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# RCP response to the UK government consultation on the 10 Year Workforce Plan

## November 2025

The Royal College of Physicians (RCP) is the membership body for physicians working in 30 medical specialties, representing around 40,000 fellows and members in the UK and around the world.

The RCP welcomes this consultation on the 10 Year Workforce Plan (10YWP), following our call for meaningful engagement on the plan. We also welcome the UK government's intention to now publish the plan in spring 2026 to get the process right, following feedback from stakeholders. **This additional time must result in further proactive engagement with NHS staff and the medical workforce in England to test ideas and assumptions.** We support government's health mission for 'people deserve to live in a fairer Britain, where everyone lives well for longer', and its ambitions to build a workforce that is 'ready, resilient and capable of delivering world-class care'. That vision will only be achieved through investment in the quality and experience of medical training, protected time for teaching, supervision and non-clinical skills, and meaningful and genuine engagement with the NHS workforce.

A transparent and open approach will be crucial. Physicians, and the wider medical profession, have unique and important insights to support the development of a credible workforce plan. The independent National Audit Office (NAO) analysis of the 2023 NHS England Long Term Workforce Plan (LTWP) recommended that assumptions should 'be generated in transparent and systematic consultation with external stakeholders.' **A lack of proactive engagement on the LTWP – as well as the lack of any implementation document – harmed the medical profession's confidence in that plan.** The development of the 10YWP must address this to avoid repeating the same mistake. The Department of Health and Social Care (DHSC) must implement the NAO's recommendations and engage meaningfully with doctors and royal colleges on the development of the 10YWP. It must also produce an implementation plan, and actively and consistently involve the NHS workforce in its delivery of both documents. The involvement and confidence of the medical profession is critical to the success of the plan.

**The RCP is a strong supporter of a long-term approach to workforce planning.** Historic short term decision making is evident in the staffing crisis we see today, where demand is growing, our workforce is burnt out and demoralised, and yet despite those challenges, early career doctors are left without an NHS training post. Preparing to meet the challenges that we know are coming is an essential foundation to a sustainably staffed health service, and a well-resourced and well-supported workforce will be central to government delivering its three shifts. **We continue to believe that a regularly refreshed dedicated workforce strategy, with independently verified modelling of medical staff, is the right approach to ensure population needs are met.**

We understand that the 10YWP is taking 'a decidedly different approach' to the LTWP. We are clear that a meaningful, credible workforce plan should be future looking, recognising and accounting for expected future trends as well as population need, so it models and delivers the medical workforce required to

deliver the health service that patients need. The 10YWP must be realistic and deliverable, with clear priorities underpinned by funding and a clear implementation plan.

## Recommendations

The UK government must:

- invest in the medical workforce to deliver excellent patient care in the NHS.
- engage effectively with doctors and royal colleges on the development of the 10YWP by testing the ideas and assumptions that underpin it.
- develop and publish a 10YWP implementation plan that actively involves the NHS workforce.
- maintain the commitment to grow the domestic medical workforce through an expansion of medical school places, using the 10YWP to set out a feasible plan and timetable for delivery.
- set out independently verified modelling of the workforce numbers we need to meet population need and address health inequalities, including projections of training places for the medical specialties.
- expand the number of medical specialty training places to meet population demand – the 1,000 specialty places promised in the 10 Year Health Plan (10YHP) must be the start of a bigger expansion.
- commit to reforming postgraduate medical training and set out plans for addressing competition ratios to fair and sustainable levels.
- maintain the commitments made to regularly refresh the 2023 LTWP, so the 10YWP is refreshed every two years, or aligned with a fiscal event.
- accept the NAO's recommendations on the 2023 LTWP and provide clarity on how those NAO recommendations are informing the development of the 10YWP.
- deliver a plan to support educators, supervisors, mentors and trainers by working with employers in the NHS to increase capacity for medical education and training.
- recognise that AI and technology alone will not solve the problem of capacity in the health system.
- provide the necessary funding to deliver the priorities that the plan sets.
- limit the pace and scale of the roll out of the physician assistant (PA) role as laid out in the 2023 LTWP, reviewing and revising the projections for the role.

## Meeting the needs of an ageing population with complex, multiple conditions

**Patient need over the next decade must be central to government's assumptions about the type of workforce the NHS needs:** Improvements in life expectancy in England have stopped and in more deprived populations, life expectancy has gone backwards. England's population is ageing, and more people are living with multiple conditions. While getting older doesn't have to mean getting sicker, we know older people often live with multiple health conditions and that too many children, young people and working age adults are already living in poor health. For example, there has been an overall upward trend in the percentage of adults aged 18 and over living with overweight or obesity in England since 2015 to 2016, and the Health Foundation estimates that 2.5 million more people will be living with serious illness by 2040.

Bringing down avoidable illness is a critical part of reducing avoidable demand for healthcare. We urge government to swiftly deliver its 'sickness to prevention' commitments, tackle poverty, especially child

poverty, and to commit to a cross-government strategy to reduce health inequalities. The 10YWP must prepare for the challenges that we know are coming: a society with widening inequality where many people live with more than one health condition. Almost one in five (17%) people over the age of 65 are expected to live with four or more long-term health conditions by 2035. That makes patient care more medically complex, where the expertise of physicians is key.

Physician training ensures that patients with acute and long-term conditions can be supported to an accurate timely diagnosis and have treatment plans that take into account the best evidence, address uncertainty and consider other medical problems holistically. This provides the most efficient approach to simple as well as complex problems. Skilled decision making is needed at an early stage in healthcare, and not just when problems have escalated.

**Physicians' training enables them to integrate complex, uncertain information with holistic clinical judgement, combining broad diagnostic insight and specialist expertise to make safe decisions for medically complex patients while leading multidisciplinary teams:** doctors are trained to deal with uncertainty, skilled in synthesising complex – and often imprecise or complete – information, weighing up different elements and then making decisions about a course of action. Physicians' medical training gives them a unique depth and breadth of understanding of the whole patient across all systems in the body. Physicians' specialist training then builds on this foundation, adding disease-specific expertise while retaining the capacity to see the bigger picture. This is profoundly different to other professionals who may have a specific narrow technical expertise, even when they are at a senior level. Patients benefit from the range of skills and expertise that make up a multidisciplinary team, but physicians' training as generalists and specialists equips them with comprehensive medical understanding to safely exercise clinical judgement for acutely unwell patients – when to treat, and how; how to respond to changing circumstances and new information; when not to treat, or to stop treatment altogether. It means physicians have the diagnostic breadth and decision-making ability to make nuanced diagnostic decisions outside of algorithmic pathways to provide safe, holistic, patient centred care. This is essential for a patient population with increased complexity, as physicians are not only trained to holistically understand that complexity, but to also deal with the risks associated with managing it. It is why physicians are senior decision makers, who hold ultimate responsibility and accountability for an MDT and medical pathway.

This unique physicianly expertise was critical in the COVID-19 pandemic, where physicians' generalist understanding of the whole patient, ability to synthesise complex information, hold risk and make nuanced decisions in response to new information made them perfectly placed to be redeployed from their usual roles to manage patients with COVID-19. These skills will be as vital for the next pandemic as they are for managing complex patients over the next decade with a shift to community care.

**We must ensure future physicians receive high-quality training to manage complexity and risk, maintaining their generalist abilities and expertise alongside specialisation:** the diagnostic report of the recent postgraduate medical training review rightly recognised the critical importance of doctors' generalist capabilities and the need to move away from the fragmented 'disease by disease' to the coordinated management of each patient's medical conditions. It also highlighted key tensions and issues that need to be addressed within training on this point, including that generalist skills are better defined. We need to ensure that the next generation of physicians is provided with high quality generalist training that equips them to develop key physicianly skills like managing complexity and holding risk, so they can treat patients today and in the future. We stand ready to play our part in supporting the review of postgraduate training

curricula, including maintaining generalist skills while specialising and support its recommendations that resident doctors training in craft and procedure heavy specialties must have time to develop procedural skills. It is critical that we improve the quality and experience of general internal medicine training, and guarantee protected specialty training time in every rota template.

**Innovation and research are essential to discovering solutions to the problems the NHS and its patients face**: the COVID-19 vaccine illustrated the fundamental importance of clinical research in healthcare and the UK's status as a world leader, and there will be future discoveries that are equally world changing. Physicians are leaders in innovation and research, and the RCP has long called for research to be embedded in everyday practice for all physicians to ensure the NHS has the research capacity it needs. We agree with the 10YHP that research, development and innovation should be a core part of everyday clinical work. But until workforce supply and healthcare demand is rebalanced, doctors will continue to be drawn away from both leading and undertaking research by the need to deliver frontline clinical care.

**All of this begins with having enough doctors to meet population demand:** a healthy society needs patients to be able to benefit from the expertise of NHS doctors, which is why the RCP campaigned for an expansion of medical school places. The 10YWP is an important opportunity to rethink a feasible delivery plan and timetable for making this promised expansion work. For every new medical school place created, we also need a corresponding increase in foundation and specialty training posts, based on population need in different parts of the country, especially in areas that are most deprived. We will need more clinical academics, educators and supervisors (including plans for increasing educator and supervisor capacity so that senior doctors have the time to give meaningful support), as well as physical capacity to cope with a larger number of students. The expansion will not succeed without a training system that works, either, and we urge government to set out how it will deliver on its promise to address competition ratios and ensure that NHS doctors are able to continue their careers in the NHS. But if government wants to reduce international recruitment to less than 10% by 2035, increasing the pipeline of domestically trained NHS doctors has to be a priority. Government must maintain the commitment to grow the domestic medical workforce through an expansion of medical school places, using the 10YWP to set out a feasible plan and timetable for delivery.

# Modelling assumptions

## Consultation on government's assumptions

It is vital that doctors are consulted on the DHSC assumptions that underpin the 10YWP. The RCP was concerned by the suggestion in the 10YHP that staff numbers in 2035 will be lower than those projected in the LTWP – **we need to see the evidence and assumption underpinning this**. AI and technology the potential to increase efficiency of some tasks, but it will not solve the problem of capacity in the health system alone.

The independent analysis from the NAO provided a range of recommendations that should be accepted in full for the 2025 refresh, particularly the recommendation that assumptions should 'be generated in transparent and systematic consultation with external stakeholders.' The RCP is extremely supportive of the approach to workforce planning where modelled projections (and the independent analysis of those projections) are in the public domain so they can be scrutinised. We were one of over 100 health and care organisations calling for regular, independent assessments of the staff needed to keep pace with patient demand to be included in the Health and Care Act 2022. We welcomed Labour's support for that call, and

its subsequent manifesto commitment to publish regular, independent workforce planning across health and social care. Testing assumptions with the medical community and others in the health sector is key to ensuring that the modelling is credible, and the plan is feasible and deliverable. We would welcome clarity from DHSC on how the NAO's recommendations are informing the 10YWP development. DHSC must accept the NAO's recommendations and provide assurance and commitment that the NAO will independently verify the modelling in the 10YWP.

## Challenges facing the medical specialties that must be factored into assumptions

Services and teams must be designed based on population demand, understanding the workforce needed to deliver the best care to patients with different medical conditions across different regions. The RCP recognises this is no easy task, with each medical specialty facing its own unique challenges, as well as many that are shared across all physicianly practice. The RCP held a roundtable with the medical specialties in November 2024 which identified common themes around future demand for the medical workforce. These assumptions should be considered by the 10YWP. The write up is available here.

Population demands are changeable. There is a 'leaky pipeline' of disillusioned resident doctors considering leaving the NHS, just as many consultants are considering early retirement. Over a third (35%) of respondents to our 2025 national next generation survey told us they didn't know if they would be, or did not expect to be, working in the NHS in 5 years. Many more doctors are training and working less than full time. These challenges all need to be understood and accounted for when projecting how the workforce will expand and change in the future. The 10YWP is the vital opportunity to do this.

Lord Darzi's review highlighted the worrying trend in medical clinical academic numbers, and we welcomed the 10YHP committing to reverse the decline in clinical academic roles. Government must develop a specific strategy to deliver this commitment so clinical academia is supported at all stages.

## Assumptions about demand

The 10WP should set out assumptions on population health needs and demand, as well as service reform. This was lacking in the LTWP.

We know people are living longer with multiple conditions, and this has an impact on the workforce skills required to understand and manage medical complexity and the risk that comes with that.

Government must also set out its assumptions on the impact of delivering the sickness to prevention shift on avoidable illness and swiftly deliver its 10YHP commitments: opt-out tobacco dependence treatment across all routine hospital care, new healthy food standards and mandatory reporting on them and updates to nutrient profile models. It must then go further. The health mission is now rarely mentioned, and despite repeated calls from the RCP and hundreds of other organisations, there remains no cross-government strategy to reduce health inequalities.

Bringing down avoidable illness through robust action on prevention is a vital opportunity the government must grasp. Action to reduce health inequalities and poverty are critical. It is an essential part of reducing avoidable demand on the health service. Government must deliver its manifesto commitments to tackle the social determinants of health and halve the gap in healthy life expectancy between the most and least deprived regions in England.

## Projections of medical specialty places

The modelling of the medical specialty places needed to meet population demand is a consistent concern of our members. The 2023 LTWP did not cover the demand and supply of the medical specialties and did not project any increase in medical specialty numbers that would be needed as part of the expansion of medical school places. It cited a lack of 'sufficiently granular data' and the challenges involved with predicting demand in 15 years' time but said that 'the objective for future iterations was to establish the data and methodologies needed to form a richer range of information from across the NHS'. Since then, the RCP has repeatedly called for more granular data to support modelling of the specialty training places required to meet population demand. This detail, lacking from the 2023 LTWP, is vital to ensuring that we can meet future patient demand, doctors can continue their NHS careers and specialty workforce pressures are alleviated.

Having the right the supply and demand of medical specialties are key to ensuring that our health service can meet the needs of the changing population, especially with the shift from hospital to community. Without comprehensive workforce planning for medical specialties, the NHS will not be able to give patients the high-quality care they need. Modelling these places is central to better workforce planning that is focused on meeting the needs of local populations, improving population health and reducing health inequality.

DHSC must set out what it needs from royal colleges and others in the health sector to inform their work on projections. Government must increase the number of medical specialty training posts. **Not doing so is not an option.** The 1,000 specialty places promised in the 10YHP must be the start of a bigger expansion.

## Assumptions about hospital to community

Medical specialists must be part of the community shift. That shift must mean delivering more patient-centred, equitable and sustainable care, and requires truly integrating the expertise of medical specialists – physicians – with primary care, supported by well-resourced community teams. Neighbourhood health should mean physicians have a more proactive role earlier in the patient's journey, rather than after a patient's condition has deteriorated. Without input from the right medical specialist at the right time in the right setting, neighbourhood health risks replicating current problems: fragmented services unable to meet the needs of patients holistically, particularly those with long-term conditions and complex needs. For example, currently the majority of people with respiratory disease, largely managed in the community, report that they are missing out on numerous aspects of care.

Physicians will need more time to provide specialist care at an earlier point in patient journeys. A snapshot survey of RCP members earlier this year found that 80% of respondents already deliver Advice and Guidance (A&G) as part of their role – but half reported not having dedicated time in their job plans for this work.

**Government must consult with the medical royal colleges about the impact of the community shift on where and how physicians work.**

Job planning must encourage and actively support new ways of working, including A&G, remote and virtual working and providing expert 'cover' for MDT hospital or community teams.

Outpatient reform is also key and will have an impact on how physicians work in future. The RCP is uniquely placed to support with putting together what a good service is, the workforce needed for patient care in the medical specialties and possible data. We are not clear on the evidence underpinning the aim to replace two-thirds of outpatient appointments with services delivered through the NHS App. As clinicians, we want to avoid unnecessary appointments, but targets like this risk prioritising the wrong thing. We need to focus on the value of appointments, not the volume. We support all patients being able to access the full range of NHS App services to ensure there is a level playing field. But there is significant clinical value in seeing patients face to face.

The skillset of physicians as medical specialists will be critical to healthcare delivery in neighbourhood models, including managing risk, as well as in upskilling, educating and advising other clinicians in the community on specific conditions and diseases. Bolstering the physician workforce will be key, requiring an expansion of postgraduate medical specialty places and projections of which medical specialty places we need to meet patient demand in future in these models.

## Assumptions about analogue to digital

Functioning digital systems will be critical to realise the hospital to community shift and increasing use of remote care and monitoring. During recent RCP hospital visits, clinicians have reported that digital innovation is improving care where systems are interoperable, designed with user input and supported by adequate training: electronic handover systems in Nottingham and Southampton have significantly reduced omitted tasks and improved team communication, and virtual wards and remote monitoring for heart failure and COPD can free up inpatient beds while maintaining good patient outcomes.

But the RCP is clear that AI and digital solutions alone will not solve the problem of capacity. Physicians repeatedly emphasise that digital systems often add burden rather than reduce it when implemented without co-design or integration. Digital literacy, information governance barriers, and poor interoperability between hospital and community IT systems remain persistent obstacles.

**We need to see the evidence underpinning any assumption that greater use of technology will mean fewer staff are needed.** Government must be alert to optimism bias in its assumptions about the analogue to digital shift. Many previous digital tools, like electronic patient records (EPRs), which have been poorly rolled out and not integrated with other clinical systems, have made staff less productive.

The implementation of technology in the NHS has also led to 'task shifting', where routine tasks that would previously be carried out by administrative roles have been transferred to clinicians to undertake alongside their clinical roles. Many physicians responding to our survey also talked about the added time and inefficiencies introduced by having new EPRs rolled out.

Respondents to our survey highlighted that if the NHS App allows patients to have more direct contact with clinicians to receive specialist advice, there would likely be a need for more staff, not fewer, as doctors will take on additional tasks. We know referrals to A&G have significantly increased since the RCP snapshot survey in February of this year showing the proportion of UK consultant physicians providing A&G without time for it in their job plans. This is likely to increase further still.

### Assumptions about training

The RCP fully supports reform of postgraduate medical training, and the commitment in the 10YHP to reform to curricula to provide comprehensive training in the use of AI and digital tools and promote acquisition and retention of generalist skills. In our 2025 next generation survey, only 9% felt equipped to use health technology.

The community shift will require physician training to work differently. The training that currently takes place in the community varies from specialty to specialty. This will need to be changed to ensure that physicians are able to lead community-based MDTs in future. We need dedicated time for community-based training to align with future workforce needs.

The RCP has also called for the NHS to pilot 'stay local' training schemes, particularly in areas with high health inequality or recruitment challenges. Local, college-accredited training pathways could offer a new route to the certificate of completion of training (CCT), helping residents build lasting relationships with patients, supervisors and services in the areas that need them most. Doctors building connections with their communities will be critical to deliver the community and prevention shifts – something that is made hard at the moment with frequent rotations.

Residents must be supported to develop their leadership skills and contribute meaningful QI projects which align with 10YHP aims. Leadership and 'systemic QI' should be considered in curriculum changes.

Reforming curricula to include training in AI and digital tools is a welcome move, but we must go further to ensure all staff have the skills, confidence and support they need to thrive in a digitally enabled health service. There is a need for improved training in digital skills and data science for future physicians. Current training does not fully prepare physicians for remote and digital care models, nor digital clinical leadership in future. Doctors' education and training must reflect the digitised NHS they are already learning and working in and understand the new ways of working that will come from further increasing use of digital tools like AI.

### Physician assistants

Following a vote of RCP fellows in 2024 to limit the pace and scale of the roll-out of physician assistants (PAs), the RCP has been calling on NHS England to review its modelled projections for growth in the PA workforce laid out in the LTWP until issues of regulation, standards and national scope of practice are addressed. We urge government to review and revise the projections for the PA workforce in the 10YWP. The rollout that was projected in the 2023 LTWP must be limited in pace and scale.

## Productivity gains

Digital tools, including AI, are not a silver bullet to increased productivity or a workforce solution.

Poorly implemented digital tools reduce productivity. Digital tools that are not user friendly, or not interoperable or well-integrated, can increase administrative burden, while basic infrastructure issues such as a lack of functioning computers or poor Wi-Fi hinder productivity and training. Many survey responses talked about the introduction of new digital systems in their trust that had significantly increased the time taken for a task. Stories of how long it takes clinicians to log onto computers, or finding a working computer

in the first place, are common. We need digital infrastructure that is made or suitable for 24/7 acute hospital units and medical emergencies. One respondent talked about resident doctors becoming 'computer operators' and rarely being able to interact with patients anymore. AI tools that are working on inaccurately collected data will produce bad outcomes. There should be a role for agentic AIs collating material from EPRs to allow doctors to access the salient information they need to make decisions.

Ambient voice technology (AVT) could free up time, and lead to more patient centred care with less cognitive load on clinicians. It could support more patient contact, more training and less administration done by doctors. But it is unlikely that we will achieve the full potential of AI until systems are fully integrated with EPRs.

Digital tools may automate tasks, but they cannot and should not replace relational aspects of care. There is clinical benefit in seeing patients face to face to make decisions about their diagnosis and treatment. This is especially the case for the most disadvantaged patients, and the digital shift must not be allowed to increase health inequality. Medical care for acutely unwell patients routinely involve sensitive conversations about treatment or end of life care – these conversations cannot and should not be rushed. They require time.

It is critical that the 10YWP considers a better definition of productivity for physicianly care. **We need to measure clinical outcomes, not activity.**

A lack of administrative staff has also had a big impact on doctor productivity. Tasks that were previously done by administrative staff have now shifted to doctors, taking them away from patient care. We need to restore administrative support roles to improve clinician productivity and allow focus on clinical work.

Doctors should be trained and supported to work across the full range of their capabilities using their expertise as appropriate to patient need. This will include both leading the accurate and efficient delivery of care for people with routine cases and complex 'top of license' work. There must be recognition that defining the role of a doctor to the latter only will produce an inefficient system (the most sophisticated decision makers need to be at the front door) and also risks taskification and burnout.

## Culture and values

The 10YWP must be stronger on retention than the LTWP was. Our 2025 national Focus on physicians survey of 2,038 UK consultant physicians found that 45% enjoy their job less than last year.

**Staff must feel supported and valued by the NHS.** We welcome that improving the working culture is a focus of the government. We know too many staff, especially early career doctors, feel demoralised and disillusioned. The recent NHS England 10 Point Plan to improve resident doctors' working lives highlighted many issues (such as accurate pay and access to parking) that have over the years damaged trust between resident doctors and the NHS. This 10 Point Plan must be delivered in full and it is welcome that 'trusts will be expected to provide updates for national reporting on progress'.

Addressing bottlenecks in training and competition ratios will also have a significant impact on ensuring residents feel supported and valued by the NHS as their employer.

**We need a dedicated retention strategy for the NHS workforce.** To deliver a positive culture across the NHS for the medical workforce, the RCP recommends that the 10YWP must set out a clear plan of action for:

- getting the basics right: safe, supportive workplaces where wellbeing is prioritised.
- supporting flexible working and training.
- protected time for career development, clinical research activity and quality improvement for all doctors, including locally employed doctors and those not in national training programmes.
- 24/7 access to affordable food and proper rest/study spaces at all hours of the day.
- a zero-tolerance approach to workplace harassment, bullying and sexual misconduct in the NHS with systems to hold individuals and organisations to account.
- a plan to support educators, supervisors, mentors and trainers by working with employers in the NHS to increase capacity for medical education and training.
- balanced, team-based job plans for consultants and specialists that give time for wider professional activities that drive professional reward and commitment: the RCP has published job planning guidance for consultants and specialist physicians.

There must be specific emphasis on early career doctors; these are the physicians that we need to become the consultants of the future delivering the government's reform plan. Government and the NHS must:

- reform postgraduate medical training, recognising it is not currently fit for purpose, and the recommendations in the national medical training review must be acted upon urgently.
- deliver the NHS England 10 Point Plan and continue to provide regular updates for progress.
- bringing competition ratios down to fair and sustainable levels and expanding medical specialty training posts.
- use data to target retention risks, improve continuity of supervision and care, and embed a culture of continuous listening to tackle the real drivers of attrition.
- level the playing field for locally employed doctors by standardising inductions, guaranteeing access to supervisors and ensuring fair study leave and budgets.
- review workplace-based assessments and the annual review of competency progression. Improve supervisor training and streamline portfolios to reduce burden and maximise learning benefit.
- introducing clear minimum standards for self-development time (SDT), built into rota plans for resident and LED/SAS doctors to make the process fairer and increase the hours of professional development taking place.
- define what 'good' looks like for supervision and mentorship, and enforce national minimum standards for supervision, promote regular scheduled meetings.
- reform rotas, giving more doctors the option of self-rostering.
- improve the quality and experience of general internal medicine training and guarantee protected specialty training time in every rota template.
- guarantee protected time for research, education and CPD by building it into rotas and job plans.
- ensure workforce planning balances service demand with the need for doctors to develop and learn throughout their career.

- modernise training to recognise and reward doctors' non-clinical contributions – including research, teaching and leadership – and embed skills like financial management and digital health in curricula.
- publish clear recruitment criteria, reform tick-box processes, recognise the full breadth of doctors' skills and drop proposals that risk adding more unfairness to the system (like the Multi-Specialty Recruitment Assessment).
- make training more flexible and supportive by piloting 'stay local' schemes in hard-to-recruit areas, properly consulting clinicians and royal colleges on changes to rotational training and giving doctors practical help with housing, childcare and transport so they can train where they are most needed.

There are also a range of 'hygiene' factors that would make a difference to the NHS workforce's wellbeing: investing in functioning IT equipment and administrative staff. In our 2025 Focus on physicians survey of UK consultant physicians, when asked about issues negatively affecting wellbeing at work, the most common responses were clinical workload, followed by poorly functioning IT equipment and a lack of administrative support. On the flipside, when asked what would make the biggest improvement to their wellbeing at work, well-functioning IT equipment was the most common response, ahead of fewer administrative tasks and reduced clinical workload. NHS staff must have working IT equipment and user-friendly software, new digital tools should be designed with clinicians and patients, a bank of trusted clinical apps provided at induction and remote multidisciplinary team working and handovers enabled.

**Direct clinical care in modern medicine is intense work, with patients often having more co-morbidity and complexity.** Building in elements that make work rewarding, such as time to do quality improvement and research, as well as more flexible working patterns, is likely to ensure staff do not burn out from their working week. In our 2025 Focus on physicians survey of UK consultant physicians, when asked about the top three activities that get squeezed out of physicians' weeks when things get too busy, the most common responses were continuing professional development, quality improvement activity and the education, training and supervision of doctors (of all grades, including appraisal of colleagues).

We know that opportunities to participate in and present research are motivating for NHS doctors. An NHS that values research, and its benefits to job satisfaction as well as patients, would also help to foster a positive environment in the NHS. Clinical research is crucial to improving outcomes for patients, yet many are not given the time or opportunities to do so. Findings from the 2023 RCP census of UK consultant physicians found that just 41% respondents undertake research, and that a lack of time in job plans is the main barrier to taking part in research (52% said this). When asked why they undertake research, the top three most commonly cited reasons were: it improves care for patients, makes them a better doctor, and improves their job satisfaction. Government must set out a plan to deliver its aim for research, development and innovation to be a core part of everyday clinical work. Doctors must have protected time for research.

Finally, the RCP strongly urges government to recognise the impact of rising inequality and growing poverty on workforce wellbeing as well as patients. We routinely hear examples of physicians seeing health inequality first hand in their work. Earlier this year, nearly 90% of respondents to an RCP member snapshot survey reported they were concerned about the impact of health inequalities on their patients, while 46% said that at least a half of their workload was due to illnesses linked to social and economic factors - such as poor housing, education, and employment. We also hear how demoralising it is for physicians to have to

discharge patients back into the conditions that made them sick in the first place. It is unfair and inefficient. Government must act decisively to tackle health inequalities and poverty.

Further resources

- RCP. 2025 Focus on physicians survey. November 2025.
- RCP. 2025 Next generation survey of resident doctors. October 2025.
- RCP. 2025 Corridor care guidance for physicians. October 2025.
- RCP. Prescription for outpatients: reimagining planned specialist care. April 2025.
- RCP. Making the case for research: resource kit for doctors. May 2025.
- RCP. 2025 snapshot survey of UK physicians: obesity, smoking and alcohol harm. July 2025.
- RCP. Effective job planning for better patient care. July 2025.

# Appendix 1

The RCP also submitted a number of case studies about preventative, digital and community based models of care. These case studies were shared by RCP members who either attended focus groups or responded to an all member survey.

Many highlighted that as the shifts have not yet been implemented, the workforce impact is difficult to quantify, and without detail on what implementation looks like, it is difficult to imagine what the impacts could be. Key themes that came up in our engagement were ensuring we have enough physician training places to support the community shift and the senior decision making required in medicine, as well as the urgent need for improved IT and digital infrastructure. Lack of sustainable staffing, poor digital infrastructure and lack of sustainable funding were also recurrent themes in rolling out initiatives.