RCR submission to Public Accounts Committee Inquiry into NHS England's modelling for the NHS Long-Term Workforce Plan

Introduction

1. The Royal College of Radiologists is the leading professional membership body for clinical radiologists and clinical oncologists. Our world class education and training resources allow members to advance their career and expertise to the benefit of their patients. The broad perspective provided by our two specialties enables us to develop and deliver a unique body of work and set out standards of excellence for diagnostics and cancer care.

2. Clinical radiologists are specialist doctors who use medical imaging to diagnose, monitor and benign and malignant diseases and injuries. They are the backbone of the NHS, responsible for the vast majority of diagnoses made and the modern management of patients. Interventional radiologists, a subspecialty of clinical radiology, undertake minimally invasive and potentially life saving surgical treatments. Clinical oncologists are specialist doctors who are responsible for cancer management. They deliver cutting-edge treatments such as radiotherapy and systemic anti-cancer therapies, including chemotherapy.

3. Both of our specialties are at the forefront of the NHS's ambitions to reduce waiting lists, ensure early detection and treatment of major conditions such as cancer and stroke, and improve the health and wellbeing of patients. We therefore greatly welcome the opportunity to contribute to the Public Accounts Committee's (PAC) Inquiry into the modelling of the NHS Long-Term Workforce Plan (LTWP).

Summary of recommendations

Here we summarise the recommendations we make throughout our submission. For further details, please consult the relevant sections below.

Future iterations of the LTWP should:

- Give greater consideration to the cost effectiveness of expanding domestic training capacity, and how this would enable international recruitment to be reduced
- Include further details on how the use of costly outsourcing measures will be reduced over time
- Urgently include measures to improve the retention of staff already in the NHS, including:
    - Providing basic wellbeing measures such as 24/7 access to hot food and drink, up-to-date computer equipment, and sufficient administrative and clerical staff
    - Developing metrics to report on staff wellbeing
    - Ensuring doctors have sufficient time in their job plans for revalidation, medical leadership and training
    - Introducing exit interviews for all doctors
- Make clear the link between productivity and morale, since poor morale can inhibit productivity
- Translate productivity drives into language that NHS staff understand and find motivating

- Take action to encourage senior clinicians to take up leadership roles, and empower those clinicians to effect change in those roles, in order to transform services and improve patient outcomes.
- Develop more sophisticated measures of productivity that empower NHS organisations to make sustainable long-term decisions for providing care
- Ensure basic infrastructure is in place to enable productivity to be increased
- Expand on how specifically Artificial Intelligence will release time for clinicians, and how barriers to implementing AI will be overcome
- Include modelling of the supply and demand for medical specialties
- Provide commensurate increases to foundation and specialty training posts, to ensure the expanded cohort of medical students have jobs into which to progress
- Include extra details on how NHS England will support trusts to ensure all specialty training posts are filled
    - In clinical oncology, NHS England should fund a recruitment campaign to attract more trainees to the profession
    - In clinical radiology, NHS England should fund 100% of radiology trainees' costs for the first two years. The current, expanded number of training posts should be maintained
- Introduce measures to encourage retired doctors to return to support training
- Include funding details for additional physical space and resources to accommodate increased numbers of medical students and doctors in training.
- In addition, we are calling on all political parties to commit to a fully-funded, 15-eat funding framework for the LTWP in their manifestoes ahead of the next general election.

Models underpinning the Long-Term Workforce Plan

4. The RCR welcomed the LTWP's publication. This much-needed strategy is a significant step towards ensuring a sustainable and resilient NHS workforce. We wholeheartedly support the Plan's ambition. It is right that the Plan not only addresses the need for an increase in the number of doctors and healthcare professionals being trained, but also recognises the importance of retaining their expertise.

5. Nonetheless, the iterative nature of the LTWP allows us to constructively present areas of weakness and suggest solutions we believe ought to be included in future versions of the Plan.

6. We believe that greater consideration ought to be given, in future iterations of the LTWP, of the cost-effectiveness of different models of staff recruitment. Factors to be considered should include (a) the costs of increasing the number of UK trainees, versus the use of overseas recruitment, and (b) the costs of training more consultant doctors domestically, versus the use of outsourcing to fill in gaps in capacity.

7. With regards to (a), it is clear that a balance must be struck between expanding the domestic production of trainee doctors and in recruiting staff from abroad. Whilst the outlay costs of boosting domestic production may be significant, the long-term costs may be much less than those of overseas recruitment. Reliability of supply would also be

improved. RCR census data shows that attrition rates are considerably higher for International Medical Graduates (IMGs), and in particular those IMGs who did not complete their specialty training in the UK. This necessitates further recruitment from overseas, with all the costs that entails.

8. The need to recruit more staff arises from the fact that demand for healthcare services is exceeding existing capacity. Demand is rising sharply. CT and MRI activity grew by 5% in 2022, whilst the radiologist workforce grew by just 3%. Similarly, the rate of SACT delivery grows at around 6-8% per year, versus a 5% growth in the oncology workforce in 2022.[1] This partly is a result of an ageing population, i.e. a population with an increasing proportion of elderly people, who are more likely to spend many years with multiple complex health conditions. Other contributing factors include population growth and increasing rates of chronic illnesses, such as hypertension, diabetes, and obesity, with many people living for far longer with chronic conditions in relatively poor health, requiring a great deal of medical care. The time taken to plan and deliver complex radiotherapy is also increasing as a function of rising cancer incidence. The time taken to plan and deliver a cancer treatment plan where multiple treatments are deployed – such as SACT and radiotherapy – is also increased where the patient's healthcare needs are more complex as a result of frailty (with age) and the existence of other morbidities.[2]

9. This is not a problem unique to the UK. Many nations are experiencing similar demographic changes that the UK is seeing. These include nations from which the UK recruits many overseas staff to the NHS. Over time, therefore, we will not be able to recruit the same proportion of staff from abroad as we do currently; these staff will be needed in their own countries, and we will face increased competition from other nations to attract them to the UK. The NHS must also be careful to recruit ethically. It is morally dubious to recruit large volumes of doctors from other nations whose own healthcare systems are struggling and whose populations struggle with higher rates of illness and disease than does the UK.

10. We are grateful for all the excellent work that doctors from abroad provide for the NHS and its patients, whether these be International Medical Graduates (IMG) or consultants recruited from overseas. To argue that the NHS workforce needs to expand its domestic production should in no way diminish the outstanding contributions of overseas recruits, nor our debt to them for all they do for our patients.

11. Nonetheless, the RCR believes that, on balance, a rational long-term view would be to place the NHS workforce on a sustainable footing by prioritising the expansion of the domestic training pipeline.

12. With regards to (b), it is well documented that the NHS spends huge sums of money on outsourcing to manage demand. This will of necessity continue for the short term, given the length of time required to train from undergraduate to junior doctor and consultant level. However, the RCR believes that future iterations of the LTWP should include much greater

[1]RCR, 2022 Clinical Radiology and Clinical Oncology Workforce Census Reports. Available at: https://www.rcr.ac.uk/news-policy/policy-and-influencing/

[2] E. Montague, T. Roques, K. Spencer, A. Burnett, J. Lourenco, N. Thorp, 'How Long Does Contouring Really Take? Results of the Royal College of Radiologists Contouring Surveys,' *Clinical Oncology*, (2024) https://doi.org/10.1016/j.clon.2024.03.005.

detail as to how the use of outsourcing will be phased down over time. The budget currently used to fund outsourcing should be progressively converted into funding for new training and consultant posts.

13. The phasing down of this practice would deliver significant cost savings to the NHS. Our latest figures show that the NHS spent £223 million in 2023 on outsourcing, insourcing and hiring locum staff in radiology alone. This would fund 2,309 full-time consultant salaries – a figure far greater than the current workforce shortfall in radiology.[3]

Retention

14. It is equally essential that future iterations of the LTWP acknowledge and plan for the gap between the present day and the time until the next, expanded cohorts of trainees reach the junior doctor and consultant level.

15. From the start of specialty training, it takes on average (median) 5.3 years to become a consultant clinical radiologist and 6.5 years to become a consultant clinical oncologist. This is of course in addition to at least two years of Foundation Training, after 4-6 years of undergraduate training, and an additional two years' internal medicine training for clinical oncologists. The time taken to train needs to be considered in light of the current situation, which is becoming desperate. Currently, there is a 29% shortfall in the clinical radiology workforce and a 15% shortfall in the clinical oncology workforce. These figures are expected to rise to 40% and 25%, respectively, by 2027.[4] Any measures to boost the capacity to produce doctors domestically, whilst extremely welcome, will not have an immediate impact on workforce shortfalls.

16. The current LTWP provisions, therefore, do not address the very real workforce crisis the NHS is in the middle of here and now. This crisis can be seen in the latest diagnostic and cancer waiting times data released by the NHS, which show that 19.7% of people are waiting over 6 weeks for a diagnostic test (MRI and CT), against a target of 1%, and just 62.3% of patients are starting cancer treatment within 31 days, against a target of 85%.[5] Workforce shortfalls are already having a detrimental effect on patient outcomes – and this will worsen over time, unless action is taken.

17. Whilst this means that, in the short-term, measures including outsourcing and using overseas recruitment are unavoidable, further action is also required. Beyond the expansion of domestic training, in the short-term the NHS must urgently do more to improve the retention of its current workforce.

18. The latest RCR census reports show that doctors are leaving the workforce at a younger age. The average age of leavers in 2023 was 51 years in radiology and 52 years in oncology. Over three-quarters of radiologists who left the NHS in 2022 were under the age of 60.[6] We

[3] Ibid.
[4] Ibid.
[5] RCR, Diagnostic and cancer waiting times data for January 2024 (March 2024). Available at: https://www.rcr.ac.uk/news-policy/latest-updates/diagnostic-and-cancer-waiting-times-data-for-january-2024/
[6] RCR, 2022 clinical radiology workforce census

are also seeing increasing levels of stress and burnout reported by our members, which is no doubt contributing to greater staff time off work and more staff leaving the NHS entirely.

19. There has been a gradual erosion of working conditions in the NHS – not only in terms of workload, but also in terms of the physical environment in which doctors work and the amenities they are provided with. For example, increasingly doctors' offices are not routinely cleaned. Many hospitals cannot provide 24/7 access to hot food and drink. There is routinely not enough desk space for all clinicians to work. All these small factors accumulate and make a significant difference to doctors' morale, and hence their likelihood of remaining in the NHS.

20. The current iteration of the LTWP does not go nearly far enough to address the NHS's retention problem. Future iterations must expand upon the actions the NHS will take to prevent its staff leaving the service early.

21. The RCR makes the following recommendations for actions the NHS should take to boost retention:
    a. Trusts should ensure basic wellbeing measures are in place. These include: up-to-date computer hardware and software, sufficient administrative and clerical staff, and access to hot food and drink at all hours of the day.
    b. Trusts need to measure the wellbeing of their staff. The NHS should support them to develop metrics and policies to this end.
    c. Trusts should ensure doctors have sufficient Supporting Professional Activities (SPA) protected time in their job plans to allow them to vary their work and engage in non-patient-facing, but equally essential, work. Workforce planning will need to accommodate this.
    d. All doctors should receive exit interviews, so their employers can understand their reasons for departing and work to address any problems impacting retention of their staff.
    e. Trusts should enable their staff to adopt flexible working arrangements. This would especially benefit senior clinicians, e.g. by allowing them to reduce their on-call commitments, or to increase their teaching and mentoring commitments.

Future NHS productivity

22. The LTWP currently is premised upon an optimistic prediction of the rate at which NHS productivity will increase. Whilst far from impossible, given the current challenges the NHS faces – rising demand, a shrinking and exhausted workforce, and funding problems – it will be difficult to achieve.

23. It is important that the link between productivity and morale is made clear. The LTWP currently neglects this important factor. A demoralised workforce is likely to be less productive than a happy and motivated workforce.

24. Morale in the NHS is at an all-time low. The latest RCR census found that 98% of service leaders are concerned about morale, stress and burnout in their workforce.[7] This suggests that productivity gains will be hard to achieve.

25. The measures to improve staff wellbeing detailed in the previous section would go some way towards addressing poor morale, and could therefore enable productivity to be boosted.

26. Another factor to consider is how ineffective 'productivity' is as motivating rhetoric for NHS staff. The current moment is not the first time that NHS staff have been told that they must boost their productivity. For many staff, when they hear 'productivity', they believe simply that they will be asked to work harder, with fewer resources, and will be blamed for poorer performance and patient outcomes. It is not language that encourages most doctors.

27. It is important, therefore, that NHS management translate productivity drives into language that NHS staff understand and will buy into. Staff buy-in is essential if measures designed to boost productivity are to be successful. But staff need to feel that those measures are a cooperation between themselves and senior management, and will empower them to deliver the best possible care for their patients.

28. Siva Anandaciva of the King's Fund has proposed using the language of tackling "waste" as an alternative terminology that would motivate doctors.[8] Another way would be to talk of *empowering* NHS staff to deliver excellent care; of enabling staff to take the measures their expertise and experience tells them is necessary to improve the quality of patient care and increase the number of patients who can be seen – striking the best possible balance between these two.

29. Another issue is the productivity of training of junior radiologists by consultants. Currently, many training centres distinguish between "training lists" and "service lists". Consultants on the former are expected to get through fewer cases, as they are spending time also on training junior radiologists. Consultants on the latter are expected to get through more cases. This limits training opportunities and there is a strong argument to be made that all lists should have training time built in. Though it would reduce each individual consultant's productivity – *when productivity is measured crudely as simply the number of scans reported per day* – it would increase the service's productivity as a whole, when considered in the round and over time, by producing more skilled trainee radiologists earlier. The NHS should develop more sophisticated measures of productivity which empower NHS organisations to make sustainable long-term decisions for providing care. Ideally, all lists should be considered training lists, as in the long run this will help train more radiologists and thus address the workforce shortfall and its effects, the chief of which are long waiting lists.

[7] RCR, 2022 clinical radiology and clinical oncology workforce censuses

[8] Anandaciva, S. *"Thoughts on the NHS's productivity decline"*. The King's Fund (2024). Available at: https://www.kingsfund.org.uk/insight-and-analysis/blogs/nhs-productivity-decline.

30. Another crucial component to productivity is infrastructure. If adequate processes, equipment and services are not in place, productivity is severely diminished. Take the NHS's IT infrastructure, for instance. It is incredibly patchy, with each local system having its own setup and at varying stages of digital readiness. In the worst cases, though, it is not uncommon for computers to take upwards of 20 minutes to switch on; for frequent software failures; for limited internet bandwidth preventing work; and so on. Often there are constraints because there is not enough physical space to do the work. Radiologists lack reporting workstations, and interventional radiology services lack sufficient day case beds and laboratories. Getting the basics right by modernising IT systems and addressing the issue of lack of interoperability is essential.

Productivity and artificial intelligence (AI)

31. Much has been made of the potential for AI and other digital technologies to radically improve NHS productivity. Indeed, much of the 2024 Spring Budget measures for health and social care implicitly make the assumption that AI will automatically do so.

32. The RCR is hugely optimistic about the potential of AI to augment doctors' abilities to diagnose and treat their patients. In both clinical radiology and clinical oncology, there is much scope for AI applications to assist in the analysis of medical images to reach diagnoses, triage waiting lists by flagging likely anomalies, aid in clinical decision making for treatment regimes, facilitate rapid auto-contouring of target areas in radiotherapy treatment planning, and much more.

33. However, we would also ring a note of caution. The potential productivity gains promised by AI will not arise automatically. It is not just about the AI tool; it is about how the AI tool works in practice, and how human doctors make use of it. The following (non-exhaustive list) must be considered:
    a. AI tools may slow down doctors' rate of working, at least in the short term, as they become used to working in a new way. Staff training in the use of AI tools will be essential.
    b. Any time freed up by an AI tool can be re-used in various ways – direct patient care, increased throughput (e.g. a radiologist reporting more scans per hour), reduction of overtime, service improvement projects etc. It would be foolish to assume time would be re-used in just one of these ways uniformly in all times and places.[9]
    c. There exist barriers to AI implementation that must be overcome if its benefits are to be maximised. These include the basic IT infrastructure to support innovative AI software; if doctors' computers take 20 minutes to turn on and operate incredibly slowly, it is unlikely that an AI tool will deliver much in the way of efficiency gains.[10]
    d. AI are only effective if there are sufficient numbers of staff to commission, implement, test and then use them in clinical practice. Currently, staffing

[9] RCR, Embracing AI to support the NHS in delivering early diagnoses (2024). Available at: https://www.rcr.ac.uk/news-policy/policy-reports-initiatives/embracing-ai-to-support-the-nhs-in-delivering-early-diagnoses/

[10] RCR, Overcoming barriers to AI implementation in imaging (2023). Available at: https://www.rcr.ac.uk/our-services/artificial-intelligence-ai/overcoming-barriers-to-ai-implementation-in-imaging/

shortages are preventing implementation in some instances. AI will not replace highly trained doctors, rather enable them to focus their care. AI must be considered in the round with the NHS's workforce requirements.

34. The current iteration of the LTWP notes that AI "will transform our ability to prevent, diagnose, treat and manage disease" and "will change ways of working, releasing staff time to focus on patient care". Future versions of the LTWP should expand upon how AI is to achieve this, and in so doing must reference the considerations laid out above.

Expansion of training places

35. The RCR was disappointed that the first iteration of the LTWP did not include details about how specialty training will be expanded. That such detail will be essential is inarguable. If the LTWP is successfully delivered and the number of medical school places is doubled, there must be training places for these future doctors to progress into and expand their skills.

36. We appreciate the scale of the challenge in modelling supply and demand for individual medical specialties. Nonetheless, such modelling will be required in future iterations of the LTWP. There needs to be a clear plan for how the boost in medical student numbers translates into more senior doctors working in the NHS. As the number of medical graduates increases from 2028 onwards, a commensurate increase in the number of specialty training posts will be required.

37. Indeed, if the LTWP is implemented and there are many more medical school places, it would be self-defeating to not introduce a commensurate increase in speciality training posts. If this is not done, the NHS will simply export many of the extra doctors to other counties such as Australia and Canada, which are already popular destinations.

38. In clinical oncology, there are not enough applicants to fill the available training places. In 2023, the fill rate was just 53%, meaning nearly half of posts went unfilled. Further work needs to be done to address this. NHS England should, in collaboration with the RCR and the Association of Cancer Physicians, fund a recruitment campaign for clinical oncology to attract more trainees into the profession, to avoid the shortfalls of clinical oncologists continuing to deteriorate. There is also a need to ensure there are sufficient Internal Medicine Training (IMT) posts for trainees to enter, prior to progressing onto the oncology common stem. An expansion of the number of IMT posts may be needed to ensure specialty training posts that follow on, including clinical oncology, are filled. NHS England should look into this issue further and take the necessary action.

39. Conversely, clinical radiology training places are oversubscribed. In 2023, there were over 8 applicants for ever one training place. In recent years, the Government and NHS England have expanded the number of specialty training places to address the shortfall of clinical radiologists. However, training programmes are increasingly unable to take up these places and offer them to trainees. Radiology clinical directors give various reasons for this, with most citing a lack of staff time to deliver training, a lack of space in

which training can be delivered, and funding problems (see paragraphs 43-48).[11] Our latest data shows that in 2023, just 59 of 75 of the additional expansion specialty training posts in radiology were taken up by training programmes (78%). The RCR estimates that there are over 100 doctors in training in clinical radiology who are yet to be appointed to specialty training posts.

40. Therefore, future iterations of the LTWP should include detail on how NHS England will support Trusts to ensure all specialty training posts are filled. There must be a commensurate expansion and investment in training capacity, since local systems are no longer able to accommodate new trainees right now – let alone the huge increase in numbers we expect to see over the next five years as the LTWP comes into force.

41. We look forward to working with NHS England to deliver the ambitions of the LTWP and in developing future iterations of the Plan. To that end, we believe the following recommendations for specialty training must be adopted:
    a. The government should at least maintain the current expanded number of specialty training places for clinical oncology and clinical radiology to grow the future workforce. As the LTWP leads to an increased number of medical graduates (from 2028 onwards), the government should work with the NHS to further expand the number of training posts available.
    b. The government should provide funding to support expansion of clinical and office space to accommodate increased numbers of trainees.
    c. Doctors should have protected SPA time, which they can use to provide training in addition to their own revalidation.
    d. Retired doctors should be encouraged to return to support training.
    e. Innovative solutions such as the use of novel technologies and cross-centre support should be used to expand training capacity.
    f. NHS England should support and fund a recruitment campaign to attract trainees to oncology training posts.

Leadership

42. As well as training and innovation, medical leadership is a crucial aspect of providing adequate care in the face of the significant gap between capacity and demand. As described throughout this submission, the NHS needs to work differently if it is to provide the levels of care patients deserve and expect. The best people to lead these changes are senior clinicians themselves – and this work is at least as important as frontline clinical work.

43. Senior doctors' knowledge and distinctive skills drive quality of care in multiple ways. One of these is service design, where doctors are well place to understand the complex influences on patients' needs across the entire healthcare system. They also play key roles in operational management and in developing positive cultures and behaviours.

[11] RCR 2023 census reports (not yet published).

44. There is also some evidence that medical organisations led by clinicians perform much better in terms of positive patient outcomes.[12,13]

45. The NHS currently does not make the best of its senior doctors. Their potential to improve services is limited if they are always doing direct clinical work, important as this is. The NHS needs also to be able to have the capacity to think about the longer-term.

46. Currently, medical leadership is limited by various factors. There is insufficient time in job plans for leadership activities. Senior leaders lack adequate administrative and financial services support. A lack of incentives, such as recognition and reward schemes, makes senior roles less attractive. Trainees are not encouraged to develop their leadership skills. Often, leadership roles in practice do not represent a career progression opportunity.

47. All these barriers need to be addressed. Senior doctors need to be empowered to undertake the vital work of medical leadership. Actions that could be considered include: ensuring medical leaders have appropriate professional support and the right training and experience; create an environment in which medical leadership is seen as prestigious; devise appropriate rewards for medical leadership roles; and ensure senior clinicians have sufficient time in their job plans for leadership activities.

48. The RCR made a submission to the Health and Social Care Committee's Inquiry into NHS leadership, performance and patient safety, which developed these arguments in detail.[14]

Funding

49. Funding is a crucial aspect of the LTWP's proposals. We welcome the new funding already announced to deliver the Plan. However, we would emphasise the need to establish a proper long-term funding framework to deliver the LTWP and set the NHS workforce on a sustainable footing.

50. We would encourage policymakers to refer to our proposals above when crafting such a framework. Those included in paragraphs 4-13 should be given particular attention. The size of the challenge facing the future of healthcare in the UK is significant; we need a long-term funding settlement that reflects its scale.

51. We are calling on all political parties to commit to a fully-funded, 15-year funding framework for the LTWP in their manifestoes, ahead of the next general election that is

[12] Clay-Williams R, Ludlow K, Testa L, et al. Medical leadership, a systematic narrative review: do hospitals and healthcare organisations perform better when led by doctors? BMJ Open 2017;7:e014474. doi:10.1136/bmjopen-2016-01447

[13] Veronesi, G. Kirkpatrick, I. and Vallascas, F. Clinicians on the board: what difference does it make? Social Science and Medicine 2013, 77:147-155. https://doi.org/10.1016/j.socscimed.2012.11.019

[14] Health and Social Care Committee Inquiry into NHS Leadership, Performance and Patient Safety, Written evidence submitted by the Royal College of Radiologists (NHL0064). Available at: https://committees.parliament.uk/writtenevidence/128685/html/

expected within the next nine months.[15] As mentioned above, this should include commensurate expansions to foundation and specialty training posts. Already in some specialties, doctors are stuck in limbo because there simply are not enough training posts for them to enter. If this is not addressed, the additional doctors trained will have nowhere to go – except to emigrate to other countries.

52. The aforementioned funding framework must also consider, in concert with our call for further detail on how specialty training posts will be expanded, how specialty training places are funded. Currently, the Plan includes funding only for increasing the number of undergraduate medical school places. Funding must also be provided for expanding specialty training in line with the expansion at the undergraduate level.

53. The current model in England is for NHS England to fund 50% and for individual NHS Trusts to fund the other 50% of each training place. It is a mixed picture, but in many instances, this model presents a barrier to training posts being taken up. Trusts operating under significant financial constraints are sometimes unable to pay for their 50% of the cost of training places, so simply do not offer them out to trainees.

54. In radiology, trainees may not be seen as a worthwhile investment by senior management because, for the first two years of their training (ST1-2), they require significant consultant supervision (as compared to other specialty trainees who have undergone internal medicine training). Therefore, NHS England should fund 100% of radiology trainees' costs for the first two years, before reverting to a 50/50 model in subsequent years.

Conclusion

55. The RCR warmly welcomes both the LTWP and the opportunity presented by this Inquiry to share our thoughts and recommendations for future iterations of the Plan.

56. We stand ready to assist NHS England with the development of the LTWP over time, particularly with regards to the details of expanding specialty training and boosting retention of NHS staff.

57. Likewise, we would be glad to assist the PAC further with this Inquiry, or with any other of their ongoing work. For more information, please contact policy@rcr.ac.uk.

[15] RCR, RCR response to the publication of the NHS Long Term Workforce Plan (2023). Available at: https://www.rcr.ac.uk/news-policy/latest-updates/rcr-response-to-the-publication-of-the-nhs-long-term-workforce-plan/