David Oliver: The welcome for the NHS workforce plan should come with some challenging questions

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Well, it’s finally here. Initially promised in 2019, and after years of inaction and detail-free interim reports, the NHS long term workforce plan for England was published today. After so many of us have pushed for so long for it, I’m thankful that there is now one (although only for England and not yet for the devolved UK nations). It takes a huge amount of work, negotiation, and overcoming setbacks, changes, and interference to get something like this over the line, and I’m grateful to all of those who did all the hard graft—especially clinicians within NHS England.

Finally, we have modelling and projections about NHS workforce gaps and growth that have been published by a government agency and not just health policy think tanks. The plan is explicit that we already have 112 000 clinical vacancies and that population ageing and growth may leave us with a shortfall of 360 000 by 2037. It admits that we need more home trained substantive staff on the NHS payroll to reduce expensive spending on agencies and ethically dubious over-reliance on staff trained in other—often poorer and more short staffed—nations in the midst of a global healthcare workforce shortage. It’s good to see all of this openly acknowledged and not airbrushed out with complacent political spin.

The plan is structured around “training” and “retaining” more staff and “reforming” how they’re trained, how they work, the mix of skills in teams, and a proposed shift towards more community models and more digitally enabled care. It targets 60 000 more doctors, 170 000 more nurses, and 71 000 more allied health professionals in the workforce by 2036—although, rightly and helpfully, there’s a plan to review the projections and targets every two years.

The plan states an intention to shift more staff into primary, community, and mental health roles and a greater emphasis on prevention, but it doesn’t give much detail on the funding mechanisms to make this happen, when acute hospitals remain under extreme pressure and secondary elective care faces dreadful backlogs.

The plan proposes a new “earn while you learn” apprentice training model for 22% of clinical staff, including one in six for medical school places. An “apprenticeship” route to medical degrees is a very new concept. It also plans to shorten medical degrees from the current five or six years to four years and to get doctors into the clinical workforce sooner through internships, as well as getting newly qualified nurses into the workforce four months sooner than the current norm. And it promises a major expansion of nursing associates as opposed to graduate registered nurses.

There’s far less on various allied health professions, even though they’re a crucial part of the multidisciplinary team crucial to patient care. And, because this is the NHS plan, there’s nothing of note on social care, which faces even more pressing workforce gaps and demographic challenges than the NHS, with the two sectors mutually dependent.

Logistics

So, what’s missing? Well, I remain to be convinced that we can shorten training, in what’s already a packed curriculum, without risks to the quality of how, or how the logistics of “apprenticeship doctors” will work. Our medical schools already reject around five in six applicants, so why not just expand conventional places? If we want more students from deprived backgrounds, we could just waive their course fees or loans or restore some financial support.

I’m also concerned about the growing tendency to replace the most highly trained and qualified staff with alternative groups such as nursing or physician associates, who have shorter training, less clinical autonomy, and less career progression. A shift from “education and professionalism” to “training and tasks” looks set to disempower professionals and to water down the quality and safety of care.

We’ve also had promises to increase medical school places in recent years, notably from 7500 to 10 000. But last year the government told medical schools to stop recruiting students, as the money wasn’t there. How do we prevent a repeat of that?
Medical school places need to be accompanied by adequately resourced and expanded postgraduate training rotations for those new graduates (and the support for the senior doctors who must do all the training and supervision). This detail is lacking from the plan.

Likewise, we’ve seen targets to increase GP numbers through GP training schemes, but we have 2000 fewer full time equivalent GPs now than in 2015 despite the workload rising rapidly. We need to make sure that this isn’t just a repeat of the empty pledge.

Terms and conditions

You can’t recruit your way out of a retention crisis, and without a sustained focus on what we do to retain staff at all career stages by valuing them, supporting them, and rewarding them, they’ll continue to leave—and we risk merely training more staff only for them to go and work elsewhere, or leave medicine entirely. The plan predicts “keeping 130 000 staff in the workforce for longer,” but it’s threadbare on the “how?”

In particular, there’s nothing on improving terms and conditions. There is some magical thinking on keeping late career or recently retired doctors in the workforce, despite many retiring precisely because they’re burnt out and disillusioned. There are also some suggestions on increasing training budgets and continuing professional development budgets for nurses and allied health professionals. But the whole issue of workplace wellbeing and of treating and supporting people better seems to be outsourced to local executives. This is all basically a reiteration of the vague “jam tomorrow” platitudes in the 2020-21 interim NHS people plan.3

Finally, the funding is for only five years, which will take us to the midpoint of the next parliament, by which stage current ministers and many current NHS England staff will be long gone. It would be good to see a serious cross party commitment to give this plan more long term stability.

It’s good to see a plan. It’s also good to ask challenging questions about the logistics, resourcing, feasibility, and risk for the things in it—and to highlight the elements that are missing.

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