High priority? The past, present and future of specialty training recruitment

Increased competition for specialty training posts (the final training stage before becoming a GP or consultant) has emerged as a significant workforce issue facing the NHS's medical profession, alongside concerns over pay. For many years, the number of applications has exceeded the number of available training posts, and a growing number of doctors are unable to secure a specialty training place.

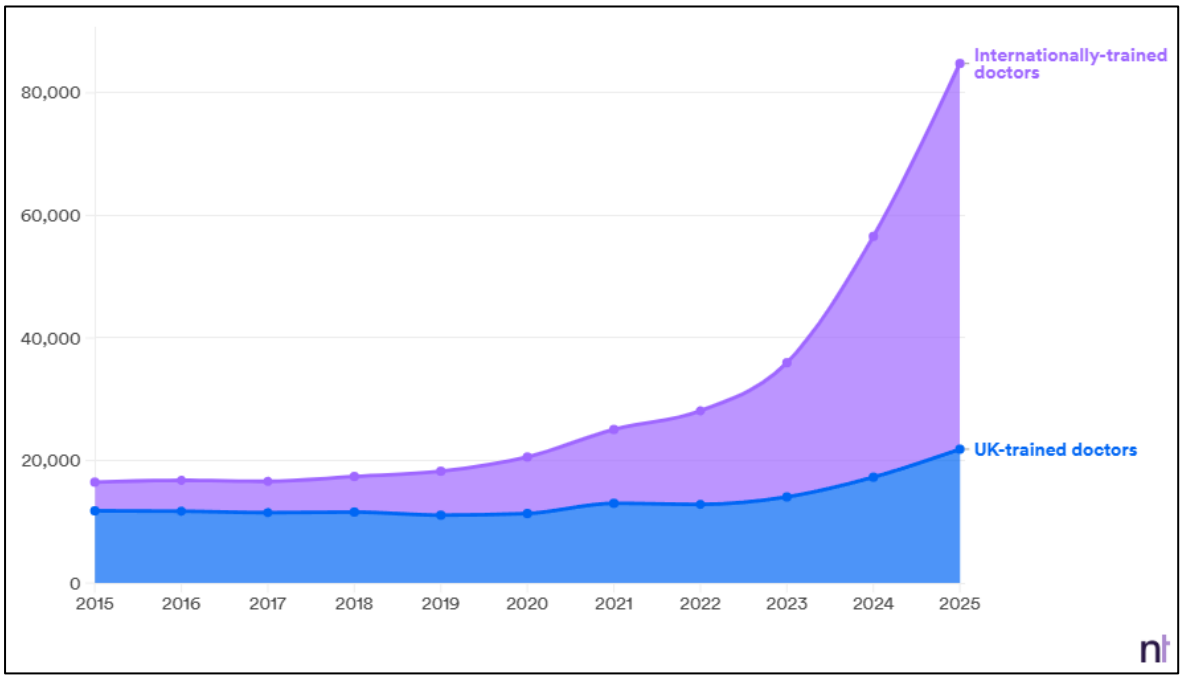
In response to these concerns, the government has brought in measures to alleviate the discontent over specialty training. The Medical Training (Prioritisation) Act became law in March 2026, and it has fundamentally changed how specialty training places are allocated in the UK. Under this new system, applicants in a priority group – predominantly UK-trained doctors, among others – are offered places before applicants in a non-priority group, marking a significant departure from the previous recruitment process. The government has also committed to expanding the number of training places over the next three years.

This blog explores how the NHS reached a point where legislative intervention was considered necessary and examines data from the first cycle of applications since the Prioritisation Act was introduced. What impact has the Act had so far, and can it help address workforce challenges for medics in the longer term?

The scale of change over the last decade

The total number of specialty training applications increased more than five-fold in the decade to 2025, rising from around 16,500 to almost 85,000 applications annually. While applications from UK-trained doctors nearly doubled during this period, growth was driven primarily by doctors trained overseas, whose applications increased more than thirteen-fold (Figure 1).

Figure 1: Number of specialty training applications by world region of training



Note: Data includes all applications made by doctors for the first stages of core and specialty training (known as CT1 and ST1) in the UK. Any higher specialty training applications (ST3 and beyond) are not included. Each doctor can submit multiple applications, so this data does not represent the number of individual candidates.

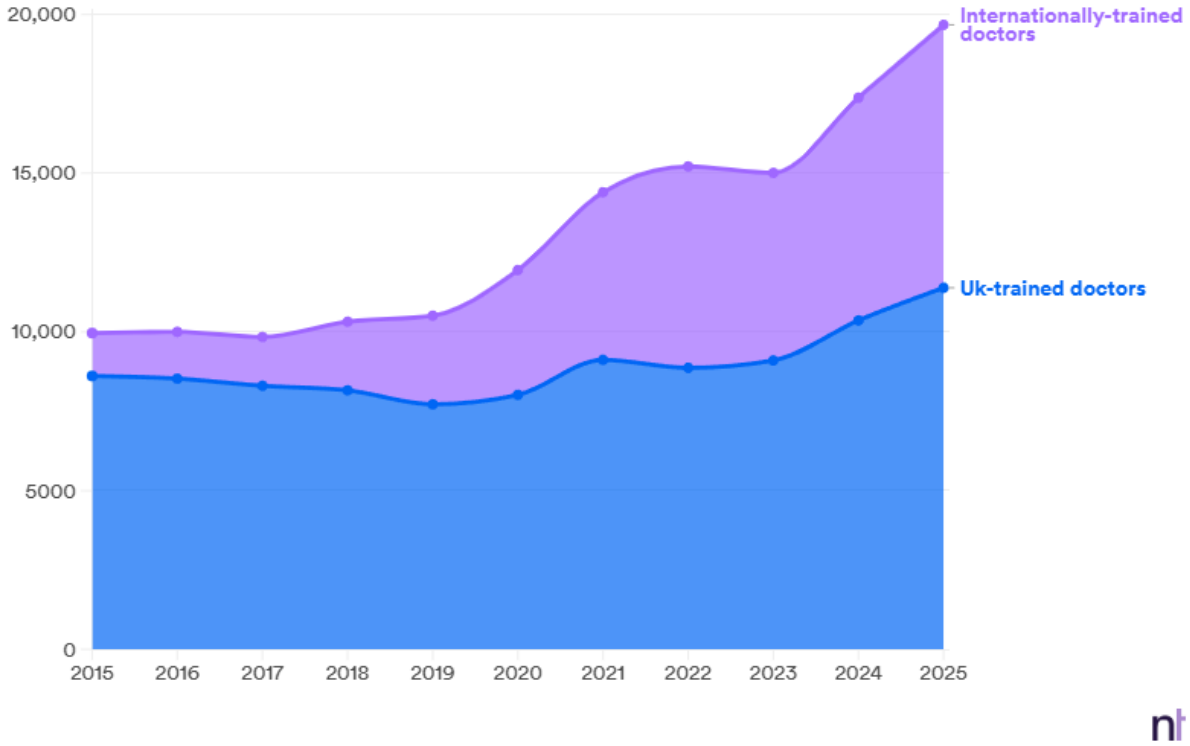
Source: Nuffield Trust analysis of bespoke GMC data.

Prior to the introduction of the Act, any doctor – as long as they met the initial eligibility threshold – could apply to any specialty training route, irrespective of where they had trained. Doctors were also able to submit applications to multiple specialty training programmes, so the total number of applications received was substantially higher than the number of individual candidates. As competition increased, candidates may have submitted applications across a wider range of specialties to improve their chances of securing any training post. Given the cap on UK medical school places, it is perhaps not surprising that the increase in the number of applications from UK graduates has been more modest than that from international medical graduates, who greatly outnumber their UK counterparts.

While the total number of applications has increased substantially, the number of specialty training posts has increased by only 11% over the same period. Furthermore, changes in the number of posts have not been uniform across different specialties – for example, places for clinical radiology increased by 44%, while anaesthetics roles fell by 14%.

The number of offers made for training places depends on how many training places there are available, as well as the number of applications made. In the decade to 2025, the number of offers made to applicants doubled. However, breaking this down further to compare UK-trained doctors with internationally trained doctors, there was a six-fold increase in offers among doctors who trained overseas (an increase of 513%), compared to an increase of just a third (32%) for UK-trained doctors.

Figure 2: Number of specialty training offers by world region of training



Note: Data includes all offers given to doctors for the first stages of core and specialty training (known as CT1 and ST1) in the UK. Any higher specialty training applications (ST3 and beyond) are not included. Each doctor can receive multiple offers, so this data does not represent the number of individual candidates. Receiving an offer does not mean doctors have accepted a place on a training programme.

Source: Nuffield Trust analysis of bespoke GMC data.

Based on the number of applications and offers made over time, it would be easy to conclude that internationally trained doctors are filling training posts in place of UK-trained doctors. However, the reality is not as clear-cut.

Firstly, headline application numbers may overstate the extent to which doctors are competing for the same jobs. Each physician will apply to multiple specialties, but the data does not provide insight into the preferences or ranking of those specialties. For example, a doctor may apply for general practice as a backup, while their preferred career is in radiology. Not every application therefore represents the same level of competition for a training post. Secondly, receiving an offer does not mean a post is filled, as not all offers are accepted. Thirdly, as highlighted in the GMC's 2025 workforce report, in 2023/24 the proportion of applicants receiving an offer fell for both UK graduates and doctors who trained overseas, with the latter group actually seeing a steeper decline.

However, that does not diminish the underlying problem. The number of training posts has grown only modestly in recent years despite a substantial rise in the number of applications, meaning many UK- trained doctors are unable to progress into specialty training posts.

How has the Medical Training (Prioritisation) Act changed the route to specialty training posts?

The Act established a new way in which specialty training posts are allocated, with the intention of prioritising UK-trained doctors to strengthen the domestic training pipeline. The legislation creates two pools of candidates: a priority group and a non-priority group. The priority group includes UK-trained doctors, doctors who trained in countries with which the UK has longstanding reciprocal agreements around recognising medical graduates, including Ireland, Iceland, Liechtenstein, Norway and Switzerland, as well as individuals meeting specified immigration criteria. From 2027 onwards, further provisions requiring "significant NHS experience" are expected to be introduced, which will replace eligibility based on immigration status that has only been used for this year's recruitment round.

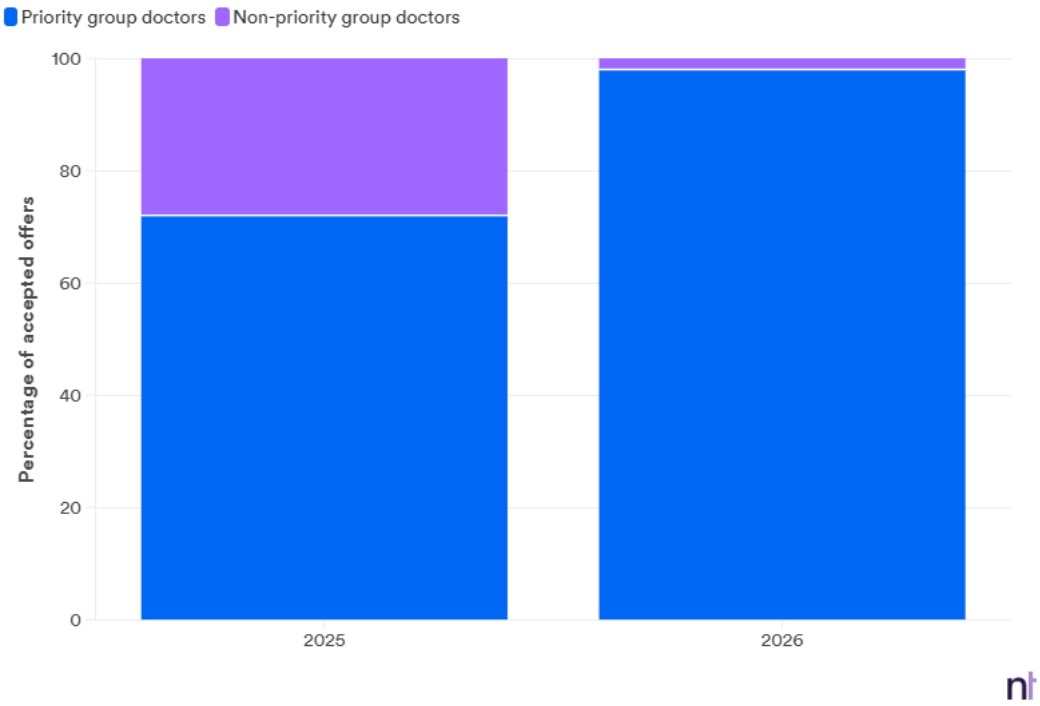
Under this system, appointable candidates in the priority group are offered places before appointable candidates in the non-priority group. Prioritisation status therefore becomes the first determinant of access to specialty training, ahead of candidate ranking across the overall applicant pool. This is a significant departure from the previous system in which specialty training posts were offered to those who ranked highest, irrespective of where they trained.

What impact has the Act had on the allocation of specialty training places so far?

Provisional data from NHS England allows for comparison of the number of accepted posts in the 2026 recruitment round – after the Act was implemented – and the previous year. Early evidence suggests that the policy has had a substantial effect on who is offered and accepted onto specialty training programmes.

While over one-in-four (28%) doctors accepting a specialty training place in 2025 were in the non-priority group, this has now fallen to less than one-in-50 (1.8%) in 2026 (Figure 3). In fact, only five out of 16 specialties had any acceptances from non-priority candidates at all. And this isn't because doctors in the non-priority group aren't applying to specialty training posts – they made up just over half (51%) of all applications.

Figure 3: Proportion of accepted offers for specialty training places by priority group status



Note: Data shows the proportion of doctors accepting offers for a specialty training place in the UK by priority group status. For more information on prioritisation criteria, see here.

Source: NHS England management data.

This suggests that the policy has largely achieved its immediate objective: building a domestic workforce through prioritising more UK-trained doctors (who will make up much of the priority group) for specialty training posts.

Looking forward

There is no doubt that the Act has had an impact in terms of strengthening the domestic training pipeline. However, striking the right balance will be important. While the new system aims to improve training opportunities for priority candidates, policymakers must avoid unintentionally reducing the overall supply of doctors entering specialty training. Not even a decade ago, the NHS struggled to fill specialty training posts, with all but two training programmes failing to completely fill every training place. These shortfalls ultimately led to doctors of all grades being added to the shortage occupation list – meaning shortages could be filled by medics who had trained overseas – reflecting the recent need for international recruitment to help meet workforce demand.

It remains unclear how doctors in the non-priority group will respond to the new system. While application volumes remained high in the first year of the Act taking effect, future cohorts may reassess whether applying for UK specialty training offers a realistic route into a training programme. If non-priority applications fall significantly, the impact is likely to vary between specialties. Training programmes that have historically relied more heavily on overseas graduates (including general practice, psychiatry and obstetrics) are at risk of being most affected by future workforce shortfalls.

Alongside these uncertainties in the future training pipeline, the BMA accepted the government's offer to create up to an additional 4,500 specialty training places in the next three years. However, indications that these posts will be distributed within hospital settings do not fully align with the NHS's wider ambition to shift more care *out* of hospital, where additional medical expertise in the community will be increasingly important. This raises wider questions for a forthcoming long-term workforce plan. If future service models rely on more care being provided closer to home, any training expansion should target specialties most critical to delivering that shift, rather than concentrating growth in traditional hospital-based pathways. It will also require training programmes to equip doctors with the skills needed to support more specialist care outside of hospital settings.

The Medical Training (Prioritisation) Act appears to have achieved its immediate aim of improving access to specialty training for priority-group applicants – predominantly UK-trained doctors. But the NHS has moved from a period of unfilled training places to one of intense competition in less than a decade. Whether the policy is judged a long-term success will depend on its ability to improve opportunities for priority-group doctors, without undermining the future supply of specialists.