Pay satisfaction and intentions to leave the NHS: a UK-based cohort study

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Most staff working in the UK National Health Service (NHS) earn less in real terms than in 2010 and NHS pay lags behind the rest of the public sector.[1] In 2024 only one-third of healthcare staff were satisfied with their pay.[2] Following strikes in July 2025, resident doctors remain in dispute with the government, and other healthcare unions have also announced they are in pay disputes with the government.[3,4]

Staff are leaving the NHS at high levels: one in ten left in the 12 months to September 2024,[5] and staff retention is a focus of the new NHS 10-year plan. Pay satisfaction could influence retention[6] but this will likely vary by occupational group and seniority, reflecting differences in absolute pay, financial security, employment alternatives and structural inequities, e.g., over-representation of women and ethnic minority groups in the lowest pay bands.[7]

Understanding how pay satisfaction relates to attrition across diverse healthcare staffs and settings is urgently needed to identify those most affected by relative pay disparities, inform NHS pay negotiations and improve retention.

We collected data in 2024–5 from the UK-REACH cohort which included all UK registered healthcare professionals and those working in healthcare in the UK,[8] as part of the NIHR-funded I-CARE project. A booster sample of participants new to healthcare since 2021 were recruited in 2024–2025.

Restricting analyses to participants working wholly or mainly in the NHS (Appendix A2.1), we investigated the association between satisfaction with the 2024 NHS pay deals and a binary outcome of attrition intentions. Pay satisfaction was coded on a Likert scale, in response to the question: "*How satisfied are you with the most recent pay deal that was reached for your profession/role?*" Attrition intentions were derived from the question: "*If you are considering leaving your current job, what would be your most likely destination?*"[2] Those considering moving to a healthcare job outside the NHS or leaving healthcare, retiring, or taking a career break, were coded as having attrition intentions. We compared findings with results using a different outcome which asked about intentions or actions taken to leave healthcare or take early retirement in the past year (A1.1).

Using logistic regression, we computed marginal probabilities for attrition intentions by pay satisfaction in senior doctors (General Practitioners, consultants, speciality and specialist doctors [SAS]) or dentists (community or hospital); resident doctors or dentists; higher-band healthcare workers from other professions (NHS Agenda for Change Band 7 or above); and lower-band healthcare workers (Bands 1–6).

We also analysed free-text responses to the open-ended question: "*At a national level, what would be the most effective way to encourage healthcare staff to stay in their jobs?*", using text-mining and comparing proportions of staff citing pay (or a synonym) to encourage retention (A1.4).

Of 10,542 consenting participants, 4254 were recruited in 2020–1 and 6288 in 2024–5. In total, 6005 participants had complete data (A2.1, A2.2, and A2.8). Of these, 26% were considering leaving the NHS and 48% were somewhat to very dissatisfied with their pay.

Amongst HCWs 'very dissatisfied' with their most recent pay deal, attrition intentions were highest for medical and dental staff. Resident doctors/dentists had the highest attrition intentions, with 52% intending to leave, followed by senior doctors/dentists (45%),

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higher-band (36%) and lower-band (34%) other healthcare workers (Fig. 1 and A2.3).

Pay deal satisfaction and attrition associations were more pronounced in lower-paid groups. Per 1-point increase in pay dissatisfaction, odds ratios for attrition were 1.40 [95% CI 1.24–1.58] for resident doctors/dentists, 1.26 [95% CI 1.20–1.32] for lower-band healthcare workers, 1.20 [95% CI 1.09–1.31] for senior doctors/dentists and 1.14 [95% CI 1.07–1.22] for higher-band healthcare workers (A2.4). Sensitivity analyses excluding dentists and participants aged over 55, showed similar results (A2.3–A2.6).

Of 4776 participants responding to the free-text question on staff retention, 62% suggested improving pay: this included 67% of lower-band HCWs, 59% of resident doctors/dentists, 58% of higher-band HCWs, and 46% of senior doctors/dentists, demonstrating the relative importance of pay for those on lower incomes. Those who proposed pay as a solution had greater attrition intentions and were younger than those who mentioned non-pay solutions (A2.7).

In summary, pay deal dissatisfaction was strongly associated with intentions to leave the NHS. Amongst the most dissatisfied, medical and dental staff–particularly residents–had the highest attrition intentions. Lower paid staff groups showed the strongest associations between pay dissatisfaction and attrition intentions, reflecting pay's greater importance at lower incomes. However, other studies have observed that those with highest levels of pay satisfaction are more likely to leave, perhaps reflecting greater opportunities for the financially secure.[6] However, intentions to leave serve as important early indicators of potential workforce change as they are often related to subsequent actions and maybe also indicative of severe workforce dissatisfaction, which may have adverse healthcare impacts.

A possible limitation of the study sample is response bias among participants. Reassuringly however, levels of pay deal satisfaction measured in our study were similar to that in the 2024 NHS staff survey, suggesting limited response bias on our outcome variable.[2] Our findings may be in part driven by other predictors of attrition that correlate with pay satisfaction, and which may be particularly salient for different groups of staff at different career stages. These include: poor working conditions, work-life balance and/or wellbeing[9]; experiences of discrimination,[10] and poor pay growth potential,[1] all of which are experienced disproportionately by minoritised groups.[10] Effect sizes for some of these other factors are even larger than those we report for pay.[10] Nevertheless, in our analysis of free-text data, pay was the most common suggestion for improving retention, especially amongst the lowest paid. Notwithstanding public sector financial pressures, our results indicate that pay-related reform will be seen as an important policy solution by healthcare staff. Policies that reduce workload, increase embeddedness and improve staff autonomy must also continue, even if these complex interventions may be harder to design and evaluate.

Our data show pay dissatisfaction is strongly associated with attrition intentions. Pay reforms targeting

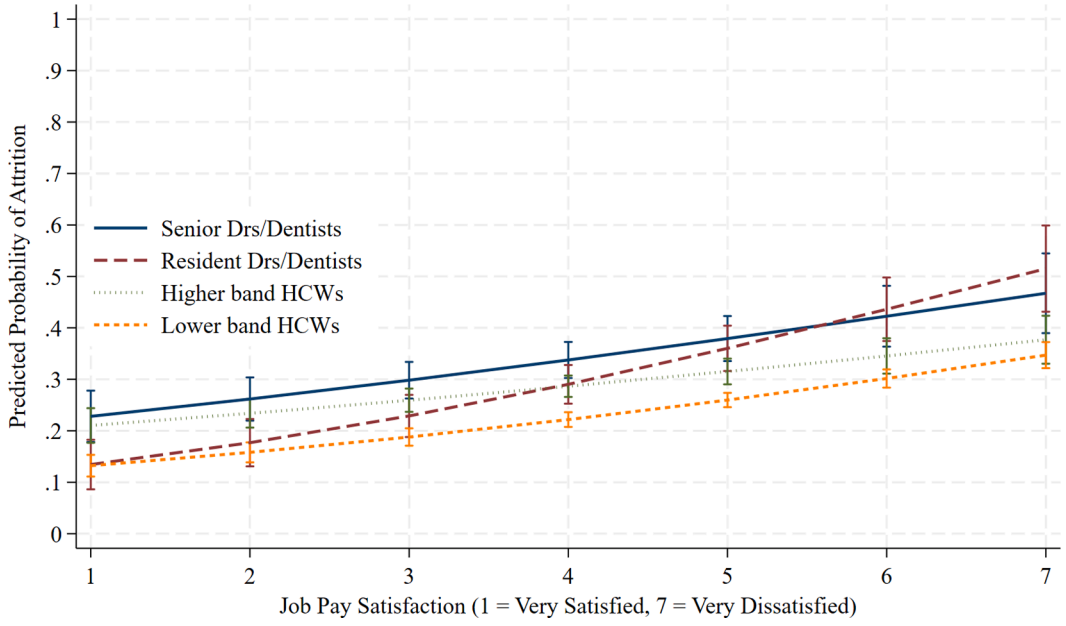

Fig. 1: **Predicted marginal probabilities of current attrition intentions (by levels of pay satisfaction) with 95% CIs, for all four job groupings.**

lower paid healthcare workers will require careful consultation but could lead to the biggest retention gains, which could also improve conditions for staff who stay. Overall, fair pay is a necessary but not sufficient measure to counter the crisis in NHS workforce retention and morale.

Contributors

MP conceived of the idea for the original UK-REACH study and led the funding application. MP and KW conceived of the idea for I-CARE and led the funding application, with CAM, AMe, ALG, and SVK. The I-CARE questionnaire (wave 6 for the UK-REACH cohort) was designed by CAM, ALG, KW, MP, and the Study Collaborative group. AMa and LB built and maintained the study database and consent platform and curated data to ensure anonymity. HR managed the project, including interactions with recruiting sites and supporting all aspects of the project including design of participant facing documentation, website and database and recruitment. VM supported the project including participant support. KW, MP, SVK, RM, and ALG formulated the analysis plan. RM and ALG accessed, verified, and analysed the data. ALG and RM drafted the manuscript with input from SVK, KW, and MP. All named authors reviewed and approved the final version of the manuscript for publication.

Data sharing statement

To access data or samples produced by the UK-REACH study, the working group representative must first submit a request to the Core Management Group by contacting the UK-REACH Project Manager in the first instance (uk-reach@leicester.ac.uk). For ancillary studies outside of the core deliverables, the Steering Committee will make final decisions once they have been approved by the Core Management Group. From Autumn 2026 quantitative data will be available to approved researchers via the UK Longitudinal Linkage Collaboration.

Declaration of interests

ALG reports collaborative research funding from Orion Pharma, outside of the submitted work. MP reports grants from Sanofi, grants and personal fees from Gilead Sciences and personal fees from QIAGEN, outside the submitted work.

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Appendix A. Supplementary data

Supplementary data related to this article can be found at https://doi.org/10.1016/j.lanepe.2025.101454.

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