



Department
of Health &
Social Care

The Department of Health Social Care and NHS England's joint written evidence to the Review Body on Doctors' and Dentists' Remuneration (DDRB) for the 2027 to 2028 pay round

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Chapter 1: introduction

This document is the government's written evidence to The Review Body on Doctors' and Dentists' Remuneration (DDRB), submitted in response to the DDRB's call for evidence.

In July, the government remitted the DDRB to commence the 2027 to 2028 pay round to provide recommendations for the 2027 to 2028 headline pay award for medical and dental workforces. The remit letter was issued earlier than in the previous year as part of the government's commitment to restoring a more timely annual pay round. We recognise the importance to staff of receiving timely pay awards as close to the start of the financial year as possible. Once the evidence-gathering process is complete, the DDRB will provide recommendations to government as part of its annual report.

For the 2026 to 2027 pay round, DDRB made headline pay recommendations for all doctors in its remit, additionally they separated out the dental workforce for an additional award and made 2 further non-pay recommendations. We responded, by accepting the headline pay recommendations and will respond to those further 2 recommendations in due course.

This evidence recognises the progress made over the past year, including improvements in access to NHS services, signs of recovering public confidence in the NHS, and the delivery of reform and pay awards within departmental budgets without recourse to the reserve. However, significant financial and workforce challenges remain, and further progress will require continued productivity gains and careful prioritisation of public finances.

This chapter introduces the government's evidence for the 2027 to 2028 pay round. This year's evidence follows a similar structure to previous years, summarised below.

Chapter 2 provides an overview of the economic context and government and NHS finances. This year's Spending Review (SR) confirmed that pay awards must be funded from departmental budgets with no additional funding available for pay settlements. Pay awards above the level considered affordable within the SR settlement would require further difficult national and local re-prioritisation, that would affect delivery of the 10 Year Health Plan.

Chapter 3 outlines the work being undertaken to implement workforce strategy and on planning, as well as detailing programmes relating to training, education, and international recruitment. The chapter also considers medical and dental education pipelines, recruitment performance and actions to build a sustainable workforce able to meet future patient demand.

Chapter 4 examines the experience of NHS staff, drawing on survey findings and evidence relating to engagement, wellbeing, flexible working, and career development. It also outlines the steps being taken to improve working environments, support staff retention and address issues affecting workforce morale.

Chapter 5 provides detailed information on each remit group, including resident doctors, speciality, associate specialist and specialist doctors (SAS) doctors, consultants, General Practitioners (GPs) and dentists. It highlights workforce trends, recruitment and retention challenges, recent contract and pay developments, and issues that are specific to individual professions. The chapter also sets out progress against previous DDRB recommendations.

Chapter 6 presents evidence on pay, earnings and wider remuneration, including trends over time and comparisons with other professions and sectors. It provides information on the positioning of medical and dental earnings within the wider labour market.

Finally, chapter 7 reflects the total reward package that NHS staff receive which is above the statutory minimum and exceeds that offered in other sectors.

Evidence approach

This evidence has been jointly developed by the Department of Health and Social Care (DHSC) and NHS England. This approach ensures the delivery of a coherent set of evidence during the ongoing organisational transformation programme. This is the same approach as for our joint evidence last year.

As with last year, supporting datasets are presented separately in the accompanying data pack. We will provide our own narrative and interpretation, signalling clearly where data pack figures, or publicly available data sources, are being referenced. Note, where we use the date format '2027 to 2028' we are referencing the financial year, unless otherwise stated.

We look forward to receiving the DDRB's report in 2027.

Chapter 2: NHS finances

This chapter outlines the financial landscape within which NHS pay awards will need to be funded, including considerations of efficiency and productivity. The government's position is that pay awards must be funded from departmental budgets and there is no additional funding available for pay settlements.

Pay awards above what is considered affordable within the SR settlement will require further tough national and local re-prioritisation of the decisions already made through the planning process and would impact on the speed and delivery of the 10 Year Health Plan.

To set a balanced budget post SR we have made significant prioritisation decisions across both DHSC and NHS England. The productivity and efficiency section sets out the significant ask on both integrated care boards (ICBs) and NHS trusts in relation to productivity and efficiency, alongside pay and non-pay pressures, given unplanned events such as industrial action, which directly impact the scale of the challenge.

For the 2025 to 2026 and 2026 to 2027 pay uplifts, funding was found from within DHSC budgets through decisions on reprioritisation, the dissolution of NHS England, and reshaping and reducing ICB costs. Further pay awards above what is considered affordable will require difficult government trade-offs within existing DHSC budgets, including a reduction in ambitions for service or performance improvement.

Under the SR 2025, NHS funding will rise by an average of 3% in real terms annually and the NHS is expected to deliver ambitious productivity targets of 2% per year equating to £17 billion in savings. The departmental financial plan for 2027 to 2028 is predicated on the successful delivery of the 2% productivity target, alongside managing a wide range of material financial risks.

Economic context

Headline Consumer Prices Index (CPI) inflation has risen to 3.1% in August 2026 with core inflation (excluding energy, food, alcohol and tobacco) reaching 2.6%. While CPI remains below its recent peak of 3.8% in September 2025 it has increased from 2.6% in June 2026 as higher energy prices have begun feeding through to household bills.

The Bank of England's July Monetary Policy Report (MPR) projection expects inflation will rise further in the near term and global pressures, particularly higher energy prices, mean that risks to the inflation outlook remain tilted to the upside with the potential to feed through to the domestic economy and generate second-round effects in price and wage setting.

The unemployment rate has fallen back slightly, reaching 4.9% in the 3 months to July 2026. The latest indicators suggest that the labour market remains slack. HMRC Real Time Information data show employee numbers have fallen on the year for 17 consecutive months to July 2026, while vacancies have continued to decline over the past 12 months.

Private sector regular pay growth has continued to fall and was 2.9% in the 3 months to July 2026. Private sector regular wage growth has now been below public sector regular pay growth (currently 6.3%) for 17 consecutive months although this is partly impacted by the timing of public sector pay awards.

Data on pay settlements are more limited but provide a more direct comparator for PRB recommendations as they remove the impact of compositional changes in the labour force or changes to working patterns which have historically been a factor in higher earnings growth. The Bank of England's Agents' survey reports average pay settlements of 3.6% for 2026, lower than the average settlement of 4.0% in 2025, while the Brightmine survey indicates businesses are reporting average settlements of 3.0% for 2027.

Funding growth

Table 1: mandate funding for NHS England

Year	NHS England revenue departmental expenditure limits (RDEL), excluding ringfence (RF) (cash) £ billion	NHS England capital departmental expenditure limits (CDEL), excluding ringfence (RF) (cash) £ billion
2023 to 2024	171.036	0.439
2024 to 2025	186.838	0.626
2025 to 2026	198.095	0.768
2026 to 2027	205.235	0.852

Source: [2026 to 2027 financial directions to NHS England](#)

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

Financial position of the NHS

In the Spending Review 2025 (SR25) to Parliament, the NHS England Revenue Departmental Expenditure Limit (RDEL) budget rose to £195.6 billion in 2025 to 2026 and is set to rise to £226 billion in 2028 to 2029. The 2025 to 2026 Financial Performance Report shows the NHS ended the year with a £70 million underspend at a national level. Against the total NHS budget, the £70 million underspend was minimal and broadly reflects a breakeven position. However, local systems reported combined overspends of £563 million. The national position was balanced only after these pressures were managed, including through deficit support. Material risks remain from the cost of managing industrial action, implementing planned restructuring and headcount reductions and delivery of efficiency plans over 2027 and 2028.

Table 2: NHS providers RDEL breakdown

NHS Providers RDEL breakdown (£ million)	2023 to 2024	2024 to 2025	2025 to 2026
Gross deficit	1,606	1094	1408
Gross surplus	Minus 305	Minus 318	Minus 514
Reporting adjustment	12	0	23
NHS providers sector reported performance (SRP)	1,312	776	917
Plus additional RDEL adjustment	69	293	103
Net NHS providers resource departmental expenditure limit - non-ring-fenced. (RDEL NRF)	1,382	1070	1020

Table 2 shows the breakdown of funding provided to NHS providers since the 2023 to 2024 financial year, including preliminary outturn data for 2025 to 2026. The aggregate provider position shown here was a net deficit of £0.9 billion to £1 billion (depending on the technical measure). Integrated care board (ICB) underspends within systems offset some of this deficit, such that the net system overspend was a £563 million deficit, and other national offsets and savings resulted in the aggregate NHS position being £70 million underspend (as described above).

Share of resources going to pay

The growth rate in NHS trust and foundation trust provider sector (primary care services are not included in the growth rate) permanent and bank staff spend has exceeded the growth rate in overall NHS England funding in each of the past 3 financial years.

Given the SR settlement and funding allocated to the NHS already assumes a stretching productivity assumption of 2% as well as reductions in deficits, and performance improvements, any additional unfunded cost increases will manifest as trade-offs and delivery risks across service and workforce objectives.

Table 3 shows the proportion of funding consumed by NHS trust and foundation trust permanent and bank staff spend since the 2023 to 2024 financial year. This only covers staff working within hospital and community health services (HCHS) and excludes agency spend by these organisations.

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

Year	NHS England RDEL (£ billion)	NHS provider permanent and bank staff spend (£ billion)	% of spend on staff	Increase in total spend	Increase in provider permanent and bank staff spend
2023 to 2024	171.036	82.004	47.95%	7.95%	10.9%
2024 to 2025	184.873	89.823	48.59%	8.09%	9.53%
2025 to 2026	196.130	96.086	48.99%	6.09%	6.97%

Notes:

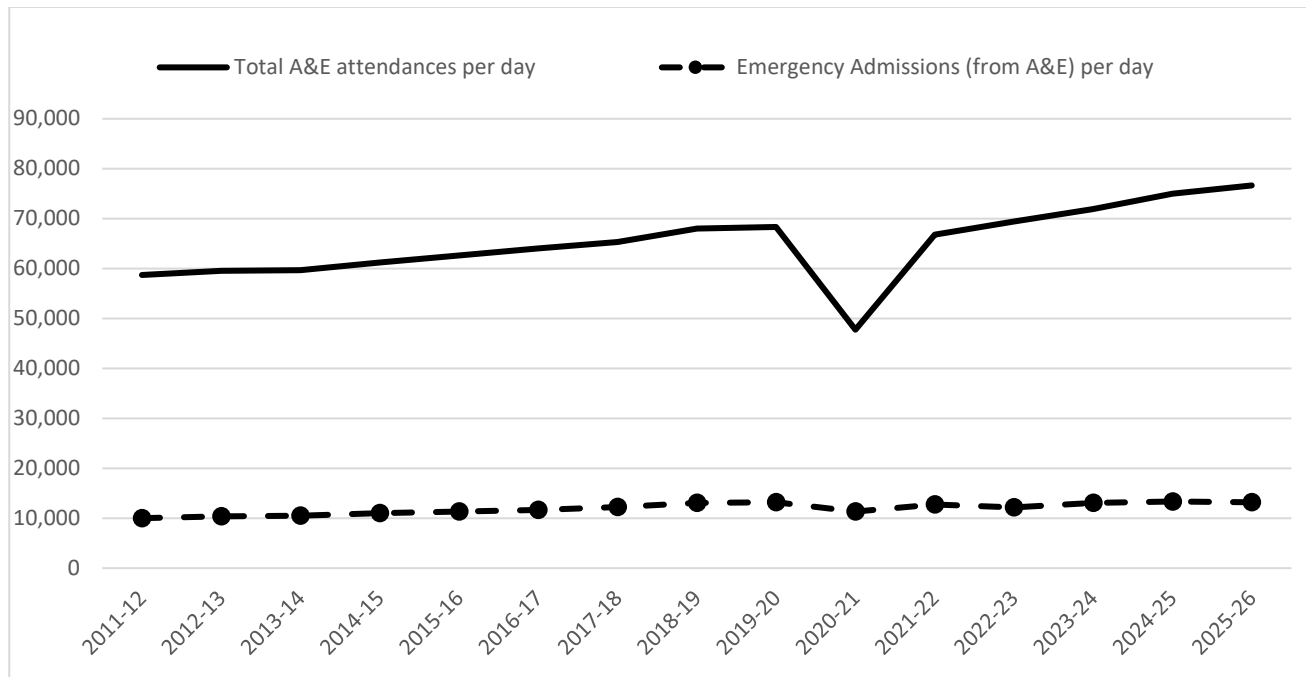
- 2024 to 2025 and 2025 to 2026: NHS England RDEL figure excludes additional pensions funding (the further 3.1% employer contribution rate rise from 1 April 2024). NHS trust and foundation trust permanent and bank staff spend excludes a corresponding amount for additional pensions spend
- figures in the table are high-level estimates. Percentage increases may not match increases calculated from budget or spend figures as given in the table, due to rounding
- table 3 excludes agency expenditure from the NHS Provider Permanent and Bank Staff Spend column. However, agency spend remains included within the NHS England RDEL figure and has fallen substantially where agency costs made up 0.6% of the Agenda for Change (AfC) pay bill in 2025 to 2026, down from 1.3% in 2024 to 2025, representing a cost reduction of approximately £568 million (0.7%)

Demand pressures

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

for secondary mental health services has continued to increase. The average number of new referrals reached 453,930 per month in 2024 to 2025, representing a 15% increase compared with 2022 to 2023 levels and community service demand referrals have risen from 1.73 million in June 2025 to 1.83 million in June 2026 demonstrating a 5.7% increase.

Figure 1: total and emergency admissions per calendar day

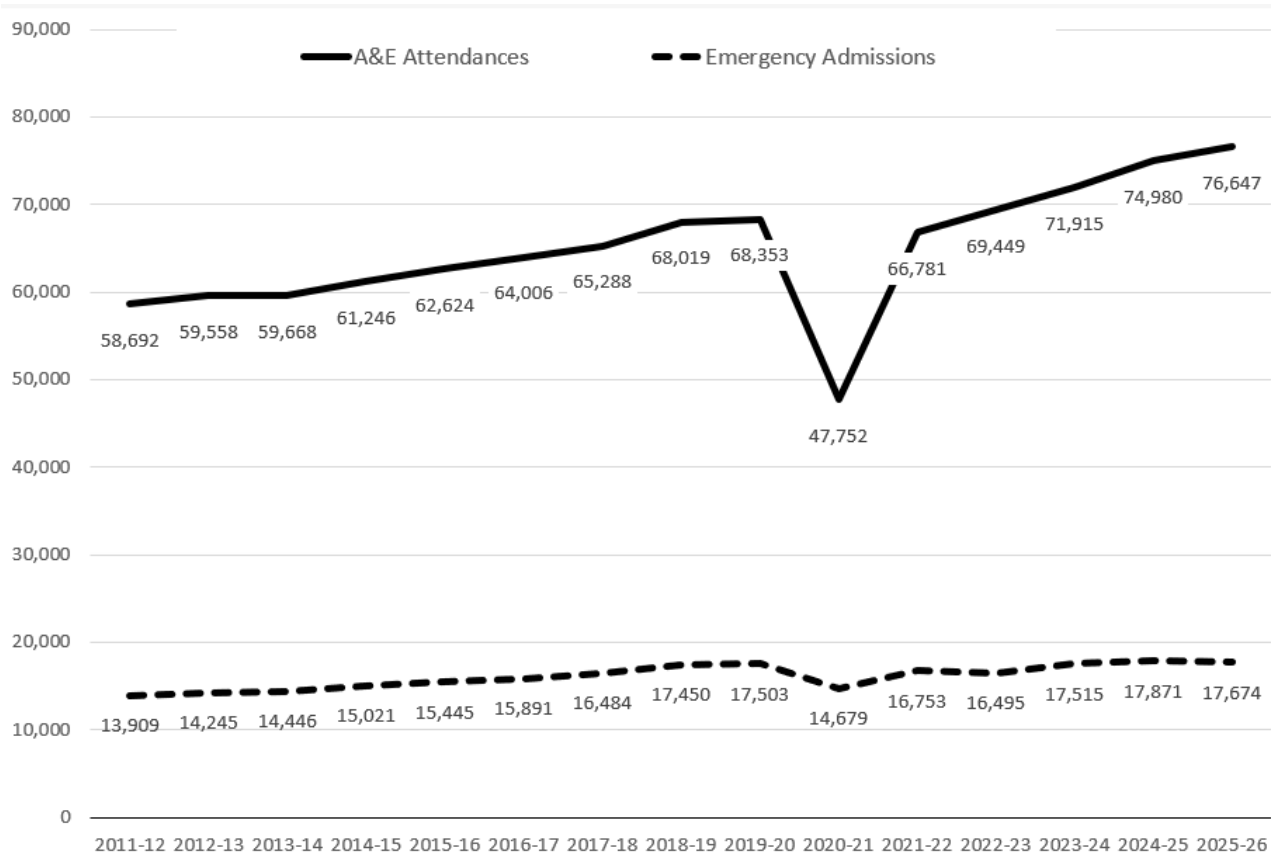


Source: [NHS England A&E attendances and emergency admissions](#)

Figure 1 shows the total attendances and emergency admissions per calendar day between 2011 to 2012 and 2025 to 2026.

Between 2011 to 2012 and 2019 to 2020, both A&E attendances and emergency admissions increased steadily. In 2019 to 2020, there were an average of 68,353 A&E attendances and 13,167 emergency admissions per day. In 2025 to 2026, there were 76,647 A&E attendances and 13,202 emergency admissions per day. This equates to a 12.1% increase in A&E attendances, while emergency admissions via A&E grew more slowly, demonstrating an increase of 0.3% between 2019 to 2020 and 2025 to 2026. However, changes to the recording of same day emergency care activity over this period has reduced recorded growth in emergency admissions.

Figure 2: people in contact with secondary mental health and learning disabilities services



Source: [NHS England Mental Health Services Monthly statistics](#)

Figure 2 shows the number of people with an open referral to any secondary mental health service between October 2023 and May 2026.

This shows a rise from 1.79 million people at the beginning of the period to 2.36 million in May 2026, showing a consistent rise. This equates to a 31.8% increase across the period.

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

Year	RTT estimated clock starts per working day	RTT total completed pathways and unreported removals per working day	Waiting list
2018 to 2019	82,231	81,272	4,345,467
2019 to 2020	79,712	79,552	4,386,297
2020 to 2021	55,824	53,595	4,950,297
2021 to 2022	74,916	69,322	6,365,772
2022 to 2023	79,511	75,665	7,331,186
2023 to 2024	82,163	81,332	7,538,830
2024 to 2025	82,440	82,913	7,418,598
2025 to 2026	84,925	86,160	7,106,135

Source: [NHS England consultant led referral to treatment statistics](#).

Elective performance improvement, in order to deliver the NHS constitutional standard, is a central focus for the NHS to deliver on the commitment for 92% of patients to wait no longer than 18 weeks from referral to consultant treatment, by March 2029. The size of the challenge to achieve this remains significant. The waiting list stands at 7.37 million (as of August 2026). This is down from 7.6 million in July 2024, but up from 4.5 million in July 2019 before the pandemic. At the end of June 2024, the start of the current parliament, 58.9% of waits were within the 18-week standard with over 300,000 patients waiting more than 52 weeks for elective treatment. The data for March 2026, has shown improvement with 65.3% of waits now within the 18-week standard. This is a material improvement but remains significantly below the constitutional commitment of 92%.

The Elective Reform Plan, published in January 2025, outlines an ambitious package of reforms that the NHS is expected to deliver with national funding and support. It includes action to manage demand and transform outpatient services. This includes expanding advice and guidance and introducing a single point of access to support effective triage to the most appropriate next step for patients. We will also provide faster and more local diagnostics, implement more productive surgical pathways and improve patient experience.

The SR 2025 settlement includes £1.8 billion of additional funding, announced in the Autumn Budget 2024, to support the delivery of 2 million extra operations, scans and appointments (equivalent to 40,000 per week) during this government's first year. The government reached and surpassed this target delivering 5.2 million additional appointments between July 2024 and June 2025.

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

Record levels of RTT activity were seen in 2025 to 2026 which was driven by non-admitted activity. This meant monthly per working day RTT activity across 2025 to 2026 was above pre-pandemic levels, 9.8% higher than activity seen in 2019 to 2020.

Average elective demand growth pre-pandemic (between October 2016 and February 2020) was 2.1%. Demand returned to pre-pandemic levels in January 2023 and rebounded at a rate of 6.1% across 2022 to 2023. After slower growth across 2024 to 2025 (0.3%), the rate of demand growth has increased to 3.0% in 2025 to 2026. This is higher than the long-term trend seen before the pandemic at around 2% and includes mitigations from advice and guidance interventions.

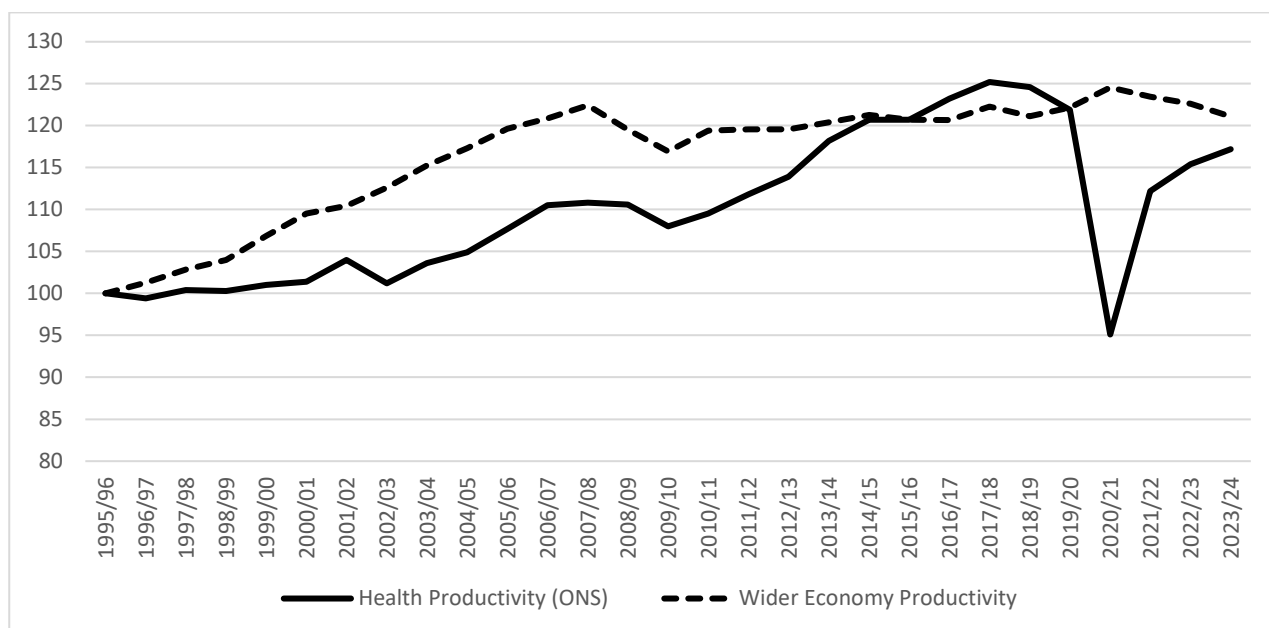
Calculating productivity in the NHS

The NHS has been set a target to deliver a 2% year-on-year productivity gain. This would return productivity to pre-pandemic levels by the end of this parliament. Research reported within the [10 Year Health Plan](#) has shown that reaching this level of productivity gain would reduce the long-term cost pressures facing the NHS by slowing the growth in health spending relative to the wider economy.

The Office for National Statistics (ONS) publishes annual estimates of productivity for public services, including healthcare. Between 1995 to 1996 and 2019 to 2020, healthcare productivity increased on average by 0.8% each year, with similar growth rates observed in the wider economy. Before the 2008 financial crisis, healthcare productivity initially declined in the early 2000s but recovered from the middle of the decade, averaging annual growth of around 1.4% as hospital activity, survival rates and overall efficiency caught up with earlier funding increases.

Figure 3: ONS annual estimates of productivity for public services, including healthcare

ONS England Health vs Wider Economy Multi Factor Productivity (index 1995/96 = 100)



Source: [Health Data from ONS Public service productivity estimates: healthcare, England, FY 2024](#) and [Wider Economy Data from ONS Multi-factor annual productivity, UK](#)

Figure 3 shows a 22% reduction in health productivity in 2020 to 2021. This was the result of both increased inputs (for example, staff capacity to cover the risk of surges in COVID-19 patients) and reductions in measured outputs (for example, fewer operations due to infection controls and limits on elective treatments). Infection control measures and lockdowns implemented during the COVID-19 pandemic delivered health benefits (for example fewer COVID-19 cases), but it is important to note that these benefits are not reflected in the usual measures of productivity. ONS has since reported a substantial recovery in productivity, with the 2023 to 2024 level estimated to be 4% below the 2019 to 2020 level.

These formal ONS estimates are currently only available to 2023 to 2024. However, NHS England now publishes monthly estimates of productivity at provider-level and these are recommended as the best available data on monthly productivity performance for the provider sector. These measures estimate that:

Acute productivity growth was 2.6% between 2024 to 2025 and 2025 to 2026 year to date (YTD). Acute productivity:

- acute productivity growth was 2.6% between 2024 to 2025 and 2025 to 2026 year to date (YTD)

- acute productivity growth was still 7 to 8% below the 2019 to 2020 level in 2024 to 2025 and was estimated to be 5 to 6% below the 2019 to 2020 level in 2025 to 2026
- productivity measures across all providers, including acute and non-acute, are less robust but do suggest higher growth in 2025 to 2026 (3.3%)

ONS's 2023 to 2024 versus 2019 to 2020 measure should not be compared with NHS England's 2025 to 2026 versus 2019 to 2020 measure as they measure different things. ONS has a wider scope and will therefore tend to show a smaller reduction versus 2019 to 2020.

NHS England data indicates the service is delivering against the SR 2025 commitment to achieve 2% annual productivity growth goal, ([NHS recovery continues with above target productivity growth](#)), which is well above the historic average; however, even where productivity is currently running above that level, these gains primarily support higher activity and service delivery within individual organisations rather than creating cash-releasing savings or headroom to absorb further pay pressures.

The focus now is on delivering further improvement through clinical and operational reform, workforce productivity, prevention, digital transformation, and reducing waste and unwarranted variation across the NHS.

It will also mean harnessing benefits from investment in technology and other digital tools. These investments will free up staff time, improve patient experience, and ensure the NHS is better equipped to meet future demand.

Affordability

SR25, published in June 2025, set departmental budgets for day-to-day spending until 2028 to 2029 based on the economic assumptions made at that time. The government has been clear in the SR that pay awards need to be funded in full from within these budgets and there will be no access to the reserve.

The government has allocated its SR funding to deliver on its commitments, including through setting multi-year planning guidance this allocated budgets to NHS ICBs already committing the majority of the SR settlement. The government is continuing to deliver its commitments on elective recovery, supported by increased activity levels this year, alongside wider service and performance objectives. Maintaining progress against these priorities will remain a key focus in 2027 to 2028.

DHSC is balancing these spending commitments across NHS England, its other Arm's Length Bodies (ALBs) and the core department, with an ambitious productivity assumption

of 2% each year in the NHS which will be required to balance the settlement. DHSC has developed financial and delivery plans that currently plan for a pay uplift of 2.4% without having to make trade-offs against headline government health commitments. Should the independent pay review bodies recommend an award above this level, we would need to consider whether and how this could be made affordable from within existing DHSC budgets. Accepting such an award would inevitably have an impact on healthcare delivery.

DHSC, along with the NHS, is already managing a wide set of material financial risks. These include the impact of higher inflation, energy costs, industrial action and reducing immigration health surcharge income. NHS pay is a significant material pressure where every 0.5% increase to pay costs is approximately £750 million (equivalent of more than 89,000 hip or knee replacement operations). That's why anything above the pay plan outlined above will require difficult trade-offs for the government, particularly as most of the budget is already committed in ICB allocations.

These trade-offs could include a reduction in ambitions for service or performance improvement (for example, additional elective activity to reduce waiting lists or additional investment in digital and technology to support productivity improvements in future years).

The government has now overseen a series of difficult decisions to reform the health service. Over the last year, substantial workforce reductions have been delivered across both DHSC and NHS England as part of the commitment to reduce the size of the centre.

Chapter 3: workforce planning and supply

This chapter sets out how the government's approach to workforce planning supports delivery of the 10 Year Health Plan to create a new model of care to deliver the NHS of the future. It provides an overview of recent trends in medical workforce growth, recruitment and retention, including changes in vacancy rates, leaver rates and the balance between domestic and international supply. It describes how future workforce strategy will support a more sustainable workforce through improved productivity, retention and better deployment of skills.

This chapter also sets out the government's approach to education and training, including reforms to postgraduate training pathways through the Medical Training (Prioritisation) Act 2026, alongside the Medical Education and Training Review. It highlights the ambition to strengthen domestic training pipelines and reduce reliance on international recruitment over time, while maintaining socially responsible recruitment practices. This chapter gives particular attention to the general practice and dental workforces given the government's commitment to improving access to primary care, and the importance of maintaining sustainable workforce pipelines to support delivery of these ambitions. The chapter also covers the role of leadership, workforce planning and system reform in supporting service delivery and transformation.

Health and Community Health Services (HCHS)

This section describes the trends in the medical workforce employed by NHS provider trusts, ICBs and support organisations. It sets out a high-level picture of the staffing position, covering key issues with regards to patterns of recruitment and retention. It does not replicate all the data that is already regularly published, such as in [NHS workforce statistics](#) and other data sources cited in the accompanying data pack.

Decisions around workforce growth are made by employers, mainly NHS trusts. Overall NHS workforce numbers (medical and non-medical) grew relatively quickly between 2019 to 2020 and 2024 to 2025 but have since slowed. We expect slower medical workforce growth over the coming years given financial constraints.

As at March 2026, there were 166,415 medical staff across NHS trusts and NHS central and support organisations, equivalent to 154,383 full time equivalent (FTE) staff. This saw that from:

- the 16 years to March 2026 saw average growth in medical staffing numbers of 3.0% per annum

- between April 2019 and March 2025 there was particularly fast growth of 4.7% per annum
- in the last year this slowed to 3.8%, though this remains above the long-term average

Medical workforce growth over the past year also remained significantly above the rate of change in the non-medical workforce, which saw a 0.3% reduction. The growth in medical workforce continues to be driven by both increased numbers of domestically trained doctors, alongside a significant recruitment of internationally qualified staff. However, the number of internationally trained doctors joining the General Medical Council (GMC) register is starting to slow and is expected to be further reduced by the implementation of the Medical Training (Prioritisation) Act, 2026.

The rate of medical staff leaving active service in the NHS continues to be at a level below that seen pre-pandemic. This is in line with the trend seen for non-medical staff. Leaver rates reflect those leaving the NHS trust and ICB sector, therefore include those leaving to work elsewhere in the health and care sector, including those moving to work in primary care, which includes a significant number of resident doctors. As such, the raw rate is not indicative of the absolute numbers of doctors leaving the profession. Leaver rates from the GMC register give a sense of numbers leaving the profession entirely including those retiring (source: [The state of medical education and practice in the UK: workforce report 2025 - GMC](#)). Register leaver rates for doctors (excluding those who had joined the register but never gained a job) are 3.6% in 2024. This is a small increase from the 2 preceding years (3.4% and 3.2% respectively). The rate of staff leaving who obtained their primary medical qualification outside the UK was 4.3% (up from 4.0% in 2022 and 3.6% in 2023) compared to 3.2% for those with a UK primary medical qualification.

[The 2025 NHS Annual Staff Survey results](#) suggest around 54% of medical staff considering leaving their current job intend to stay in the NHS, around 19% are wanting to leave the NHS but stay in healthcare, and 7% are considering leaving for a job outside of healthcare. 20% of those considering leaving are considering this for an entirely different career and roughly 25% are considering taking a temporary career break.

Vacancy rates for medical staff have remained low over the past 3 years sitting at 4.5% as of March 2026. (source: [NHS Vacancy Statistics \(and previous NHS Vacancies Survey\)](#)) There are a range of different factors driving vacancy rates and it is not clear what the 'natural' level of vacancies would be as people also move between roles (churn), move sectors, or retire.

Workforce planning

The 10 Year Health Plan, published in July 2025, set out a transformative vision for a future healthcare system based around 3 shifts, to move healthcare from hospital to community, from analogue to digital, and from sickness to prevention. We need to support the workforce to deliver this new service model, where the right people, with the right skills, are in the right places to provide effective care. Workforce planning and strategy over the next 10 years will therefore be guided by that overarching vision.

Improving staff experience

Significant work continues across the system to improve staff experience, building on tools such as the Staff Experience Assessment Tool and a suite of initiatives supported through the NHS England retention programme. Regional teams continue to develop staff experience plans in response to survey findings, while individual trusts deliver ongoing action plans in line with the NHS Standard Contract, with progress assessed via the National Oversight Framework.

There has also been targeted action to improve the experience of resident doctors through the NHS England 10 Point Plan, as well as a programme to improve recognition of the contribution of SAS doctors and support provided to them. Through the SEID award, Trusts and employers are incentivised to support their SAS doctors to have a better and more equitable professional experience by measuring them against 8 specific criteria points (pillars). These 8 pillars relate to the specific support and development opportunities a Trust provides to its SAS doctors. The criteria on which Trusts will be measured against has been co-designed, developed and agreed through extensive engagement with SAS doctors, NHS England, Academy of Medical Royal Colleges, GMC, BMA and employers.

The 10 Year Health Plan sets out clear ambitions to address retention issues and there has been continued targeted and evidence-based interventions which have contributed to the improvements in leaver rates for doctors and dentists in recent years.

Annual leaver rates for medical and dental staff have improved, falling from 15.4% in August 2023 to 12.8% in March 2026, with consultant leaver rates falling from a peak of 6.4% in April 2022 to 4.9% in March 2026 (source: [NHS Workforce Statistics, NHS England](#)), and fully qualified GP leaver rates decreasing from 10.0% in March 2023 to 7.7% in March 2026 (source: [General Practice Workforce](#))

Leaver rates for medical and dental staff have improved, falling from 10.7% in August 2023 to approximately 9% in March 2026, with consultant leaver rates falling from a peak of 4.5% in April 2022 to 3.2% in May 2025, and fully qualified GP leaver rates decreasing

from 8.8% in June 2022 to 6.9% in June 2026. (Source: [GP Joiners and Leavers, England - June 2026](#)).

Although retention has improved across medical and dental staff, it remains uneven by specialty and career stage. Early career attrition continues to be higher for more established staff, reinforcing the importance of targeted support during transition into practice and the early years of a career. Evidence from retention initiatives suggests that interventions that strengthen workforce experience, including flexible working, career development, staff engagement and health and wellbeing, can contribute to improved retention outcomes. However, retention is influenced by a combination of workforce, organisational and labour market factors. Not all staff movement represents a loss to the wider NHS workforce, with retirement, career progression and movement within the wider health system forming part of a dynamic workforce. Wider pressures, including workload, financial constraints and organisational change, also affect retention and workforce stability.

NHS England is progressing a more consistent approach to early career support to reduce attrition. It is aligned to the 10 Year Health Plan and includes the Newly Qualified Health Registrants (NQHRs) commitment and strengthened support in the first years post-qualification.

Medical education and training for doctors

Undergraduate

The government caps the number of places that it funds for each medical school in England. This is to ensure the sufficient provision of high-quality education, training and clinical placements for students. Each medical school is allocated a specific number of places, a 'maximum fundable limit' that is set by the Office for Students (OfS) (source: [Funding for medicine and dentistry, OFS](#)). For the academic year 2026 to 2027, there is a total maximum fundable limit of 8,126 places. This is the same number as for the 2025 to 2026 cohort.

Postgraduate

NHS Medical Training (Prioritisation) Act 2026

Since removal of the Resident Labour Market Test in 2020, UK-trained doctors have faced growing competition from overseas-trained doctors for postgraduate medical training posts. This has been an increasing cause of doctor discontent. While international staff will always play an important role, there is already a substantial pool of eligible applicants who have trained in the UK or are already employed in the NHS. These doctors are more likely

to work in the NHS for longer and be better equipped to deliver healthcare tailored to the UK's population because they better understand the UK's epidemiology.

Growing bottlenecks in postgraduate medical training were threatening career progression, retention and the attractiveness of being a doctor in the UK and were a particular concern among resident doctors struggling to secure a place on a postgraduate medical training programme at the start of their careers (source: [Medical Training \(Prioritisation\) Bill: impact statement](#)). The need to address this issue was recognised in the 10 Year Health Plan.

The Medical Training (Prioritisation) Act 2026 came into force on 6 March 2026, creating a new legal framework for determining which applicants should be prioritised for postgraduate medical training places across the UK. The Act prioritises UK medical graduates for foundation training places, and UK medical graduates and other doctors with significant NHS experience for specialty training places.

The Act is designed to support a sustainable medical workforce that can meet population health needs, reducing the UK's reliance on an unpredictable international labour market. UK taxpayers make a significant investment of over £4 billion each year in training doctors in medical school, foundation and specialty training. Prioritising UK medical graduates for postgraduate training aligns with the UK government's workforce planning aims, which links the number of medical school places to postgraduate training capacity to meet the needs of the UK patient population. By creating a clear pathway from medical school to specialty training, we strengthen the domestic talent pipeline and improve retention.

For specialty training places starting in 2026, we are using immigration status as a proxy to capture applicants who are most likely to have significant experience working in the health service in the UK. From 2027, immigration status will not automatically determine priority for specialty training. Instead, the Act provides a power to specify in regulations any additional groups who will be prioritised by reference to criteria indicating significant experience as a doctor in the health service, or by reference to immigration status.

The 4 UK statutory education bodies sought views from stakeholder organisations on how best to define and evidence significant NHS experience as part of the development of these regulations through a targeted engagement exercise coordinated by NHS England. We aim to have regulations in place ahead of the 2027 application rounds opening in October 2026.

Medical Training (Prioritisation) Act 2026 monitoring and evaluation

The government will, as for all legislation, keep the Act under review to ensure that it delivers its policy intent. We published an Impact Statement alongside the Bill's introduction to Parliament. NHS England and the government will monitor the impact of the

Act as recruitment data becomes available through the revised recruitment process and Oriel system reporting. This will include, tracking application numbers, prioritisation outcomes, offers, acceptances and broader recruitment patterns.

Emerging Round 1 management information indicates that overall accepted offers remained broadly stable between 2025 and 2026, with 9,315 accepted offers in 2026 compared with 9,366 in the equivalent round in 2025. However, the profile of accepted offers changed substantially (source: [Medical Training \(Prioritisation\) Bill - information for applicants to medical training](#)). Priority applicants accounted for 9,147 accepted offers (98.20%) in Round 1 2026, compared with 6,748 (72.05%) in 2025. Priority applicants represented 48.55% of all applications and 47.32% of applicants deemed appointable. Application rates among priority applicants were particularly high in Internal Medicine Training Core Training Year 1 (CT1) (53.28%), Core Surgical Training CT1 (66.71%) and Paediatrics Specialty Training Year 1 (ST1) (64.57%). Similarly, priority applicants accounted for high proportions of appointable candidates in several specialties, including Clinical Radiology ST1 (82.80%), Paediatrics ST1 (82.46%) and ACCS Emergency Medicine ST1 (89.51%).

These figures describe the composition of the applicant pool and appointable candidates and are not themselves affected by prioritisation. The effect of prioritisation is evident at the offer and acceptance stages, where priority applicants received 98.59% of offers and accounted for 98.20% of accepted offers. Across most specialties, priority applicants received almost all offers and accounted for almost all accepted offers. In General Practice ST1, Core Psychiatry Training CT1, Core Surgical Training CT1, Clinical Radiology ST1 and Anaesthetics CT1, all accepted offers were from priority applicants.

The data suggest that prioritisation arrangements are operating as intended in round 1, by increasing the proportion of offers and accepted offers made to priority applicants, without evidence at this stage of a reduction in overall accepted offers. However, this remains early management information and does not yet provide a full assessment of applicant behaviour, or the position across later recruitment rounds. NHS England and DHSC will continue to monitor for any emerging impacts of the Act on applications, offers and acceptances for specialty training, including in less popular specialties and geographies, alongside wider workforce planning considerations.

Foundation programme allocation review

The allocation process for the UK Foundation Programme for the 2026 intake continued to use a 'preference informed allocation' (PIA) method. This method was introduced in 2024 and involves applicants being given a computer-generated rank, and removes the requirement to sit the Situational Judgement Test. The new system aimed to address

concerns that the previous allocation process was stressful for applicants and created unnecessary competition, and that there was lack of standardisation within and across schools. This change was based on extensive stakeholder engagement by the 4 UK statutory education bodies, medical students and key stakeholders. The introduction of PIA was broadly supported by stakeholders.

Most medical graduates are placed in their first choice of foundation school, and this has increased since PIA was introduced. In 2023, before PIA was introduced, 71% of applicants received their first-preference school. In 2026, 82% of applicants received their first preference. This maintains improvements on 2024 allocations when 75% got their first preference.

The higher proportion of first-preference placements, and the more balanced distribution of overseas applicants across foundation schools has been associated with a more consistent withdrawal rate across the country, and reduced vacancy hotspots in less popular regions or trusts. NHS England will continue to review and improve the allocation methodology based on the data for 2024, 2025 and 2026.

When confirming the move to the new system, Health Education England (HEE), which is now part of NHS England, set out that once implemented it would be subject to ongoing review. The review is aiming to commence later in 2026.

UK Foundation Programme 2026 allocations

Foundation posts are allocated across the UK to support workforce needs. The number of places is agreed on a 4-nation basis by the statutory education bodies in England, Scotland, Wales and Northern Ireland. In 2026, at the point of primary allocation, there were more applicants than programmes available. 10,810 eligible prioritised applicants were allocated to a Foundation School in the primary allocation. While most prioritised applicants were assigned to specific foundation programmes in April 2026, a small number were allocated to placeholder posts, with details of their posts confirmed at a later date. In 2026, there were significantly fewer applicants in placeholder posts nationally due to the prioritisation of applicants as a result of the Medical (Prioritisation) Training Act 2026.

Eligible non-prioritised applicants were placed on a national reserve list. The UK Foundation Programme Office (UKFPO) delivered 5 reserve list allocation rounds to support applicants in the non-priority group in accessing available training posts on the 2026 Foundation Programme. By the conclusion of the reserve list process, a further 476 non-prioritised applicants had been allocated to a Foundation School. This comprised 154 applicants in Round 1, 114 in Round 2, 124 in Round 3, 69 in Round 4 and 15 in Round 5.

The number of applicants allocated in each round was determined by the vacancies available in each nation at the point that each allocation round took place.

Table 5: UK Foundation Programme 2026 reserve list allocations by nation

Nation	Round 1	Round 2	Round 3	Round 4	Round 5	Total
England	123	98	115	65	15	416
Northern Ireland	27	14	4	3	0	48
Scotland	0	0	0	0	0	0
Wales	4	2	5	1	0	12
Total	154	114	124	69	15	476

Medical education and training review

Following the commission from the Secretary of State in October 2024, Phase 1 of the Medical Education and Training Review (METR) has now been completed. This included extensive engagement with stakeholders across the system, including resident doctors, educators, employers and patients.

[The Medical Training Review: Phase 1 diagnostic report](#) confirmed that, while the UK postgraduate medical training system remains highly regarded, there is a need to evolve the model to better meet the changing needs of patients, communities, doctors and service providers. Key issues identified include increasing competition at key transition points, delays in progression to specialty training and evidence of increased time out of training for some doctors.

Stakeholders also highlighted the impact of frequent rotations on continuity of care and team integration, alongside limited flexibility in some training pathways and variation in experience across regions and specialties. These factors can affect both training experience and the ability of services to deliver consistent, high-quality care.

Dame Jane Dacre is leading Phase 2 of METR as an independent, profession-led programme of reform. Building on the Phase 1 diagnostic and earlier recommendations from the diagnostic phase, the focus is now on developing and implementing practical solutions to longstanding challenges in medical education and training, including flexibility, progression, equity and alignment with future workforce and service needs. In response, a programme of work is underway to improve flexibility, progression and the overall training experience.

Targeted reform is being taken forward through focused workstreams, focused on rotations, flexibility, career progression, curriculum reform and training delivery, alongside improvements to supporting structures such as the postgraduate workforce and support

teams. Rotational pilots are being developed to explore alternative approaches to placement design, with the aim of improving continuity for both doctors and services.

Future reforms will be informed by the results and evaluation of these programmes ensuring effective approaches are embedded and persistent challenges addressed. The aim is to deliver a clear, actionable plan for system-wide reform over the next 5 to 10 years, ensuring training pathways are flexible, inclusive and aligned with the ambitions of the 10 Year Health Plan, supporting both the needs of the workforce and patients.

International recruitment

We want to ensure the NHS has the right people, with the right skills, in the right places to deliver high-quality care for patients. We value the skill and dedication overseas staff bring, alongside a clear focus on building a more sustainable domestic workforce.

In 2024, 66% of doctors taking up or returning to a licence to practice on the GMC register had a non-UK Primary Medical Qualification according to the GMC (source: The state of medical education and practice in the UK: workforce report 2025 - GMC).

However, numbers of international joiners to the GMC have plateaued in recent years. Furthermore, the 10 Year Health Plan sets an ambition to reduce reliance on international recruitment to under 10% by 2035 by recruiting and retaining more homegrown staff, and prioritising UK medical graduates for training places.

[Monthly entry clearance visa applications, September 2026](#) shows that across 2021 to 2023, the average annual number of health and care worker visas granted for doctors was 7,772. This has been falling since 2023, with the latest data from the Home Office showing 5,916 visas granted in the year to Q1 2026, 24% fewer than the average annually across 2021 to 2023. The number of health and care worker visas granted to dentists is much smaller than those granted to doctors. In an opposite trend to that seen for doctors, the number of visas granted to dentists has increased, with 488 visas granted in the year to Q1 2026, compared to an average of 226 annually across 2021 and 2023.

National data for health and care worker visas granted to doctors and dentists shows in the year to Q1 2026, that those of Indian nationality made up the largest group with 1,283 visa grants. This is in comparison to 786 of Pakistani nationality and 658 of Nigerian nationality, who make up the second and third largest groups over the same period.

Alongside this, immigration policy is being reformed to build a sustainable workforce for the future. The Migration Advisory Committee reported in December 2025 on [salary requirements across the Skilled Worker route](#), including the health and care worker visa. The government is considering its recommendations as part of wider reforms. The

government has also consulted on proposals for an 'earned settlement' model, linking access to settlement more closely to contribution, as part of a more selective and controlled migration system.

Taken together, these changes are expected to moderate international inflows while maintaining access to essential skills, supporting a longer-term shift towards a more domestically trained workforce. This places greater emphasis on domestic recruitment and retention, including ensuring roles remain attractive to the UK-trained workforce.

The government continues to emphasise high ethical standards in international recruitment through the Code of Practice for International Recruitment, ensuring recruitment does not undermine health systems in other countries and that employers act responsibly.

NHS temporary staffing

Influenced by seasonal factors and broader labour market fluctuations, NHS demand may lead providers to rely on temporary staff to maintain safe staffing levels and patient care.

In 2016, measures were introduced to curb NHS agency spending, including price caps and mandatory use of approved procurement frameworks through the launch of the Agency Rules. These measures, regularly monitored for compliance and effectiveness, aim to reduce costs and give greater assurance of quality in temporary staff and ensure that bank and agency workers provide the same standard of patient safety and care continuity as permanent personnel. Performance metrics on agency usage are included in the NHS Oversight Framework and linked to improving NHS productivity growth levels, reinforcing compliance with the agency rules for NHS trusts and foundation trusts.

The measures were relaxed during the pandemic but re-established in September 2022, to control agency expenditure, including a system level allocation agency expenditure limit. Further measures, to increase data transparency and additional governance provisions are being implemented in 2026 to 2027 to drive down the reliance on agency staff.

In 2025 to 2026, total expenditure on medical temporary staffing decreased by 11.8% (£321 million) compared to 2024 to 2025.

Bank staffing costs increased by 0.4% (from £1.759 million to £1,765 million) in 2025 to 2026, though bank staff as a proportion of the overall medical pay bill decreased by 0.4 percentage points, from 7.7% to 7.3%.

Agency costs made up 2.6% of the medical NHS pay bill in 2025 to 2026, down from 4.2% in 2024 to 2025, representing a cost reduction of approximately £328 million (34%).

On aggregate for total agency spend, we have achieved a 43.2% reduction across 2025 to 2026 well in advance of the 30% reduction target, spending approximately £896 million less in 2025 to 2026 than 2024 to 2025.

We have not hit the aggregate bank reduction of 10% with provisional data showing about a 5.2% reduction year on year, however, spend is about £338 million lower in 2025 to 2026 than in 2024 to 2025.

This demonstrates trusts have exceeded the target set of reducing agency spending by at least 30% for the full year in 2025 to 2026. Agency spend is the lowest on record, on track to eliminate agency expenditure by 2029, as per the commitment in the 10 Year Health Plan.

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

Leadership

Clinical leaders, including doctors, nurses and allied health professionals are essential to delivering and assuring high-quality NHS care. Visible senior clinical leadership supports this and will help the NHS to improve quality outcomes and performance.

The 10 Year Health Plan sets an ambition for the NHS to have world-class leadership and management. Leadership has been a key enabler of the progress the service has collectively achieved over the last year, as reflected in the 6 percentage point improvement in public satisfaction with the NHS reported in the [2025 British Social Attitudes Survey](#). As the NHS enters a new phase, with a more devolved operating model and greater local autonomy, leadership and management will continue to play a vital role in determining how services are delivered. Individually, NHS leaders and managers will need to navigate a rapidly changing environment - particularly as technologies such as AI reshape how people across the NHS will work - and drive the transformation these changes make possible. Leaders and managers across the NHS are not only responsible for delivering and improving services but also play a key role in leading anchor institutions within their communities, supporting wider social and economic outcomes alongside improving health outcomes.

A key development in the last year has been the progress made with establishing the new NHS College of Leadership and Management, a 10 Year Health Plan commitment. The college was launched in July 2026, and appointments of the college chair and interim chief executive have been confirmed. The college will be engaging closely with stakeholders to

inform the development of its business plan. The college is a clear response to the ambition in the 10 Year Health Plan for world-class leadership and management, and to the need for a more coherent, consistent and modern approach to developing the people who lead services, manage resources and deliver change across the NHS. It will provide a single national home for leadership, management and talent development, bringing together standards, curriculum, development, talent management, evidence and evaluation.

The college will be the national delivery vehicle for the NHS's leadership and management reform agenda, translating commitments in the 10 Year Health Plan into consistent standards, development and talent interventions across the service. This includes implementation of the Leadership and Management Framework, published on 6 July 2026 in response to a key recommendation of the Messenger Review, which for the first time establishes a consistent set of professional standards, a code of practice and a core national development curriculum for NHS managers and leaders. More broadly, it will coordinate a coherent, consistent and multiprofessional leadership and management development offer, provide clear career pathways and supporting managers and leaders at every stage of their career to develop, progress and fulfil their potential.

In partnership with regions and professions, the college will also have an explicit role in supporting the development of talent pipelines to board level roles, including new processes for identifying and assessing readiness for board-level roles and the development of aspiring executives and clinical leaders.

Dentistry education and training

Dental undergraduate training

The maximum fundable limit for training places is set by the government for home and overseas students (defined as those from countries outside the European Economic Area). According to Universities and Colleges Admissions Service (UCAS) management information, the number of unique applicants that applied to study dentistry in 2025 was at an all-time high, with 5,705 applicants and 880 acceptances. This equates to a 15% success rate for applicants.

The number of government-funded undergraduate training places in England for dentistry for the 2025 to 2026 academic year remains 809 places. From the 2027 to 2028 academic year, the total number of government-funded undergraduate dental training places in England will increase to 859, supported by approximately £11 million per year at steady state. This is the first sustained expansion in nearly 20 years. This total is delivered across all providers, with the expansion including new provision at the University of Portsmouth,

alongside additional capacity at the University of East Anglia, contributing to increased training in areas without existing government-funded dental programmes.

The 10 Year Health Plan set out that, having consulted on the principle of requiring all dentists to work in the NHS for a minimum period, the government will now make it a requirement for newly qualified dentists to practice in the NHS. Work continues on the detailed design of the policy, and how it can best support access to NHS dentistry. There has been active engagement with a range of stakeholders on how to strengthen the domestic workforce pipeline and support more dentists to deliver NHS care.

Dental foundation training

Dental foundation training (DFT) plays a significant role in introducing graduate dentists to NHS general dental practice and is also the main route for UK dental graduates to be accepted onto the NHS Performers List. As of August 2026, all DFT posts in England are filled.

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

Dental core training

Dental core training (DCT) recruitment for 2026 again received an overall above-average rate of applications for posts across the UK. As of August 2026, England-only data showed an improved fill rate for DCT on the previous year, with a total fill rate of 95.9%, including with year 1 filling 97.3% of positions, year 2 filling 95.9% and year 3 filling 90.4%.

Dental specialty training

Recruitment to dental specialty training remains strong across most specialties. August 2026 fill rates reached 100% in Dental and Maxillofacial Radiology, Dental Public Health, Oral Medicine, Oral Surgery, Orthodontics (ST1 and ST4), Paediatric Dentistry ST4, and Restorative Dentistry. Fill rates were also high in Paediatric Dentistry ST1 (92%).

However, recruitment pressures remain in a small number of specialised disciplines. Special Care Dentistry filled 57% of posts in 2026, following fill rates of 53% and 77% in the previous 2 years. Oral and Maxillofacial Pathology also filled 50% of posts. These figures indicate that, while overall demand for specialty training is sustained, there are continued pipeline risks in smaller specialties.

Under-recruitment in Special Care Dentistry is a particular concern given the patient groups supported by the specialty, including older people and those with complex medical, behavioural and oral health needs. Demand for this workforce is expected to increase as the population ages and as patients present with more complex oral health needs, comorbidities, polypharmacy and previous complex dental care.

We continue to work with the sector to promote Special Care Dentistry as a career pathway and to strengthen awareness of the specialty, recognising its relative newness as a career option and its importance to future service provision.

Dental education reform

[The Dental Education Reform Programme \(DERP\)](#), which closed at the end of March 2026, delivered a more flexible training experience across a wider range of settings, strengthen training pathways for dentists and dental care practitioners (DCPs), whilst providing support to multidisciplinary working. The DERP dental training distribution workstream sought to improve patients' access to dental services in areas of greatest need by directing growth in training posts to those geographies.

DERP key achievements

The DERP programme's key achievements to support multidisciplinary NHS care, improve local access and deliver the ambitions of the NHS Long Term Health Plan are:

- dental foundation: introduction of a single lead employer model across England for all foundation trainees, providing consistent, high-quality employment conditions
- early years dental: introduction of 2-year longitudinal programmes across all NHS England regions to provide broader experience in managing complex dental care
- new early years dental curriculum: introduction of an outcomes-based curriculum for the Early Years programme, bringing together Dental Foundation Training and Dental Core Training Year 1 (DCT1) within a flexible framework designed to support broader experience across primary care, community and secondary care settings
- middle years dental: introduction of a new curriculum forming the basis for 24-month programmes spanning DCT years 2 and 3, supporting training across healthcare settings; the e-portfolio has been updated to align with the new curriculum

Dental international recruitment

This year we have taken significant steps to increase the availability of examinations for overseas-qualified dentists, some of whom are already living in the UK, to enable them to join the UK dental register faster and contribute to the dental workforce. While our long-term priority remains building a sustainable UK-trained workforce, international recruitment provides an important short- to medium-term route to increase capacity and improve access to care.

The General Dental Council (GDC) has signed a new contract to increase capacity for their Overseas Registration Exam (ORE). This is expected to lead to an increase of more than 1,000 overseas qualified dentists registered annually by 2028 to 2029.

Alongside this, we have provided grant funding of over £400,000 to the Royal College of Surgeons of England to support a rapid expansion of its Licence in Dental Surgery exam. This is expected to generate approximately 1,350 additional registered dentists each year from 2028, compared with approximately 135 under the current capacity arrangements.

Combined, these 2 interventions will significantly boost access to NHS and wider dental care, enabling an additional 2,000 dentists to join the register annually from 2028.

Alongside efforts to strengthen the dental workforce pipeline and increase training capacity, the government continues to progress wider reforms to NHS dentistry. Further information on these reforms is provided in Chapter 5.

General practice (GP)

Changes to the additional roles reimbursement scheme (ARRS)

As we set out in last year's evidence, in February 2025 we announced that the Additional Roles Reimbursement Scheme (ARRS) would increase in flexibility to support Primary Care Networks (PCNs) to respond to their local workforce requirements. We combined the funding in the 2 ARRS pots to create a single pot for reimbursement, with no restrictions on numbers or type of staff who are covered, including GPs and practice nurses.

Since these changes were introduced, PCNs have recruited an additional 806 Full Time Equivalent (FTE) Salaried GPs and 137 FTE Enhanced Practice Nurses through ARRS (source: [Primary Care Network Workforce Official statistics, 30 June 2026](#))

As announced in February 2026, the restriction that ARRS funding can only be used for recently qualified GPs was removed to enable the recruitment of a wider range of GPs via the scheme. For 2025 to 2026, we also announced that the salary element of the

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

As part of the 2026 to 2027 changes to the ARRS, PCNs may also recruit other non-direct patient care roles if agreed with the commissioner. These changes were designed to help increase capacity in general practice, support patient access, enable practices to prioritise clinically urgent needs, and ensure general practice remains sustainable for the future.

Alongside workforce planning and recruitment initiatives, the government is continuing to develop reforms to general practice. These include wider contractual and funding reforms intended to support the delivery of neighbourhood health services. Further detail is provided in Chapter 5.

Chapter 4: staff experience

To be able to achieve our aim of making the NHS the best employer in the country we must continue working at pace to improve experience for staff working in the NHS.

This chapter shares progress on the ambitions that were set out in the 10 Year Health Plan and other key work that has been underway to improve the workplace experience and retention of doctors and dentists.

NHS staff survey

The [NHS Staff Survey](#) remains the key source of data in providing insights into the experience of the NHS workforce.

The engagement score for medical staff has shown modest improvement since its lowest point in 2022 (6.61 out of 10), increasing to 6.75 in 2024 but reducing to 6.72 out of 10 in 2025. While motivation has remained stable, declines in involvement and advocacy have contributed to this overall position. Engagement remains lowest among doctors in training, at 6.56 in 2025 (up from 6.48 in 2024), indicating continued variation across career stages.

For medical and dental staff, 5 People Promise elements (we are recognised and rewarded, we are safe and healthy, we are always learning, we work flexibly, and we are a team) and the morale theme are at their highest levels over the past 5 years, 13 of 21 sub-scores improved since 2024 and 2 have remained the same. However, 6 of 21 sub-scores have not improved, including compassionate culture, compassionate leadership, autonomy and control, development, involvement and advocacy.

Pay-related indicators show improvement, with the proportion of medical and dental staff satisfied with their level of pay increasing from 48.39% in 2024 to 49.68% in 2025, and the score for we are recognised and rewarded rising slightly from 6.04 to 6.07.

Consultants continue to report the higher relative satisfaction with their pay despite a slight decrease (58.51%, down from 59.60% in 2024). Satisfaction remains lowest among resident doctors, although this has still notably increased (32.69% in 2025, up from 2024's score of 26.41%).

Satisfaction with pay is also lower among internationally recruited medical and dental staff (40.52%) compared to those trained in the UK (51.25%).

While there has been some improvement in specific areas, staff experience remains variable across organisations and staff groups. These findings highlight the continued importance of sustained, system-wide action to improve engagement, support retention

and ensure that workforce investment translates into improved productivity and patient outcomes.

General practice staff survey

2025 was the third year that the NHS Staff Survey has been extended to general practice on a voluntary basis. The General Practice Staff Survey (GPSS) supports a 'one workforce' approach, providing standardised and actionable data on staff experience across general practice organisations, including practices, primary care networks (PCNs) and ICBs. However, as participation has not been mandatory, year-on-year comparisons and trend analysis remain limited due to variation in participating organisations.

The GPSS is a critical step toward implementing the NHS Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) in primary care settings.

Reports at national, ICB, and PCN level include results against the survey questions, which are benchmarked against average scores as well as 4 of the 9 WRES indicators and 5 of the 9 WDES indicators. This enables comparison of staff experience and selected equality indicators, helping to identify variation across general practice.

In 2025, 33 ICBs participated in the third year of the GPSS, covering over 2,300 organisations and 60,830 individuals, 37.5% of whom responded to the request to share their views. This represents a 29.7% increase in staff invited to participate and a 27.9% increase in staff responding to the survey.

All practices and PCNs have been mandated in 2026 to 2027, via the GP Contract and the Network Contract DES, to enable the survey to be shared with staff for their voluntary participation. This will enable an improved national picture of staff experience in General Practice.

In 2025, the staff engagement score for medics working in General Practice was 7.78 the highest engagement score was Partners at 8.60 and the lowest from Salaried GPs at 7.14. 60.55% of all medics working in General Practice were satisfied with their level of pay, Partners had the greatest levels of satisfaction with pay at 72.62% and Trainee GPs had the lowest satisfaction with pay at 48.53%. In 2025, 66.77% of medics in GP practices were satisfied with recognition for good work. Locums had the highest score in this area at 75.68% whereas Salaried GPs had the lowest score at 60.82%.

Results for the GPSS are not publicly available. However, the move to a nationally mandated survey for general practice is a positive shift. We know that listening to

employee voices is a key enabler of employee engagement; this data will help guide efforts to enhance recruitment and retention and mitigate the prevalence of burnout.

GP workload and morale

In our written evidence for the 2026 to 2027 pay round, we provided insights from the 12th iteration of the [National GP Worklife Survey](#), published in July 2025. The 13th iteration of this survey, commissioned by DHSC and carried out by a team based at the University of Manchester, on behalf of the National Institute for Health Research's (NIHR) will be carried out in the Autumn of 2026 so we cannot provide fresh insight from that survey in this year's written evidence.

The GMC's The State of Medical Education and Practice in the UK: Workplace Experiences (2026) report found that consistent with recent years, GPs were the least likely doctor group to be satisfied. They were also more likely than other doctor groups to cite high workloads as a reason for dissatisfaction (50% compared with 32% of all doctors surveyed). GPs were however the most likely doctor group to report recent improvements in their workplace. Over a third of GPs (37%) noted at least one positive change.

National education and training survey (NETS)

In 2025, 43,618 health and care students, trainees and resident doctors and dentists in training responded to the [National Education and Training Survey \(NETS\)](#), representing all healthcare learner groups. Results across all indicator groups improved in 2025, including overall experience, bullying and undermining, teamwork, workload and wellbeing and reflect the work of NHS England Quality teams, the healthcare educator workforce, and education and placement providers to deliver high quality healthcare education and training.

Although improved, the results still describe a challenging situation for all healthcare learners. In 2025, 26% considering leaving their course or training programme, most because of stress, feeling overwhelmed and workload pressures. Among medical and dental undergraduate and postgraduate learners, 14.2% reported experiencing bullying and/or harassment, compared to 13.2% for all healthcare learners, and 16.11% reported witnessing it compared to 15.4 overall. Of those who experienced or witnessed bullying or harassment, 20.13% reported the incident to their placement provider, training post provider or education institution, compared with 29% across all healthcare learners. Continued action to support learner experience is important to support improved learner outcomes, patient experience and the retention of learners and subsequent NHS workforce.

From 2021 to 2025 there has been an upward trend in the number of learners reporting a positive experience in several areas including:

- overall educational experience 88% (84% in 2021)
- overall quality of supervision 90% (87% in 2021)
- induction 87% (83% in 2021)
- range of learning opportunities 88% (84% in 2021)
- ability to learn from other professions 90% (87% in 2021)
- access to health and wellbeing resources 77% (72% in 2022)
- 58% of learners reported that the balance between learning and workload had a negative impact on their education and training in 2025, which is a slight improvement on 2024 (59%)

NHS England continues to work with placement providers, through the standards set out in the NHS Education Quality Framework, to understand the concerns around workload and take actions to improve. NHS England:

- continues to see improvements in the number of learners feeling able to access support from a local Freedom to Speak Up Guardian from 50% in 2021 to 78% in 2025. Overall, 95% of learners know how to raise concerns in their placement or education organisation with 84% feeling comfortable to do so
- measures indicate that 76% of learners would recommend their placement area to friends and colleagues as a place to work or train. This measure has steadily improved since 2021 and has now exceeded pre-pandemic levels of 74% in 2019
- statistics on the number of learners that would recommend their placement area to family and friends if they should require the care or treatment provided there has also improved in 2025 to 79% (78% in 2024)

Staff standards

The 10 Year Health Plan set out plans to introduce a series of staff standards for modern employment. These have now been published and were developed in close partnership with the Social Partnership Forum (SPF) to ensure they reflect the issues that matter most to staff.

The standards aim to ensure that there is greater consistency in staff experience across the NHS and that it is prioritised at board level. The NHS Staff Survey results for 2025 showed that there are still issues with levels of morale and staff engagement where there has been significant improvement so we know there is much more to be done to shape workforce culture in the NHS.

The standards will be an important tool in addressing this and will complement existing initiatives, such as the People Promise, and provide a framework to measure the progress of employers. A key point of difference from what's gone before is that the standards are mandatory and will be measured, initially through the [NHS Oversight Framework](#) which includes a headline composite metric on delivery against the standards for 2026 to 2027. The standards have also been incorporated in the Provider Capability Assessment and the next phase of work will look at further embedding the standards in assurance processes. This will ensure much stronger Board accountability for staff experience. There are 6 staff standards:

1. health and Wellbeing (prevention, occupational health and wellbeing support).
2. effective line management (ensuring appropriate support for line managers).
3. promoting flexible working.
4. preventing and reducing violence against staff.
5. championing sexual safety.
6. tackling racism.

Health and wellbeing

The health and wellbeing of the NHS workforce remain a key priority in the 10 Year Health Plan, reflecting the relationship between staff wellbeing, productivity and patient outcomes.

There are still challenges with sickness absence with the overall NHS sickness absence rate of 5.43% in February 2026, compared to 4.45% in February 2018. However, HCHS doctors continue to report comparatively low sickness absence rates (2.11% in February 2026) (source: [NHS Sickness Absence Rates February 2026](#)). Data from the NHS Staff Survey, available at the NHS Staff Survey results page, shows a small reduction in the proportion of respondents reporting work-related stress for medical and dental staff (41.08% in 2025, down 1.1% from 2024), but overall levels remain high.

NHS England's national programmes continue to focus on the development of health and wellbeing standards. [The Growing occupational health and wellbeing together strategy](#) continues to support the expansion of integrated, multi-professional occupational health and wellbeing services across NHS organisations. In 2025, the [Workforce Wellbeing Programme](#), in partnership with NHS Charities Together and NHS England, commenced and has funded 61 local initiatives to improve health and wellbeing for all staff groups. These have included: a focus on the impact of shift work, fatigue risk management and the provision of mental health support for clinicians experiencing trauma. Further programmes are being developed in each region to focus on the specific needs of their staff.

Work on the development and investment of Staff Treatment Hubs is underway. These regional treatment centres will focus on the mental health and musculoskeletal problems faced by staff with an expected roll out commencing 2027 to 2028.

10 point plan to improve resident doctors' working lives

The [10 Point Plan](#) was published in August 2025. The purpose of the 10 Point Plan is to fix unacceptable working practices and get the basics right for resident doctors. As part of the 2026 deal, we have committed to look for ways to enhance and go further on the 10 Point Plan.

There has been progress made across several elements of the plan including the following:

Lead employer arrangements

As set out previously, NHS England is progressing a national programme, in partnership with KPMG, to develop a comprehensive and financially sustainable approach to expanding Lead Employer Model (LEM) coverage across the resident doctor workforce.

Since last year's submission, further progress has been made through continued development work and close joint working between DHSC and NHS England to support the advancement of the model.

Payroll improvement programme

As set out in our evidence submission last year, resident doctors experience a disproportionate level of payroll errors, in part due to frequent rotations between employers. NHS England launched a Payroll Improvement Programme in June 2024, initially across 31 trusts, with early results reported last year. Since then, the programme has been expanded to all NHS trusts in England following the publication of the 10 Point Plan. It now supports ongoing national monitoring of payroll performance, with a continued

focus on improving accuracy, strengthening oversight, and embedding sustained system-wide improvements.

Reform of exception reporting processes

As set out in last year's evidence, reforms of the exception reporting system were agreed under the 2024 pay deal. Implementation has now been completed, with the revised system and contract in place across all trusts in England from February 2026. A programme of national data collection will take place over a 2 year period from July 2026 to monitor the impact of these changes, with a formal review to follow at the end of this period.

Trust leadership

Trusts across the NHS have continued to report progress in improving the working lives of resident doctors, building on the position set out in last year's submission. Local initiatives remain focused on improving working environments, including making enhancements to facilities such as doctors' messes, on-call rooms and parking, alongside wider work to improve staff experience and wellbeing. As previously reported, trusts were asked in 2024 to appoint a nominated resident doctor lead to support the identification and escalation of issues. This arrangement has largely been sustained, with resident doctor leadership roles now embedded within organisational governance structures, reporting directly to trust boards and supporting ongoing oversight of resident doctor workforce issues.

Trusts are expected to continue using a combination of national and local data sources, including the [General Medical Council National Training Survey](#) and [Guardian of Safe Working reports](#), to inform board-level consideration of resident doctor workforce issues. They should also strengthen local governance arrangements, including developing improvement plans with the same level of rigour applied to staff survey responses and maintaining a Board Assurance Framework that incorporates resident doctor workforce considerations, with appropriate oversight and accountability reflected in annual reporting.

Study leave and upfront payment of course fees

Early reimbursement arrangements are now embedded across the system, with trusts supported to reimburse resident doctors at the point of course booking, rather than following attendance. This approach is intended to remove financial barriers to participation and improve timely access to training opportunities.

Targeted work is also underway with several specialty pilots to streamline approval processes for commonly undertaken courses that align with curriculum requirements. Learning from these pilots will inform potential wider roll-out.

In addition, collaborative work with the Joint Committee on Surgical Training (JCST) has enabled the development and approval of a series of practical 'boot camp' training programmes for resident doctors in surgical specialties. This is supported by a complementary e-learning offer delivered through the NHS Postgraduate Virtual Learning Environment (PGVLE) platform, ensuring alignment with curriculum requirements and improving accessibility of training provision.

Statutory and mandatory training reform

A longstanding challenge for resident doctors has been the repeated completion of core statutory and mandatory training when rotating between employers, even where compliance remains valid. This duplication creates administrative burden and reduces time available for training and service delivery. To address this, a national reform was introduced on 1 May 2025, with 262 NHS organisations in England, including all provider trusts, ICBs and most national bodies, signing a Memorandum of Understanding (MoU) to accept prior training aligned with the Core Skills Training Framework (CSTF). This includes 11 CSTF subjects as well as Learning Disabilities and Autism training. The position remains unchanged, with the MoU continuing to support portability of training across organisations for resident doctors and the wider workforce.

This reform has reduced unnecessary repetition, with an estimated 6,000 hours of resident doctor time redirected to patient care each month and supports a more consistent and efficient approach to workforce development. Further progress has been made through a comprehensive review of nationally mandated training. A new national skills framework is in development and will replace the CSTF, alongside new assessments of competence and updated learning materials, to be introduced across the workforce from April 2027. This will represent a significant shift in approach, moving from repeated completion of standardised e-learning, towards a model focused on demonstrating core competencies at defined intervals, supported by targeted updates and refresher learning.

10 point plan implementation progress

Since the 10 point plan's publication, progress has continued in addressing long-standing issues affecting resident doctors, with most commitments now delivered or on track. Key achievements include improved workplace wellbeing, with 167 of 189 trusts reporting enhancements to facilities, all trusts appointing a board-level lead for resident doctors, Resident Doctor Peer Lead coverage increasing from 32% to 98%, and 80% of trusts appointing dedicated non-executive directors for resident doctors.

At a national level, improvements include publication of minimum standards for annual leave, reduced duplication of statutory and mandatory training, introduction of a national exception reporting framework, a 94.8% reduction in resident doctor payroll errors by

March 2026, and faster study leave expense reimbursement in 98% of trusts. Further work is underway to improve rota transparency, test rotation reform pilots and further progress the Lead Employer model. The next phase of the programme will focus on embedding changes.

Violence prevention and reduction (VPR)

Violence against NHS staff remains a significant issue. The 2025 NHS Staff Survey indicates that 14.47% of staff experienced physical violence from patients, service users, relatives or the public in the previous year, the highest level in 3 years. For doctors and dentists, 15.8% reported experiencing at least one incident of physical violence from patients, relatives or members of the public in the previous 12 months. (source: NHS Staff Survey 2025).

We have been working with the SPF to implement the 2023 AfC non-pay agreement recommendations, to protect all staff from violence and abuse, including, mandatory implementation of the Violence Prevention and Reduction (VPR) Standard across all NHS trusts from April 2026. Additional Measures include improvements to data and guidance for staff, and the development of the Staff Standard for VPR.

Flexible working

Doctors and dentists report the lowest levels of satisfaction with flexible working experience across all staff groups and this is reflected across multiple indicators. (source: NHS Staff Survey 2025). At a national level, based on aggregated NHS Staff Survey results, the overall flexible working score for medical and dental staff ranges from 5.06 (out of 10) to 6.03, compared to nurses at 5.63 to 7.07 and the all-staff average of 6.3. Doctors and dentists tend to score lower than both nurses and the overall workforce.

Doctors and dentists report lower perceived opportunities for flexible working (37.76% to 57.10% compared to 48.35% to 71.80% for nurses and 57.66% overall), lower confidence in approaching managers to discuss flexible working (47.05% to 63.75%, compared to 67.27% to 83.61% for nurses and 71.75% for all staff), and weaker perceptions of organisational support for work-life balance (29.03% to 44.91%, compared to 33.83% to 62.31% for nurses and 49.77% overall). Together, this suggests that barriers to flexible working relate not only to implementation but also to availability, access and organisational culture.

There is also variation by organisation type. Work-life balance scores are lowest in acute settings (34.5%), higher in community (51.1%) and ambulance services (56.1%), and

intermediate in acute specialist (40.2%) and mental health and learning disability settings (46.8%).

To support more consistent delivery and realise the productivity benefits of flexible working, NHS England and DHSC have worked together to develop a staff standard on flexible working, aimed at encouraging organisations to adopt a more flex by default culture. NHS England has also supported partners to develop guidance and tools that promote wider access to flexible working, alongside targeted support on the use of e-rostering to help improve flexible working opportunities for frontline staff in 24/7 services. In addition, NHS England has partnered with NHS Employers to create a flexible working campaign and support hub, raising awareness and helping organisations embed the benefits of flexible working.

Equality, diversity and inclusion (EDI)

Published in June 2023, the [NHS equality, diversity and inclusion improvement plan](#) remains the main mechanism for strengthening EDI across the NHS. A series of online engagement events were held in 2026, seeking feedback from EDI and HR leads to hear their experience of delivering the EDI Improvement Plan and gain their insight as we shape the direction of travel and policy for future developments in EDI.

In addition, and as referenced earlier, 6 Staff Standards (which currently apply to secondary care only), were launched in July 2026 and set the required minimum national standard for employment across a range of areas, aimed at improving staff experience. One of the standards focuses specifically on tackling racism. It sets the expectation that organisations should take sustained and meaningful action to prevent all instances of racism and discrimination in the NHS workplace. The standards are mandatory and employers' performance against them will be assessed through the NHS Oversight Framework and wider assurance arrangements.

Harassment and bullying remain a significant concern across the NHS. 9.1% of staff reported experiencing harassment or bullying from managers and 17% from colleagues in the last 12 months, a slight decrease from 2024. For doctors and dentists, the picture remains challenging. 12.02% reported experiencing harassment from managers compared to 9.1% across all staff and their overall reported harassment rate stands at 27.9% (Q14a) compared to 25.3% across all staff. This is a gap that points to a consistently less favourable workplace experience for this group. Tackling violence, racism and sexual harassment will be reflected in the new staff standards, due to be launched in summer 2026 (Source: NHS England Staff Survey).

This year's WRES data shows that Black and Minority Ethnic (BME) medical and dental staff are more likely than white staff to experience harassment, bullying or abuse from colleagues (27.3% compared with 21.3%) and continue to face disparities in career progression and representation at senior leadership. Only 49.6% of BME staff report equal opportunities for progression or promotion, compared with 59.1% of white staff, and BME staff hold 14.1% of senior and very senior roles compared with 82.9% held by white staff. Alongside the introduction of the staff standards, NHS England continues to address these issues with an Educator Workforce Programme and inclusive pedagogy work, which includes toolkits and e-learning on inclusive leadership and cultural awareness, and aims to support fair progression, retention and more equitable care (source: [NHS England Workforce Race Equality Standard: 2025 data analysis report for NHS trusts](#)).

In October 2025, the former Prime Minister and Health Secretary asked Lord John Mann to conduct a rapid review into antisemitism and other forms of racism in the NHS following recent incidents of antisemitism from doctors, which drew attention to the problems of culture and regulation in the health system. In June 2026 the recommendations from the Lord John Mann review into antisemitism and other forms of racism in the NHS were accepted. Work between NHS England and DHSC is now underway on the implementation of his recommendations. NHS England wrote to organisations immediately after this announcement requesting that action was taken to tackle racism including antisemitism in the NHS.

In March 2026, a non-statutory definition of anti-Muslim hostility was announced by the government to provide clarity and consistency in understanding and responding to anti-Muslim hostility. The government is encouraging the adoption of this definition across the public, private and third sectors with NHS England requesting that NHS organisations also adopt this definition.

Ethnicity pay gap reporting

In July 2025, the NHS Race and Health Observatory (RHO) commenced an independent and comprehensive review of ethnicity pay gaps across the NHS. The review is scheduled for completion in December 2026 (source: [Observatory commissions review into NHS Ethnicity Pay Gap](#)).

Gender pay gap

The ONS reports the gender pay gap among full-time employees in the UK fell to 6.9% in April 2025, down from 7.1% the previous year. For part-time employees, the gap remained in favour of women at minus 2.9%, a slight change from minus 3.0% in April 2024. The

overall gender pay gap across all employees continues to be higher because women are more likely to work in part-time roles (source: [Gender pay gap in the UK 2025](#)).

Within the medical workforce, the Office for National Statistics reports notable variation in the gender pay gap, based on median gross hourly earnings (excluding overtime). Female Medical Practitioners earn 7.5% less than male colleagues, female Specialist Medical Practitioners (which includes consultants, SAS doctors and some speciality trainees) earn 9.2% less, while female Generalist Medical Practitioners (which includes GPs) earn 0.7% more than male colleagues.

NHS England also publishes data on gender and ethnicity pay gaps specifically for NHS staff which can be split in various ways including by staff group and grade. It shows that while a gender pay gap exists across the entire medical workforce, differences in basic pay per full-time equivalent are largely driven by differences in staff distribution across medical grades with smaller differences visible after accounting for this (source: [NHS Staff Earnings Estimates, April 2026 \(including supplementary analysis on pay by ethnicity\)](#)).

Gender pay gap in medicine review

The Gender Pay Gap in Medicine Implementation Panel continues to meet regularly, bringing together relevant stakeholders to oversee progress against the recommendations set out across the 7 themes identified by Professor Dame Jane Dacre. There continues to be progress with the introduction of the staff standards, 10 Year Health Plan and the implementation of the recommendations emerging from the [Medical Education Training Review](#) (chaired by Professor Dame Jane Dacre). In Summer 2026, an analysis of the latest ESR data will be undertaken and will establish how the changes to the consultant contract, reforms to National Clinical Impact Awards, and wider culture changes are impacting on the gender pay gap in medicine. The data will be published towards the end of the 2026.

Gender and ethnicity pay gaps in general practice

The Independent Review into Gender Pay Gaps in Medicine identified a wider gender pay gap among salaried GPs compared to HCHS doctors, clinical academics and contractor GPs. [Table 14 of the GP Earnings and Expenses Estimates, 2022 to 2023](#) provides the most recent available data, comparing pay per head for men and women salaried GPs and contractor GPs in the same age bracket. However, from the [GP Earnings and expenses estimates, 2022 to 2023](#) has limitations and accurate conclusions cannot be drawn from it. Comparing pay per FTE would give a better picture of the gender pay gap for salaried GPs, given the difference in average working hours between male and female salaried GPs.

The 2024 to 2025 GP Earnings and Expenses Estimates break down earnings by gender and ethnicity, showing variation between groups. However, the published figures do not control for differences in working patterns.

Since 2023, NHS England has published [quarterly data on ethnicity of GPs by job role](#).

Chapter 5: remit groups

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

Resident doctors

In March 2026, approximately 69,900 resident doctors were recorded in postgraduate training programmes in England, equivalent to around 64,700 whole-time equivalents (WTE), including doctors undertaking approved training extensions and those in a period of grace following completion of training requirements (source: NHS England, Trainee Information System). Data from 2026 shows that the NHS employs approximately 1.4 million Full Time Equivalent (FTE) staff, including around 153,000 FTE qualified doctors (an increase of 3.8% compared to last year).

In 2026, resident doctors' salary scales were increased by 3.5%, from 1 April 2026 in line with the DDRB's recommendation. Following the acceptance of an offer made by the government to the British Medical Association Resident Doctor Committee (BMA RDC) in June 2026, resident doctor pay is being reformed. This means some resident doctors, depending on their pay point, will receive an additional uplift in 2026 to 2027. NHS England also launched pilot schemes in August 2026 to reform the resident doctor rotational training system. Reform to the rotation system was part of the deal that ended resident doctor industrial action in 2024.

The BMA RDC took industrial action at various times between July 2025 and the agreement of a deal in summer of 2026. The full details of the Deal agreed with the BMA RDC, including pay scale reform which covers both 2026 to 2027 and 2027 to 2028, are set out in the offer document published online: [Government offer to resident doctors: June 2026](#)

Rotations Review

The Rotations Review was agreed as part of the 2024 pay deal between the government and the British Medical Association (BMA). As the review enters its closing stages, it has been incorporated as a dedicated workstream within the wider Medical Education and Training Review (METR). It responds to longstanding concerns from doctors in training about the impact of frequent rotations on wellbeing, continuity of care and workforce stability. These concerns, reflected in recent BMA survey evidence, include disruption to

personal lives, challenges for those with caring responsibilities or disabilities, and difficulties in building relationships with teams and patients arising from frequent moves between placements.

Findings from the diagnostic phase of the METR reinforce these concerns, with stakeholder engagement indicating that the current rotations model can undermine wellbeing, continuity and retention, particularly in rural and underserved areas. Emerging evidence also suggests that frequent rotations may disrupt continuity of training and contribute to challenges in progression, including increased periods of time out of training in some cases. (source: [The Medical Training Review: Phase 1 diagnostic report](#))

Disruption associated with rotations can limit opportunities to develop sustained clinical experience and integrate within teams, with wider implications for both training experience and service delivery. The review is therefore exploring how alternative approaches to rotations could improve stability while maintaining training quality.

The findings from the Rotations Review will be integrated into the next phase of the METR and wider work on postgraduate medical training. This will support broader reform ambitions set out in the 10 Year Health Plan, including improving training experience, supporting progression and strengthening workforce stability.

We are taking forward a number of other reforms to postgraduate medical education and training, including the METR and changes to the Foundation Programme. These reforms are relevant to resident doctors and are discussed in detail in Chapter 3.

Locally employed doctors (LEDs)

Locally employed doctors are doctors employed by NHS organisations on local contracts rather than nationally negotiated terms and conditions. LEDs span a range of grades and specialties, with some working in roles comparable to resident doctors and others undertaking duties comparable to SAS doctors.

As set out in previous evidence, centrally held data on LEDs remain limited, reflecting variation in Electronic Staff Record (ESR) coding across employers, which constrains the precision of estimates. The analysis below therefore uses ESR data to provide an indicative breakdown of the HCHS medical workforce by contract type for 2024 to 2025 and 2025 to 2026.

Table 6 indicates that, on average, around 10% of the HCHS medical workforce (FTE) were employed on 'trust grade' contracts in 2024 to 2025, which broadly corresponds to locally employed doctors. This proportion increased to approximately 11% in 2025 to 2026, indicating a continued, incremental growth in the LED workforce over the reporting period.

The deal agreed between the government and the BMA RDC sets out a range of measures for LEDs in relation to standardising and reforming terms and conditions. These are set out in Part 4 of the offer document: Offer to BMA UK resident doctors committee (June 2026).

Table 6: estimated HCHS medical workforce split by grade and contract status average for 2024 to 2025 and 2025 to 2026

Role	2024 to 2025 estimated FTE	2024 to 2025 estimated FTE share	2025 to 2026 estimated FTE	2025 to 2026 estimated FTE share
Consultants (open contracts)	57,845	40%	60,139	40%
SAS - specialist contract (open contracts)	1,255	1%	1,586	1%
SAS - specialty contract (open contracts)	5,811	4%	6,954	5%
Resident doctor - 2016 contract (open contracts)	50,591	35%	53,146	35%
Resident dentist - 2016 contract (open contracts)	326	0%	351	0%
Closed grades all doctors on old TCS	13,246	9%	11,409	8%
Trust grades (LEDs)	14,763	10%	16,689	11%
Other	29	0%	27	0%

The new Locally Employed Doctor (LED) Career Progression Pathway model introduces a structured, competency-based approach to career development, enabling LEDs to progress through defined stages by evidencing achievement against Royal College curricula. It will be delivered through a trust-led model where progression is assessed annually via a standardised progression panel process, while maintaining flexibility to reflect service delivery needs and local workforce priorities. Collectively, it provides a scalable and equitable mechanism to improve progression, retention, and productivity within the LED workforce. It is anticipated that the programme will go live in Autumn 2026.

The NHS England co-produced with LEDs and stakeholders, sets out targeted high-impact actions to improve LED career development and support. This position is unchanged from

2026 to 2027. Regional LED Associate Deans continue to be funded to support trusts to deliver the Blueprint's high-impact actions.

Speciality, associate specialist and specialist doctors (SAS)

The SAS workforce has continued to expand steadily over the long term, with headcount increasing from 10,327 in March 2010 to 14,967 in March 2026. This represents growth of approximately 45% over the period, reflecting sustained increases in SAS participation within the HCHS medical workforce. In HCHS across all organisations in March 2026, resident doctor grades (over 48%) and consultants (around 40%) made up the majority of the medical grade headcount (source: NHS England Workforce Data, March 2026).

Growth has been broadly linear, without the more uneven patterns observed in other medical grades. This suggests that expansion of the SAS workforce has been driven primarily by incremental service demand and ongoing workforce supply, rather than discrete policy interventions or large-scale programme expansion.

More recent trends show continued growth in SAS numbers. Between March 2025 and March 2026, the SAS headcount (Associate Specialist, Specialty Doctor, Staff Grade) in HCHS across all organisations increased from 14,224 to 14,967 (an increase of over 5%) (source: NHS England Workforce Data, March 2026). This indicates that SAS roles continue to contribute to meeting short-term workforce pressures, although the rate of increase remains moderate in the context of overall workforce expansion. The SAS workforce therefore represents a stable and important component of the medical workforce, providing continuity and flexibility in service delivery. By contrast, other medical grades (Hospital Practitioner, Clinical Assistant, and other HCHS Doctor Grades) show a decrease in recent years, whilst training grades (Core Training, Foundation Year 1, Foundation Year 2, Specialty Registrar) and consultants have shown consistent growth.

Pay and conditions

Salary scales for SAS doctors increased by 6% in April 2024, 4% in April 2025, and 3.5% in April 2026 (in line with DDRB recommendations). These uplifts apply to doctors on the 2021 specialty doctor and specialist contracts, as well as those on legacy SAS contracts, including specialty doctor (2008), associate specialist, staff grade, and senior clinical medical officer roles.

2024 SAS deal

Since the previous submission, implementation of the 2024 SAS Pay and Reform deal has concluded. As previously reported, the offer introduced uplifts to 2021 contract pay points to address pay scale compression, alongside a £1,400 consolidated uplift for doctors on

pre-2021 contracts. The Joint Negotiating Committee for Specialty and Specialist Doctors, JNC (SAS), co-chaired by the BMA and NHS Employers, is responsible for negotiating pay, contracts and career progression for SAS doctors. Since the previous submission, the SAS Deal Implementation Group, established in August 2024 as a time-limited subgroup of JNC (SAS), has completed its role and has been closed. Ongoing oversight will now transfer to JNC (SAS), which is being re-established.

New contracts

A key output of the SAS Deal Implementation Group was the development of transfer guidance to support locally employed doctors (LEDs) to move onto SAS contracts. The SAS Eligibility and Permanency Framework, for which guidance was published by NHS Employers in June 2026, enables eligible LEDs working substantively in NHS trusts to transfer to SAS contracts, subject to meeting the relevant professional requirements.

In 2025 to 2026 71% of the specialty doctor workforce, over 6,900 out of over 9,800 FTE are now on the new 2021 contract, an increase of 8 percentage points from 2024 to 2025 (source: sub-group metrics).

Specialist grade

The specialist grade provides a structured progression route for experienced SAS doctors, aligned with service need and filled through open recruitment. The 10 Year Health Plan maintains the policy direction to develop a more streamlined and predictable pathway into specialist roles.

Headcount data as of March 2026 shows there are a total of just over 1,900 specialist doctors on the 2021 contract. In the 24 months to March 2026, the number of specialist doctors (2021 contract) increased on average by around 30 each month (approximately a 2% headcount increase each month on average). Since April 2021 around 40% of all specialist doctors (2021 contract) were on one of the 2 specialty doctor contracts (2008 and 2021) the month before they transferred and around 7% were on the Associate Specialist grade the month before they transferred. Due to data limitations, previous contracts have only been identified for roughly three-quarters of specialists (source: Bespoke ESR analysis by NHS Employers).

As part of the 2024 SAS deal, DHSC commissioned a piece of research to understand why more specialist roles are not being created. Consideration of the findings will be the responsibility of the Joint Negotiating Committee (SAS) once re-established. DHSC is holding ongoing discussions with the BMA SAS Committee on ways to ensure a more streamlined and predictable pathway is in place for experienced specialty doctors to develop and operate at a specialist level.

Supporting the career development and progression of SAS doctors

Concerns around opportunities for career support and development have consistently been raised by SAS doctors over a number of years. As mentioned above, this was the impetus for introducing the specialist grade in 2021 and the commitment to improving SAS development is reiterated in the 10 Year Health Plan. Since our previous submission, SAS development guidance was published and is now available online. The guidance has been revised to strengthen support for SAS doctors' career progression, including by clarifying the use of the acting-up provisions in the terms and conditions for specialty doctors undertaking specialist-level roles.

To further support career development for SAS doctors, NHS England have launched progression panel pilots in 3 NHS trusts (North West, West Midlands, and Yorkshire and the Humber) to better recognise specialty doctors already working at specialist level and to support equitable career progression.

The SAS Excellence in Development (SEiD) Award

The [SAS Excellence in Development \(SEiD\) Recognition Award](#) has been developed to incentivise trusts and employers to support their SAS doctors to have a better professional experience, by improving equitable promotion and ensuring options for career diversification and development. It incentivises trusts to improve progression pathways, development opportunities, and career support for SAS doctors.

The SEiD Recognition Award is awarded in the form of a 'digital badge', with 3 levels of award available (Gold, Silver and Bronze). Trusts who can demonstrate their excellence in developing and supporting SAS doctors will be able to advertise themselves as such with one of the 3 levels of award. Trusts will be able to reapply for a higher level of award in subsequent application rounds, provided they are able to demonstrate significant improvements against the agreed criteria. The criteria on which trusts will be measured against has been co-designed, developed and agreed through extensive engagement with SAS doctors, NHS England, Academy of Medical Royal Colleges, GMC, BMA and employers.

The SEiD award opened in January 2026, with the first awards announced in July 2026.

SAS Week

SAS Week is an annual event which is a collaboration between NHS Employers and the BMA to celebrate the work of specialist, associate specialist and specialty doctors. In 2025, SAS week took place from 6 to 10 October 2025 and DHSC actively supported the event with the then Secretary of State issuing a dedicated social media message marking SAS Week and recognising SAS doctors as the engines of delivery across hospitals,

clinics and community settings. The message highlighted the vital contribution SAS doctors make to patient care, their diverse skills and backgrounds, and the government's commitment to ensuring SAS doctors are recognised, valued and supported within the NHS. SAS Week 2026 will take place between 5 to 9 October.

Consultants

NHS consultants are senior doctors who have completed full medical training in a specialised area of medicine and are listed on the GMC's specialist register. Since the year 2022 to 2023, the number of consultant FTEs in NHS trusts and core organisations has grown by 11.5%, from an average of around 53,800 in 2022 to 2023 to an average of 60,000 in the year 2025 to 2026.

Contract reform

The consultant contract dates back to 2003 and despite reforms as part of previous deals, it remains significantly out of date. The government has indicated that it is prepared to explore the reform of the contract to ensure that it better reflects present and emerging ways of working for senior doctors. Over the past 6 months we have worked with trade unions, NHS Employers and NHS England to review the consultant contract and identify possible areas for change. This work is in early stages, and we have not yet reached consensus on priorities for change.

DHSC has instructed NHS Employers to reestablish a Joint Negotiating Committee (JNC) for consultants for the first time since 2013. This would support maintenance of the contractual terms and conditions and provide a regular forum for discussions between employers and staff side. Progress on the reestablishment of JNC Consultants was postponed due to the BMA industrial action ballot.

2024 pay deal

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

While it is not possible to isolate the effect of the 2024 reforms from that of wider pay awards and labour market factors, the reforms have delivered faster progression to the top of the pay scale, increased basic pay at all career stages, and modernised several aspects of consultant terms and conditions.

Table 7: consultant basic pay uplifts between 2022 to 2023 and 2026 to 2027 and the 2024 pay deal

	2022 to 2023	2023 to 2024	Additional pay agreement	2024 to 2025	2025 to 2026	2026 to 2027
Basic pay	4.5%	6.0%	Average increase to Basic Pay of around 4.95%*	6.0%	4.0%	3.5%

* Funded through mixture of new investment (around 3.45%) and closure of old or Local Clinical Excellence Awards (around 1.5%)

For the 2024 pay deal specifically, there were differential impacts depending on someone's experience at the time the deal was agreed.

Table 8: impact of the 2024 consultant pay deal on basic pay, earnings and future progression by career stage

	Basic pay impact	Earnings impact	Future progression
New or Early career (0 to 5 Years)	Starting pay increased by 6.3%	No new local clinical excellence awards	Faster progression to top of scale (14 years v 19)
Mid-career (6 to 14 Years)	Basic Pay increase of just under 3% (4 to 7 years) or over 5.8% (9 to 13 years) with transfers to new pay points	No new local clinical excellence awards	Faster progression to top of scale (14 years v 19)
Experienced (14 to 19 Years)	Transferred to top of scale (10.6% rise)	No new local clinical excellence awards. Pre 2018 and national awards remain	No further progression - moved to top
Already at top of Scale	Basic pay increased by 4.5%	No new local clinical excellence awards. Pre 2018 and national awards remain	None - Already at top of scale

Consultant burnout

The results of the inquest into the death of Dr Naeem Ahmed have rightly raised concerns over consultant workloads and professional burnout alongside the balance of private and NHS work.

The NHS Staff Survey indicates a gradual improvement in consultant burnout with the proportion of consultants saying they are “always” or “often” burnt out, reducing from about 31% in 2021 to about 28% in 2025. In order to build further on this trajectory, the department is working with trade unions to establish how to improve consultant working conditions.

Clinical academics

The UK benefits from a world-class research environment, with clear evidence of both health and economic value. However, a critical workforce gap remains as growth in the research-active workforce, and in the number of clinical research leaders, has not kept pace with the expansion and increasing complexity of health services.

Clinical academics play a central role in addressing this gap. They provide research leadership across the health system, generate evidence to support service transformation and the adoption of new interventions, and contribute expert advice nationally. Sustaining and growing this workforce is therefore essential to maintaining the UK’s research capability and ensuring that innovation translates into improved patient care.

The Office for Strategic Coordination of Health's commissioned report sets out challenges facing the clinical academic workforce. Over the last decade, the number of clinical academics has fallen by 6%, including a 24% fall at senior lecturer level. The workforce is also ageing: 35% of clinical academics are now aged over 55, rising to 63.7% among medically qualified professors. Relative to the growth of the NHS workforce, this decline is more pronounced, indicating that clinical academic capacity is not keeping pace with the expansion of health services. The proportion of academic GPs remains critically low, making up less than 0.7% of the overall GP workforce (source: [UKRI Clinical researchers in the UK: reversing the decline](#))

Without corrective action, these trends are likely to continue. The report makes a series of recommendations to address the decline in the proportion of medically qualified NHS staff pursuing clinical research careers. These include establishing a national career framework, enabling more flexible training pathways, strengthening visible leadership, supporting equitable pay, and ensuring fair approaches to performance evaluation. The government has committed, through the 10 Year Health Plan, to reversing the decline in clinical academic roles.

Progress against the recommendations includes mapping and streamlining career funding opportunities as well as launching the new Clinical Future Leaders Fellowship awards by NIHR, UK Research and Innovation, Cancer Research UK and the British Heart Foundation.

DHSC, through the National Institute for Health and Care Research (NIHR), is the UK's largest funder of clinical academic training. NIHR provides comprehensive research career pathways for clinicians across all career stages, from undergraduate level through to professorial appointments.

The NIHR Academy is responsible for the development and coordination of NIHR academic training, career development and research capacity-building. Since 2006, NIHR has supported more than 14,500 clinical and non-clinical academics across more than 200 professions, through over 18,000 career development awards. Overall, NIHR invests more than £230 million each year in research training programmes.

The NIHR Integrated Academic Training (IAT) Programme funds clinical academic training for doctors and dentists through Academic Clinical Fellowships (ACFs) and Clinical Lectureships (CLs); 278 medical and 23 Dentistry ACFs as well as 120 medical and, 11 Dentistry CLs each year, costing £97.7 million in 2026 to 2027.

Table 9: numbers of active NIHR Academy award holders by award level, as of June 2026

	Number of award Holders	Number of medically qualified award holders	Number of dentist award holders
Predoctoral	1973	836	49
Doctoral	1055	265	9
Postdoctoral	1105	630	22
Chair	52	39	0
Senior Investigators	201	119	2

National clinical impact awards

The reformed National Clinical Impact Awards (NCIA) scheme was introduced in 2022 to broaden access to national awards, improve fairness, and increase diversity among applicants and award holders. The reforms, informed by a 2021 public consultation, DDRB recommendations and wider evidence including the Gender Pay Gap in Medicine Review, increased the number of awards available and removed barriers such as the pro-rating of awards for less than full-time (LTFT) applicants.

The 2025 award round saw an increase in applications. This was largely driven by the significant number of National Clinical Excellence Awards (NCEAs) awarded in 2021 that were due to expire in 2026 and therefore required award holders to reapply. There was also an increase in applications from consultants who did not currently hold a national award, which may have reflected both the closure of the Local Clinical Excellence Award scheme in 2024 and increased stakeholder engagement activity following the lower number of applications received in 2024.

Equalities data

The Advisory Committee on Clinical Impact Awards (ACCIA) publishes annual reports summarising the equalities data collected from applicants. Since the introduction of the reformed scheme in 2022, the application portal has collected information across all 9 protected characteristics defined in the Equality Act 2010. All diversity information is self-reported, and applicants can choose not to disclose any characteristic (source: [ACCIA annual report for the 2025 awards round](#)).

4 full award rounds have now been completed under the reformed scheme, allowing ACCIA to assess progress against its inclusivity objectives. Overall, the data suggest that the reforms have helped broaden participation in the scheme. The proportion of female applicants has increased significantly, reaching 35.2% in 2025 compared to 27.4% in 2021.

The 2025 award round saw a reduction in success rates for women and ethnic minority applicants compared to 2024. Female success rates decreased from 49.0% in 2024 to 23.7% in 2025, while success rates for ethnic minority applicants decreased from 38.7% to 23.2%. This is likely to reflect the impact of the unusually high number of existing NCEA holders reapplying ahead of their awards expiring in 2026. Historically, this cohort has been less diverse than the wider consultant population and therefore was expected to impact on the overall applicant pool and award outcomes for the year.

Longer-term trends remain encouraging. Among applicants without an existing NCEA, female success rates continue to exceed those of male applicants, maintaining the pattern seen since the introduction of the reformed scheme in 2022. In addition, the proportional difference between success rates for white and ethnic minority applicants has closed. Since 2022, an average of 39.5% of successful applicants have been women (28.3% in 2021) and 34.2% have been from ethnic minority backgrounds (24.4% in 2021). We have also seen increased participation from earlier-career consultants, with applicants aged 35 to 44 achieving an average success rate of 27.8% (5.7% in 2021).

ACCIA recognises that disparities remain and continues to work towards a scheme that attracts applications and grants awards that are representative of the wider consultant

workforce. As part of this work, ACCIA has undertaken a range of engagement activities to improve awareness and accessibility of the scheme. Examples include working with networks representing doctors from different backgrounds, engaging with professional societies and organisations and supporting stakeholder engagement through ACCIA's regional sub-committees.

Award values

The government accepted the DDRB recommendation to increase the value of National Clinical Impact Awards. The uplift has been backdated to 1 April 2025.

Table 10: National Clinical Impact Award (NCIA) values before and after the 2025 uplift

NCIA Level	Award value (2022 to 2025)	Award value from 1 April 2025
Level 1	£20,000	£21,000
Level 2	£30,000	£31,500
Level 3	£40,000	£42,000

General medical practitioners (GPs)

The DDRB provides recommendations on the minimum and maximum pay range for salaried GPs and earnings uplifts for contractor and salaried GPs.

Clinical educators make an important contribution to the education, training and development of the future medical workforce alongside their wider clinical responsibilities. NHS England and DHSC are aware of continuing concerns regarding recruitment and retention within parts of the educator workforce, particularly amongst GP trainers. Evidence and stakeholder feedback suggest that educator remuneration can influence recruitment and retention where educational roles compare unfavourably with alternative clinical opportunities. The GP Educator Pay Scale and GP Trainer Grant provide recognition for the additional responsibilities associated with educational roles. NHS England and DHSC therefore invite the DDRB to consider whether these arrangements continue to provide sufficient support for recruitment, retention and educator workforce sustainability, and whether a different uplift approach may be justified in light of workforce pressures affecting the educator workforce.

The government usually provides an increase to core funding for practices to allow the pay uplift to be passed on to salaried and contractor GPs. The additional funding will also allow general practice contractors to implement pay rises for other salaried general practice staff in line with the uplift in funding they receive. As self-employed contractors to the NHS, GP practices make decisions on how to distribute pay and benefits to staff based on their own

financial circumstances. DDRB recommendations, therefore, inform GP practice decisions about the pay of their salaried GPs and other practice staff.

Most GP partners work under General Medical Services (GMS) contracts as independent contractors. They are self-employed or members of partnerships running their own practices as small businesses. In 2024 to 2025, there were 1,475 Personal Medical Services (PMS) contracts (23.1% of all contracts). Any uplifts in investment for PMS contracts are a matter for local commissioners to consider. In addition, a small number of GPs work, or hold contracts, under a locally contracted Alternative Provider Medical Services (APMS) arrangement across 332 practices (5.2% of all contracts) (source: [NHS Payments to General Practice, England 2024/25, Management Information](#)).

Table 11: Annual pay uplifts for salaried and contractor GPs, 2024 to 2025 to 2026 to 2027

Financial year	Salaried GP pay range uplift	Contractor GP (GMS/PMS) pay range uplift
2024 to 2025	6.0%	6.0%
2025 to 2026	4.0%	4.0%
2026 to 2027	3.5%	3.5%

Average earnings - income before tax per GP Earnings and Expenses Estimates (GPEE)

GPEEE

The [GPEEE](#) publication provides annual estimates of GP earnings and expenses and is a key source of information on GP income.

Table 12: Average income before tax for salaried and contractor GPs, England

Financial year	Salaried GPs - GPMS	Contractor GPs - GPMS
2023 to 2024	£72,200	£158,700
2024 to 2025	£74,800 (+3.7%)	£164,200 (+3.5%)

GP recruitment and retention

[General practice workforce data, June 2026](#) is published by NHS England. These workforce numbers are subject to fluctuations over the year, due to training and recruitment cycles. They are typically highest in September as a new cohort of GP trainees begin their training and gradually decline throughout the year. Comparisons of workforce data should take this into account and take a year-to-year view.

In last year's evidence, we showed that the GP workforce was growing over time, and it has continued this trajectory.

As of June 2026, there are 39,880 FTE doctors in general practice. This includes:

- 15,085 FTE GP partners
- 14,133 FTE salaried GPs
- 9,698 FTE GPs in training grade
- 278 FTE GP retainers
- 688 FTE GP regular locums

As independent contractors, practices are responsible for recruitment decisions.

As of May 2026, 2,300 individual GPs were currently in post via the Additional Roles Reimbursement Scheme, preventing them from graduating into unemployment and in turn increasing clinical capacity; we now have the highest number of fully qualified GPs since 2015. This figure reflects GPs recruited through the scheme and should not be added to the overall GP workforce figures presented above, as ARRS GPs are already included within those statistics (source: [Primary Care Workforce Recruited through the Additional Roles Reimbursement Scheme](#)).

Following feedback from the 2026 to 2027 GP contract consultation, we have introduced a practice-level GP reimbursement scheme to further address GP unemployment and underemployment. The reimbursement scheme ring-fences and repurposes £292m of funding from the current Capacity and Access Payment (CAP) and is available to practices to improve access in general practice by:

- hiring additional GPs
- funding additional sessions from existing GPs

- where the practice is a core member practice of a PCN, for the continuation of a salaried GP where the post was previously funded (and the funding has stopped, or will stop) through either: the PCN capacity and access payment or the PCN test sites programme

GP turnover and vacancies

Joiners and leavers

Longitudinal data tracking GPs in training into employment

NHS England publishes data showing [counts of GPs in ST3 training placements](#) recorded in the Trainee Information System (TIS) who transition into the fully-qualified general practice workforce, as recorded in the National Workforce Reporting Service (NWRS).

The aim is to gauge how many GPs who can be identified in General Practice Specialty Training placements subsequently take up fully qualified GP roles in traditional high street practices and PCNs, as well as the length of time it takes for them to do so. This publication is accompanied by a guidance note on the tracking methodology and interpretation, which should be read before attempting to interpret the figures.

Vacancies

NHS England publishes quarterly data on the [number of FTE General Practitioner roles advertised on NHS Jobs](#). As practices have freedom to advertise across different recruitment platforms, this should not be viewed as a full picture of recruitment across general practices in England; just recruitment using the NHS Jobs platform.

They relate only to jobs advertised by or on behalf of General Practices in England; adverts from other parts of the Primary Care health sector such as PCNs are not included in this release.

The first publication of this data was released in December 2025 and covers data from 1 April 2022 onward. The second release, which shows data from 1 April 2022 to 31 March 2026 was published in May 2026.

Advertised GP FTE shows a substantial decline from early 2022 to 2023 levels, followed by a partial recovery in 2025 to 2026. Levels fell from 918.9 in Q1 and 891.9 in Q2 of 2022 to 2023 to 647.9 in Q3, before a slight recovery to 716.0 in Q4. This downward trend continued through 2023 to 2024, dropping from 619.9 in Q1 to 404.8 in Q4.

In 2024 to 2025, levels remained lower overall, reaching a low of 340.1 in Q2 before increasing to 435.5 by Q4. In 2025 to 2026, advertised GP FTE recovered further to 524.7 in Q1, dipped slightly to 503.3 in Q2, and rose again to 523.2 in Q3.

A total of 710 advertised FTE were placed on the NHS Jobs service during Q4 2025 to 2026 for roles that could be identified as GPs, an increase of 63.0% on the same period last year, but slightly lower than the same period in 2022 to 2023 (716 FTE).

A total of 4,250 advertised FTE were placed on NHS Jobs during Quarter 4 of 2025 to 2026. This compares to 3,789 in Quarter 4 of 2024 to 2025, an increase of 12.2%.

We understand that DDRB would like to receive a further breakdown of this data, for example by type of role or the number of sessions available. Unfortunately, it is not possible to provide this as this information isn't contained in the raw data.

Working hours

Participation rates for GPs recruited via the Additional Roles Reimbursement Scheme have a higher average participation rate. Combining the headcount and FTE data for May 2026 shows that GPs recruited through the scheme had an average participation rate of 64%, which is 2 percentage points higher than salaried GPs employed directly by practices (62%).

GP partners

Numbers of GP partners are continuing to decline as we have reported in previous years' evidence.

Between June 2025 and June 2026, the proportion of GP partners in general practice fell from 55% of fully qualified GPs to 52% in FTE terms and from 47% to 44% in headcount terms.

We remain committed to the GP partnership model and recognise its many strengths, including efficiency, innovation and continuity of care. GP partnerships deliver high-quality care to patients all over the country. As set out in the 10 Year Health Plan, where the GP partnership model is working well, it should continue.

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

GP educators

GP educators play a vital role in supporting postgraduate medical education, workforce growth, curriculum delivery and the development of the future primary care workforce. Senior GP educators also undertake important educational leadership responsibilities at regional and national level, contributing to workforce planning, educational governance, quality assurance and the delivery of strategic workforce priorities. The GMC's 'The state of medical education and practice in the UK: workplace experiences (2026)' report found that declining satisfaction among more experienced doctors, including GPs and specialists, was linked to workload, training responsibilities and the coordination of patient care.

The National Training Survey 2026 suggests that wellbeing pressures among GP trainers in England remain significant. Nearly half (48.0%) of GP trainers were assessed as being at moderate or high risk of burnout, an increase from 45.3% in 2025, although lower than the 55.2% reported in 2024. The GMC also reported more negative responses across 6 of the 7 work-related burnout measures, indicating ongoing challenges for the medical trainer workforce. These pressures were particularly evident in general practice, where the proportion of GP trainers assessed as being at high risk of burnout increased to 10.2% in 2026, up from 8.9% in 2025.

Stakeholder feedback continues to highlight concerns regarding recruitment and retention within parts of the educator workforce, particularly amongst GP trainers. Concerns have also been raised regarding whether current educator payments and grants provide sufficient recognition of the additional workload, responsibility and leadership commitments associated with educator roles. These concerns reinforce the importance of maintaining attractive and sustainable educator career pathways.

These findings reinforce the importance of maintaining a sustainable educator workforce capable of supporting future training capacity, workforce growth and educational quality. NHS England's Educator Workforce Strategy highlights the need to maintain sufficient educator capacity and leadership capability to support workforce expansion and evolving models of care, including a sustainable pipeline of experienced educators able to progress into senior educational leadership roles. Senior GP educator roles increasingly extend beyond direct educational supervision to encompass workforce planning, educational governance, quality assurance, curriculum implementation and leadership of regional workforce priorities. As education and workforce systems become increasingly integrated, NHS England and DHSC consider it important that educator frameworks continue to reflect the scale, complexity and accountability associated with these responsibilities.

GP contract funding and reform

We are investing £601m in general practice in 2026 to 2027, bringing the total investment in the GP contract to £14 billion. This builds on last year's £1.1 billion additional investment, the largest uplift to GP contract funding in over a decade. Together, they delivered real terms funding growth of 8.1% over the last 2 years.

The additional £601m invested in 2026 to 2027 included funds towards implementing the DDRB and NHS PRB headline pay recommendations.

General practice reform

We are committed to moving towards a Neighbourhood Health Service, with more care delivered in local communities to spot problems earlier. In last year's evidence we shared that the 10 Year Health Plan announced the introduction of 2 new contracts, the Multi Neighbourhood Provider Contract and the Single Neighbourhood Provider Contract. Multi-neighbourhood providers (MNPs) will co-ordinate the consistent delivery of services across multiple neighbourhoods. Single neighbourhood providers (SNPs) will deliver new services through Integrated Neighbourhood Teams (INTs) within a defined single neighbourhood. We are in the process of consulting with stakeholders on the 2 new contracts. These new contracts will sit alongside the current General Medical Services (GMS) contract. The government has also publicly committed to reform of the GMS contract within the parliament.

Following feedback from stakeholders in the 2026 to 2027 GP contract consultation, we have introduced a practice-level GP reimbursement scheme, using £292 million of repurposed funding from the previous PCN level Capacity and Access Payment. The funding is available to practices to recruit additional GPs, or fund additional sessions from existing GPs, particularly to support clinical same day urgent access in general practice and to tackle the issue of GP unemployment and underemployment.

We recognise the importance of ensuring funding for core general practice services is distributed fairly between practices across the country and know that the current distribution formula is considered outdated. The first phase of a review of the Carr-Hill formula concluded in May and the recommendations are being considered.

Introduced in 2004, the Carr-Hill formula accounts for factors that affect the practice's workload - patient sex, age, additional needs (levels of mortality and morbidity in the area that the GP practice serves), patient list turnover, care home residents, and geographic location (rurality and area costs).

Evidence shows the funding distribution does not adequately recognise health need, may contribute to variation in the quality of care, and is outdated. GP practices serving more deprived areas receive on average 9.8% less funding per needs adjusted patient than those in less deprived communities, despite having greater health needs and significantly higher patient-to-GP ratios. There is general agreement among stakeholders that the Carr-Hill formula does not adequately account for the socioeconomic circumstances of patients.

The objective of reform would be to better match funding with higher need from poorer health. This could improve retention, reduce unwarranted variation in access and improve patient outcomes in the long term.

In addition, improving the accuracy of GP patient lists helps ensure NHS funding is distributed fairly and ensures the delivery of care is targeted efficiently to people who live in England. Whilst NHS England has always worked with GP practices to review and update their patient lists, it is vital that this happens on a regular basis, so the lists are as accurate as possible. The process for managing patients who have left the country has recently been updated, which will help ensure lists are up to date - and therefore funding is allocated as accurately as possible.

Expenses uplift process

In their 53rd report, DDRB recommendation 6 referred to the mechanism by which general practice expenses are uplifted and, in their 54th report, committed to keep it under review and revisit it next year.

DDRB recommended pay uplifts are applied to all practice staff, including salaried and contractor GPs, not just those within the DDRB remit who are GPs. The guidelines on the implementation of those uplifts, the drafting of which was agreed with GPCE for 2026 to 2027, clarifies that contractor GPs have discretion over how the total uplift is applied. The latest GPEEE report data, which shows an average increase of 3.5% in contractor pay for 2024 to 2025, suggests this has not had an impact on the sustainability of general practice.

The current mechanism is as follows:

- the proportion of total practice expenditure attributable to non-pay related costs, known as 'Other expenses', is calculated based on the analysis of average total practice expenditure published in the GP Earnings and Expenses Estimates. The statistically valid HM Revenue and Customs (HMRC) data that underpins that information is sourced from Contractor GP income tax returns

- the proportion of the overall practice contract funding attributable to other expenses is calculated by deducting contractor income before tax and staff costs from gross practice income, less pass-through costs (such as premises reimbursements)
- this then shows expenditure attributable to non-pay related costs that are other practice expenses. That is then divided by gross practice income less pass-through costs to arrive at the percentage of the contract value attributable to other expenses
- that percentage, 16% for 2026 to 2027 is then multiplied by the overall contract value nationally to arrive at the national total to be uplifted by inflation for the contract year. In this case, using the GDP deflator, which is consistent with practice in other parts of the NHS and the basis on which the NHS is funded by HM Treasury. The overall uplift to the national contract is then calculated by multiplying the share of costs linked to other expenses and is delivered through an uplift to the global sum each year. That ensures that the proportion of contract expenditure attributable to practice non-staff expenditure is calculated in accordance with the most up to date data available from practice accounts, which is then uplifted by the GDP deflator

GP specialty training

NHS England continues to expand the GP Specialty Training (GPST) programme. An additional 250 places will be available from September 2026, bringing the total number of training places to 4,500 with plans to expand further each year and reach 5,000 places by 2028. [Medical specialty recruitment fill rates for 2025 round 1 and 2](#) are publicly available. Round 3 recruitment data is not published but we can confirm that a total of 4,250 GPST places were filled in 2025 across the recruitment rounds.

General dental practitioners

In 2026, the pay elements of primary care dental care contracts have been increased by 3.75% from 1 April 2026.

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

Dental workforce data

As of August 2026, there are 38,701 dentists registered with the GDC in England. 25,419 dentists performed NHS activity (any amount over one unit of dental activity) during 2025 to 2026, an increase of 764 (plus 3.1%) on the previous year and 743 more than the number who performed NHS work in 2019 to 2020.

The number of dentists per 100,000 population in England was 43 in 2025 to 2026, one up from 2024 to 2025. However, the number of dentists per 100,000 population varies across England by ICB.

NHS England published findings from its dental workforce data collection on 27 August 2026. General Dentists spent 70% of their FTE working time on NHS care, consistent with the previous year. However, there was marked regional variation, with NHS FTE percentages ranging from 53% in the South West to 77% in London. Vacancy rates improved notably for general dentists, dropping from 19% in December 2024 to 10% in December 2025 and the proportion of general dentist vacancies that were NHS vacancies also decreased from 92% to 85%. It should be noted that the national response rate to the underlying survey fell from 97% to 84% between December 2024 and December 2025.

The 2025 to 2026 NHS dental statistics continue to show a positive trend in the recovery of NHS dentistry following the reduction in access that started during the pandemic. 18.8 million adults were seen by an NHS dentist in the 24 months up to 30 June 2026, an increase of approximately 337,000 (1.8%) when compared to the previous year. 7.2 million children were seen by an NHS dentist in the 12 months up to 30 June 2026, 151,000 (2.1%) higher than the pre-pandemic figure (7.0 million) for the 12 months up to 30 September 2019.

Furthermore, 37.6m Courses of Treatment (CoT) were delivered, an increase of approximately 2.2m (6.2%) compared with 2024 to 2025. In total, 49.3% of courses of treatment were delivered to non-paying adults and children in 2025 to 2026, unchanged from 2024/25.

Table 13: number of dentists with NHS activity by dentist type, including as a percentage of the total, from 2019 to 2020 and 2025 to 2026

Dentist type	2019 to 2020	2025 to 2026	% of total (2019 to 2020)	% of total (2025 to 2026)
Providing performer	4,850	4,347	19.7%	17.1%
Associate (performer)	19,786	21,065	80.2%	82.9%
Unknown	40	7	0.2%	0.0%
Total	24,676	25,419	100%	Not applicable

Source: [Dental statistics - England 2025 to 2026 NHSBSA](#)

Table 14: number of dentists with NHS activity by dentist type, from 2019 to 2020 through to 2025 to 2026

Dentist type	2019 to 2020	2020 to 2021	2021 to 2022	2022 to 2023	2023 to 2024	2024 to 2025	2025 to 2026
Providing performer	4,850	4,684	4,752	4,604	4,468	20,252	4,347
Associate (performer)	19,786	19,024	19,485	19,512	19,804	4,396	21,065
Unknown	40	25	28	35	35	7	7
Total	24,676	23,733	24,265	24,151	24,307	24,655	25,419

Source: [Dental statistics - England 2025 to 2026 NHSBSA](#)

Demographics

As of 2025 to 2026, there were more female dentists performing NHS dental activity than males, with a headcount of 14,066 females (55.3%) compared to 11,353 males (44.7%). By comparison, in 2019 to 2020 there were still more female dentists performing NHS dental activity than males, though by a smaller proportion (51.3% female to 48.7% male).

In 2025 to 2026, the age group with the highest proportion of female dentists was the under 35 band (60.8%). The age group with the highest proportion of male dentists was the 55 or over band (64.7%).

Table 15: number of dentists with NHS activity by gender, from 2019 to 2020 through to 2025 to 2026

Dentist gender	2019 to 2020	2020 to 2021	2021 to 2022	2022 to 2023	2023 to 2024	2024 to 2025	2025 to 2026
Female	12,654	12,301	12,775	12,931	13,240	13,487	14,066
Male	12,022	11,432	11,490	11,220	11,067	11,168	11,353
Total	24,676	23,733	24,265	24,151	24,307	24,655	25,419

Source: [Dental statistics - England 2025 to 2026 NHSBSA](#)

Table 16: percentage of dentists with NHS activity by gender across age groups, for 2025 to 2026.

Age band	Female	Male
Under 35	60.8%	39.2%
35 to 44	60.2%	39.8%
45 to 54	53.3%	46.7%
55 and over	35.3%	64.7%
All	55.3%	44.7%

Source: [Dental statistics - England 2025 to 2026 NHSBSA](#)

International workforce

Overseas-trained dentists remain an important part of the NHS workforce. As of December 2025, 34.1% of the 47,916 dentists registered with the GDC in the UK qualified outside of the UK. Of those that qualified outside of the UK, the largest individual group was dentists with a European Economic Area qualification (headcount of 8,974; 18.7% of the total), followed by those dentists that qualified through the GDC's Overseas Registration Exam (ORE) (headcount of 4,819; 10.1% of the total). We expect recent changes in the capacity of the ORE and Licence in Dental Surgery (LDS) exams to enable an additional 2,000 dentists to join the register annually from 2028¹.

¹ Compared to 2023 to 2024 baselines

Table 17: number of dentists on the GDC register as of 31 December 2025 by region of qualification, including as a percentage of the total

Region of qualification	Amount	% of total
UK qualified	31,563	65.9%
Licence in Dental Surgery Examination	1,017	2.1%
EEA qualified	8,974	18.7%
ORE - UK statutory examination	4,819	10.1%
Rest of the world qualified	1,543	3.2%
Total	47,916	100%

Source: [GDC Registration reports](#). General Dental Council, Registration Statistical Report 2025, Dental professionals on the register by route to registration, Dentists, by route to registration2025

Community dental services

The Community Dental Services (CDS) workforce provides vital specialised dental services for patients who may find it harder to access care in high street dentists. This includes patients with complex health needs, those who have learning disabilities, mental health issues, or very severe dental anxiety. CDS provides continuing care and treatment for some patients, while others may only access one-off specialist or complex care before being referred to their usual dentist after their course of treatment.

Depending on local commissioning arrangements, some CDS providers are commissioned to deliver additional services, such as minor oral surgery, periodontics, epidemiology, health promotion, and paediatric services. The commissioning responsibility for epidemiology and health improvement programmes currently sits with Local Authorities.

In the 2026 to 2027 pay round, the government implemented a 3.75% uplift to salaried dentists working in CDS. The DDRB also recommended that the government undertake a review of pay and progression for salaried dentists working in CDS. This recommendation is under consideration, and the government will respond in due course.

There are 75 contracts that provide CDS in England. 74% of these are held by NHS trusts, 23% by Community Interest Companies (CICs) and the remainder are held by limited companies. Dentists employed by NHS trusts are remunerated based on nationally agreed pay rates and their terms and conditions will include:

- a single pay spine with 3 competency pay-bands: Band A (dentists), Band B (senior dentists), and Band C (specialist dentists and managerial dentists)

- 6 pay points per pay band: the dentist will need to demonstrate the competencies for the post to progress
- mandatory annual appraisals and job planning to support salaried dentists' career development

Dentists employed by CICs or limited companies are likely to be engaged on varying terms and conditions and pay frameworks. While CICs and limited companies commonly reference NHS dental pay bands when setting their own salary structures and must comply with the employment protections set out in the Statement of Financial Entitlement, actual remuneration is not fixed.

As of September 2026, England-only data shows that almost all specialties had full recruitment. Oral surgery, orthodontics (ST1), dental public health, oral medicine, dental and maxillofacial radiology and restorative dentistry all filled 100% of their posts. However, special care dentistry had notable gaps (57% of all posts filled in 2025 to 2026), which reflects similar challenges in previous years (53% in 2024 to 2025 and 77% in 2023 to 2024). This puts the future workforce pipeline for special care dentistry at significant risk. This is particularly concerning given the ageing profile of the current specialist workforce and wider demographic trends which are likely to increase demand for special care dentistry services in future.

37 CDS contractors provided responses in the latest published Dental Workforce Management Information, representing a drop of 17 responses from 2024. The general dentist vacancy rate in community services was 14%, higher than the overall rate, and all vacancies were NHS vacancies. In these services, general dentists spent 98% of their FTE working time on NHS work, with NHS FTE across all staff groups between 95% and 100% (source: [Dental Workforce Management Information](#))

Recent work has focused on improving the quality and transparency of CDS waiting list data, in response to the recommendations set out in [Community Dental Services: A supplement to the GIRFT national report on Hospital Dentistry](#). NHS England continues to work through data quality issues ahead of any wider publication. Emerging data indicate significant demand for CDS and geographical variation in services' ability to meet that demand.

Improving the quality of national CDS data will support better benchmarking, operational management and visibility of variation in access to services. Our actions include publishing and asking ICBs to work with providers and managed clinical networks to review local data for quality concerns, ensure consistent returns, and apply the clock start and stop rules set out in the guidance.

Urgent dental appointments

As set out in the 10 Year Health Plan, the government's first step is to stabilise NHS dentistry and make sure the budget we have is spent on those who need care most, initially prioritising urgent care. During 2025 to 2026 ICBs commissioned additional urgent dental appointments and there is now an urgent care safety net available in all areas of the country.

From April 2026, we have embedded the delivery of urgent care into contracts for the first time. Dentists will be required to offer a minimum number of urgent appointments each year. In 2026 to 2027 this will be 8.2% of their contract value.

2026 quality and payment reforms

We have started to bring into force a package of reforms to address some of the most pressing issues that dentists and dental teams have been experiencing.

The proposals are intended to make it easier for those who need dental care and treatment to get it by requiring all dental practices to provide an agreed amount of urgent care which is accessible to all who need it, irrespective of whether they have been to the practice before.

We have made the payment for urgent care fairer, increasing it from an average of £42 to £77.49. Most providers will have seen at least an 80% increase in payment, and for some this will be more than double what they are currently paid.

We know that many dentists feel the money received for treating patients with more complex needs is not sufficient to cover the costs and labour involved. We are therefore making the payment for complex care fairer and enabling the care to be provided over a longer time period than current banded courses of treatment.

Regulations introducing the first phase of these reforms came into force on 1 April 2026, and the remainder of the reforms, including the introduction of complex care pathways, are being implemented from June 2026.

Dental contract reform

As set out in the 10 Year Health Plan, by 2035 the NHS dental system will be transformed, so it provides high quality care at the right time, and nobody goes without care because they cannot afford it.

Since last year, we have moved into delivering reform. From April 2026, we started introducing changes to prioritise patients with the greatest need, improve access to urgent care and make the contract more attractive to dentists. Changes to the contract now enable commissioners to more readily redistribute funding in cases where providers are persistently unable to meet their NHS commitments, helping to ensure that allocated resources are used to deliver care to patients.

The government is committed to reforming the dental contract, before the end of this Parliament. We want a contract that matches resources to need, improves access, promotes chair-side prevention and enables practices to deliver a financially sustainable NHS dental service, while enabling the whole dental team to work to the top of their capability.

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

NHS dentistry operates within a complex delivery model, and there are no perfect payment systems. Any changes must therefore be carefully considered to ensure they deliver genuine improvement for patients and the profession. On this basis, the government will publicly consult on future proposals.

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

Dental finances

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

The government is committed to ensuring that every penny committed to dentistry is spent on dentistry. We reduced the NHS dentistry underspend from £392 million in 2023 to 2024 to £36 million in 2024 to 2025. In 2024 to 2025 this investment delivered 35.4 million courses of treatment which represents an increase of 3.8% compared to the previous year. Dental budgets remain ringfenced for 2026 to 2027. The opening total ringfenced budget for dentistry for the financial year 2026 to 2027 is £4.33 billion, including PCR.

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

Where a contract holder has delivered more than 96% of contract value, the contract is considered fulfilled. Where a contract holder has delivered less than 96% of contract value by the end of the financial year, funding for the contract under-delivery is recovered by the NHS in the following financial year. In addition, for contractors who persistently under-deliver their required activity, regulatory amendments made in 2023 gave ICBs additional powers to unilaterally and permanently reduce the contract value and associated activity to an achievable level. Making this amendment to the regulations allows ICBs to release resources on an ongoing basis to be used to commission dental care elsewhere to improve access.

Where a contractor delivers more than their contracted activity, this does not automatically result in additional payment. Commissioners may agree over-delivery, usually up to 110% of contracted activity, where this supports local access needs and is affordable within available budgets. This gives ICBs flexibility to secure additional NHS dental activity where it is needed, while maintaining control over overall expenditure.

We have made significant progress since last year to improve the dental contract. From 1 April 2026, we have started to implement a package of reforms to address some of the most pressing issues that dentists and dental teams have been experiencing. This includes requiring NHS dental practices to deliver a set proportion of their contract as urgent care, as detailed above. In addition, from 23 June 2026, complex care pathways will be introduced for patients with significant dental decay and/or significant gum disease, with improved payments to cover the costs and labour involved in treating these patients for dentists. The final stage impact assessment for the 2026 Quality and Payment Dental Contract Reforms can be found here: [Impact Assessment -The National Health Service \(Primary Dental Services and Dental Charges\) \(Amendment\) Regulations 2026](#).

We are clear that even greater change is needed. We have begun the process of more fundamental contract reform, building on the first phase of changes introduced from April 2026 to prioritise patients with the greatest need, support better access to urgent care and make the contract more attractive to dentists. We remain committed to delivering

fundamental reform of the dental contract by the end of this Parliament. We are continuing to engage with dentists and patients to ensure reforms are effective and sustainable

Dental patient charges

From 1 April 2026, dental patient charges in England increased by 1.66%. This means that a dental charge payable for a band 1 course of treatment rose by 50 pence, from £27.40 to £27.90. For a band 2 course of treatment, there was an increase of £1.30 from £75.30 to £76.60. A band 3 course of treatment increased by £5.40 from £326.70 to £332.10.

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

Chapter 6: earnings and expenses (HCHS)

This chapter provides an assessment of pay and earnings for the medical workforce working under medical terms and conditions in HCHS. It includes 3 principal sections:

- data on current pay and earnings for the HCHS workforce - This helps to set a baseline for the pay round
- data and evidence on current economic conditions and how they might be expected to evolve over the coming year - this helps us understand the broader landscape which we are operating in
- a more detailed assessment of specific benchmarks and comparators which may impact the standing of specific sections of the workforce. This helps us understand if there are any specific challenges facing sections of the workforce which may require a more focussed pay response

We find that:

- the increase in pay and earnings for medical staff in 2025 to 2026 was broadly consistent with the most recent pay award. Where this was not the case it can be explained by either factors relating to the 2024 to 2025 pay decision or other base effects. Changes to average pay are always impacted by workforce composition and are not necessarily indicative of personal experience
- the economic landscape is more uncertain than usual with global events having the potential to impact labour market conditions, earnings and prices. The DDRB will wish to monitor the evolving situation over the course of the pay round
- the relative position of medical staff as part of the UK income distribution has been broadly maintained in recent years with larger increases for resident doctors largely reversing some deterioration for this part of the workforce
- the value of medical degrees remains high, medical graduates have some of the highest earnings following graduation and still have clear progression routes available to them

Pay and earnings for HCHS doctors

As part of standard earnings statistics, [NHS England publishes data on average pay and earnings estimates](#) for different sections of the medical workforce with staff assigned to medical grades based on their grade code. Consultants are in the 'consultant' grade group,

SAS doctors usually being in either 'Associate Specialist', 'Specialty Doctor' or 'Staff Grade' groups and resident doctors being in either 'Foundation Doctor Year 1', 'Foundation Doctor Year 2', 'Core Training' or 'Specialty Registrar' medical grades. The other, small, groups 'Hospital Practitioner' and 'Other grades' are not explicitly linked to a standard national contract but are sometimes combined with SAS groups for costing purposes.

These data provide information on average pay and earnings across the workforce - average basic pay per FTE reflects the distribution of staff across pay grades and points while average earnings then include the impact of additional earnings for things like additional activity or Clinical Excellence Awards. Where changes in average pay / earnings do not match the annual pay award this usually means there have been slight changes to workforce composition.

Table 18 provides data on average pay and earnings for the 12 months to March 2026 as well as growth over the past year. These data include the impact of the 2025 to 2026 pay awards (4% for consultant / SAS doctors, 4% plus a consolidated £750 for resident doctors) but will not include the expected impact of pay decisions in 2026 to 2027 including the 3.5% uplift to all pay points following acceptance of the DDRB recommendation or the additional pay agreement with resident doctors which is expected to result in an average pay uplift of around 4.9% for this group in 2026 to 2027 before additional pay reform prior to the 2027 to 2028 standard pay uplift.

Table 18: average basic pay, earnings and annual growth by HCHS medical grade, 12 months to March 2026

Medical grade	Average basic pay per FTE (£)	Average earnings per person (£)	Growth in basic pay per FTE (%)	Growth in earnings (%)
All medical grades	90,458	102,216	4.6%	2.2%
Consultants	130,251	147,066	3.6%	1.5%
Associate specialist	111,199	115,816	3.5%	2.1%
Specialty doctor	85,158	87,953	3.7%	2.2%
Staff grade	67,577	79,088	4.1%	-0.5%
Core training	63,104	77,476	8.4%	3.8%
Specialty registrar	55,238	69,322	7.4%	3.5%
Foundation year 2	43,280	54,118	10.8%	3.5%
Foundation year 1	37,286	46,248	9.5%	6.9%
Hospital practitioner / clinical assistant	131,953	49,359	1.8%	4.1%
Other and local HCHS doctor grades	113,365	57,094	3.3%	2.0%

Source: [NHS England Earnings Statistics, 12-months to March 2026](#)

The data shows that average basic pay per FTE ranged from £37,000 for Foundation Year 1 doctors to over £130,000 for consultants while average earnings per person ranged from over £46,000 for FY1 doctors through to over £147,000 for consultants.

The change in pay and earnings reflects more than just the impact of annual pay awards, with any changes to workforce distribution (across grades or across pay points) also having an impact. While staff will generally have experienced pay increases in line with the pay award, there have been some changes to workforce composition impacting aggregate data:

- for consultants the growth in average basic pay per FTE is slightly lower than the pay award. This is largely because pay received by consultants in 2024 to 2025 included an additional month of backpay as a result of a previous negotiated pay agreement which acts as a one-off, non-recurrent, payment and means the expected increase in 2025 to 2026 is less than the 4% pay award
- for SAS doctors the growth in average basic pay per FTE is also slightly lower than the pay award - this may reflect continued workforce growth in the SAS workforce who will usually enter at the bottom of the pay scale, as well as a continued change in the balance between people on new and old SAS contracts
- for both consultant and SAS doctors the growth in earnings is lower than the growth in basic pay. In 2025 to 2026 average payments for 'local' and 'additional activity' were lower than in the previous year as well as a continued reduction in CEA payments following the withdrawal of local CEAs as part of the 2024 pay agreement
- for resident doctors the observed increase to both pay and earnings is higher than can be explained through the pay award. As noted by NHS England, earnings data for November 2024 was anomalous due to the combined impact of pay awards, back pay and pay linked to additional pay agreements which increased the proportion of data failing usual data quality processes. We believe the best way to consider changes in pay or earnings is to look at known changes to the pay scale
- in 2025 to 2026 the proportion of staff in resident doctor and SAS grades increased slightly compared to consultants. This will result in a slightly higher proportion of doctors on lower pay points

Core economic context

The NHS operates within the wider labour market. It is therefore important to consider broader economic conditions in the context of this pay round alongside the other factors

within the DDRB's remit, which are explored elsewhere in this evidence, including morale and motivation, recruitment and retention, and total reward. We will generally place greater emphasis on forecasts for 2027 to 2028, as that is the pay period under consideration and we are focused on pay levels being appropriate going forwards.

Data on earnings growth and pay settlements help us to understand pay in the wider economy and how different NHS pay awards might impact comparisons against wider labour markets. These are 2 different measures, with 'pay settlements' measuring the outcome, or expected outcome, of annual pay setting processes (and is most similar to the pay review body recommendation), while data on average earnings also includes the impact of any changes to workforce composition or pay drift. This can mean that earnings grow at a different pace to pay settlements as has been the case this year in the NHS.

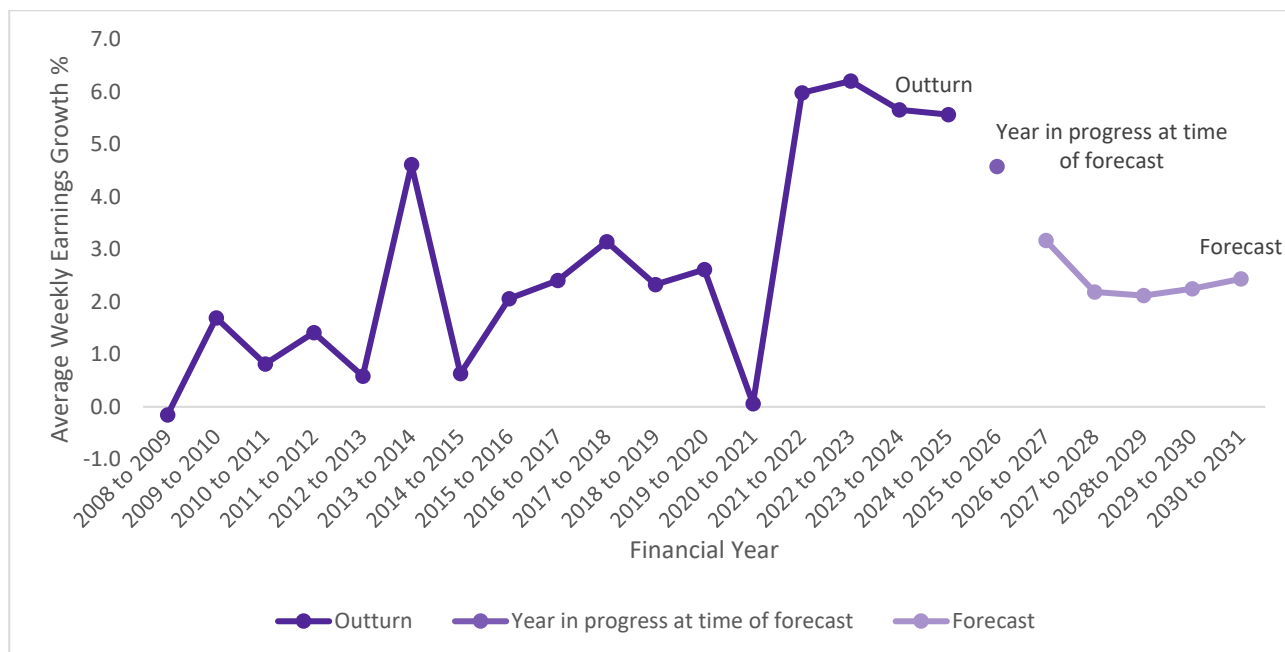
While there are no official statistics on pay settlements several organisations undertake surveys which can provide an indication of current conditions:

- data shows a median pay settlement of 3.2% in the 3 months to June 2026 and the forecast for the rest of 2026 is also 3.0%
- from the [pay trend data from Incomes Data Research](#) shows the median pay increase in the private sector was at 3.5% for the 3 months to April 2026 with around half of all settlements being between 3% and 3.99%
- from the latest [Bank of England Agents' summary of business conditions](#) showed a median pay award of 3.5% in 2026 with around 80% of firms having completed pay setting for this year. They did however note conflicting pressures for future pay rounds with the risk of higher inflation being offset by concerns around a looser labour market and weaker demand outlook

Through the rest of this review period, it will be important to monitor evolving conditions including the extent to which higher inflation occurs and the resulting impact on economic conditions and pay setting.

The ONS publish data on [average weekly earnings \(AWE\)](#) for different sectors of the economy. While this can provide useful information on general trends, it is recognised that this is a broader measure than pay settlements and can be impacted by things like changes to workforce composition or pay drift (for example an increase in average earnings by a reduction in jobs at the bottom of the income distribution, but this would be a purely compositional effect).

Figure 4: average weekly earnings growth, outturn and forecasts since 2008 to 2009



Source: [Office for Budget Responsibility \(OBR\) Table 1.6](#)

The [economic and fiscal outlook March 2026](#) forecast shown in figure 4, made alongside the Spring Statement in March 2026, before the impact of events in the Middle East, forecast earnings growth in 2027 to 2028 would be around 2.2%, which would be down from 3.2% in 2026 to 2027. In comparison, in July the [Bank of England's Monetary Policy Report](#) forecast average private sector earnings growth of around 3.2% in 2027 to 2028 and 3.1% in 2028 to 2029.

Wider economy pay settlements and earnings growth, partly driven by inflation, are more useful indicators for aligning NHS pay with relevant labour market comparators; subject to any additional issues around morale, recruitment and retention as per the DDRB's wider remit.

The Bank of England also forecasted in the July 2026 Monetary Policy Report that CPI in 2027 to 2028 would be around 2.4% after averaging 3.0% in 2026 to 2027 but with the BoE recognising considerable uncertainty and with risks that skew more to the upside (meaning higher inflation) This is higher than the previous OBR forecast in March made before the start of the Iran conflict.

Whilst the importance and impact of high inflation for individuals is understood the extent to which it should be a factor in pay setting is less clear, as inflation is driven by complex global and national factors, which inevitably raises the cost of living.

Increasing the pay of everyone in the country in line with inflation would not alter these supply pressures and would be expected to fuel further inflation. Limiting such inflation-matching pay rises to the public sector, NHS or specific workforces would be unfair and would be expected to still be inflationary to the detriment of purchasing power across the country.

We expect that the DDRB will want to consider the most recent data and information at the time they are conducting deliberations and there is a higher-than-normal degree of uncertainty due to global conditions.

Comparators and staff group analysis

1. Income distribution

As part of its earnings publication the ONS produce data on earnings growth across the earnings distribution. Because doctors are at the upper end of the income distribution, we are particularly interested in growth at this part of the distribution.

The pace of earnings growth is currently higher for lower paid staff with slower growth further up the earnings distribution. This is consistent with increases to the National Living Wage (NLW), resulting from policy decisions to increase the relative value of NLW while there have been smaller increases further up the earnings distribution. This is contributing to wage compression, where pay differentials are not maintained in full, which comes as a natural result of this NLW policy.

Average earnings for medical staff place them toward the very top of the earnings distribution where data suggests there has been lower earnings growth. This has been a consistent trend in recent years (source: [Earnings and employment from Pay As You Earn Real Time Information, seasonally adjusted](#))

Table 19: average earnings growth across the UK income distribution by percentile, latest 12-month period

Position in income distribution	10th percentile	25th percentile	Median	75th percentile	90th percentile	95th percentile
Change in average pay over last 12-months	6.4%	5.7%	4.8%	4.1%	3.3%	2.5%

Source: ONS, Real-Time Information - Seasonally Adjusted

2. Annual Survey of Hours and Earnings (ASHE) comparators and earnings percentiles

The [Annual Survey of Hours and Earnings](#) (ASHE) collects detailed information on pay through time and for more detailed sectors of the workforce. It can be used to see how NHS pay compares against different parts of the wider economy or to see how the place of NHS staff within the income distribution has changed.

This 'earnings percentiles' analysis estimates where average pay for different NHS staff compares against the wider economy and shows how the relative position of NHS pay has changed over time. Theory suggests this is likely to be more relevant to recruitment and retention than inflation alone because it reflects how NHS pay is changing relative to wider labour market conditions and opportunities, which are more likely to influence individual career decisions.

The data shows that:

- average earnings for HCHS doctors remain in the top 5% of the earnings distribution and this has been the case since the start of this analysis in 2011
- consultants have consistently been in the top 2% of the earnings distribution throughout
- the relative position of SAS doctors has also been consistent with Associate Specialists and/or Specialists being above the 97th percentile and Specialty and Staff Grade doctors being around the 94th percentile
- for resident doctors in the Foundation Grades, there are notable movements between 2011 and around 2024 with a reduction of around 10 percentage points however these have largely been reversed following recent pay decisions. For other grades, including other resident doctors, the impacts during the 2010s were more muted and again have since largely been reversed

Table 20: percentile position of HCHS medical grades within the UK earnings distribution, 2011 to 2025

Medical grade	2011	2015	2020	2023	2024	2025
All medical grades	96	96	96	96	96	96
Consultants	98	98	98	98	98	98
Associate specialist	97	97	97	97	97	97
Specialty doctor	94	94	93	94	94	94
Staff grade	94	94	93	93	93	93
Core Training	93	92	91	91	90	91
Specialty registrar	90	87	86	86	85	88
Foundation doctor year 2	82	80	77	75	73	79
Foundation doctor year 1	72	70	67	64	62	68
Hospital practitioner and/or clinical assistant	61	62	69	78	76	73
Other and local HCHS doctor grades	88	89	87	90	90	81

Source: [NHS England Earnings Statistics, Annual Survey of Hours and Earnings](#)

3. Longitudinal Education Outcomes of the graduate premium

The Department for Education (DfE) publish data on [Longitudinal Education Outcomes](#) (LEO) which combines data from the education system with information from Department of Work and Pensions (DWP) and HMRC to track the earnings and employment outcomes of graduates and can be used to compare outcomes across subjects or providers.

Table 21 shows median earnings, and employment outcomes, for medical and dental graduates. The [latest graduate labour market outcomes \(LEO\) education statistics](#) shows that:

- median earnings for medical and dental graduates are consistently among the highest across subjects. While it is true that after 10 years they are not in first position, we note that even with perfect progression it will usually take more than 10 years for someone to go from medical school to consultant and this measure of earnings does not include measures of total reward (detailed further in chapter 7) which add considerable value to the employment package, including membership of the NHS pension scheme

- as well as some of the highest average earnings, medical graduates also continued to have some of the best employment prospects offered by any university degree
- [data from the Graduate Industry Dashboard](#) shows that around 92% of medical and dental graduates remained in 'human health' after 5 years and there is nothing to suggest that average earnings and/or employment data are being skewed by people moving into other industries

Table 21: graduate earnings and employment outcomes for medicine and dentistry graduates, 1 to 10 years after graduation

Medicine and dentistry graduates	1 Year after graduation	3 Years after graduation	5 Years after graduation	10 Years after graduation
Median earnings	£42,800	£51,600	£56,400	£64,800
Rank of median earnings	1	1	1	2
Proportion in sustained employment / training	97.0%	95.1%	90.6%	88.7%
Employment rank	1	2	5	5

Source: [Longitudinal Education Outcomes](#)

4. Estimates of the long-term returns from medical degrees

The Institute for Fiscal Studies have recently published new estimates of the [impact of undergraduate degrees on lifetime earnings](#) and this is another source which points to the long-term value of a medical degree. This research is built around data from LEO, the Labour Force Survey (LFS), linked Higher Education Statistics Authority (HESA) and HMRC records, and focusses on the cohort of students who took GCSEs in 2002 and considers how variables such as subject, institution and prior attainment impact long-term outcomes.

The report generally shows benefits to those undertaking degree level education, with graduates earning substantially more than non-graduates in their thirties and with earnings gaps expected to persist throughout their working lives.

Within the overall picture, there is substantial variation between subjects with medicine and economics offering the highest individual lifetime returns, which is the same pattern as seen in other LEO data, while the average returns from some subjects may be negative.

5. Longitudinal analysis of the experience of the pay system and progression pathways

While pay should be appropriate across the pay scale and ensure that the profession remains attractive, it is important to consider the pay structure for doctors in the round and how people progress through the pay system over the course of their careers.

Table 22 shows pay scales in 2026 to 2027, following the most recent pay award and including the impact of the 2026 resident doctor pay agreement, for different sections of the medical workforce and pay scale progression within those contracts. For example, it shows that the increase in pay between new (F1) and most experienced (ST7 to ST8) resident doctors is just under 90% while the increase in pay between new doctors and the most experienced consultants is around 265%.

Table 22: pay scales by contract stage in 2026 to 2027, following the acceptance of the 2026 pay agreement by members of the British Medical Association

Pay journey	Starting basic pay	Maximum basic pay	Increase
Resident doctors	£41,226	£77,348	88%
Specialty Doctor (2021 Contract)	£63,696	£102,689	61%
Specialist Contract (2021 Contract)	£104,401	£115,341	10%
Consultants	£113,565	£150,569	33%
Pay route	Starting basic pay	Maximum basic pay	Increase
F1 to Consultant max	£41,226	£150,569	265%

Source: [NHS Employers pay and conditions circulars for medical and dental staff](#)

Data from ESR can be used to show how people progress through medical careers over time and how they experience the pay system, including the impact of both annual pay awards as well as progression through their current grade and movement to higher grades.

Table 23 shows the total increase in basic pay per FTE for doctors employed in HCHS in both March 2016 and March 2026 based on their grade 10 years ago. It highlights the substantial growth that is available to those in resident doctor grades - for example it shows that the average increase in pay for people who were employed as Specialty Registrars in 2016 and were still employed in 2026 was nearly 190%, with many of those staff finishing training and moving into consultant or SAS roles. For people who have been consultants throughout the period, the median increase is still 64% (around 5.1% pa),

which includes the impact of annual pay awards and any progression within the pay system.

Table 23: longitudinal pay analysis for individuals employed in HCHS in March 2016 and still employed in HCHS after 10 years

Medical grade in March 2016	Lower quartile (annual)	Lower quartile (total)	Median (annual)	Median (total)	Upper quartile (annual)	Upper quartile (total)
Consultant	4.8%	59%	5.1%	64%	5.6%	72%
Associate specialist	3.8%	45%	4.2%	50%	4.8%	60%
Specialty doctor	4.7%	58%	5.9%	77%	7.6%	109%
Staff grade	3.6%	42%	5.5%	71%	7.3%	102%
Specialty registrar	10.2%	164%	11.2%	189%	12.2%	216%
Core training	9.4%	147%	12.3%	219%	13.8%	265%
Foundation year 2	10.2%	164%	10.2%	164%	14.6%	291%
Foundation year 1	11.1%	187%	12.6%	227%	12.6%	227%
All grades	4.9%	61%	5.7%	74%	11.1%	187%

Source: [DHSC Analysis of ESR, annualised median increase in basic pay per FTE, grade in 2026.](#)

When combined with other longitudinal analysis, such as that provided by LEO, we believe it continues to be the case that those entering the medical profession are joining a profession where doctors are very likely to progress to senior roles and with a higher probability than is available in other careers.

6. International pay and devolved governments comparisons

The DDRB have previously invited evidence regarding comparability of medical pay against either international labour markets or evidence of issues relating to different pay (and contracts) across the devolved governments of Scotland, Wales and Northern Ireland.

Making robust comparisons across administrations, even those within the United Kingdom, is extremely challenging due to differences in employment models across jurisdictions including variation in wider employment terms and conditions (including pensions), working hours or the cost of living. For example, some doctors in Scotland remain employed on the 2002 resident doctor contract which has a different balance between basic pay and additional earnings, and data from other countries may only include self-employed staff who are typically on higher pay.

As part of the annual [Health at a Glance 2025](#), the OECD attempt to compare remuneration for specialist doctors in monetary terms and in comparison to the respective economy, with data from 2022 being assessed by the Nuffield Trust (source: [Exploring the](#)

[earnings of NHS doctors in England](#)). While comparisons are difficult and it will always be hard to construct a methodology that addresses all challenges and differences between countries and healthcare systems, it does still suggest that salaries for specialist doctors in England, adjusted for purchasing power, were in the top quarter of developed economies covered by the analysis.

When considering the data in other chapters of this evidence, we do not see evidence of either material issues being caused by differences in pay across the devolved governments or any differences in pay across countries impacting either the ability of the NHS to operate in international labour markets or issues with UK staff moving overseas and not returning in significant numbers.

General dental practitioners' earnings and expenses

While pay elements for General Dental Services and Personal Dental Services contracts are uplifted in line with the DDRB's recommendation (3.75% for 2026 to 2027), expenses (costs) are uplifted in line with inflation (calculated using GDP deflators) at the same time each year.

The final uplift figure applied to the value of each contract combines both DDRB's recommended uplift rate (for pay) and the inflation uplift rate (for expenses) based on proportion of pay (around 71% for 2026 to 2027) and expenses (around 29%) in the contract. We formally consult with the British Dental Association (BDA) on the uplift proposals each year before implementing them.

The DDRB recommended that we consider replacing the GDP Deflator with a dentistry-specific index of inflation. We recognise that parts of the dental sector consider that the current approach to measuring expenses does not fully reflect the cost pressures faced by dental practices. However, developing a robust dentistry-specific inflation measure is complex. Any alternative would need to be based on reliable, representative and regularly updated evidence on practice costs, and be capable of supporting a consistent national approach to uplifts.

At this stage, we have not identified a credible alternative index that would provide a more accurate and stable basis for setting national uplifts. We are continuing to consider the DDRB's recommendation and to strengthen the evidence base.

In the absence of a sufficiently robust alternative, we used the established methodology for 2026 to 2027 to maintain consistency with other NHS primary care groups. It also supports the timely implementation of the pay recommendations.

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

Dental earnings and expenses data publication

Data on dental earnings and expenses estimates is available for self-employed primary care dentists who have completed some NHS work during the financial year; however, figures relate to both NHS and private income and these figures should not be interpreted as full-time equivalent earnings. Private earnings are determined by the amount of demand from individual patients, which may be in addition to NHS care.

In 2024 to 2025, there was a 6.1% increase in the taxable income of self-employed dentists who perform NHS services in England from £78,200 in 2023 to 2024 to £83,000 in 2024 to 2025. The average expenses to earnings ratio for all self-employed dentists who perform NHS services remained unchanged at 50.5% between 2024 to 2025 and 2023 to 2024.

Table 24 shows the average gross earnings, expenses, taxable income and expenses to income ratio for all dentists who performed some NHS dental services from 2019 to 2020 through to 2024 to 2025. This data is for England only. For the years marked with an asterisk, the methodology changed in these years and are not comparable to earlier years. There were a small number of dentists in these years where it was unknown whether they were a providing-performer or associate.

Table 24: average gross earnings, expenses and taxable income for dentists performing NHS dental services in England, 2019 to 2020 through to 2024 to 2025

Period	Average gross earnings	Average expenses	Average taxable income	Expenses ratio
2019 to 2020*	£144,700	£76,100	£68,600	52.6%
2020 to 2021*	£141,400	£68,900	£72,500	48.7%
2021 to 2022*	£156,100	£78,200	£77,900	50.1%
2022 to 2023	£155,200	£79,300	£75,800	51.1%
2023 to 2024	£158,100	£79,900	£78,200	50.5%
2024 to 2025	£167,500	£84,500	£83,000	50.5%

Source: [Dental Earnings and Expenses Estimates, 2024 to 2025](#)

In England, the earnings of a dentist vary depending on whether they are a contract-holder or an associate dentist. Providing-performer dentists hold a contract with NHS England to provide a given number of units of dental activity or units of orthodontic activity. Associate dentists work as performers under the contract - they deliver NHS dental services and hold a contract with their providing-performer but do not hold a contract with the NHS.

Generally, providing-performers tend to earn more (higher gross earnings and taxable income). In 2024 to 2025, providing-performer dentists had an average taxable income of £146,300, an increase from £134,400 in 2023 to 2024. Associate dentists also saw their average taxable income increase, to £70,500 in 2024 to 2025 compared to £66,700 in 2023 to 2024.

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

Table 25: average taxable income, in cash and real terms, for providing-performer dentists in England, from 2019 to 2020 through to 2024 to 2025

Providing performer dentists

Year	Cash terms average taxable income	Real terms GDP	Real Terms CPI
2019 to 2020	£112,600	£139,300	£140,300
2020 to 2021	£132,200	£155,400	£163,600
2021 to 2022	£135,000	£158,300	£160,700
2022 to 2023	£128,800	£141,100	£139,400
2023 to 2024	£134,400	£139,900	£137,600
2024 to 2025	£146,300	£146,300	£146,300

Source: [Dental Earnings and Expenses Estimates 2024 to 2025](#)

Table 26: average taxable income, in cash and real terms, for associate dentists in England, from 2019 to 2020 through to 2024 to 2025

Associate dentists

Year	Cash terms Average taxable income	Real terms GDP	Real terms CPI
2019 to 2020	£58,100	£71,900	£72,400
2020 to 2021	£58,700	£69,000	£72,700
2021 to 2022	£64,900	£76,100	£77,200
2022 to 2023	£64,300	£70,500	£69,600
2023 to 2024	£66,700	£69,400	£68,200
2024 to 2025	£70,500	£70,500	£70,500

Source: [Dental Earnings and Expenses Estimates 2024 to 2025](#).

General Practitioners' earnings and expenses

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

Trends in pay and earnings for contractor GPs

In England, the estimated average income before tax of a contractor GP in either a General Medical Services (GMS) or a Primary Medical Services (PMS) practice was £164,200 in 2024 to 2025. This is a statistically significant increase of 3.5% from 2023 to 2024. This follows the 13.2% increase in 2023 to 2024 that came after an 8.6% fall in 2022 to 2023, resulting from the reduction in COVID vaccination funding.

Trends in the earnings and expenses of salaried GPs

In England, the estimated average income before tax of a salaried GP in either a GMS or a PMS practice was £74,800 in 2024 to 2025. This is a statistically significant increase of 3.7% from 2023 to 2024.

Chapter 7: total reward

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

The total reward package in the NHS includes a range of benefits that exceed the statutory minimum and those offered in other sectors. These include:

- a generous holiday allowance, in addition to public holidays, increasing with years of service (up to 33 days)
- sickness absence arrangements of up to 12 months of payment
- access to a defined benefit pension scheme with an employer contribution rate of 15.5%
- enhanced parental leave
- career progression support, learning and development

Measuring the value

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

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

GAD changed the approach for CEA's last year, and in line with the new contract, have moved on to the new LCEAs. These awards are £3,092 and are treated as non-

pensionable pay. It is important to note that, as in previous years, the basic pay definition used for the analysis is mean annual basic pay per person.

Figure 5: wider reward packages for a range of NHS staff roles

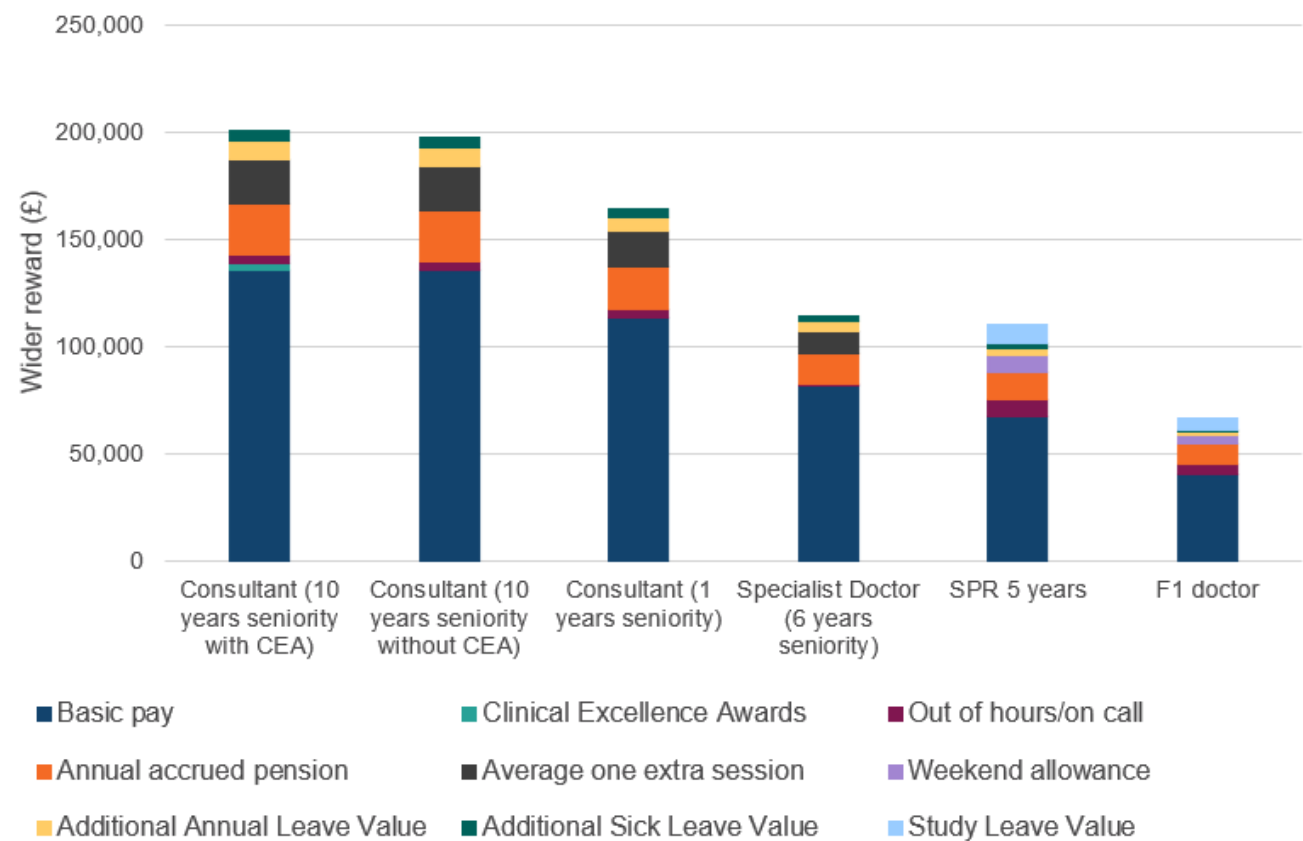
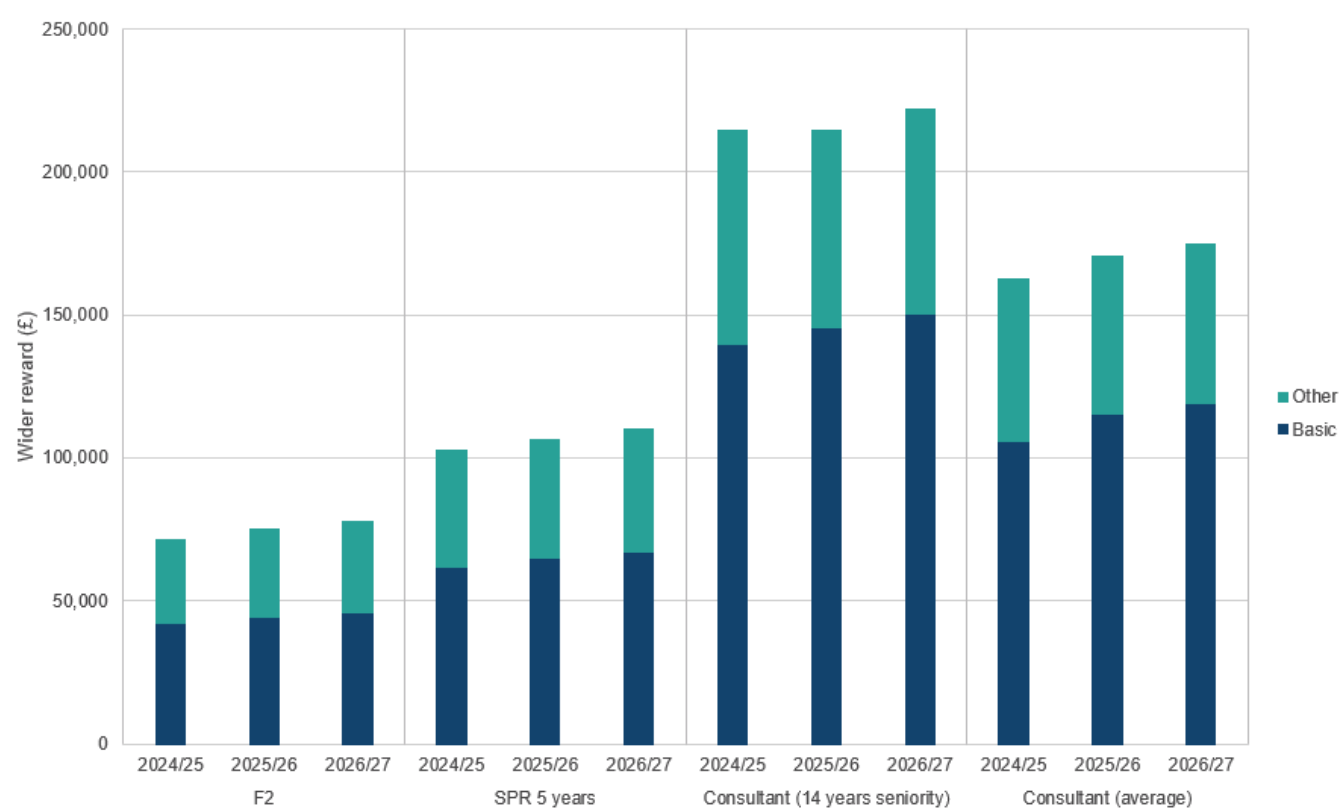


Figure 5 shows the wider reward package for a range of NHS staff roles. The wider reward package, as could be anticipated, correlates with the level of seniority of staff. It ranges from over £66,000 for F1 doctors to over £200,000 for some consultants.

The wider reward package is calculated based on 2026 to 2027 pay terms and GAD included the same staff roles as adopted in last year's analysis.

Figure 6: analysis of the trend in wider reward over the period 2024 to 2025 to 2026 to 2027



The analysis in figure 6 shows the split of total reward packages between basic and other pay over the years 2024 to 2025, 2025 to 2026 and 2026 to 2027. This shows that all doctor roles considered as part of this analysis have experienced an increase in total wider reward in monetary terms over the period 2024 to 2025 to 2026 to 2027. It also shows that for multiple staff groups, basic pay and other pay have continuously increased over the past 3 years. All doctor roles considered have at least 32% of the total reward made up of non-basic pay.

Figure 7: summary of increases in reward over the total period 2024 to 2025 to 2026 to 2027

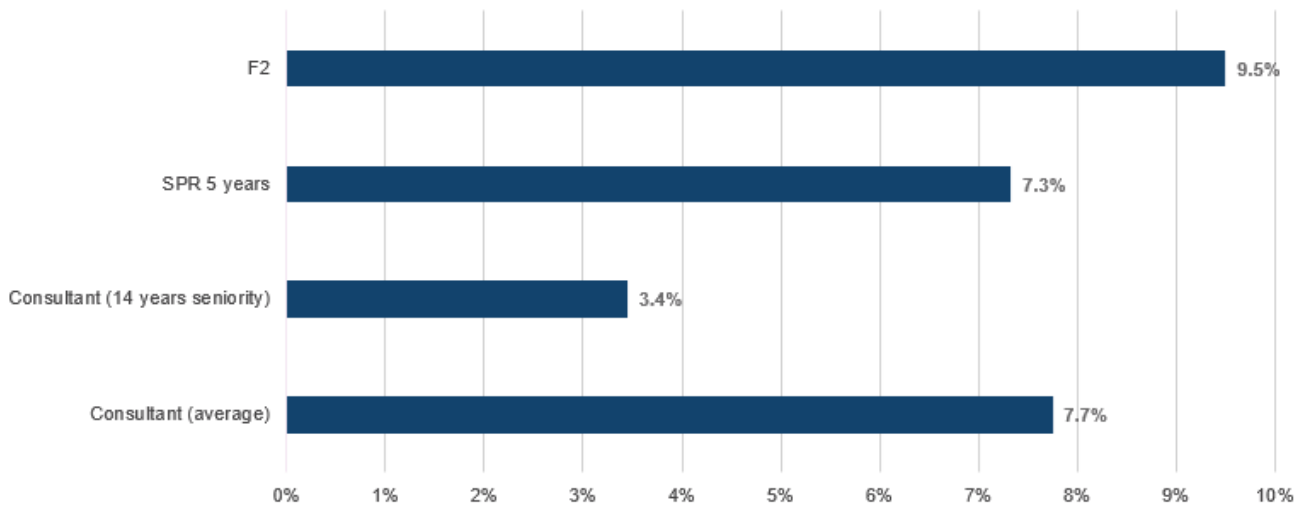


Figure 7 shows a summary of the increase in wider reward from the financial year 2024 to 2025 to the financial year 2025 to 2026. It shows that the total reward continues to increase each year for doctors, and that the largest percentage increase was received by F2 doctors. These increases have reduced compared to the analysis last year as the large increase awarded during 2024 has dropped out of the period.

NHS Pension Scheme

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

There are 2 NHS pension schemes. A legacy scheme, which includes the 1995 and 2008 sections, and the 2015 scheme. Both are defined benefit schemes, but they have some key differences, as shown in table 27; the way benefits are calculated, the normal pension ages and the accrual rates. The legacy scheme is now closed to new members and all NHS staff who joined the NHS Pension Scheme since 1 April 2022 are automatically enrolled in the 2015 scheme.

Table 27: comparison of retirement ages and accrual rates for members of the 1995 Section, 2008 Section and 2015 Scheme

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

NHS Pension Scheme contributions

Members and employers are required to pay towards the cost of benefits built up in the NHS Pension Scheme. Following a recent actuarial valuation and subject to consultation on updates to scheme regulations, from 1 April 2027, employers will contribute 15.5% of each member's pensionable earnings, plus a charge of 0.08% to fund the administration of the scheme. As a defined benefit scheme, the value of these benefits is determined by a member's earnings and length of service, rather than by the level of contributions alone. The change in employer contribution rate does not alter the generosity of pension rights that staff build up. The valuation shows that those rights are now not expected to cost as much in the long-term, compared to the last valuation that led to the change in employer contribution rate in 2023.

DHSC reviewed member contributions in 2021 and introduced changes in October 2022 and April 2024. More information on these changes is available from the relevant consultation documents (source: [NHS Pension Scheme: member contributions phase 2 and miscellaneous amendments 2026](#)). Following these changes, member contribution tier thresholds are updated automatically each April, in line with CPI from the previous September. If the AfC pay award in England is higher than this figure, the thresholds are updated again. This policy ensures that the tier thresholds remain up to date, and to reduce the likelihood of members moving into the next contribution tier solely as a result of receiving a nationally agreed pay award. While doctors and dentist are not paid under AfC, the contribution tiers are increased in line with the AfC pay award because this is the pay award that applies to the largest cohort of staff eligible to join the NHS Pension Scheme.

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

Table 28: NHS Pension Scheme member contribution threshold structure (as of 1 April 2026)

Pensionable pay range	Contribution rate from 1 April 2026, based on actual annual pensionable pay
Up to £13,259	5.2%
£13,260 to £28,854	6.5%
£28,855 to £35,155	8.3%
£35,156 to £52,778	9.8%
£52,779 to £67,668	10.7%
£67,669 and above	12.5%

Pension projections

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

GAD have produced a series of pension projections, which are based on example members with existing service in the NHS Pension Scheme built up prior to 2025. These example members are assumed to have continuous membership in the scheme from the point of joining, and to qualify in their respective fields in 2026. They assume that the example members remain in service and work full-time before retiring at age 65.

The GP partner and Salaried GP are assumed to have joined the 2015 Scheme in 2021 aged 25 and to have qualified as GPs in 2026. The consultant is assumed to have joined the 2015 scheme in 2017 aged 25 and to have qualified as a consultant in 2026.

We expect that many NHS doctors will choose to commute some of their pension for a tax free lump sum. We also recognise that many doctors now work less than full time and this will be reflected in their pension accrual. However, for simplicity, the illustrative projections shown below are based on a member continuing in full-time employment throughout their career. Table 29 therefore shows the pension benefits the example members above could expect to receive, assuming that they commute 20% of their pension for a tax-free pension commencement lump sum (PCLS) at retirement, on current commutation terms. The projected lump sums are within the maximum amount of £268,275 for a tax-free lump sum allowing for real terms increases by retirement.

Table 29: projected annual pensions and lump sums for NHS doctors qualifying in their respective fields in 2026 and retiring age 65 (in today's monetary terms)

Role	Year of joining	No commutation Projected pension (pa)	Allowing for commutation Projected residual pension (pa)	Allowing for commutation Projected PCLS
GP partner	2021	£74,000	£59,000	£177,000
Salaried GP	2021	£60,000	£48,000	£144,000
Consultant pathway	2017	£81,000	£65,000	£195,000

The projections provided this year differ slightly from those provided last year. The extent of these changes differs between the example members. In particular:

- GP partner projections are slightly lower than those provided last year. This is primarily due to higher projected annual allowance tax charges, partially offset by higher pensionable pay
- salaried GP projections are slightly higher than those provided last year due to higher pensionable pay than assumed previously
- consultant pathway projections are unchanged from those provided last year, as higher pensionable pay is broadly offset by the impact of updated factors and the associated effect on projected annual allowance tax charges

Calculations assume the annual allowance remains fixed at £60,000, in line with the current policy position.

NHS Pension Scheme membership

We continue to monitor scheme membership rates for HCHS doctors through ESR. Table 30 shows the percentage of doctors, by grade, who were members of the scheme in March 2026 in comparison with March 2025.

Table 30: NHS Pension Scheme membership for HCHS doctors as at March 2026 and comparison with March 2025

Medical grade	March 2026	One year change (percentage point change)
All HCHS doctors	88.9%	1.6pp
Consultant	93.3%	1.4pp
Associate specialist	90.2%	1.3pp
Specialty doctor	85.5%	3.1pp
Staff grade	86.4%	Minus 5.5pp
Core training	79.4%	2.1pp
Foundation year 1	91.3%	Minus 0.4pp
Foundation year 2	89.3%	2.7pp
Specialty registrar	88.5%	1.9pp
Hospital practitioner and / or clinical assistant	72.5%	1.6pp
Other and local HCHS doctor grades	91.5%	0.3pp

Table 30 shows that while overall membership rates remain high, there continues to be reductions in the membership rates for doctors at some grades. In comparison, there have been significant increases in specialty doctor and foundation year 2 membership rates.

ESR data shows that the most prominent reasons for medical and dental opt-outs are temporary opt-out due to other financial priorities (42%) and affordability (35%).

Retirement options

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

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

Doctors and dentists also have the option, with the agreement of employers, to take partial retirement or retire and return. These flexibilities allow members to claim their pension when it is most valuable to them but do not require them to leave or change their job. As well as supporting doctors and dentists with their work-life balance later in their careers,

partial retirement may also support NHS employers, by allowing them to retain experienced doctors and dentists for longer.

In October 2023, partial retirement was extended to 1995 NHS Pension Scheme members aged 55 and over in an effort to retain more doctors. This means that members of the NHS Pension Scheme aged 55 or older can take between 20% and 100% of all their pension benefits in one or 2 drawdown payments, without having to leave their current job

As of 23 March 2026, 211 dentists (36 hospital dentists and 175 GPs) and 5,112 doctors (4,815 hospital doctors and 297 GPs) had completed applications for partial retirement. Of these, 27.78% of hospital dentists and 29.71% of GPs took partial retirement after reaching their NPA, compared with 39.67% of hospital doctors and 19.19% of GPs. This suggests that a significant proportion of clinicians are choosing to continue working in the NHS beyond their NPA, rather than fully retiring from the workforce.

Average GP retirement ages

Data is not held on overall age of retirement for GPs as there are 2 types of retirement - voluntary early retirement (explained above) and age retirements. The normal pension age (NPA) is the age at which members can take their pension benefits in full, without any actuarial reduction or enhancement. For members of the 1995 Section, the NPA is 60; for the 2008 Section, it is 65; and for the 2015 Scheme, it is linked to the member's State Pension age. Age retirements are taken at or after pension age, while voluntary early retirements are taken before reaching NPA. Members of the 1995 section can take early retirement from age 50 or 55 depending on active membership periods, and for the 2008 section and 2015 scheme the minimum age is 55.

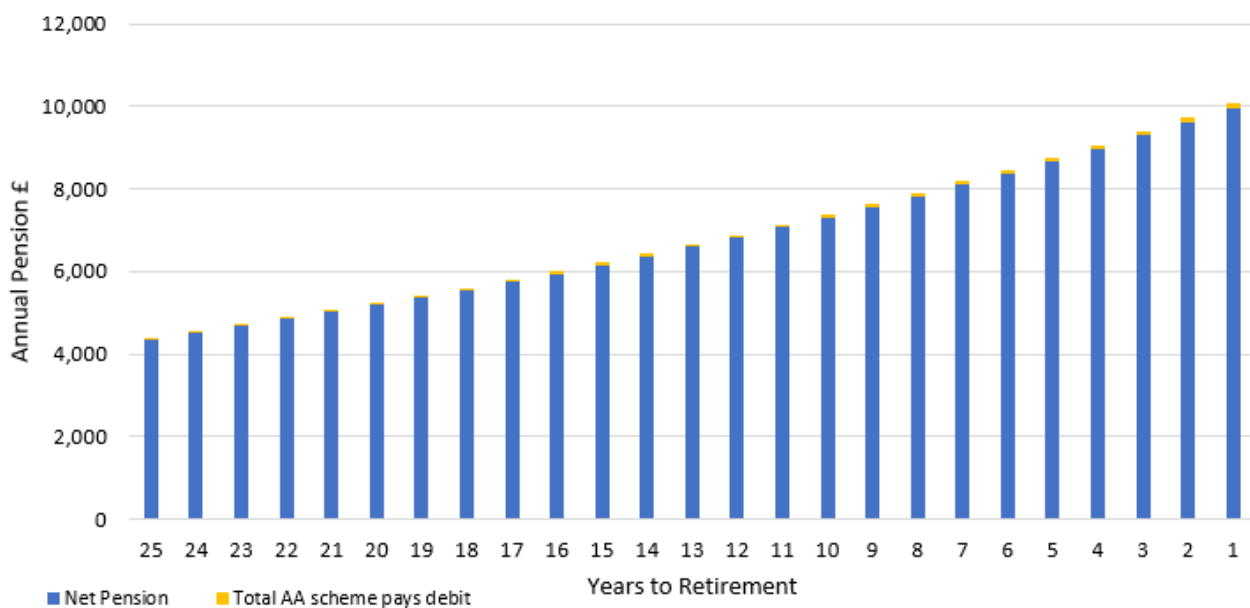
Pension tax

Some senior doctors and dentists exceed the Annual Allowance (AA) threshold. As a result of the 2023 Budget, the minimum tapered annual allowance increased from £4,000 to £10,000 and the adjusted income threshold for the tapered AA increased from £240,000 to £260,000. The 2023 Budget also announced the abolition of the lifetime allowance (LTA) for tax-free saving and an increase to the AA, which meant that fewer doctors and dentists were likely to breach this threshold.

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

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

Figure 8: illustrative growth in pension earned over year 2026 to 2027 for a member with pensionable pay of £195,000



The figure above shows the pension growth of a 43-year-old 2015 scheme member with pensionable pay of £195,000, no non-pensionable earnings and 4 years of service in the 2015 Scheme. Over 2026 to 2027, the member's accrued pension is expected to increase by around £4,400 per year. This is expected to be £10,100 per year projected at retirement age 68 assuming it is projected with CPI plus 1.5%. At retirement, this would be reduced by around 1% to £10,000 per year once the scheme pays debit is applied. The graph illustrates the progression up to retirement of pension benefits accrued and the annual allowance charges incurred over a single year. 2024 valuation assumptions have been used for long-term CPI and salary increases.

The scheme pays charge is relatively small as the member is below the AA taper threshold. Exceeding the AA taper can lead to larger tax charges. This could occur if the above example member also has non-pensionable earnings during 2027 to 2028.

Gender pensions gap

Work is being undertaken to assess the gender pension gap within the NHS Pension Scheme. Evidence suggests that the gap is smaller among members of the 2015 Scheme. This scheme has a career average design, which builds pension benefits more evenly over a member's working life and reduces the impact of differences in pay progression and working patterns.

Communicating the package

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

All NHS Pension Scheme members also receive an Annual Benefit Statement (ABS) every August, which shows the current value of their scheme benefits. For the period 17 August 2025 to 25 April 2026 there were 3,124,205 statements available, with 953,961 views. In comparison, on 25 July 2025 there were 3,073,848 statements available, with 1,091,850 views.

The NHS Pension Scheme is committed to complying with pensions dashboards legislation and supporting the objectives of the Pensions Dashboards Programme (PDP). The scheme has successfully connected to the dashboards ecosystem and continues to work with the PDP and The Pensions Regulator to meet its regulatory obligations.

The MoneyHelper Pensions Dashboard, delivered by PDP, is designed to let people find the public during the 2027 to 2028 financial year. It aims to make pension information easier to access and help people better plan for their retirement.

The My NHS Pension member portal is available to all NHS Pension Scheme members. Access to the portal requires registration either through invite or contacting the scheme. Registered members can access information about their pension benefits and self-serve some administrative tasks, for example, managing pension nominations or viewing a pension payslip or P60.

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