering our vital public services deserve timely pay awards. We announced 2025 to 2026 pay awards 2 months earlier than last year and remain committed to bringing 2026 to 2027 pay announcements forwards further. That is why we are launching this pay round 2 months earlier than the previous pay round, I would be grateful if you could support an earlier pay announcement by submitting your report at the earliest point that allows you to give due consideration to the relevant evidence. I recognise that changing the timeline from recent years will present challenges for you, but I am sure you also share the government's belief in the importance of returning to more timely annual pay processes. To enable you to submit your report earlier, our department will aim to cooperate with all your deadlines and bring the evidence process forward.

As always, whilst your remit covers the whole of the United Kingdom, it is for each administration to make its own decisions on its approach to this year's pay round and to communicate this to you directly.

I would like to thank you again for your and the review body's invaluable contribution to the pay round and look forward to receiving your report for 2026 to 2027 in due course.

Yours sincerely,

A handwritten signature in black ink that reads "Wes Streeting". The signature is written in a cursive style with a long, sweeping underline that extends to the right.

RT HON WES STREETING MP

Jeremy Miles AS/MS
Ysgrifennydd y Cabinet dros Iechyd a Gofal Cymdeithasol
Cabinet Secretary for Health and Social Care



Llywodraeth Cymru
Welsh Government

Our ref: MA/JMHSC/1433/25

Mr Mark Hoble
Chair of Review Body on Doctors' and Dentists' Remuneration
Dentists Remuneration
1st Floor, 10 Victoria Street
London
SW1H 0NB
ddrb@businessandtrade.gov.uk

23 July 2025

Dear Mark,

Congratulations on your new appointment and I look forward to working with you on this pay round.

I am writing to formally commence the 2026-27 pay round for medical and dental staff in Wales.

In order to support your work, I will provide written evidence and I also plan to attend the oral evidence session when arranged.

I would like to take this opportunity to say I truly value the hard work and commitment of all our dedicated healthcare workers in Wales and recognise the pressures on our workforce.

Therefore, I would like to receive your advice and recommendations as soon as possible to ensure that payment of any award to our dedicated NHS workforce is not unduly delayed past April 2026.

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1SN

Canolfan Cyswllt Cyntaf / First Point of Contact Centre:
0300 0604400

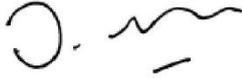
Gohebiaeth.Jeremy.Miles@llyw.cymru
Correspondence.Jeremy.Miles@gov.wales

Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

Whilst I am aware that the timetable for your reports is being brought forward taking April timeframe into account, which is only right and necessary, this means they likely to be received within our pre-election period. I would still like to receive the reports as early as possible so these can be considered and responded to as soon as Welsh Ministers are able to do so.

Yours sincerely,

A handwritten signature in black ink, consisting of a circular mark followed by a series of wavy lines and a short horizontal stroke at the end.

Jeremy Miles AS/MS

Ysgrifennydd y Cabinet dros Iechyd a Gofal Cymdeithasol
Cabinet Secretary for Health and Social Care

FROM THE MINISTER OF HEALTH



Mr Mark Hoble
Chair of the Review Body for
Doctors' and Dentists' Remuneration
3rd Floor, Windsor House
42-50 Victoria Street
London
SW1H 0TL

Castle Buildings
Stormont Estate
BELFAST, BT4 3SQ
Tel: 028 9052 2556
Email: private.office@health-ni.gov.uk

Our Ref: SUB-0432-2025

Date:  July 2025

By email: ddrb@businessandtrade.gov.uk

Dear Mr Hoble

Firstly, I would like to welcome you to your new role as chair of the Review Body for Doctors' and Dentists' Remuneration (DDRB) effective from 1 August. I look forward to engaging with you throughout the pay round and to the leadership and insight you will bring to the process.

I am writing to you now to formally commence the 2026/27 pay round for doctors and dentists in Northern Ireland and provide you with an update on the implementation of the 2025/26 pay award in Northern Ireland. I want to thank the Review Body for Doctors' and Dentists' Remuneration (DDRB) for its invaluable work on the 2025/26 pay round and the recommendations contained therein. I have accepted in full the pay recommendations and I am still considering further the non-pay recommendations made in that report.

I want to state my commitment to implementing this year's pay award in full, and to doing so as promptly as possible. Due to the Department not being in a position to afford the full pay award, I have issued a Ministerial Direction for immediate implementation of the pay awards for all HSC staff in 25/26 in full. This is currently with the Northern Ireland Executive for consideration. I have a meeting scheduled with representatives of the BMANI in August to discuss the current position regarding implementation of the 2025/26 recommendations. My department remains committed to ongoing engagement with unions as this process continues.

Working for a Healthier People

Appropriate reward and recognition for our staff is clearly an important part of demonstrating that we value the work that they undertake. Therefore, my aim is to move towards having the pay award in Northern Ireland paid to a similar timescale as in England. However, there is a need to recognise the challenge my department faces in relation to our budget. Issuing the Ministerial Direction is only the first step in moving forward with pay. We need to find significant additional funding in order to proceed with implementation of the award. I will continue to make the case, to Executive colleagues, for additional financial allocations that would allow me to implement a pay award in line with the recommendations from DDRB for 25/26.

Similar to the statement made by the Secretary of State for Health and Social Care in England my department's evidence will set out the funds available to the Department of Health in Northern Ireland for 2026/27 as well as the recruitment and retention context alongside, earnings data and our plan for building a HSC fit for the future.

In line with the approach taken by the Department of Health and Social Care, my department will also seek to work collaboratively with you to meet your timelines and bring forward the provision of evidence. This will help to support the aim of enabling earlier pay announcements.

I would therefore welcome your pay recommendations for health and social care staff in Northern Ireland for 2026/27. The Department will, of course, keep you updated in regard to any progress made in respect of 2025/26 awards.

Yours sincerely



Mike Nesbitt MLA
Minister of Health

Cabinet Secretary for Health and Social Care
Rùnaire a' Chaibineit airson Slàinte agus Cùram Sòisealta
Neil Gray MSP
Niall Gray BPA



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Mr Mark Hoble
Chair of Review Body on Doctors' and Dentists'
Remuneration
Office of the Pay Review Bodies
London
SW1H 0NB

By email: ddrb@businessandtrade.gov.uk

7 October 2025

Dear Mark

Congratulations on your new appointment as Chair of Review Body on Doctors' and Dentists' Remuneration. I look forward to collaborating with you on this pay round.

I am writing to offer my observations in relation to the 2025/26 round and to outline my position in relation to the recommendations. I am also seeking to formally commence the 2026/27 pay round for Doctors and Dentists in Scotland.

2025/26 Round

In my remit letter last year, I offered my full support to the agreed reforms to the DDRB process which formed part of the Department of Health and Social Care's offer to Consultants in England for 2024/25. I am pleased to confirm that, in my view, these reforms were successfully implemented by the DDRB, and having carefully considered the 2025/26 report, I can now confirm that the Scottish Government has accepted the recommendation of a 4.0% uplift for the senior staff groups covered by the DDRB.

With regard to the other recommendations in your report, several do not apply to NHS Scotland due to significant differences in employment practices and procedures.

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

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www.gov.scot



Note: This is a revised version of the original remit letter from the Scottish Government which was dated 24 September 2025. The revised version added 'or Resident Dentists' to the end of the sixth paragraph on the second page.

However, in relation to Recommendations 6 and 7, I would note that there is considerable variation in scope of work undertaken by General Medical and Dental Practices across the UK, the range of services provided, and the demands placed upon them, both across the four nations, but also between urban and rural practices within each nation. These variations are further shaped by the unique demographic characteristics of each locality, to the extent that it is in my view impractical to compile a detailed and meaningful index of typical expenses which accurately reflects the costs faced by contractors in Scotland.

I note here that my officials are currently working with the Scottish General Practitioners Committee (SGPC) on an approach to non-staff expenses, as well as with the Scottish Dental Practice Committee (SDPC) to agree realistic approaches to recognising expenses in service contracts. Further to this, we are committed to maintaining regular engagement with colleagues from the other UK nations to share insights on developments and areas of mutual interest, and this will also inform any action on recognition of expenses.

Regarding Recommendation 7, it is important that the British Dental Association (BDA) is encouraged to take the lead in proposing plausible and sustainable solutions to a range of issues, including recruitment, retention, and overall job satisfaction within the Public Dental Service. My dentistry policy officials are in regular dialogue with the BDA on these matters in a number of forums, including the regular meetings of the BDA Scottish Joint Negotiating Forum (SJNF) and I am keen to support their continued engagement with NHS Employers.

It is important to note that any changes to contract terms must be proposed, agreed and ratified by Board Chief Executives and the Management Steering Group, and this is independent to the work and direction of Scottish Government.

DDRB Remit for 2026/27

The Scottish Government continues to value the independent review process, and I would like to take this opportunity to thank your predecessor and colleagues for the significant work that took place in producing the 2025/26 report and recommendations.

Accordingly, the Scottish Government will provide a written evidence document, and we would be pleased to receive the DDRB views regarding a recommendation for 2026/27. This will be for all medical and dental staff in NHS Scotland and for medical and dental contractors in primary care but not Resident Doctors or Resident Dentists.

I am aware that you and your colleagues are seeking to accelerate this year's process and expedite the publication of the DDRB process to an earlier point in 2026/27. I fully support this as I believe that giving staff certainty around pay increases and having uplifts in pay packets as soon as possible is beneficial to staff morale. I can confirm that my officials are working to deliver an initial draft of the Scottish Governments evidence for later this month.

I would highlight that this will just be an initial draft of our evidence, and we will provide an update following the Scottish budget announcement. This would normally take place in December, but I am not in a position to confirm this at this time due to the implications stemming from the timing of the UK budget. Once I have a confirmed position on the timing of the Scottish Budget my officials will notify their OPRB colleagues.

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

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Copies of this letter will be sent to the Secretary of State for Health and Social Care and the respective Ministers in the devolved governments as well as representatives of the Staff Side and NHS Employers.

Yours sincerely



NEIL GRAY

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

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Appendix B Detailed recommendations on remuneration

Recommendations on remuneration in England from 1 April 2026

	2025	2026
	£	£
Doctors and dentists in training (2016 contract)		
Foundation doctors – year 1	38,831	40,190
Foundation doctors – year 2	44,439	45,994
Core/run-through training – years 1-2	52,656	54,499
Core/run-through/higher training – years 3-5	65,048	67,325
Core/run-through/higher training – years 6+	73,992	76,582
Flexible pay premia (2016 contract)		
General practice	11,118	11,508
Psychiatry core training	4,520	4,679
Psychiatry higher training (three year)	4,520	4,679
Psychiatry higher training (four year)	3,390	3,509
Academia	5,424	5,614
Histopathology	5,424	5,614
Emergency medicine/oral & maxillofacial surgery:		
3 years	9,040	9,357
4 years	6,780	7,018
5 years	5,424	5,614
6 years	4,520	4,679
7 years	3,875	4,010
8 years	3,390	3,509
Dental foundation training	42,408	43,893
Specialty doctor (2021 contract)	61,542	63,696
	70,901	73,383
	79,038	81,804
	87,486	90,548
	99,216	102,689
Specialist (2021 contract)	100,870	104,401
	104,816	108,484
	111,441	115,341

	2025	2026
	£	£
Specialty doctor (2008 contract)	53,310	55,176
	57,736	59,757
	63,491	65,713
	66,575	68,905
	71,018	73,504
	75,445	78,085
	79,970	82,769
	84,498	87,455
	89,025	92,141
	93,551	96,825
	98,078	101,511
 Associate specialist (2008 contract)	 74,123	 76,717
	79,957	82,756
	85,790	88,792
	93,493	96,765
	100,170	103,676
	102,940	106,543
	106,554	110,284
	110,169	114,025
	113,783	117,766
	117,398	121,507
	121,016	125,251
 Staff grade practitioner (1997 contract)	 49,502	 51,235
	53,310	55,176
	57,116	59,115
	60,924	63,056
	64,731	66,997
	69,214	71,636
	72,345	74,877
	76,151	78,816
	79,959	82,757
	83,766	86,698
	87,572	90,637
	91,381	94,580

	2025 £	2026 £
Consultant (2003 contract)	109,725	113,565
	116,182	120,249
	119,490	123,672
	131,058	135,645
	145,478	150,569
National clinical impact awards		
Level 1	21,500	21,500
Level 2	31,500	31,500
Level 3	42,000	42,000
Salaried general medical practitioner range		
Minimum	76,038	78,699
Maximum	114,743	118,759
Salaried primary care dental staff (2008 contract)		
Band A: Salaried dentist	52,532	54,502
	58,369	60,558
	67,124	69,641
	71,502	74,183
	75,879	78,725
	78,798	81,753
Band B: Salaried dentist ⁶⁷	81,716	84,781
	84,635	87,809
	89,012	92,350
	91,201	94,621
	93,390	96,892
	95,579	99,163
Band C: Salaried dentist ^{68,69}	97,768	101,434
	100,686	104,462
	103,604	107,490
	106,523	110,518
	109,441	113,545
	112,360	116,573
London weighting		
Resident staff	602	602
Non-resident staff	2,162	2,162

⁶⁷ The first salary point of band B is also the extended competency point at the top of band A.

⁶⁸ The first salary point of band C is also the extended competency point at the top of band B.

⁶⁹ The first three points on the band C range represent those available to assistant clinical directors.

Recommendations on remuneration in Scotland from 1 April 2026⁷⁰

	2025 £	2026 £
Foundation house officer 1	35,967	
	38,215	
	40,459	
Foundation house officer 2	44,613	
	47,531	
	50,448	
Specialty registrar (full)	47,438	
	50,341	
	54,395	
	56,846	
	59,801	
	62,758	
	65,719	
	68,675	
	71,631	
	74,591	
Dental core training⁷¹	52,686	
Dental senior house officer/senior house officer	44,613	
	47,531	
	50,448	
	53,364	
	56,282	
	59,198	
	62,115	
Specialty doctor (2022 contract)	64,158	66,404
	76,537	79,216
	81,223	84,066
	90,600	93,771
	99,975	103,475

⁷⁰ DDRB is not making recommendations for doctors and dentists in training in Scotland for 2026.

⁷¹ On completion of core training, employees move to the nearest point on or above their existing salary on the dental senior house officer scale.

	2025	2026
	£	£
Specialty doctor (2008 contract)	52,812	54,661
	57,327	59,334
	63,196	65,408
	66,342	68,664
	70,875	73,356
	75,391	78,030
	80,007	82,808
	84,625	87,587
	89,244	92,368
	93,860	97,146
	98,477	101,924
 Specialist (2022 contract)	 100,870	 104,401
	104,816	108,485
	111,441	115,342
 Associate specialist (2008 contract)	 74,041	 76,633
	79,993	82,793
	85,943	88,952
	93,802	97,086
	100,611	104,133
	103,438	107,059
	107,126	110,876
	109,704	113,544
	113,286	117,252
	116,865	120,956
	120,448	124,664
 Consultant (2004 contract)	 111,430	 115,331
	113,784	117,767
	117,169	121,270
	120,558	124,778
	123,937	128,275
	131,982	136,602
	140,026	144,927
	148,064	153,247
 Salaried general medical practitioner range		
Minimum	77,160	79,861
Maximum	115,167	119,198

	2025	2026
	£	£
Salaried primary care dental staff (2008 contract)		
Band A: Dental officer	54,117	56,147
	60,131	62,386
	69,150	71,744
	73,657	76,420
	78,168	81,100
	81,174	84,219
Band B: Senior dental officer	84,180	87,337
	87,186	90,456
	91,696	95,135
	93,951	97,475
	96,207	99,815
	98,460	102,153
Band C: Assistant clinical director	100,715	104,492
	103,722	107,612
	106,726	110,729
Band C: Specialist dental officer	100,715	104,492
	103,722	107,612
	106,726	110,729
	108,659	112,734
Band C: Clinical director/chief administrative dental officer	100,715	104,492
	103,722	107,612
	106,726	110,729
	108,659	112,734
	111,577	115,762
	114,496	118,790

Recommendations on remuneration in Wales from 1 April 2026

	2025 £	2026 £
Foundation house officer 1 (2015 contract)	35,390	36,629
	37,487	38,800
	39,587	40,973
Foundation house officer 2 (2015 contract)	43,466	44,988
	46,192	47,809
	48,915	50,628
Specialty registrar (full)	46,324	47,946
	49,046	50,763
	52,853	54,703
	55,157	57,088
	57,929	59,957
	60,706	62,831
	63,482	65,704
	66,259	68,579
	69,034	71,451
71,814	74,328	
Dental foundation training	Waiting for Wales Govt	
Dental core training	43,670	45,199
	46,411	48,036
	49,148	50,869
	51,887	53,704
	54,625	56,537
	57,364	59,372
	60,102	62,206
Specialty doctor (2021 contract)	62,117	64,292
	71,563	74,068
	79,777	82,570
	88,302	91,393
	99,216	102,689
Specialist (2021 contract)	100,870	104,401
	104,816	108,485
	111,442	115,343

	2025 £	2026 £
Specialty doctor (2008 contract)	52,306	54,137
	56,777	58,765
	62,593	64,784
	65,708	68,008
	70,195	72,652
	74,668	77,282
	79,239	82,013
	83,814	86,748
	88,389	91,483
	92,962	96,216
	97,536	100,950
 Associate specialist (2008 contract)	 76,126	 78,791
	82,245	85,124
	88,362	91,455
	96,440	99,816
	103,420	107,040
	106,347	110,070
	110,140	113,995
	113,931	117,919
	117,721	121,842
	121,514	125,767
	125,308	129,694
 Staff grade practitioner (1997 contract)	 51,876	 53,692
	55,993	57,953
	60,110	62,214
	64,226	66,474
	68,345	70,738
	72,459	74,996
	76,579	79,260
	80,695	83,520
	84,814	87,783
	88,931	92,044
	93,046	96,303
	97,165	100,566
 Consultant (2003 contract)	 110,240	 114,099
	115,752	119,804
	121,264	125,509
	126,776	131,214
	135,596	140,342
	143,312	148,328
	152,132	157,457

	160,951	166,585
National clinical impact awards		
Level 0	10,500	10,500
Level 1	21,000	21,000
Level 2	31,500	31,500
Level 3	42,000	42,000
Salaried general medical practitioner range		
Minimum	79,123	81,893
Maximum	119,394	123,573
Salaried primary care dental staff (2008 contract)		
Band A: Salaried dentist	52,821	54,802
	58,693	60,894
	67,494	70,026
	71,895	74,592
	76,297	79,159
	79,232	82,204
Band B: Salaried dentist ⁷²	82,164	85,246
	85,098	88,290
	89,500	92,857
	91,699	95,138
	93,902	97,424
	96,103	99,707
Band C: Salaried dentist ^{73,74}	98,306	101,993
	101,237	105,034
	104,171	108,078
	107,107	111,124
	110,041	114,168
	112,974	117,211
	New	2026
	Contract	£
Foundation house officer 1 (2026 contract)	40,000	41,400
Foundation house officer 2 (2026 contract)	50,000	51,750
Specialty registrar (2026 contract)	55,000	56,925
	62,000	64,170
	68,000	70,380
	74,000	76,590
	78,000	80,730

⁷² The first salary point of Band B is also the extended competency point at the top of Band A.

⁷³ The first salary point of Band C is also the extended competency point at the top of Band B.

⁷⁴ The first three points on the Band C range represent those available to assistant clinical directors.

Recommendations on remuneration in Northern Ireland from 1 April 2026

	2025 £	2026 £
Foundation house officer 1	35,704	36,954
	37,733	39,054
	39,758	41,150
Foundation house officer 2	43,510	45,033
	46,142	47,757
	48,779	50,487
Specialty registrar (full)	46,274	47,894
	48,910	50,622
	52,585	54,426
	54,812	56,731
	57,495	59,508
	60,179	62,286
	62,862	65,063
	65,546	67,841
	68,230	70,619
70,914	73,396	
Specialty doctor (2021 contract)	61,542	63,696
	70,901	73,383
	79,038	81,805
	87,486	90,549
	99,216	102,689
Specialist (2021 contract)	100,870	104,401
	104,816	108,485
	111,442	115,343
Specialty doctor (2008 contract)	53,563	55,438
	58,013	60,044
	63,794	66,027
	66,892	69,234
	71,358	73,856
	75,807	78,461
	80,354	83,167
	84,903	87,875
	89,451	92,582
	94,001	97,292
98,549	101,999	

	2025	2026
	£	£
Associate specialist (2008 contract)	74,477	77,084
	80,340	83,152
	86,201	89,219
	93,942	97,230
	100,649	104,172
	103,434	107,055
	107,067	110,815
	110,698	114,573
	114,331	118,333
	117,961	122,090
	121,599	125,855
Staff grade practitioner (1997 contract)	49,738	51,479
	53,562	55,437
	57,388	59,397
	61,215	63,358
	65,040	67,317
	69,545	71,980
	72,691	75,236
	76,515	79,194
	80,342	83,154
	84,167	87,113
	87,993	91,073
	91,821	95,035
Consultant (2004 contract)	110,681	114,555
	116,193	120,260
	119,501	123,684
	131,076	135,664
	145,517	150,611
Salaried general medical practitioner range		
Minimum	77,140	79,840
Maximum	116,406	120,481

	2025	2026
	£	£
Salaried primary care dental staff		
Band 1: Salaried dentist	48,218	50,027
	52,118	54,073
	56,017	58,118
	59,920	62,167
	63,820	66,214
	67,718	70,258
	71,622	74,308
	75,522	78,355
Band 2: Senior salaried dentist	68,900	71,484
	74,354	77,143
	79,806	82,799
	85,258	88,456
	90,711	94,113
	91,915	95,362
	93,114	96,606
Band 3: Assistant clinical director salaried dentist	91,557	94,991
	92,973	96,460
	94,388	97,928
	95,807	99,400
	97,222	100,868
	98,639	102,338
Band 4: Clinical director salaried dentist	91,557	94,991
	92,973	96,460
	94,388	97,928
	95,807	99,400
	97,222	100,868
	98,639	102,338
	100,057	103,810
	101,499	105,306
	102,917	106,777
	104,332	108,245

Appendix C The number of doctors and dentists in the NHS/HSC in the UK⁷⁶

England ⁷⁷	2024		2025		Percentage change 2024-2025	
	Full-time equivalent	Headcount	Full-time equivalent	Headcount	Full-time equivalent	Headcount
Hospital and Community Health Services medical staff						
Consultant	58,282	63,109	60,585	65,786	4.0%	4.2%
Associate specialist	2,629	2,976	2,860	3,228	8.8%	8.5%
Specialty doctor	9,352	10,506	9,932	11,140	6.2%	6.0%
Staff grade	359	389	351	381	-2.2%	-2.1%
Specialty registrar	35,690	37,560	36,278	38,353	1.6%	2.1%
Core training	23,709	24,337	25,636	26,395	8.1%	8.5%
Foundation doctor year 2	7,453	7,540	7,811	7,919	4.8%	5.0%
Foundation doctor year 1	8,331	8,384	8,605	8,670	3.3%	3.4%
Hospital practitioner/ clinical assistant	710	1,941	745	2,013	5.0%	3.7%
Other staff	831	1,336	815	1,332	-1.9%	-0.3%
Total	147,347	157,574	153,619	164,688	4.3%	4.5%
General medical practitioners⁷⁸						
GP partner	15,703	18,425	15,254	17,974	-2.9%	-2.4%
Salaried GP	11,613	18,557	12,632	20,324	8.8%	9.5%
GP in training	10,167	10,524	9,442	9,848	-7.1%	-6.4%
GP retainers	295	707	309	733	4.7%	3.7%
General dental practitioners^{79,80}						
Providing-performer		4,458		4,383		-1.7%
Associate		19,714		20,155		2.2%
Unknown		21		5		-76.2%
Total general practitioners		71,976		73,034		1.5%
Total – NHS doctors and dentists		229,550		237,722		3.6%

⁷⁶ An employee can work in more than one organisation, location, specialty or grade and their headcount is presented under each group but counted once in the headcount total.

⁷⁷ Data as 30 November each year unless otherwise indicated.

⁷⁸ Data excludes locums and relates to 31 December.

⁷⁹ This is the number of dental performers who have any NHS activity recorded against them via FP17 claim forms.

⁸⁰ Data for 1 April 2023 to 31 March 2024 and 1 April 2024 to 31 March 2025.

Scotland ⁸¹	2024		2025		Percentage change 2024-2025	
	Full-time equivalent	Headcount	Full-time equivalent	Headcount	Full-time equivalent	Headcount
Hospital and Community Health Services medical staff						
Consultant	6,181	6,819	6,308	6,970	2.0%	2.2%
Staff and associate specialist grade	1,266	1,584	1,312	1,642	3.6%	3.7%
Doctor in training	7,009	7,421	7,325	7,816	4.5%	5.3%
Other staff	1,660	2,416	1,727	2,470	4.0%	2.2%
Total	16,116	18,062	16,672	18,716	3.4%	3.6%
General medical practitioners⁸²						
Performer (partner)	2,574	3,104	2,557	3,071	-0.7%	-1.1%
Performer (salaried)	927	1,360	1,070	1,518	15.4%	11.6%
Retainers	25	51	31	54	23.6%	5.9%
General dental practitioners (non- hospital)⁸³						
		3,234		3,411		5.5%
General Dental Service		2,924		3,105		6.2%
Public Dental Service		334		336		0.6%
Total general practitioners		7,749		8,054		3.9%
Total – NHS doctors and dentists		25,811		26,770		3.7%

⁸¹ Data at 30 September of each year.

⁸² Data does not include GPs in training.

⁸³ Includes general dental services and public dental service dentists.

Wales ⁸⁴	2024		2025		Percentage change 2024-2025	
	Full-time equivalent	Headcount	Full-time equivalent	Headcount	Full-time equivalent	Headcount
Hospital and Community Health Services Medical Staff⁸⁵						
Consultant	3,009	3,284	3,131	3,461	4.0%	4.4%
Associate specialist	129	149	119	142	-7.1%	-4.7%
Specialty doctor	859	963	933	1,049	8.5%	8.9%
Staff grade	2	2	2	2	0.0%	0.0%
Specialist registrar	3,211	3,468	3,312	3,600	3.2%	3.8%
Foundation house officer 2	402	406	471	478	17.2%	17.7%
Foundation house officer 1	488	495	462	470	-5.3%	-5.1%
Senior dental officer	30	45	31	46	2.0%	2.2%
Dental officer	113	143	112	142	-0.8%	-0.7%
Senior house officer	229	232	218	224	-4.7%	-3.4%
Other staff ⁸⁶	97	216	94	203	-3.0%	-6.0%
Total	8,569	9,403	8,886	9,817	3.7%	4.4%
General medical practitioners⁸⁷	1877	2569	1893	2651	0.8%	3.2%
GP partner	1035	1369	999	1353	-3.5%	-1.2%
GP salaried	417	700	467	780	11.8%	11.4%
GP retainer	11	30	11	28	-4.6%	-6.7%
GP registrar	414	470	417	490	0.8%	4.3%
General dental practitioners⁸⁸		1,399		1,335		-4.6%
Performers		1,106		1,073		-3.0%
Providing performer		283		262		-7.4%
Total general practitioners		3,968		3,986		0.5%
Total – NHS doctors and dentists		13,371		13,803		3.2%

⁸⁴ Data at 30 September each year.

⁸⁵ Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic practitioners.

⁸⁶ Other staff includes: clinical directors, clinical assistants, hospital practitioners and "other medical".

⁸⁷ Data at June 30 June each year. Data does not include GP locums.

⁸⁸ Data at 31 March each year. Figures may not match to totals due to some unknowns.

Northern Ireland ⁸⁹	2024		2025		Percentage change 2024-2025	
	Full-time equivalent	Headcount	Full-time equivalent	Headcount	Full-time equivalent	Headcount
Hospital and Community Health Services Medical Staff⁹⁰						
Consultant	2,013	2,150	2,071	2,214	2.9%	3.0%
SAS doctor	619	701	632	711	2.2%	1.4%
Registrar	1,613	1,722	1,705	1,820	5.7%	5.7%
Foundation doctor	549	555	589	596	7.4%	7.4%
Other	193	334	221	389	14.7%	16.5%
Total	4,986	5,442	5,218	5,715	4.7%	5.0%
General medical practitioners						
		1,454		1,468		1.0%
GP principal		1,129		1,104		-2.2%
GP salaried		314		348		10.8%
GP retainer		11		16		45.5%
General dental practitioners						
		1,195		1,206		0.9%
Total general practitioners						
		2,649		2,674		0.9%
Total – NHS doctors and dentists						
		8,091		8,389		3.7%

⁸⁹ At 31 March unless otherwise specified.

⁹⁰ The staff category breakdowns have changed between 2024 and 2025 so figures may not be directly comparable. This is especially the case for “SAS doctors” and “other”. In 2025, “other” doctors include: dental officer/practitioner, medical student technician and “other doctors”. Figures may not sum to totals in the headcount category as staff can be in multiple categories but are only included once in the sum.

Appendix D Previous DDRB recommendations and the governments' responses

The DDRB recommendations since 1990 for the main pay uplift are shown in the table below, together with the Governments' responses.

Report year	Main uplift	Government responses
1990	9.5%	Not accepted. Rejected increases at top of consultants' scale and in the size of the A+ distinction award; staged implementation.
1991	9.5% to 11%	Accepted, but staged implementation.
1992	5.5% to 8.5%	Accepted.
1993		No report following Government's decision to impose a 1.5% pay limit on the public sector.
1994	3%	Accepted.
1995	2.5% to 3%	Accepted.
1996	3.8% to 6.8%	Accepted, but staged implementation.
1997	3.7% to 4.1%	Accepted, but staged implementation.
1998	4.2% to 5.2%	Accepted, but staged implementation.
1999	3.5%	Accepted.
2000	3.3%	Accepted.
2001	3.9%	Accepted, but Government suspended the operation of the balancing mechanism (which recovers GMPs 'debt')
2002	3.6% to 4.6%	Accepted.
2003	3.225%	Accepted.
2004	2.5% to 2.9%	Accepted.
2005	3.0% to 3.4%	Accepted.
2006	2.2% to 3.0%	Accepted, although consultants' pay award of 2.2 per cent was staged – 1.0 per cent paid from 1 April 2006 and the remaining 1.2 per cent paid from 1 November 2006
2007	£1,000 on all pay points*	Accepted, although Scottish Executive did not implement one of the smaller recommendations relating to the pot of money for distinction awards to cover newly eligible senior academic GMPs. England and Wales chose to stage awards in excess of 1.5 per cent – 1.5 per cent from 1 April 2007, the balance from 1 November 2007
2008	2.2% to 3.4%	Accepted.
2009	1.5%	Accepted.
2010	0% to 1.5%	Mostly accepted: DDRB recommended: 0% for consultants and independent contractor GMPs and GDPs; 1% for registrars, SAS grades, salaried GMPs and salaried dentists; and 1.5% for FHOs. England and Northern Ireland both restricted the FHO recommendation to 1%.
2011	No recommendation due to public sector pay freeze	
2012	No recommendation due to public sector pay freeze	
2013	1%	Accepted.

Report year	Main uplift	Government responses
2014	1%	Accepted in Scotland. Partially accepted in England and Wales: no uplift to incremental points. 1% non-consolidated to staff at the top of pay scales. Northern Ireland – no uplift to incremental points. 1% non-consolidated to staff at the top of pay scales.
2015	1%	Recommendation only applied to independent contractor GMPs and GDPs in the UK and for salaried hospital staff in Scotland. Accepted
2016	1%	Accepted.
2017	1%	Accepted with the exception of uplifts to CEAs, discretionary points and distinction awards in Scotland and Northern Ireland
2018	2%	Staged and abated in England. Accepted in Wales and Northern Ireland. Accepted in Scotland, except for staff earning at least £80,000 who received £1,600.
2019	2.5%	Accepted with the exception of uplifts to CEAs, discretionary points and distinction awards. Additional 1% for SAS not implemented anywhere.
2020	2.8%	Accepted.
2021	3%	Accepted.
2022	4.5%	Accepted with the exception of SAS doctors and dentists at the top of the 2008 specialty doctor pay scale in Wales, where a 4.5% non-consolidated payment was made instead. Subsequent to implementing most of the recommendations, the Welsh Government also implemented an additional 1.5% consolidated uplift and made a 1.5% non-consolidated payment to HCHS doctors and dentists and uplifted the salaried GMP pay range by 1.5%.
2023	6% (6%+£1,250 consolidated uplift for doctors and dentists in training) (3% above the uplift in the SAS 2021 contract multi-year deal in England, Wales, and Northern Ireland)	Accepted in England. Partially accepted in Scotland except for doctors and dentists in training who were awarded 12.4%. Not accepted in Wales where a 5% increase was implemented except for SAS on the 2021 contract who received a 1.5% uplift above that in the multi-year deal. Accepted in Northern Ireland.
2024	6% (6%+£1,000 consolidated uplift for doctors and dentists in training)	Accepted in England, Wales and Northern Ireland. No formal response from Scotland. Additional deals for resident doctors, SAS, and consultants were agreed in England, Wales and Northern Ireland. Separate deals were agreed in Scotland.
2025	4% (4%+£750 consolidated uplift for resident doctors)	Accepted in all nations. The recommendation for resident doctors did not apply in Scotland.
2026	3.5% (3.75% for GDPs and CDS/PDS dentists).	

*£650 on the pay points for doctors and dentists in training. The average banding multiplier for junior doctors meant that this also delivered approximately £1,000.

Appendix E Pay comparability

Our approach to pay comparability

1. Our terms of reference ask us to take into consideration developments in doctors' and dentists' earnings in the context of long-term trends in the wider labour market, alongside comparator professions, including relevant international comparators.
2. The purpose of pay comparisons for any workforce are to help ensure that remuneration is fair and appropriate. Reward levels that are not in line with the broader market will create recruitment and retention problems over the medium and longer term. In our consideration of doctors' and dentists' remuneration, we do not try to track or align with any specific measure of market pay but consider a range of indicators alongside other evidence.
3. There are a number of parameters to consider in benchmarking pay for our remit group:
 - The medical and dental roles under consideration.
 - The UK nations in scope.
 - The measures of pay to be used i.e., basic pay, total earnings, pensions, hourly/annual pay.
 - The time period to be considered.
 - The comparators to be used, such as roles matched by job size, international equivalents, or broader economic indicators such as inflation or average earnings.
 - The sectors to be considered for comparisons, such as public/private healthcare, broader professions, or the whole economy.
4. We examine trends in pay for doctors and dentists in a number of ways.
 - We look at how real terms pay has changed over time. This uses CPI as the benchmark.⁹¹ We do this separately for 11 different medical and dental roles. Trends over time are sensitive to the start point chosen. We currently go back to when the data series starts (2010 for most groups, later for GDPs) and also look at growth since 2015 and 2019.
 - We look at how earnings have evolved relative to the pay distribution across the UK economy. This uses the Annual Survey of Hours and Earnings (ASHE). We do this separately for 11 different medical and dental roles.
 - We look at how pay compares to equivalent roles in other professions. Our methodology for this has been reviewed for this report, with details set out below. Data comes from a range of sources. This is done separately for 15 different medical and dental roles.
5. For our 2025 report, we commissioned Willis Towers Watson (WTW) to undertake a job levelling evaluation of 10 key medical and dental roles to enable us to benchmark the roles against broad market data. This was to provide supplementary market data in advance of the full review of our pay comparability methodology.

⁹¹ The CPI is used in the government's target for inflation and is produced to international standards in line with European regulations. We also consider CPIH, which is the ONS' lead inflation index as it is the most comprehensive measure of inflation because it includes owner occupiers' housing costs and council tax. The RPI does not meet the required standard for designation as a national statistic, so we do not use it in our analysis.

6. For this report, we commissioned Incomes Data Research (IDR) to review our approach to pay comparability. IDR's review is published alongside our 2026 report.⁹² This informs our approach for this year and will be updated in future years.
7. We also look at the Longitudinal Education Outcomes (LEO) dataset, which tracks the employment and earnings outcomes of UK graduates. And we consider pay for medical roles in other countries. The evidence on this is set out in appendix F.
8. Most of these approaches use England as the source for doctors' and dentists' pay, as we have not had access to earnings data over time for the other nations. We will keep this under review.

Changes in real terms pay

9. Analysis of real terms changes in earnings over time are sensitive to both the time period and the measure of earnings used. Our analysis starts in 2010, as it is the first year we have data on earnings for HCHS medical and dental staff. We also look at the trend since 2015 and 2019. We use both average FTE basic pay and average earnings per head for HCHS doctors and dentists. We use CPI as the measure of inflation; using CPIH shows slightly greater real terms earnings growth. More details for individual workforce groups are set out in chapters 3, 4 and 6.

Table E.1: Real terms change in average earnings for HCHS medical and dental staff, England, September 2010, 2015, and 2019 to November 2025

	Since 2010		Since 2015		Since 2019	
	Basic pay per FTE	Total earnings per head	Basic pay per FTE	Total earnings per head	Basic pay per FTE	Total earnings per head
FY1	6.2%	-4.0%	16.4%	3.6%	6.5%	5.2%
FY2	-1.1%	-9.3%	9.0%	0.2%	6.3%	3.3%
Core training	9.4%	-5.3%	20.7%	5.7%	8.4%	4.3%
Registrar	5.1%	-10.4%	14.6%	0.8%	10.2%	2.2%
Specialty doctor	-3.3%	-2.3%	3.8%	2.6%	2.2%	-0.2%
Specialist	-3.5%	-6.4%	-0.1%	-4.8%	-0.9%	-5.1%
Consultant	-5.1%	-15.9%	3.9%	-6.0%	6.5%	-0.8%

Source: OPRB analysis of ONS and NHS England data.

Note: Uses CPI. Green shading represents a real terms increase; blue shading represents a real terms fall.

10. For HCHS doctors, this analysis shows that:
 - Resident doctors across all grades (foundation year 1, foundation year 2, core training and registrars) have seen real earnings growth since 2015 and 2019 in both basic pay and total earnings. Foundation year 1, core training and registrars have seen real terms growth in basic pay since 2010 but falls in total earnings per head. Foundation year 2 doctors have seen falls in real basic pay and total earnings since 2010.
 - Specialty doctors have seen real terms growth in basic pay and total earnings per head since 2015, and growth in basic pay since 2019. This group has seen a real

⁹² On our website: <https://www.gov.uk/government/organisations/review-body-on-doctors-and-dentists-remuneration>

terms fall in both basic pay and total earnings since 2010 and a small fall in total earnings since 2019.

- Specialists have seen a real terms fall in pay on all measures. This is likely to be linked to the move from associate specialist to specialist contracts.
- Consultants have seen real terms growth in basic pay since 2015 and 2019 but a fall in basic pay since 2010. Consultants have seen a real terms fall in total earnings over each time period. This is likely driven by the reduction in the scope of clinical excellence awards.

11. For GPs, this analysis shows that:

- Contractor GPs in England and salaried GPs in Wales have seen real terms increases in average income since 2012-13, 2015-16 and 2019-20.
- Salaried GPs in Northern Ireland have seen real terms increases in average income since 2015-16, when data is first available.
- Contractor GPs in Wales and Northern Ireland, and salaried GPs in England, have seen real terms falls in average incomes since 2012-13, 2015-16 and 2019-20. The fall in salaried GP income may be linked to lower working hours.
- Both contractor and salaried GPs in Scotland have seen real terms increases in average incomes since 2012-13 and 2015-16 but falls since 2019-20.

Table E.2: Real terms change in average income before tax for GPs, by nation, 2012-13, 2015-2016 and 2019-2020 to 2023-24

	Since 2012-13	Since 2015-16	Since 2019-20
Contractor GP			
England	10.9%	15.0%	7.1%
Scotland	6.1%	8.9%	-0.7%
Wales	-3.3%	-2.5%	-9.6%
Northern Ireland	-9.3%	-6.0%	-6.1%
Salaried GP			
England	-6.4%	-1.9%	-6.7%
Scotland	3.7%	0.7%	-4.6%
Wales	5.5%	14.4%	5.1%
Northern Ireland	-	11.0%	0.3%

Source: OPRB analysis of ONS and NHS England data.

Notes: Uses CPI. Does not adjust for working hours, which have fallen over the period. Includes income from both NHS and private work. Green shading represents a real terms increase; blue shading represents a real terms fall.

12. Earnings data for GDPs does not break down into earnings from NHS and private practice. For all GDPs with some NHS work, this analysis shows that:

- In England, both providing-performer and associate dentists have seen falls in real terms average income since 2017-18 and 2019-20.
- In Scotland, associate dentists have seen real terms growth in average income since 2017-18 and 2019-20. Providing-performer dentists have seen real terms growth in average income since 2019-20, but a small fall since 2017-18.
- In Wales, both providing-performer and associate dentists have seen growth in real terms average income since 2017-18, but a fall since 2019-20.
- In Northern Ireland, both providing-performer and associate dentists have seen a fall in real terms average income since 2017-18 (especially for providing-performer dentists). Providing-performer dentists have seen a small increase in real average income since 2019-20, while associate dentists have seen a fall.

Table E.3: Real terms change in average income before tax for GDPs, by nation, 2017-18 and 2019-20 to 2023-24

	Since 2017-18	Since 2019-20
Providing-performer dentist		
England	-6.1%	-2.0%
Scotland	-0.5%	7.4%
Wales	5.7%	-5.2%
Northern Ireland	-17.4%	0.3%
Associate dentist		
England	-7.5%	-5.8%
Scotland	15.3%	13.7%
Wales	1.1%	-1.2%
Northern Ireland	-1.1%	-6.0%

Source: OPRB analysis of ONS and NHS England data.

Note: Uses CPI. Does not adjust for working hours or the balance of NHS and private work. Green shading represents a real terms increase; blue shading represents a real terms fall.

Medical and dental earnings relative to the UK pay distribution

- This analysis shows how doctors' and dentists' earnings compare to the earnings of all full-time employees in the UK, using ASHE. For example, if a doctor group is at the 90th percentile, this means their average earnings are higher than 90 per cent of all full-time employees.
- This shows that resident doctors have lost position in the earnings distribution since 2010-11, although have seen improvement over the latest year. Specialty doctors, specialists, consultants, GPs and GDPs have maintained their position. This partly reflects lower earnings growth across the economy at the top end of the earnings distribution than lower down.

Table E.4: Position of HCHS doctors in the UK earnings distribution, 2010-11 to 2024-25

	Percentile in earnings distribution					Change since	
	2010-11	2015-16	2020-21	2023-24	2024-25	2023-24	2010-11
Foundation year 1	65	62	62	52	58	+6	-7
Foundation year 2	79	75	76	67	71	+4	-8
Core training	87	85	87	83	85	+2	-2
Registrar	92	90	91	89	90	+1	-2
Specialty doctor	95	94	95	95	94	-1	-1
Associate specialist	97	97	97	97	97	0	0
Consultant	98	98	98	98	98	0	0

Source: OPRB analysis of ASHE and NHS England data.

Note: Medical/dental FTE earnings are for England.

Table E.5: Position of GPs in the UK earnings distribution, 2010-11 to 2024-25

	Percentile in earnings distribution					Change since	
	2010-11	2015-16	2020-21	2022-23	2023-24	2022-23	2010-11
Contractor GP	98	98	99	99	99	0	+1
Salaried GP	97	96	97	97	97	0	0

Source: OPRB analysis of ASHE and NHS England data.

Note: Medical earnings are for England and are FTE-adjusted.

Table E.6: Position of GDPs in the UK earnings distribution, 2017-18 to 2024-25

	Percentile in earnings distribution				Change since	
	2017-18	2020-21	2022-23	2023-24	2022-23	2017-18
Providing-performer GDP	98	98	98	98	0	0
Associate GDP	88	89	88	87	-1	-1

Source: OPRB analysis of ASHE and NHS England data.

Note: Dental earnings are for England and are not adjusted for working hours.

Review of our pay comparability methodology

15. We commissioned IDR to review our approach to pay comparability. The aims of the review were to:
 - Identify good practice on undertaking pay comparability exercises and the strengths and weaknesses of the existing approach.
 - Agree clearly identified roles/levels within medical and dental career paths for comparison, building on earlier work.
 - Develop up-to-date descriptions of each role to enable benchmarking against comparators.
 - Agree criteria for identifying comparators.
 - Identify comparators for each role using the agreed criteria.
 - Identify and source market pay data, highlighting strengths and weaknesses of the data sources.
 - Identify a method for undertaking total reward comparisons.
 - Undertake pay and reward comparisons.
 - Develop an approach for updating the comparisons in future.

16. The IDR work had a number of stages:
 - A review of the existing evidence and literature.
 - Engagement with stakeholders representing government departments, employer bodies, trade unions, pay review body members, and pay experts.
 - Assessment of the roles of doctors and dentists using an analytical job evaluation.
 - The development of a framework for assessing comparators.
 - The selection and assessment of comparator professions.
 - The sourcing and assessment of salary data.
 - Analysis and comparisons of remuneration, using measures of basic pay, total earnings and total remuneration.⁹³

⁹³ Total earnings are basic plus additional pay i.e. including allowances, overtime, bonuses etc. Total remuneration includes total earnings, pension and other non-cash benefits.

17. The review identified 17 benchmark doctor and dentist roles, including several not previously evaluated – post-foundation locally employed doctor, specialist doctor, and two community dentist roles.⁹⁴
18. The usual approach when pay benchmarking is to compare pay for the same roles at different employers. In the case of medical and dental roles, the NHS is by far the largest employer, determines the market rate for the role, and there is little alternative earnings data available from other employers. Instead, this approach looked to identify alternative careers with similar characteristics.
19. The distinct nature of medical and dental careers presented particular challenges for identifying appropriate external benchmarks, and the review therefore sought to provide a robust, transparent framework for evaluating comparability with other professions.
20. The comparator assessments identified ‘best-fit’ external professions that aligned with the core characteristics in the framework; they were not intended to identify alternative career paths for doctors or dentists. Most of the selected professions were assessed as partial matches, indicating that these roles generally shared some but not all of the core characteristics. Matches were identified on a role-by-role basis, reflecting differences in career structure, scope of practice and the availability of comparable job-level data. As the review looked at external benchmarks, the comparators roles operated in quite different labour markets and the results varied considerably.
21. For some medical and dental roles, and for more external comparators, the work was limited by data availability. All earnings data come with considerable caveats, and the exercise aimed to be broadly indicative. The comparators and pay comparability findings for each job role are set out in the IDR report and in chapters 3, 4 and 6, based on the IDR outputs. We will update this for future reports.
22. The professions considered the closest comparators, and for where pay data could be sourced, were: finance and accounting; legal; pharmaceutical (R&D); architect; nurse; community pharmacist; teacher; and vet. A number of other professions were also broad matches – actuaries, barristers, chartered surveyors and social workers – but were not taken forward into the pay comparison analysis because suitable pay data were not available.
23. Other professions were considered but not found to be suitable matches such as: air traffic controllers; airline pilots; banking/technology professionals (e.g. IT, cybersecurity, software development); graduate training schemes; military officers; physician associates; police officers; probation officers; judges; medical and dental officers in the military; private healthcare practitioners; and NHS medical directors. Details are set out in appendix 2 of the IDR report.
24. Across the medical and dental roles, the pay comparisons showed a varied picture, with results differing by career stage, comparator profession, and pay measure. The inclusion of pension values made a substantial difference. A summary of the relative market position of each role is in figure E.1.

⁹⁴ Two roles were not benchmarked separately – locally employed doctor and senior consultant – as they were not distinct from core training or consultant respectively.

Table E.7: Position of doctors and dentist roles relative to comparators

	Basic pay	Total earnings	Total remuneration
Foundation year 1	2	3	4
Foundation year 2	3	4	5
Core trainee	2	3	4
Specialty registrar	1	3	4
Specialty doctor	4	4	4
Specialist	4	4	4
Consultant	2	3	4
GP specialty trainee	5		
Salaried GP*		2	2
Salaried GP FTE		4	4
GP partner		5	
Foundation dentist	3		
Associate dentist*		2	
Providing-performer dentist		3	
Band A salaried dentist	4		
Band B salaried dentist	4		

Below all comparators	Below more than above	Broadly in line	Above more than below	Above all comparators
1	2	3	4	5

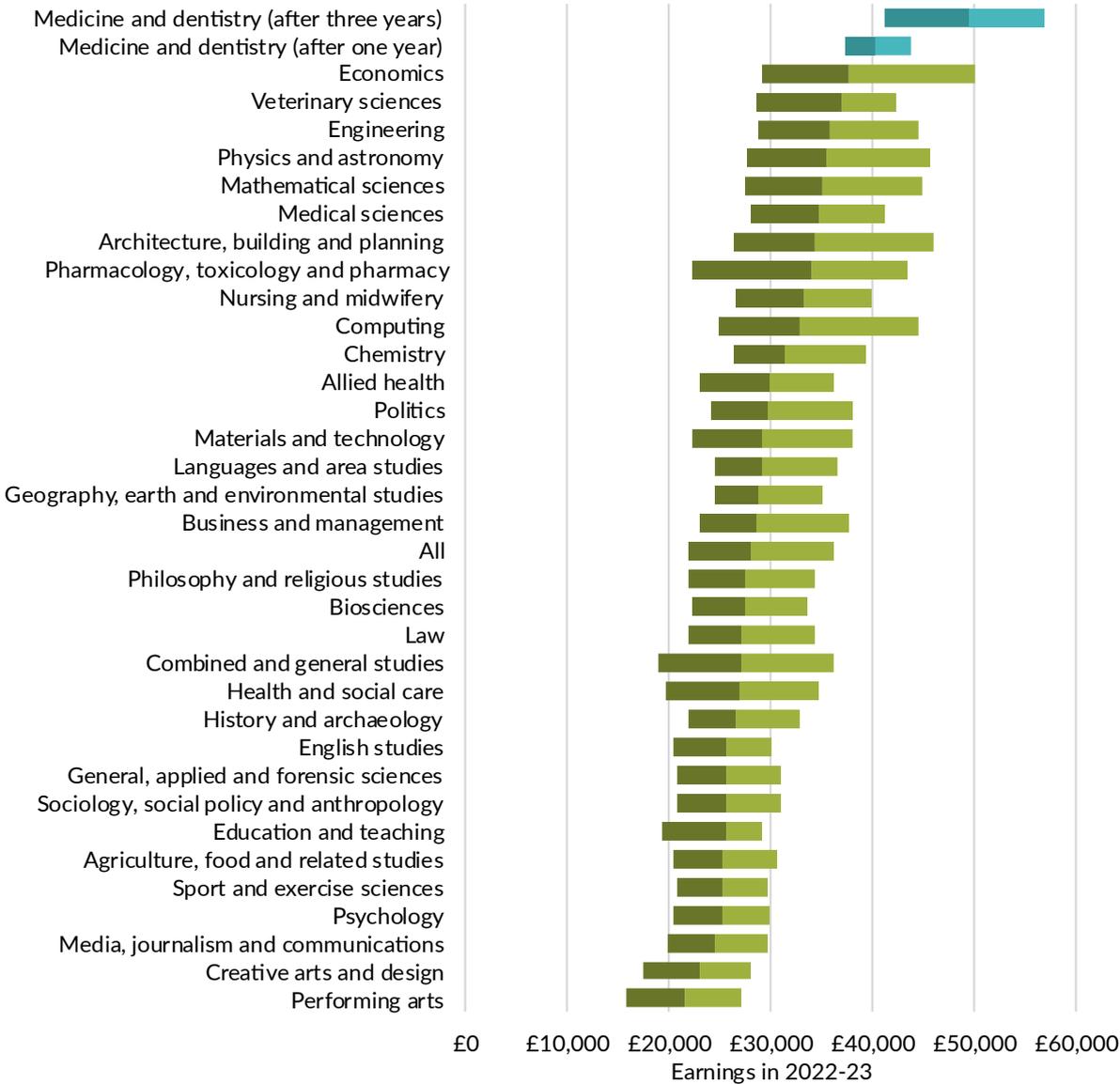
*Uses less than full-time earnings.

Note: Comparisons are based on median earnings, with a less than 5 per cent differential considered to be in line with the market for each comparator.

Longitudinal Education Outcomes data

25. The Longitudinal Education Outcomes (LEO) dataset, published annually by the Department for Education, links graduate records with HMRC and DWP data to track employment and earnings for UK-domiciled first-degree graduates from English higher education institutions, further education colleges, and alternative providers. This includes both PAYE and self-assessment data.
26. The latest data cover the 2022-23 tax year and report outcomes by subject studied at one, three, five and 10 years after graduation. Figures include earnings for both full-time and part-time workers, are not adjusted for geography, age, or other factors, and may include graduates working outside their degree field (e.g., medical graduates in non-health roles).

Figure E.1: Earnings three years after graduation, 2022-23

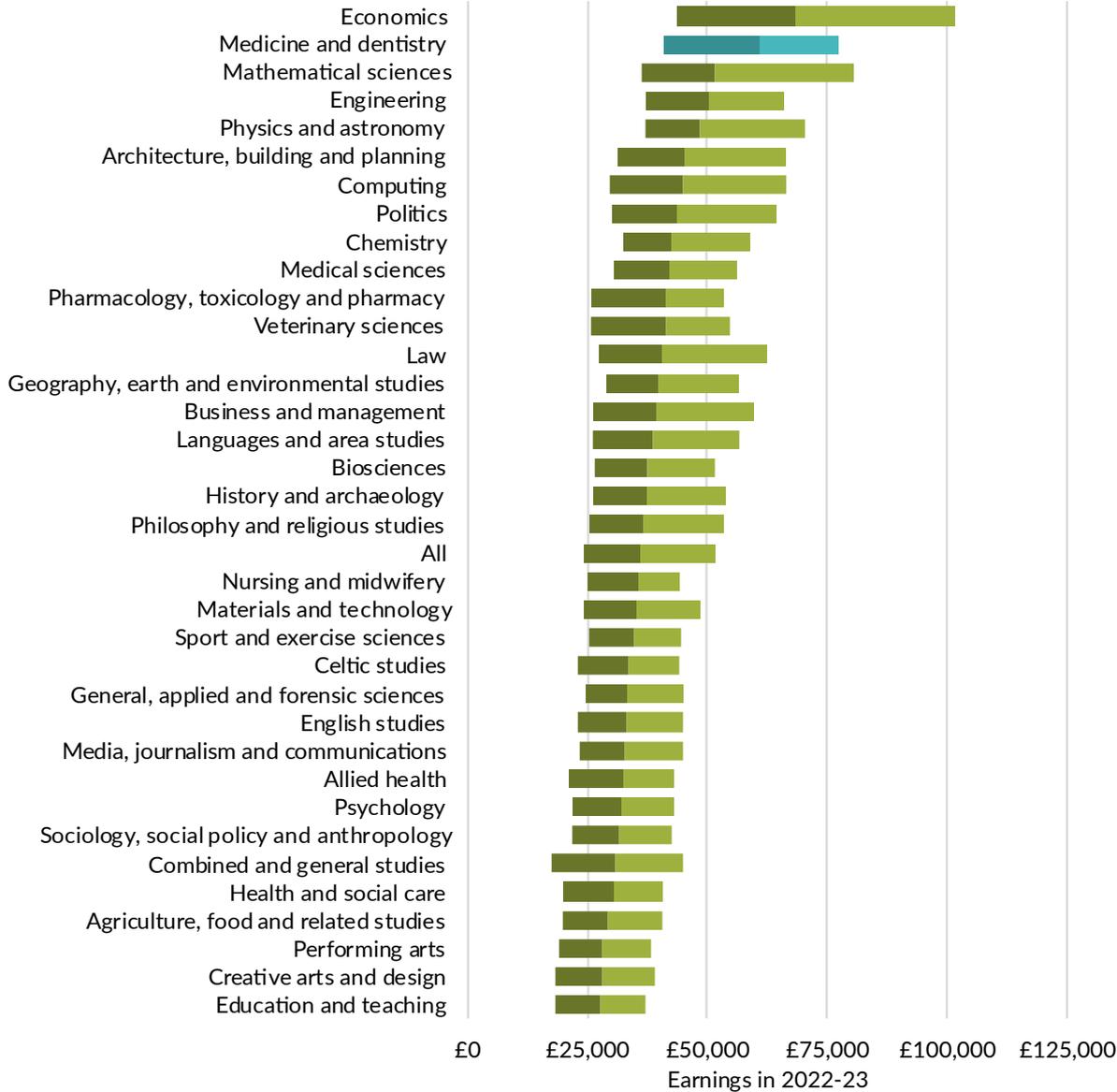


Source: Longitudinal Education Outcomes.

Note: Covers those who graduated in England only but working across the UK.

- 27. This shows that medicine and dentistry graduates have the highest median earnings at every point from one year (£40,200) to five years (£53,300) after graduation, consistently exceeding the all-subject median by a wide margin. Noting the longer time for qualification for medicine and dentistry graduates, earnings one year after graduation are also higher than all other subjects three years after graduation.
- 28. At ten years, economics is the highest-earning subject, with median earnings of £68,600, while medicine and dentistry remains second at £61,000, both far above the overall median of £36,100.

Figure E.2: Earnings 10 years after graduation, 2022-23



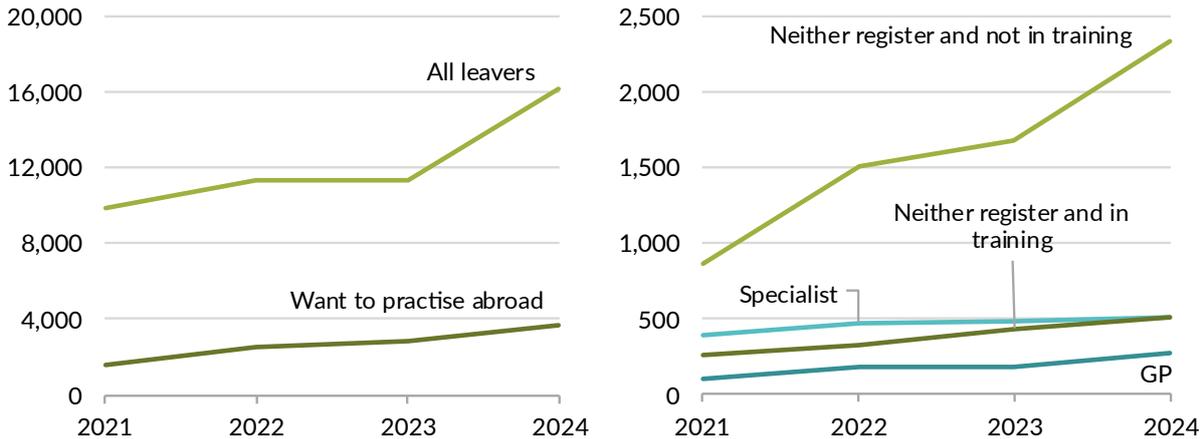
Source: Longitudinal Education Outcomes.

Note: Covers those who graduated in England only but working across the UK.

Appendix F International comparisons of doctors' pay

1. Our revised terms of reference ask us to have regard to relevant international comparisons of doctors' and dentists' earnings.
2. It is helpful to put these comparisons in the context of the international flows of doctors. In 2024, 30,444 doctors took up a licence to practise with the GMC in the UK. Of these, 66 per cent were non-UK graduates. In 2024, non-UK graduates made up 45 per cent of the GMC-registered medical workforce in 2024, up from 37 per cent in 2017.
3. A total of 16,124 doctors left the GMC register in 2024. Of these, 3,641 (22 per cent) said that their main reason for leaving was "to practise abroad". This was an increase of 30 per cent compared to the previous year. Of the doctors that left the register to practise abroad, 64 per cent were on neither the GP nor specialist register and not in training. This compared to 53 per cent in 2021. This group has been the main driver of the increase in leavers to practise abroad. Of the doctors that left the register to practise abroad, 59 per cent had a non-UK PMQ.

Figure F.1: Numbers leaving the medical register to practise abroad, UK, 2021 to 2024



Source: GMC.

Table F.1: Doctors leaving the GMC register to practise abroad, 2024

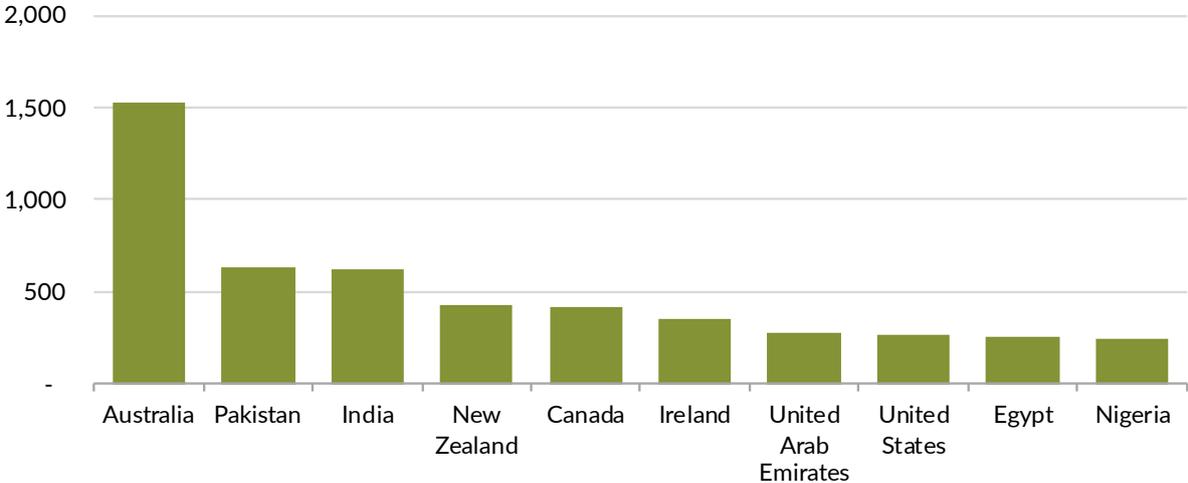
	Doctors on GMC register	Leavers to practise abroad	Leavers as % of registered doctors
GP	78,522	272	0.3%
Specialist	110,324	511	0.5%
GP and specialist	1,714	3	0.2%
Neither register and not in training	123,626	2,348	1.9%
Neither register and in training	79,171	507	0.6%
Total	393,357	3,641	0.9%

Source: OPRB calculations based on GMC data.

Note: Data on doctors leaving to practise abroad are based on the self-reported main reason for leaving the GMC register and do not capture doctors who practise overseas while remaining registered.

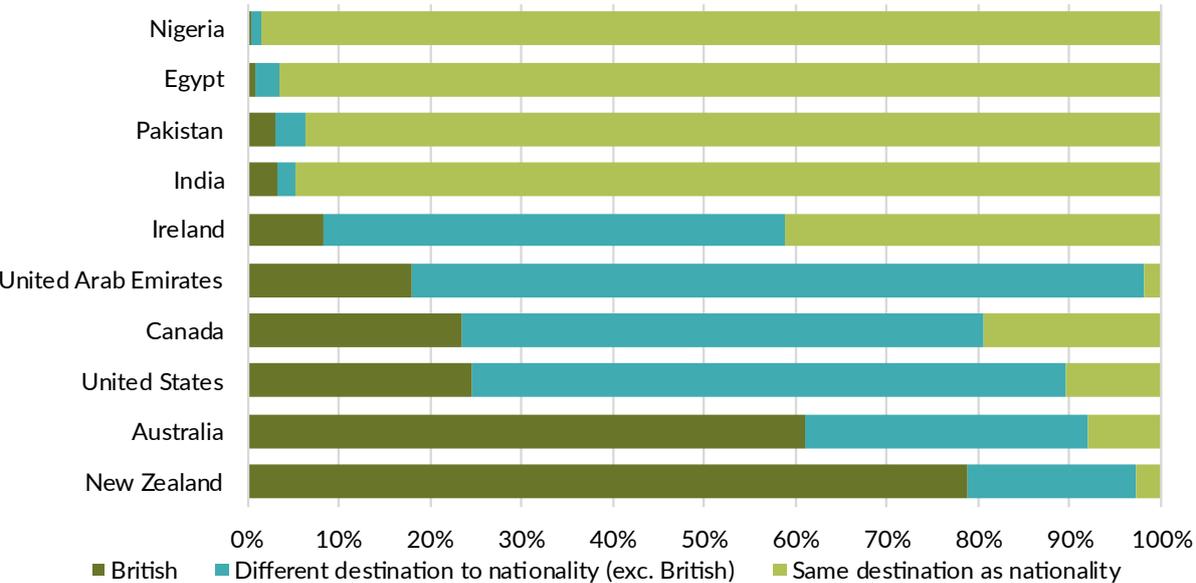
- 4. In 2024, there were over 393,000 doctors on the register meaning that those that left to practise abroad represented less than 1 per cent of the register. Those leaving the register across all reasons represented 4.1 per cent of the register.
- 5. In 2024, 3,392 leavers disclosed a country to which they intended to move to (this includes those for whom wanting to practise abroad was not the primary reason for leaving). Australia remained the main destination for these leavers with 1,527 disclosing an intention to move to Australia.
- 6. The majority of those leaving the GMC register to go to Australia (61 per cent) or New Zealand (79 per cent) were British. The majority of those moving to Nigeria (98 per cent), Egypt (97 per cent), Pakistan (94 per cent) and India (95 per cent) were of the same nationality as their intended destination.

Figure F.2: Top ten destinations of doctors who left the GMC register in 2024 and moved to another country



Source: GMC.

Figure F.3: Top ten destinations of doctors who left the GMC register in 2024 and moved to another country by nationality



Source: GMC.

Making international pay comparisons

7. Last year we set out the many issues to consider when making international earnings comparisons. There are issues with the comparability of medical roles:
 - It is hard to establish if roles are similar across countries, and often they are not. International comparisons do not tend to encompass any of the factors we would like to see in a pay comparability exercise, such as matching on specialty, experience or responsibility.
 - There are differences across countries in regard to workforce definitions, qualification requirements, grade hierarchies, and the distribution of responsibilities among specialists.
 - The career and training structures are likely to differ significantly across countries.
 - The available data typically provide an average for all doctors in a country, which might represent very different workforces.
 - There is often a large variation across medical roles within a country, and specialty has an important influence on earnings in some countries. Previous work found that earnings variations between specialties were most pronounced in the USA, where, for example, surgical specialties had incomes up to three times greater than those in family medicine. Even within the UK, there is significant variation in pay across nations and within grades.
 - There are often different employment models, such as self-employment/employee status, which make the roles less comparable.
 - Comparisons are unlikely to be able to take into account working hours.

8. There are also issues when making comparisons in earnings across countries:
 - Earnings come from different sources and are based on different payment mechanisms such as capitation, fee-for-service payments, or bonuses, as well as salary. Previous work on international comparisons did not find any schemes similar to clinical excellence awards in the UK, for example.
 - Earnings need to be adjusted for exchange rates or, preferably, purchasing power i.e. the amount that can be bought in each country with the same money.
 - Even adjusting for purchasing power may not make up for all the cost-of-living differences in a country such as housing, education or healthcare costs.
 - There will be significant tax and social insurance differences across countries that affect take-home pay.
 - There will be differences in whether doctors and dentists are liable for their own indemnity.
 - Student loan repayments and training costs, such as exam fees, will vary between countries.
 - There will be differences in the broader reward package, such as pensions and other additional benefits.
 - The data only relate to public sector employees in some countries.

9. There are further significant data issues. The selection of comparator countries will be limited by data availability, and data can be some years out of date. The information often does not come from official sources, such as national statistics bodies, and it is hard to assess data reliability.

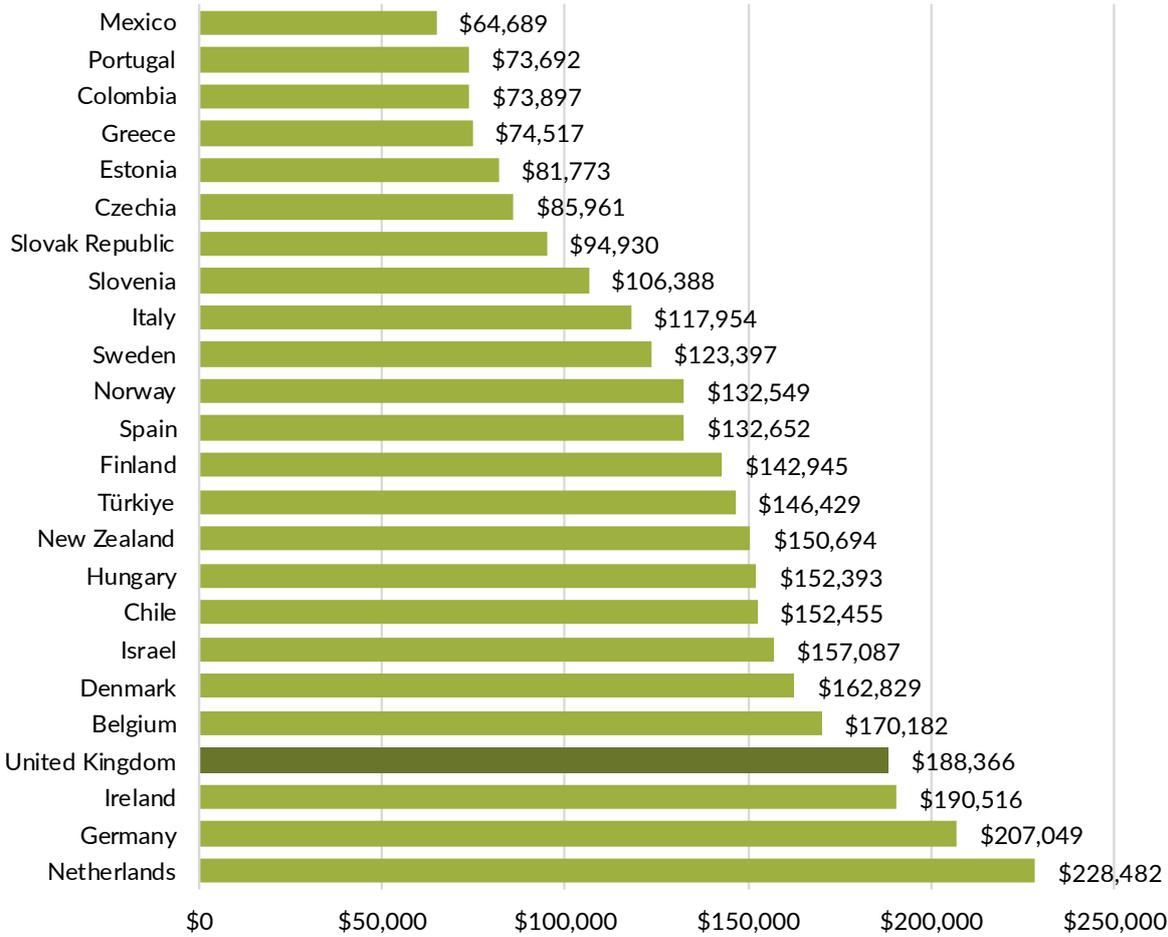
Evidence on pay in other countries

10. The main findings from the international pay comparisons are that:
 - OECD data: This shows that pay for consultants in the UK is above countries such as Belgium, Denmark, New Zealand, Spain, Norway and Sweden, while the Netherlands, Germany, and the Republic of Ireland offer higher levels of pay. OECD data for salaried GPs shows that the UK sits in the lower-middle range of countries with available data and below countries such as the Netherlands, Sweden and Finland. Data for Australia, Canada and US is not available in the OECD figures.
 - Australia: Pay for consultant equivalent specialists in Australia is substantially higher than in England. The Australian national average for specialists exceeds the England consultant figure, and the highest paying Australian states show an even greater differential. Pay for Australian specialty doctors and registrars is also higher than in England.
 - New Zealand: Comparisons with New Zealand are based on pay bands. Across all grades shown, England's pay bands are higher once adjusted for purchasing power. The differentials are present at every grade, with England ranging from around 105 per cent to 137 per cent of New Zealand's pay bands depending on grade.
 - Republic of Ireland: In the Republic of Ireland, pay scales for foundation/intern doctors, senior house officers and registrars are generally lower than those in England on a purchasing-power-adjusted basis. For consultants, the position is reversed – consultant pay scales in Ireland are substantially higher than those in both England and Northern Ireland. The gap widened in 2024 due to a sharp rise in specialist pay in Ireland.

OECD data

11. The OECD publishes data on international pay comparisons for medical specialists, which equate to consultants in the UK. It has been converted to a common currency (US\$) using purchasing power parities (PPPs). The OECD data for the UK only runs to 2020. To make a more recent comparison, we have used NHS England data for consultants' earnings to 2023 and converted to US\$ using the OECD purchasing power parity. Data for Canada, Australia and the United States are not available in the OECD dataset.
12. The UK's estimated average consultant pay of \$188,366 places it towards the top of the OECD range. It is below the Netherlands and Germany, which report the highest specialist pay in the dataset, but above Belgium, Denmark, Israel and most other European countries. Ireland is slightly higher than the UK, while New Zealand is lower.
13. OECD data is available for a more limited range of countries for 2024. Ireland reported the highest specialist pay among the countries with available data, significantly above the UK. In 2024, estimated remuneration for medical specialists in the UK was \$206,303. The UK ranks ahead of Denmark, Türkiye, Chile and New Zealand, as well as Spain and Italy.

Figure F.4: Specialists' remuneration, 2023



Source: OECD; OPRB calculations based on NHS England data.

Notes: Specialists are fully qualified physicians who have completed specialist training and work primarily in a medical specialty other than general practice (e.g. surgery, paediatrics, anaesthetics, psychiatry). This excludes doctors who are still in training. Earnings are in US\$ adjusted for purchasing power parity.

- Using OECD data to compare specialist (consultant) pay in England and the Republic of Ireland shows that, between 2015 and 2022, specialist pay in both Ireland and England increased steadily, with Ireland consistently ahead of England throughout this period. The gap narrowed as England saw stronger growth from 2020 to 2023 and in 2023, pay levels in Ireland and England were broadly similar. In 2024, Ireland saw a sharp rise in specialist pay, creating a significant divergence from England. While England also saw an increase, the scale was much smaller.

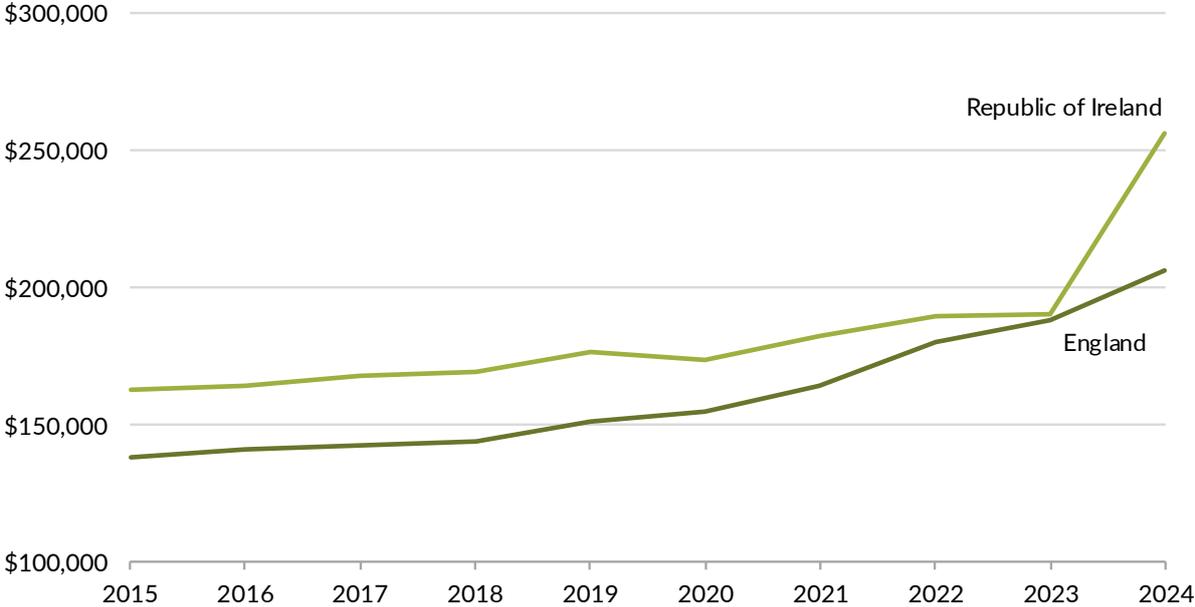
Figure F.5: Specialists' remuneration, 2024



Source: OECD; OPRB calculations based on NHS England data.

Note: Specialists are fully qualified physicians who have completed specialist training and work primarily in a medical specialty other than general practice (e.g. surgery, paediatrics, anaesthetics, psychiatry). This excludes doctors who are still in training. Earnings are in US\$ adjusted for purchasing power parity.

Figure F.6: Specialists' remuneration, England and Republic of Ireland, 2015 to 2024



Source: OECD; OPRB calculations based on NHS England data.

Note: Earnings are in US\$ adjusted for purchasing power parity.

15. OECD data also give an indication of salaried GPs earnings. In 2023, estimated remuneration for salaried GPs in the UK was \$102,346. The UK sits in the middle of the range for salaried GP pay among countries with available data. The UK is below the Netherlands, Sweden, Spain and Finland, which report the highest figures in the dataset, but ahead of Türkiye, Chile and Portugal.

Figure F.7: Salaried GPs' remuneration, 2023



Source: OECD.

Note: Earnings are in US\$ adjusted for purchasing power parity.

Australia

16. Medical pay in Australia is set at a state level, and the specialist/senior specialist role is broadly equivalent to consultants in the UK. Comparisons are in US\$ PPP to adjust for differences in price levels between the countries.

Figure F.8: Medical pay by Australian state compared to England, 2023-24



Source: OPRB calculations based on data from NHS England and the Australian Institute of Health and Welfare.

Note: Earnings are in US\$ adjusted for purchasing power parity.

17. The Australian Institute of Health and Welfare publishes average salaries for salaried medical officers employed in providing public hospital services. The latest data, for 2023-24, show significant variation across states. For specialists, salaries range from

around \$192,893 in Tasmania to \$364,898 in Queensland, with a national average of approximately \$296,741.

18. This national average is substantially higher than England consultant average pay for 2023-24 (\$192,339), representing a difference of around 54 per cent. The highest-paying state, Queensland, is almost 90 per cent higher than the England figure, highlighting a significant pay gap between Australia and England.
19. Compared to England, where specialty doctors earn an estimated average \$115,182 and registrars around \$93,687, the Australian average is 17 per cent higher than specialty doctors and 41 per cent higher than registrars.

New Zealand

20. Comparisons for New Zealand are based on pay bands, not average earnings. Comparisons are in US\$ PPP to adjust for differences in price levels between the countries.
 - For house officer/foundation year 1, the New Zealand pay band is \$52,466, compared to \$55,197 in England. This means England basic pay is around 105 per cent of the New Zealand figure.
 - For house officer/foundation year 2, the New Zealand pay band is \$55,399, while England offers \$63,169, equivalent to 114 per cent of the New Zealand figure.
 - For registrar years 1 to 2, New Zealand pay bands range from \$61,852 to \$64,799, compared to \$74,849 in England. England basic pay is therefore between 121 per cent and 116 per cent of the New Zealand range.
 - For registrar years 3 to 4, New Zealand pay bands range from \$67,722 to \$86,991, while England ranges from \$92,464 to \$105,178. This puts England basic pay at between 137 per cent and 121 per cent of the New Zealand range.
 - For medical and dental specialists (equivalent to consultants), New Zealand pay bands range from \$124,753 to \$180,339, compared to \$155,971 to \$206,793 in England. England basic pay is therefore between 125 per cent and 115 per cent of the New Zealand range.

Table F.2: Medical pay bands, New Zealand and England, 2025

	New Zealand pay band	England pay band	England/ New Zealand
House officer year 1	\$52,466	\$55,197	105%
House officer year 2	\$55,399	\$63,169	114%
Registrar year 1 to 2	\$61,852 to \$64,799	\$74,849	121% to 116%
Registrar year 3 to 4	\$67,722 to \$86,991	\$92,464 to \$105,178	137% to 121%
Medical and dental specialist	\$124,753 to \$180,339	\$155,971 to \$206,793	125% to 115%

Source: OPRB calculations based on RDA collective agreement (effective June 2024 to July 2026); ASMS; NHS England.

Note: Earnings are in US\$ adjusted for purchasing power parity.

Republic of Ireland

21. Comparisons with the Republic of Ireland are based on pay scales, rather than average earnings. These do not include additional payments such as allowances, overtime, or enhancements. Data for the Republic of Ireland is drawn from the HSE consolidated pay scales effective August 2025, with comparisons to England and Northern Ireland using 2025 pay points. All figures are shown in US\$ PPP to adjust for differences in price levels between countries.
22. For the foundation/intern year, the Republic of Ireland pay scale is \$50,178. This compares to \$55,197 for foundation year 1 in England and a range of \$50,752 to \$56,515 in Northern Ireland. This means that basic pay in England is around 110 per cent of the Republic of Ireland figure, while Northern Ireland basic pay is between 101 per cent and 113 per cent of the Republic of Ireland scale.
23. For senior house officers, Republic of Ireland pay scales range from \$58,922 to \$80,587. The comparator in England (core training years 1-2) is \$74,849, which is between 127 per cent (relative to the lower end of the Republic of Ireland range) and 93 per cent (relative to the upper end). In Northern Ireland, the pay range is \$65,777 to \$74,748, equivalent to 112 per cent to 93 per cent of the Republic of Ireland scale.
24. Registrars' pay scales in the Republic of Ireland range from \$74,888 to \$88,188. In England (training years 3-6+), the range is \$92,464 to \$105,178, meaning England basic pay is between 123 per cent and 119 per cent of the Republic of Ireland range. Northern Ireland registrar pay bands are \$74,748 to \$100,802, which is 100 per cent to 114 per cent of the Republic of Ireland scale.
25. For consultants, Republic of Ireland pay scales range from \$253,857 to \$304,933. In England, the range is \$155,971 to \$206,793, so England basic pay is between 61 per cent and 68 per cent of the Republic of Ireland scale. Northern Ireland consultant pay bands are \$157,330 to \$206,849, which is 62 per cent to 68 per cent of the Republic of Ireland scale.

Table F.3: Medical pay bands: Republic of Ireland, England, and Northern Ireland, 2025

	Ireland pay band	England pay band	Northern Ireland pay band	England/ Ireland	Northern Ireland/ Ireland
Foundation/ intern	\$50,178	\$55,197	\$50,752 to \$56,515	110%	101% to 113%
Senior house officer	\$58,922 to \$80,587	\$74,849	\$65,777 to \$74,748	127% to 93%	112% to 93%
Registrar	\$74,888 to \$88,188	\$92,464 to \$105,178	\$74,748 to \$100,802	123% to 119%	100% to 114%
Consultant	\$253,857 to \$304,933	\$155,971 to \$206,793	\$157,330 to \$206,849	61% to 68%	62% to 68%

Source: OPRB calculations based on Health Service Executive (HSE) consolidated salary scales, August 2025.

Note: Earnings are in US\$ adjusted for purchasing power parity.

Appendix G Glossary and abbreviations

ACCIA	Advisory Committee on Clinical Impact Awards
ADG	Association of Dental Groups
AfC	Agenda for Change
ARRS	Additional Roles Reimbursement Scheme
ASHE	Annual Survey of Hours and Earnings
AWE	Average Weekly Earnings
A&E	Accident and emergency
BDA	British Dental Association
BMA	British Medical Association
CCT	Certificate of Completion of Training
CDS	Community Dental Services
CEA	Clinical excellence award
CIA	Clinical impact award
CPI	Consumer prices index
CPIH	Consumer prices index including owner occupiers' housing costs
COPDEND	Committee of Postgraduate Dental Deans and Directors
COVID/COVID-19	Coronavirus disease 2019
CT	Core training
DBS	Disclosure and Barring Service
DDRB	Review Body on Doctors' and Dentists' Remuneration
DHSC	Department of Health and Social Care
EU	European Union
FY1-3	Foundation year 1-3
FTE	Full-time equivalent
GDP	General dental practitioner
GDP	Gross Domestic Product
GDP deflator	Gross Domestic Product deflator
GDS	General Dental Services
GMC	General Medical Council
GMS	General Medical Services
GP	General practitioner/General medical practitioner
GPC	General Practitioners Committee
HCHS	Hospital and Community Health Services
HCSA	Hospital Consultants and Specialists Association
HEIW	Health Education and Improvement Wales
HMRC	His Majesty's Revenue and Customs
HM Treasury	His Majesty's Treasury

HSC	Health and Social Care
HSE	Health Service Executive
ICB	Integrated Care Board
IDR	Incomes Data Research
IFS	Institute for Fiscal Studies
IMG	International medical graduate
LEO	Longitudinal Education Outcomes
NASDAL	National Association of Specialist Dental Accountants and Lawyers
NES	National Education for Scotland
NHS	National Health Service
NIMDTA	Northern Ireland Medical and Dental Training Agency
OBR	Office for Budget Responsibility
OECD	Organisation for Economic Co-operation and Development
ONS	Office for National Statistics
OPRB	Office for the Pay Review Bodies
PA	Programmed activity
PAYE	Pay as you earn
PCN	Primary Care Networks
PDS	Public Dental Service
PMQ	Primary medical qualification
PPP	Purchasing power parity
RCGP	Royal College of General Practitioners
RCN	Royal College of Nursing
RDEL	Resource Departmental Expenditure Limits
RPI	Retail prices index
SAS	Specialty, associate specialist and specialist
SPVS	Society for Practising Veterinary Surgeons
ST1-9	Specialty training, years 1-9
TERS	Targeted Enhanced Recruitment Scheme
UCAS	Universities and Colleges Admissions Service
UDA	Unit of dental activity
UK	United Kingdom
WTW	Willis Towers Watson

Appendix H Parties who provided written evidence

Party	Link to evidence
British Dental Association	https://www.bda.org/media/gsupydfd/ddrb-26-27-round-bda-submission.pdf
British Medical Association	https://cdn.intelligencebank.com/eu/share/qMbw14/BB1av/eRpVp/original/BMA+DDRB+evidence+submission+2627+FINAL
British Medical Association - Scotland	https://cdn.intelligencebank.com/eu/share/qMbw14/BB1av/96KzV/original/BMA+Scotland+DDRB+submission+-+September+2025+-+Final
Department of Health and Social Care/ NHS England	https://www.gov.uk/government/publications/dhsc-evidence-for-the-ddrb-pay-round-2026-to-2027
Hospital Consultants and Specialists Association	https://www.hcsa.com/news-views/news/2026/01/hcsa-makes-submission-to-doctors-and-dentists-pay-review-body-(1).aspx
HM Treasury	https://www.gov.uk/government/publications/economic-evidence-to-the-pay-review-bodies-2026-27-pay-round
NHS Employers	https://www.nhsemployers.org/articles/nhs-employers-evidence-ddrb-202627
Northern Ireland	https://www.health-ni.gov.uk/sites/default/files/2025-10/Northern%20Ireland%20Evidence%20to%20DDRB%202026-27%20Pay%20Round.PDF
Scottish Government	
Welsh Government	https://www.nhsconfed.org/system/files/2025-11/Written%20Evidence%20to%20the%20DDRB%202026-27.pdf

