Royal College of Physicians

The voice of physicians

RCP emerging themes report 2025

A system under pressure

Medicine is changing. Patient care is increasingly complex; service pressures are unrelenting and the role of a doctor as team leader and expert decision-maker is becoming more important as healthcare evolves.

Every year, the Royal College of Physicians (RCP) carries out membership engagement visits to hospitals across England, Wales and Northern Ireland. Our visits are intended to complement – not duplicate – General Medical Council (GMC) and postgraduate deanery reviews. During every visit, we meet with resident doctors, specialist, associate specialist and specialty (SAS) doctors, locally employed doctors (LEDs) and consultant physicians in closed sessions to listen and learn from our colleagues.

This helps us to understand what's happening on the ground in health and social care across the nations – by sharing their experiences, our members give us valuable insight that informs our influencing work and ensures that we can advocate for change with governments and health systems around the UK.

Across our visits, we found senior doctors providing high-quality patient care, leading quality improvement and delivering world-class medical education, despite significant workload and service pressure. We heard from enthusiastic and passionate resident doctors who were leading quality improvement and medical education projects, while studying for professional exams and completing workplace-based assessments.

This report looks back at the hospital visits we carried out between October 2024–September 2025 and reflects on the key themes that emerged: a physician workforce under immense pressure, a medical training system in need of radical reform, patient care that is increasingly delivered in corridors and chairs, and – in some places – a serious breakdown in communication between clinicians and senior leadership.

Our 2025 national Focus on physicians survey of over 1,000 UK consultant physicians found that:

45% enjoy their job less than last year, with clinical workload, poorly functioning IT and staff vacancies the most common negative factors

66% report resident doctor rota gaps on acute medical rotas and **83%** said these directly impact patient care by, for example, reducing access to out of hours care and increasing length of hospital stay

30% say they've made plans to bring forward their retirement age, signalling a major risk to our future medical workforce

68% report problems with delayed discharges, highlighting the impact of an overburdened social care system on patient flow.

Recommendations

1. Workforce planning and retention

- Deliver **sustainable**, **long-term workforce planning** with clear projections for the number of consultants and specialist doctors needed to meet future patient demand. Workforce plans must also address the equitable distribution of doctors across regions and specialties. All four governments in the UK should work in close consultation with the medical profession when developing and implementing NHS workforce plans.
- Tackle rota gaps by reducing over-reliance on locums and strengthening retention through **improved working conditions**, **digital infrastructure**, and **valuing non-clinical contributions** – like education, supervision, research, quality improvement and leadership roles.
- Address the **early retirement risk** by making consultant roles more sustainable, with realistic job plans and wellbeing support, and by giving them the opportunity to retire and return.

2. Training and supervision

- Address **bottlenecks in specialty training** by exploring how NHS experience could be recognised during the recruitment process.
- **Increase the number of postgraduate specialty training places** in line with medical school expansion and population need.
- **Protect training time** in job planning and rota design so medical education is not routinely displaced by service pressures.
- Ensure **adequate time and recognition for clinical and educational supervision**, so consultants and specialists can deliver meaningful feedback and support.
- Reform postgraduate training processes to be **fairer**, **more flexible and sustainable** – especially around geographic rotations and less-than-full-time options.
- Provide **equitable access to education** and **structured career development for SAS doctors**, **LEDs and international medical graduates (IMGs)**, with protected development time and consistent opportunities across the NHS to be involved in teaching, leadership and service planning to support progression and retention.

3. Patient safety and service delivery

- Take urgent **national action to prevent and eliminate corridor care** – recognising it as unsafe and unsustainable – and begin publishing data on the use of temporary care environments as soon as possible, all year round.
- Invest in **social care capacity** to prevent unnecessary hospital admissions, tackle delayed discharges and patient flow issues.
- Protect and expand services that reduce admissions, such as **frailty same-day emergency care (SDEC), community advice lines and multidisciplinary clinics**.

4. Leadership and engagement

- Strengthen **visible, stable, clinically led leadership** at every level to support morale and improvement.
- Embed **inclusive decision-making and transparent communication** between senior leaders, consultants and resident doctors.
- Recognise and replicate **good practice** – from criteria-led discharge to LED portfolio pathways – to support consistency and innovation across the NHS.

Pressures on the NHS workforce

Across our hospital visits, physicians consistently highlighted the strain placed on the medical workforce.

Recruitment and retention remain pressing challenges, particularly in geographically disadvantaged or under-resourced areas. Consultants and SAS doctors spoke of services stretched beyond safe limits; with rota gaps, high turnover among resident doctors and over-reliance on locums creating instability and undermining continuity of care.

59% of consultants reported consultant vacancies in their departments.

(Focus on physicians survey, 2025)

Workforce shortages were most acute in general internal medicine (GIM) and acute care, with several sites reporting insufficient consultant cover – leading to unsustainable pressure on specialty teams. In one hospital, colleagues said: 'GIM provision is stretched thin, with a lack of dedicated GIM wards and consultants, leading to a disproportionate reliance on geriatrics and acute medicine to provide GIM cover.' In another, colleagues warned that 'staffing levels were often at the minimum, with frequent redeployment to cover gaps'.

45% of consultants said their job enjoyment had decreased in the past year.

(Focus on physicians survey, 2025)

Beyond direct clinical shortages, doctors expressed frustration about administrative burdens, poor IT infrastructure and inadequate support for non-clinical roles. In one hospital, consultants noted that 'the administrative burden on senior doctors is increasing due to growing educational supervision needs, including assessments and portfolio management'. In another, consultants pointed to 'issues with IT (including unstable printer connections and the absence of digital dictation systems) that contribute to delays and reduced innovation'.

43% of consultants said functioning IT would most improve wellbeing.

(Focus on physicians survey, 2025)

Morale is affected not only by workload but also by cultural and leadership issues. In one hospital, consultants said that 'frequent changes in senior leadership have led to a lack of continuity, accountability and institutional memory'. Others warned that non-clinical contributions are often overlooked: 'Clinicians feel undervalued when engaged in administrative or educational tasks. High workload and the intensity of the internal medicine training (IMT) programme are forcing staff to leave teaching roles.'

30% of consultants are bringing forward their retirement plans.

(Focus on physicians survey, 2025)

Our hospital visits show that while doctors remain committed to delivering high-quality care, the current workforce environment is characterised by rota gaps and high workloads. Nationally aligned, sustainable workforce planning – with adequate consultant numbers, recognition of SAS and LED roles to meet patient need, alongside investment in working conditions – is urgently needed to safeguard patient care and retain skilled clinicians.

Clinical workload, poor IT and staff vacancies are the top three factors undermining consultant wellbeing.

(Focus on physicians survey, 2025)

Consultants also reported being overstretched as educators, with limited time allocated in job plans for supervision. High-quality training and safe service delivery depend on well-supported consultants and supervisors, yet many feel overburdened, under-recognised and unable to meet their responsibilities. Insufficient time, unacknowledged demands, heavy GIM workloads and a lack of support from their employers all contribute to a poor quality supervision and training experience for resident doctors.

Read *Empowering physicians, our job planning guidance for consultants and specialist doctors.*

Explore our webinars, podcasts, e-learning and CPD.

Supervision and medical education

Our 2025 national next generation survey of over 1,000 resident doctors found that:

Only **44%** are satisfied with their clinical training, with many citing lack of supervision, excessive rota gaps and limited access to outpatient and procedural training

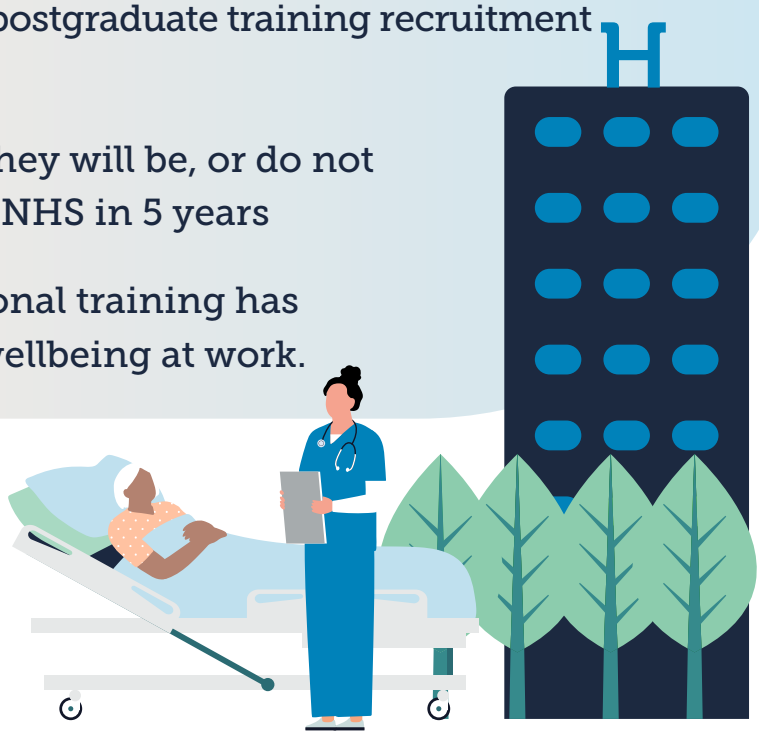
47% want to work less than full time in the future

26% say their current training role is not preparing them for the next step in their medical career

Only **17%** think the current postgraduate training recruitment processes are fair

35% say they don't know if they will be, or do not expect to be, working in the NHS in 5 years

47% say geographical rotational training has a negative impact on their wellbeing at work.



Across our hospital visits, the balance between training and service provision was a recurring concern.

Doctors consistently told us that training opportunities were undermined by rota gaps, escalating service pressures and the lack of protected time for supervision. While there are examples of innovation and supportive cultures, supervision was often described as undervalued, inconsistently delivered and at risk of being deprioritised.

Just **8%** of resident doctors said they always received constructive feedback on their performance and only **25%** were always comfortable raising concerns or feedback with their supervisors.

(Next generation survey, 2025)

Resident doctors frequently reported that their roles were reduced to service provision. At one hospital, doctors in training said that they felt 'restricted to delivering task-focused medicine and did not feel as though they were able to develop their decision-making skill set by working with senior clinicians to provide high quality patient-centred care'. They also raised concerns about insufficient protected time for portfolio development and MRCP(UK) exam preparation.

65% of consultants report resident doctor rota gaps on acute medical rotas.

(Focus on physicians survey, 2025)

Supervision itself was often constrained by workload. In one hospital, consultants highlighted that 'a major concern was the lack of protected time for clinical and educational supervision … meetings with residents [are] rushed and focused on form-filling rather than developmental discussion'.

46% of resident doctors don't have enough time for CPD.

(Next generation survey, 2025)

Similarly, consultants at another hospital warned there was 'very limited dedicated time for clinical education within certain specialties and … structural barriers to effective teaching and mentorship due to the heavy clinical workload'.

83% of consultants said rota gaps directly impact patient care by, for example, reducing access to out of hours care and increasing length of hospital stay.

(Focus on physicians survey, 2025)

Residents also described the impact of training–service tensions on patient safety. At one hospital, they told us there is 'tension between service and training across IMT nationally' and asked us to press for clearer protection of training opportunities within job planning and rota design.

In some cases, service demands actively displaced education; consultants in one hospital reported that frequent 'internal critical incidents' mean that all non-clinical activity (including training) is cancelled on a regular basis. Consultants felt this 'devalues education, normalises crisis management as 'business as usual' and undermines morale'.

72% of resident doctors cited poor staffing levels and rota gaps as the most negative impact on their wellbeing at work, with **66%** pointing to high clinical workloads and **59%** highlighting poor IT systems.

(Next generation survey, 2025)

Despite these challenges, there were strong examples of commitment to education. One hospital was praised for timetabling self-development time for resident doctors, including those on locally employed contracts. At another hospital, resident doctors welcomed 'supportive supervision, enthusiastic consultants, regular IMT / foundation teaching, mock PACES and procedural skills courses'. Consultants across several sites expressed a desire to safeguard and expand educational opportunities, provided that adequate time and resourcing could be secured.

Our findings underline that high-quality supervision and training are not optional extras; they are essential for patient safety, workforce retention and professional development. Sustained investment in supervision time, educational infrastructure and equitable access for all doctors – including SAS and LEDs – will be critical to securing the next generation of physicians.

Read our next gen top 10 campaign calls for reform of medical training.

Explore our series of NextGenPhysicians blog articles, case studies and think pieces.

SAS doctors are another important group in the physician workforce, providing continuity, expertise and leadership in many services. For lots of people, the SAS grade is a positive career choice – offering autonomy, stability and a balance between work and family life. However, across our visits, SAS colleagues repeatedly highlighted the lack of structured career progression as a source of frustration, with implications for morale, retention and patient care.

SAS doctors contribute significantly to service delivery, teaching and quality improvement, often acting as senior decision-makers on wards and in clinics.

In some health boards and trusts, local portfolio or CESR-style pathways are being developed, offering structured supervision and milestones to support SAS doctors that are aiming for specialist or consultant-level roles. SAS colleagues valued the autonomy and stability of their posts, describing their roles as both a career destination and a lifestyle choice.

However, career pathways remain inconsistent and poorly defined, with many SAS doctors feeling 'stuck', despite working at a senior level for many years.

A lack of clarity around contracts, job planning and access to study leave was a recurring theme – alongside concerns that they often have reduced access to portfolios, educational supervision and development opportunities, compared to doctors in national training programmes. Service pressures frequently displace professional development time, leaving SAS colleagues to complete appraisal or portfolio work in their own time. Many SAS doctors described being overlooked in strategic planning and service innovation, despite their expertise and continuity of service.

SAS doctors are experienced physicians who provide stability, continuity and innovation within the NHS. Ensuring equitable opportunities for their career progression is vital not only for retention, but also for patient care and the long-term sustainability of the medical workforce.

Read our educational and career support guidance for SAS doctors.

Read our educational and career support guidance for LEDs and IMGs.

Patient safety and corridor care

Across our hospital visits, we heard that rising service pressures are undermining patient safety.

Acute hospitals are struggling with limited bed capacity, delayed discharge due to limited social care and unsustainable demand at the front door. These pressures are driving corridor care from an exceptional circumstance into a routine feature of service delivery.

68% of consultants reported problems with delayed discharges.

(Focus on physicians survey, 2025)

At one hospital, consultants spoke of 'the growing reality of "day two" patients' – medical patients who remain in the emergency department or escalation areas for multiple days, due to a lack of inpatient beds. These patients are often frail, complex and at high risk of deterioration, yet are frequently managed in inappropriate environments such as corridors. The consultants described 'the moral injury of apologising daily to patients being cared for on trolleys or in waiting areas'.

78% of physicians had provided care in a temporary environment in the past month.

(RCP snapshot survey, February 2025)

Similarly, at another hospital we visited, consultants reported 'a severe lack of ward space leading to patients receiving care in corridors, with reports of up to 70 trolley bays on busy days'. Again, they warned of the 'moral injury caused by long waiting times for appointments, insufficient community care and the impact of corridor care'. They noted that such environments compromise dignity and safety: 'They are inappropriate spaces for breaking bad news.'

The impact on wider services is also profound. At one hospital, physicians told us: 'Corridor care, once a winter phenomenon, has become a year-round norm.'

59% of physicians delivered care in a temporary care environment between June –August 2025, most on a daily or near daily basis.

(RCP snapshot survey, October 2025)

Senior doctors are required to deliver additional unscheduled ward rounds for patients in escalation areas, drawing them away from specialty care, elective activity and service development. Consultants warned that services proven to reduce admissions, such as frailty SDEC and community advice lines, 'are being eroded because staff are redeployed to manage congestion. This creates a cycle of inefficiency, where clinicians work harder but outcomes worsen'.

51% of physicians are not confident that their hospital can safely manage winter pressures.

(RCP snapshot survey, October 2025)

These experiences highlight a systemic risk; service pressures are normalising unsafe models of care. Doctors across sites consistently called for national action to address the root causes, particularly the lack of investment in community and social care. As one consultant concluded: 'Funding the front door without fixing the back door will not resolve delays.'

Read *Confronting corridor care*, our updated guidance for physicians.

Read *Prescription for outpatients*, our vision to reform planned specialist care over the next 10 years.

Read *Time to focus on the blue dots*, our toolkit on the NHS shift from hospital to community care.

Leadership, engagement and communication

Across our hospital visits, it was clear that strong, visible clinical leadership is critical for safe and sustainable care. Where executive leadership engaged openly and honestly with physicians, we found collaborative problem-solving and a more positive culture.

However, across several sites, consultants and SAS doctors described feeling disconnected from decision-making processes, with concerns that leadership structures were not always inclusive, stable or clinically led. At one hospital, senior clinicians said they felt 'disconnected and excluded from clinical strategy decisions' following rapid, sometimes unplanned organisational changes, citing issues with service quality, workload and bureaucratic management layers.

Similarly, at another hospital, frequent changes in leadership were seen to undermine progress: consultants told us that 'frequent changes in senior leadership led to a lack of continuity – initiatives were often not followed through'.

Resident doctors also raised concerns about the culture of communication. At one hospital, consultants noted 'a growing gap in communication and engagement between consultants and residents, exacerbated by reliance on electronic communication rather than face-to-face interaction.' In another, some resident doctors described a culture of 'keeping your head down' and said their concerns 'were not adequately addressed by the senior leadership.'

In one hospital, we heard that there was a real disconnect between clinical solutions and organisational change. Consultants recounted business cases that took 12–18 months to go through different committees, only to stall with no transparency. The cumulative effect is a loss of agency; responsibility for risk sits with clinicians at the front line, but the authority to improve services feels remote. We also heard that when restructures are carried out without meaningful clinical co-design, it seriously affects morale.

Despite these challenges, there were positive examples of leadership and communication. At one hospital, the executive team 'welcomed the RCP visit, noting that they valued the opportunity for a constructive conversation. They emphasised a shared vision to be an outstanding organisation, underpinned by strong clinical leadership, education, training and research'.

Consultants on a different site highlighted local innovations such as criteria-led discharge, describing how this model worked only where there was 'consultant buy-in, nurse engagement and twice-daily board rounds' – demonstrating the importance of consistent leadership and communication across the multidisciplinary team.

Clinical engagement cannot be treated as optional; it is a prerequisite for effective service delivery, morale and patient care. Leadership development, transparent communication structures and inclusive decision-making were identified, by clinicians at all grades, as essential to sustaining the medical workforce and ensuring that improvement initiatives take hold.

Explore our leadership programmes and courses.

Despite the pressures facing the NHS, our hospital visits revealed outstanding examples of good practice:

Development of ambulatory care services reducing hospital admissions in Craigavon.

Criteria-led discharge tools improving weekend patient flow in Southend-on-Sea.

Quality improvement in stroke services reducing average admission times and improving patient outcomes in Chester.

LED induction and buddy systems enabling smoother IMG integration in Dorset.

Multidisciplinary specialty clinics in rheumatology, stroke and diabetic care in Blackpool.

Proactive local schemes where LEDs were supported through the portfolio pathway in Nottingham.

Reduction of the bleep burden with a 4-bleep rule and new 3pm huddles in Wrexham.

Explore our improvement resources.

Conclusion

Our programme of hospital visits in 2024–25 highlighted the extraordinary commitment of physicians, SAS doctors, LEDs and resident doctors to delivering high-quality patient care despite unprecedented service pressures. While every site showcased examples of innovation, quality improvement and high quality medical training, the systemic challenges facing the medical workforce were clear and consistent.

In one hospital, colleagues spoke of a 'supportive consultant body, strong education department, and innovative service models' but cautioned that 'persistent rota gaps, training–service tensions and exception reporting culture remain concerns'. Similarly, another hospital was described as 'a friendly, supportive place to work, with approachable seniors and a positive culture' but consultants emphasised 'the inefficiency of diverting specialty staff to day two patients at the expense of early specialty input'.

Physicians frequently stressed that many issues cannot be solved locally. During one visit, 'participants recognised that many of the challenges – particularly workforce shortages, the balance of generalist and specialty training, and discharge delays – are national issues.' At one hospital, consultants reflected on 'hospital buildings described as "not fit for purpose"', with stalled plans for new infrastructure 'due to financial pressures' and warned of 'moral injury caused by long waiting times for appointments, insufficient community care and the impact of corridor care'.

Doctors at all grades asked the RCP to amplify their concerns nationally and to champion solutions that sustain both patient care and the profession. One group of resident doctors 'asked the RCP to continue advocating nationally for training quality, social care investment and corridor care'.

Many of the underlying issues highlighted across hospitals reveal a complex interplay between transparency, communication and professional relationships and underscore the need for open dialogue and honest feedback within, and between, teams and senior leaders.

Where executive teams fostered a culture of transparency, clear communication and clinical involvement in changes and improvements, staff felt more supported and empowered to raise concerns. Conversely, strained relationships contributed to frustration and fractured working. Addressing these challenges requires a sustained commitment to building trusting relationships, promoting meaningful communication at every level and cultivating an environment where transparency is not just encouraged but expected.

The RCP will continue to press for sustainable long term workforce planning, protected time for supervision, and urgent action on corridor care and social care capacity. We will also work to share good practice, from criteria-led discharge to LED portfolio pathways, ensuring that local innovations are recognised and replicated. Above all, we will ensure that the voices of physicians are heard; their expertise is vital to shaping a safer, more sustainable health system for patients and staff alike.

Explore the work of our national and regional networks.

Between October 2024–September 2025, RCP senior officers visited hospitals in Nottingham, Blackpool, Craigavon, Llantrisant, Dorchester, Southend-on-Sea, Chester and Wrexham.

Representing around 40,000 doctors worldwide, the RCP is the voice of physicians. Our mission is to educate, improve and influence for better healthcare.

We are independent, patient centred and clinically led, and we aim to drive improvement through advocacy, education and research, in the UK and across the globe.

This report was developed by the RCP communications team in September 2025 and approved by RCP Council in October 2025.

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