

The NHS Long Term Workforce Plan: what does it mean for BMA members?



Overview

On 30th June 2023 NHS England published the long-awaited [NHS Long Term Workforce Plan](#). It was written by NHS England but commissioned and accepted by the Government. This briefing provides a summary of the key announcements, and what they may mean for the medical profession.

The plan sets out long term workforce supply and demand projections for the NHS in England up to 2036/37, as well as the actions and reforms that will be taken in the coming years at local, regional and national level across three priority areas: train, retain, and reform. 'Train' and 'retain' aim to grow the workforce through increasing training numbers and improving retention of existing staff (albeit the plan is silent on key areas supporting retention such as pay). 'Reform' sets out changes to medical education and training that aim to save time and diversify routes into the NHS.

The plan also relies on achieving ambitious increases in labour productivity by improving efficiency and making use of emerging technologies like artificial intelligence. NHS England claim the combination of actions across these three areas, in addition to capturing the benefits of productivity increases, will start to address the current staffing shortfall and grow the workforce to meet demand.

The plan also signals a 'new, iterative approach' to workforce planning, revisiting the plans every two years, and there is also a commitment to work with stakeholders to implement the actions. NHS England plan to continue to develop the model behind the staffing estimates in the plan and will publish a refreshed projection every two years.

BMA Headline Analysis

- After the refusal of successive governments to publish workforce modelling, the publication of a long-term strategy based on supply and demand modelling – which the BMA has lobbied for alongside a wider coalition of stakeholders - is a significant achievement and a major step forward. However, we believe the iterative approach with a commitment to a review the plan to ensure it remains up to date every two years must be enshrined as legislation to ensure this remains a continued commitment for future Governments.
- The headline commitment to double medical school places is welcomed: this is in line with BMA policy, and something the BMA has been campaigning on for many years. However, the plan lacks an implementation strategy beyond the immediate first steps, and its funding commitments are arguably insufficient to make this increase happen. We also have concerns about how the existing infrastructure as it currently stands (such as teaching facilities or staff capacity to train), could support the proposed expansion. The lack of capital funding allocated in the plan does not help here.
- The elephant in the room is pay. If pay is not restored, doctors will continue to feel devalued and will continue to leave, and the plan will be futile. NHS England cannot determine doctors' pay, but the Government can. Whether or not they make the right decision here will be the biggest deciding factor in how successful this plan can be.
- The profession is concerned about the impact of the proposed expansion of physician associates, anaesthesia associates and other associate roles, as well as the increase in medical apprenticeships. The proposed expansion of these groups is much lower than the proposed expansion of the medical workforce, but it is nonetheless vital that the roles, remits and responsibilities of physician associates and other associates are clearly explained to patients and other health service workers. It is also vital that training these staff does not impact on the quality of training of doctors and other existing staff groups.

- Approaches such as medical degree apprenticeships and accelerated undergraduate degrees are untested, so we have significant concerns about their role in addressing the crisis. It is imperative that medical degree apprentices receive the same high standards of training experienced by those on traditional training pathways.
- While the ambitions set out in the plan for improving culture, leadership, and wellbeing to retain staff are all positive, they are clearly limited in scope and lack resourcing or funding to make them a reality. The plan's actions on retention are also extremely broad and fail to capture the specific changes needed to support the retention of doctors, including being clear about the importance of pay and wider terms and conditions to staff retention.

1. Workforce Modelling

For at least a decade, there has not been any public attempt to consider the number of staff actually needed to run the NHS.

In the plan, NHS England acknowledges the number of staff trained in the UK has not kept pace with demand for NHS services, the large number of workforce vacancies that remain unfilled, and the need for expansion of the workforce.

The plan sets out targets for an expansion in workforce numbers over the 15-year timeline the plan covers, which are underpinned by workforce modelling. The modelling compares current demand for staff to deliver services with the level of supply. It estimates that the starting shortfall between supply and demand for NHS staff is approximately 150,000 full-time equivalent staff members, currently at least partially filled by temporary staffing. It also projects future demand and supply, to consider future shortfall. It finds that if current trends were to continue, the NHS will face a workforce gap of more than 260,000–360,000 FTE staff by 2036/37.

In the plan, NHS England then sets out the policies needed to meet that shortfall (discussed in the following sections).

The intention is that NHS England will refresh the plan at least every two years to ensure the assessment of demand for staff remains up to date.

The Modelling Underpinning the Plan

NHS England estimates that:

- Today's shortfall between demand and supply for NHS staff is approximately 150,000 full-time equivalents (FTEs) - a gap currently partly filled with temporary staffing.
- If current trends were to continue, the NHS will face a workforce gap of more than 260,000–360,000 FTE staff by 2036/37.
- Even if staff retention increased significantly and productivity rises there would still be a workforce shortfall. NHS England therefore believe domestic education and training need to expand by around 50% to 65% over the next 15 years.
- The collective impact of the actions proposed in the plan to improve retention would improve leaver rates by around 15% over the course of the Plan, reducing the number of leavers by between 55,000 and 128,000 FTEs over the 15-year timeframe.
- NHS England claim that with the plan's full implementation over the 15-year term, the NHS total workforce would grow by around 2.6–2.9% a year equating to an expansion of the NHS permanent workforce from 1.4 million in 2021/22 to 2.2-2.3 million in 2036/37.
- This would include an extra 60,000–74,000 doctors, 170,000–190,000 nurses, 71,000–76,000 allied health professionals (AHPs), and 210,000–240,000 support workers.
- If the plan is fully implemented, by 2036/37 this would be equivalent to the number of nurses per 1,000 population growing to around 9.5, and the number of doctors per 1,000 population growing to around 4.3, in the NHS in England. For context, this is the ratio Italy and Sweden have today, and below the ratio Germany and Austria have (4.5 and 5.5 respectively).

- In addition to the staffing increases, the model also assumes an ambitious labour productivity improvement of up to 2% which is more than double the long-run productivity growth for healthcare in England excluding COVID years, according to the ONS (0.9% average growth 1996/97 - 2019/20) in order to scale up delivery of care to meet demand, which it intends to achieve by action in three areas:
 - Delivering care closer to home whilst reducing costly admissions
 - Achieving 'operational excellence'
 - Expanding use of innovative and emerging technology, including AI
- The [Health Foundation's REAL Centre](#) was asked by NHS England in February 2023 to undertake an independent assessment of the modelling approach used to inform the staffing projections. They found that the approach to the modelling and the assumptions underpinning it were plausible, but they also flagged specific concerns with assumptions around productivity growth, as well as the model's focus on national demand and supply without properly considering regional distribution and geographical workforce gaps.
- Their assessment was of the modelling approach only, as it stood at the time, and not of the projections for the number of staff needed. Since then, NHS England have made changes to some of the assumptions underpinning the modelling approach which the Health Foundation have not assessed.

BMA Analysis

- After years without either a long-term workforce strategy or the publication of the number of staff needed to run the NHS, the publication of a long-term strategy based on supply and demand modelling (some of which has been independently assured) is a significant achievement and a major step forward.
- The iterative approach proposed with a commitment to a review every two years is welcomed, but this must be enshrined in legislation to ensure this remains a continued commitment for future Governments.
- The BMA has called extensively for the modelling underpinning the plan to be verified in full. The Chancellor promised this would happen in 2022's [Autumn Statement](#), but what we got is only a partial assessment: the Health Foundation did not see all underlying analysis, and their involvement was only an assessment of the modelling approach, not an endorsement of its projections. There was also no scrutiny of the staffing targets set in the plan – which are ultimately low. For example, the plan states a target of 4.3 doctors per 1,000 population by 2036/37 which is below what some comparator nations such as Germany have today. The commitment to independent scrutiny is a priority going forward and should be integrated into the approach taken to review and update the projections.
- The workforce modelling featured in the plan is also not currently broken down by medical specialty. It is unclear whether NHS England intend to published broken-down modelling for each specialty. Ongoing engagement on this with key stakeholders, such as the Royal Colleges and the BMA, will be vital to ensure the modelling underlying the headline figures is fit for purpose for individual medical specialties. It is vital that this includes the medical academic workforce and the public health workforce – without which the proposed expansion and strategic reorientation of the health service cannot happen.
- The plan relies on significant improvements in labour productivity – which, at an estimated 1.5-2%, are significantly above the long-run average of 0.9% growth for healthcare in England (1996/97 - 2019/20). It is not clear how these can be achieved, especially given the current state of NHS infrastructure and the fact no capital funding has been announced alongside or as part of the plan. Achieving productivity improvements in this range this will require continued and sustained investment in NHS infrastructure and technological capacity, a significant increase in funding for technology and innovation, and the full delivery of the broader proposals in the plan. With many hospitals and GP practices still using time-consuming, outdated and archaic IT systems, the plan's reliance on maximising the efficiencies of technological innovation to improve labour productivity seems unrealistic right now. We need more details on how the NHS will be supported to achieve a technological expansion of the degree the plan sets out.

2 “Train”

The goal of this priority area is to significantly expand domestic education, training and recruitment to have more healthcare professionals working in the NHS.

The plan commits to a new suite of actions over the next six years that claim to support and develop the NHS workforce with an immediate boost in training numbers. The Government have announced a £2.4 billion commitment to fund the 27% total expansion in training places by 2028/29: this is the ‘first step’ towards increasing education and training by 64% by 2031/32.

The plan signals a move to train more NHS staff domestically to reduce long-term reliance on international recruitment and agency staff. In 15 years’ time, NHS England estimate that around 9– 10.5% of our workforce will be recruited from overseas, compared to nearly a quarter now. This reflects the fact that global demand is increasing and that with changes such as Brexit and visa restrictions the UK is likely to become a less attractive destination for healthcare staff.

The Plan Sets Out The Intention To:

- Double the number of medical school training places to 15,000 per year by 2031/32, starting with an increase by a third (to 10,000 a year) by 2028/29, with more places in areas with the greatest shortages to help address geographical inequity.
 - The first new medical school places will be available from September 2025.
 - The plan says it will ‘also ensure there is adequate growth in foundation placement capacity and commensurate increase in specialty training places’ but there is no detail on what this looks like.
- Increase the number of GP training places by 50% to 6,000 by 2031/32.
 - In 2018 the government expanded the number of medical school places by 1,500 and the first of these graduates are now starting to join the workforce. The long term workforce plan commits to initially growing GP specialty training by 500 places in 2025/26, timed so that more of these newly qualifying doctors can train in primary care.
 - This will be followed by an additional 1,000 places (5,000 in total) in 2027/28 and 2028/29, which will offer the same opportunity to a bigger pool of doctors graduating as a result of the increase in undergraduate places outlined in the plan.
- Expand the specialist public health workforce by providing 13% more training places in 2023/24 than we do currently.
 - NHSE will work with national, regional and local system partners, including DHSC and the UK Health Security Agency, to address the demand and supply challenges of the public health workforce in future years.
- Increase training places by 26% for both clinical psychology and psychotherapy by 2031 taking the combined number of training places to over 1,300.
 - Provide 22% of all training for clinical staff through apprenticeship routes by 2031/32 (up from 7% today, and rising to 16% by 2028/29). The aim of this is to help widen participation by encouraging people from all backgrounds and underserved areas to join the NHS).
- Introduce an expanded medical degree apprenticeships scheme
 - 200 apprenticeship places are currently funded for pilots running in 2024/25 with an ambition for up to 400 places to be funded by 2026/27
 - Subject to evaluation, the proposal is to grow medical degree apprenticeships to more than 850 by 2028/29, with an overall ambition to have 2,000 medical students training via this route by 2031/32.
- Reduce the NHS’s reliance on agency staff over the modelling period, while still retaining the ability to utilise bank staff in a cost-effective way.
 - The reliance on temporary staff is estimated to reduce from 9% in FTE terms in 2021/22 to around 5% from 2032/33 onwards, with mostly bank staff fulfilling the requirement for temporary staffing.

BMA Analysis

- The BMA has repeatedly called for medical school expansion to help address long-term workforce shortages and we support the commitment to double medical school training places. However, significant questions remain regarding the implementation of this proposal and particularly how it will be funded. The plan acknowledges that its aspiration will require both the expansion of existing medical schools and the construction of new ones - but it is currently unclear how or if the £2.4 billion allocated to expanding training places will cover the cost of delivering this extra capacity.
- The plan acknowledges the need to ensure growth in foundation year placements and expansion of specialty training in future years commensurate with the growth in undergraduate medical training, but it provides no detail on how this will be funded or implemented. The whole health education pipeline – including physical capacity and the trainer workforce - will also need to grow. This initial commitment must therefore be followed with a credible expansion plan and further funding commitments for the remaining parts of the training pipeline.
- The plan's aspiration to route the increased number of domestically trained doctors to areas with the greatest need is understandable, given the acute shortages in medical staffing in certain parts of England. However, it is unclear how NHS England expects to deliver this, how it will define areas of greatest need, and, crucially, how it intends to compel newly qualified doctors to work in specific locations. These pivotal questions need to be addressed urgently.
- While this is an NHS plan, it is particularly important that we develop public health expertise and invest in public health, so that we're not just focusing on treating people when they are poorly but stopping them becoming unwell in the first place. An increase in public health training numbers is therefore a positive step, but this must be the start of a sustained commitment.
- The doubling of GP training numbers is much-needed – as is increased time in general practice for doctors on training programmes. However, it is unclear how these doctors will be supervised given how stretched GPs are, or where they will work in increasingly dilapidated and outdated premises that lack space for training additional staff. Retaining our current workforce of GPs and practice staff must therefore be prioritised in the short term given the crisis in general practice.
- Approaches such as medical degree apprenticeships and accelerated undergraduate degrees are untested, and we have significant concerns about their role in addressing the crisis. It is imperative that medical degree apprentices receive the same high standards of training experienced by those in traditional training. It is unclear how given how intensive medical training already is the length of training can be shortened by a whole year. The BMA will look very closely at and engage with proposals setting out further detail on this.
- Widening participation should not be solely focused on medical apprenticeships but should also be a priority for traditional training. We do not want to end up in a situation where those from underrepresented backgrounds are pushed towards one form of training while those from more affluent backgrounds are encouraged to take a more traditional route. Medical apprenticeships and widening participation should be avenues towards democratising medicine rather than entrenching historic elitism within the medical profession. This includes a greater concerted effort to address the educational and financial hurdles faced by school leavers and graduate entrants from underrepresented backgrounds, which themselves act as significant barriers to widening participation in medicine.
- Continued efforts are needed to improve working culture and conditions in the NHS to ensure that overseas doctors are welcomed, and UK trained doctors are incentivised to stay in the UK. It is important that focus on growing the domestic pipeline is not presented as hostility to the valuable contribution of IMGs and does not create new barriers to their recruitment, training and retention.
- It is not clear how the reduction in the proportion of international recruits from c.25% to 9.5-10% has been calculated. Even if the most optimistic assumptions in the plan are met, there will continue to be some reliance on international doctors in the short and medium term. It is in the long-term interest to ensure that those IMGs who do

choose to come and work in the NHS get the necessary support and are retained within employment, through addressing barriers to retention, including challenges around visas and sponsorship, and reviewing restrictions such as the Adult Dependent Relative rules that lead to international doctors leaving NHS employment prematurely. The recent announcement by the UK Government that most visa and immigration fees will be increased by 15-20% is likely to add significantly to the financial costs of international recruitment for both individual applicants and employers. These additional recurring costs to doctors may also act as a barrier to retention, as doctors may choose to relocate to countries with less expensive and less prohibitive visa and immigration frameworks.

3 “Retain”

The goal of this priority area is to embed the right culture, leadership and wellbeing to ensure up to 130,000 fewer staff leave the NHS over the next 15 years.

This part of the long-term workforce plan commits to implement the actions from the NHS People Plan and roll out interventions to ensure staff can work flexibly, have access to occupational health and wellbeing services and are able to work in a supportive and well led team.

Following the change on pension tax arrangements in the Spring Budget 2023, the plan pledges to modernise the NHS Pension Scheme and make it easier for doctors who have already retired to return to NHS employment.

The Plan Sets Out The Intention To:

- Implement actions in the NHS People Plan to make the NHS People Promise ‘a reality for all staff’ by rolling out interventions that have proven to be successful already, including provision of:
 - Flexible working
 - Health and wellbeing support
 - Recognition and rewards
 - CPD (Continuing professional development) Opportunities
 - Team development
 - Embedding a compassionate and inclusive culture
 - Seeking, listening to and acting on staff feedback/engagement
- Build on work to embed a compassionate and inclusive culture through systematic improvements to:
 - Recruitment and promotion practices
 - Leadership diversity
 - Disciplinary processes
 - Governance and accountability
 - Training and education
- Continue to tackle the prejudice and discrimination that some staff experience by following the six high impact actions in NHSE’s equality, diversity and inclusion (EDI) improvement plan, which was published on 8 June 2023.
- Undertake regular cultural reviews within the NHS to improve working environments for staff. The NHS Culture and Leadership Programme provides a comprehensive tool that employers can use to conduct reviews.
- Improve flexible working opportunities for prospective retirees / retired doctors and make it easier for those who have already left NHS employment to return including:
 - Deliver actions needed to modernise the NHS Pension Scheme (building on changes announced in Spring Budget 2023 to pension tax arrangements).
 - From autumn, recently retired Consultants will have a new option to offer their availability to trusts across England to support delivery of outpatient care through a new ‘NHS Emeritus Doctor Scheme’ (full details are yet to be announced).

- Create more options for doctors to return in flexible, contracted roles or as part of the temporary staffing workforce (such as through the existing Career Refresh for Medicine programme (CaReForMe) for doctors).
- Make flexible working easier for staff by encouraging employers to consider the flexible working principles, clearly communicating these to staff and supporting them to explore flexible working options.
- Employers should ensure e-rostering and regularly assess their compliance with these metrics
- Ensure that staff are working within an environment that supports their health and wellbeing, including by providing access to good quality rest areas, food and drink options, and safe storage for personal possessions.
- Employers must review the NHS Health and Wellbeing Framework and the National Standards for Healthcare Food and Drink.
- NHS organisations and system partners to collaboratively develop an employee value proposition (EVP) and promote this across the workforce. This would include national and local benefits, pensions, salary sacrifice schemes, flexible working and development and local financial wellbeing support initiatives.
- Support the health and wellbeing of the NHS workforce (e.g. through restorative supervision) and, working with local leaders, ensure integrated occupational health and wellbeing services are in place for all staff. The latter should align with the national Growing Occupational Health and Wellbeing (OHWB) Together strategy, along with the ICS Design Framework.
- Ensure domestic abuse and sexual violence (DASV) leads are appointed and evidence based policies exist to support all staff experiencing DASV crimes.
- Support team development by using tools such as the Do OD Team Toolkit published by NHS Employers. In addition to this, NHSE will focus on the Messenger Review recommendations related to talent, leadership and management, and ensure the continued success of the NHS Graduate Management Training Scheme.
- Support staff to have “a voice that counts” by ensuring that continuous feedback mechanisms are in place, and building on existing policy, NHS organisations should have a clear and regularly communicated Freedom to Speak Up approach.
- Evaluate the effectiveness of current methods of staff communication and feedback mechanisms to ensure a listening approach is in place to best engage staff.
- Involve staff in developing services and improving working environments via national tools. This would also enable the NHS to better capture and improve the experiences of staff with protected characteristics.
- Signpost and support NHS staff to access the extended childcare support to working parents announced in the Spring Budget 2023, to help staff to stay in work.

BMA Analysis

While the ambitions set out in the plan for improving culture, leadership, and wellbeing to retain staff are all positive, they quite clearly do not go far enough to improve retention of staff. With no additional money yet announced, we also have concerns about how these ambitions will be made a reality.

Pay, pensions and working conditions

- The plan is noticeably silent on the biggest determining factor for doctors deciding whether or stay or to go: pay and wider terms and conditions. Feeling chronically undervalued, underpaid and overworked is forcing more and more doctors to weigh up whether to stay in the NHS: quite simply, this plan will fail if the link between pay and retention is not addressed.
- The Chancellor’s announcement to remove the lifetime allowance (LTA) and to increase the annual allowance (AA) has been significant in removing the majority of doctors from having to pay large and unexpected punitive pension tax bills. However, the failure to address pay means that there remains an incentive for doctors to leave the workforce to access inflation-linked pension rises. The BMA’s recent consultant ballot gave a huge mandate for action to be taken, despite the pension changes that had already been announced. This shows the extent of the concern amongst BMA members about the

value of their pensions given the stagnation of pay. A truly sustainable and long-term workforce plan will require the retention of senior doctors – but this plan does nothing to improve their circumstances.

Working conditions and career development

- The emphasis on ensuring that staff are working within an environment that supports their health and wellbeing, including access to good quality rest areas and hot and nutritious meal is much needed. However, as the BMA argued in our report [Brick by Brick](#), it is crucial that NHS organisations receive adequate funding and support to upgrade their estates accordingly.
- The plan's focus on improving flexible working opportunities is positive. However, the plan does not establish any specific duties for employers and merely 'encourages' employers to consider the flexible working principles. This is a problem: encouragement alone is not enough to ensure all staff are able to access truly flexible working should they desire.
- The announcement of extended childcare support for working parents over the next three years is welcome, and, as argued in the BMA's Weathering the Storm report, should have a positive impact on retention. Additionally the NHS's EDI Improvement Plan specifically mentions the Independent Review into the Gender Pay Gap in Medicine and asks that the recommendations are implemented by employers by March 2024. When the independent review was published, the BMA called for the recommendation on increased provision of NHS nurseries and other childcare support to be prioritised.
- The plan fails to specify how it will actively provide more support with career development, progression, and more flexibility in positions available to the SAS (specialty and associate specialist) and LE (locally employed) doctors they employ. The number of SAS and LE doctors on the GMC register has increased by 40% from 2016-2021, largely driven by doctors coming from overseas. If the trend continues, by 2030 SAS and LE doctors in secondary care will form the largest group in the medical workforce. A [GMC report](#) found that these doctors are more likely to face inequality in terms of appraisal success, disciplinary referral, and career progression. SAS doctors are also more likely to be in unsupportive work environments, facing bullying, harassment, and discrimination, and they are also less likely to raise concerns due to fear of negative consequences.
- Retired doctors can play a vital role both in boosting the workforce and in contributing their careers' worth of valuable knowledge. More routes to support retired doctors returning to meaningful practice on a flexible basis are desperately needed, so the plan's inclusion of the new Emeritus Doctor Scheme is encouraging. This scheme could help pave the way for retirees to return to practice to offer their services in a flexible way. However, more detail is needed on how the scheme will work – as yet, no further information has been released. NHS England must ensure plans are developed with stakeholders to ensure the scheme works not just for patients but for the retirees it is intended for.

Prejudice, discrimination, bullying and harassment

- Prejudice, discrimination, bullying and harassment remain critical problems across the NHS, but the long-term workforce plan fails to provide a clear plan on how to address them or to fully recognise the positive impact doing so would have on retention. As the BMA's report [Bullying and harassment: how to address it and create a supportive and inclusive culture](#) stressed, there needs to be a comprehensive and strategic approach to eradicate bullying and harassment across the NHS, with action targeted at all levels to change individual behaviour, address underlying organisational factors, and deal with system pressures.
- The plan includes a focus on encouraging individuals to speak up and report bullying and harassment, which is important, but this will not be effective if complaints are not taken seriously. Our [Sexism in Medicine survey](#) clearly illustrates this issue and reinforces the need for clear sexual harassment reporting processes to ensure safe working environments for doctors.

- The plan points to NHS England’s separate EDI improvement plan, which contains very broad equality and diversity statements and overlooks key standards, such as the Medical Workforce Race Equality Standard (MWRES) which specifically focuses on doctors’ experiences and progression. NHS England’s EDI improvement plan needs to be strengthened to direct employers on the steps they must take to understand how discrimination based on protected characteristics manifests uniquely in the medical profession, for example including ensuring managers and leaders improve their racial literacy to be able to manage racism and xenophobia, multiple channels for reporting discrimination and sexual harassment, and disability awareness to ensure smooth and progressive reasonable adjustments in all settings.
- Further, the EDI improvement plan builds on previous standards/plans that have been in place for some time, without a clear picture of how the ICB/ICSs will co-ordinate delivery across employers and how the CQC will regulate compliance.
- The plan’s emphasis on conducting regular cultural reviews to improve working conditions for staff is a welcome first step. This aligns with key recommendations of our ‘Delivering racial equality in medicine’ report, which include improving reporting processes for employers and managers and evaluating interventions.
- The plan fails to offer any solutions or new support for NHS staff who are experiencing, or will experience, menopause. The BMA’s Challenging the culture on menopause for working doctors report found that a significant number of women senior doctors have reduced their hours, left management roles or intend to leave medicine altogether, despite enjoying their careers, because of the difficulties they faced when going through menopause. Serious action is needed to address this and to retain those doctors.
- Our research – including our Racism in Medicine Survey - consistently shows that there are particular points of discrimination and unequal treatment of IMG doctors – however, the plan fails to directly address their needs. Employers should be aware that IMGs may be in more vulnerable working conditions due to the way they are recruited, visa restrictions, and/or being new to practice in the UK. More needs to be done to provide appropriate induction, terms and conditions, pay and support for IMGs coming into UK practice (either through public or private companies).

4 “Reform”

The goal of this priority area is to improve productivity by working and training in different ways.

This means building broader teams with flexible skills, changing education and training to deliver more staff in roles and services where they are needed most, and ensuring staff have the right skills to take advantage of new technology that frees up clinicians’ time to care, increases flexibility in deployment, and provides the care patients need more effectively and efficiently.

The Plan Sets Out The Intention To:

- Grow the proportion of staff in enhanced, advanced and associate roles from around 1% to 5% by the end of the Plan
 - At least 3,000 to start on advanced practice pathways in both 2023/24 and 2024/25, increasing to 5,000 by 2028/29 and 6,300 by 2031/32
- Increase physician associate (PA) training places to over 1,500 by 2031/32
 - Around 1,300 PAs will be trained per year from 2023/24, increasing to over 1,400 a year in 2027/28 and 2028/29
 - This will establish a workforce of 10,000 PAs by 2036/37 (this is against a context of approx. 250-300,000 doctors by this time)
- Bring AAs and PAs in scope of General Medical Council (GMC) registration by the end of 2024 with potential to give them prescribing rights in the future – although this had already been announced and is not new policy via the plan

- Grow the number and proportion of NHS staff working in mental health, primary and community care roles by 73% by 2036/37
- Expand generalist skills / approaches to education and training and ensure that, at core stages of their training, doctors have access to development that broadens their generalist and core skills
- Support experienced doctors to work in general practice under the supervision of a fully qualified GP
 - Also ensure that all foundation doctors can have at least one four-month placement in general practice, with full coverage by 2030/31.
- Work with regulators to ‘take advantage of EU exit freedoms and capitalise on technological innovation’ to explore how nursing and medical students can gain necessary skills in less time
 - Support medical schools to move from five or six-year degree programmes to four-year degree programmes that meet the same established standards set by the GMC
 - ‘Doctors and nurses would still have to meet the high standards and outcomes defined by their regulator’
 - Pilot a medical internship programme which will shorten undergraduate training time so that in future students undertaking shorter medical degrees make up a substantial proportion of the overall number of medical students
- Building on the findings of the Topol Review, NHS England will convene an expert group to expand the use of AI across the NHS to automate basic administrative tasks and support better data analysis at the individual patient level and population health level
- Develop a framework for a robotic curriculum collaboratively with the Royal College of Surgeons to support the enhanced deployment of robotics in transforming surgical care.
- Expand the use of remote monitoring tools to improve the management of major conditions and ease pressure on services, this will primarily be achieved through further development of NHS@Home which allows better diagnostics and monitoring outside of clinical settings.
- Expand the use of technology to accelerate the flow of clinical data across ICSs, including via Federated Data Platforms accessible at trust, ICB and national levels.
- The plan notes that these ambitions requires continued effort to achieve operational excellence, reducing the administrative burden through technological advancement and better infrastructure, care delivered in more efficient and appropriate settings (closer to home and avoiding costly admissions), and using a broader range of skilled professionals, upskilling, and retaining our staff. These opportunities to boost labour productivity will require continued and sustained investment in NHS infrastructure, a significant increase in funding for technology and innovation, and delivery of the broader proposals in the plan.

BMA Analysis

Changes to education and training

- While four-year medical courses for graduate students do exist, most will already have studied a related subject in their first degree, and demonstrated they have what it takes to complete an accelerated medical degree. The graduate course is even more demanding and not suitable for everyone. This is not to mention the impact on medical trainers and academics who will have to adapt their teaching and planning to cater to a more condensed model.
- Implementing such a course will take years of planning, as it will have to be designed from scratch to ensure all learning outcomes can be met. There would be significant concerns that any further modification to an already demanding undergraduate course would result in doctors who may not be adequately prepared for medical practice, did not have the skillset to themselves teach future generations of healthcare practitioners, or the necessary exposure to cement the UK’s future as a global centre for research excellence.

- There is also significant concern with the introduction of medical apprenticeships due to the lack of details available on what these will entail, how they will be structured, the terms and conditions for doctors placed on such apprenticeships, and the supervision capacity within the system.
- Doctors appreciate the hard work of health and care professionals across the NHS, but have consistently made clear that physician associates, anaesthesia associates and other associate roles cannot replace doctors. The Government should not be under the illusion that the expansion of associate roles will make up for the huge shortages of doctors. It's vital that the roles, remits and responsibilities of physician associates and other associates are clearly explained to patients and other health service workers.
- The Government and NHS England has so far failed to communicate this sufficiently to either group, such that there is a real risk of patients being confused about the level of skill and type of treatment associates will be able to provide. It is already evident that many patients confuse physician associates with fully qualified doctors. The existence and expansion of associate roles must also not come at the expense of the education and training of medical students and doctors who should be prioritised when it comes to training opportunities and access to appropriate supervision.
- Regarding the proposals around bringing the SAS role into General Practice, we do not believe that General Practice currently has the staff, financial or premises resources to accommodate an intake of primary care doctors, nor do we believe that the proposals will benefit doctors who want to make the switch into primary care. The proposals will not increase the number of GPs, nor will they help secondary care doctors who wish to train to be GPs. It is imperative that DHSC and NHS England do not rush through a proposal that has unproven benefits and risks diminishing the GP role. We strongly urge all potential employers of primary care doctors to carefully consider the impacts before making use of any current or future regulatory changes. The BMA's detailed position on primary care doctors is available [here](#).
- On the potential introduction of a medical internship programme, which would reduce undergraduate training time; from five-years into four would compromise education and training standards in an already heavily demanding course. Medical students already work hard to acquire the knowledge and skills needed to graduate – it would neither be fair on students or safe for patients to expect them to complete their degrees in even less time.

Use of new and emerging technology

- New technologies – from applications of AI in imaging to automated admin in primary care – could, in the future, have a role in easing pressures on the workforce. However, not enough is being done to advance the safe, ethical, equitable and efficient implementation of new technologies in practice. An expert group to 'identify advanced technology' won't help. Government needs to fund the change, not just the development of technology.
- Furthermore, overemphasis on technological solutions to the workforce crisis will be subject to a catch-22. Staff need the training, skills and time to learn, use and oversee new technologies effectively, but workload pressures undermine this. Extra staff, time and capacity need to come first.
- The use of remote monitoring and remote consulting was essential during the pandemic for reducing the risk of infection in GP surgeries and in hospitals, and to make better use of limited staff resources. Digitally-based healthcare will no doubt have an ongoing role in care delivery post-pandemic, and is a central feature of health service recovery plans. However, such options must be supported by the right infrastructure and only be used where clinically appropriate – they should complement, not replace, the delivery of face-to-face care. With these models now being used more widely more needs to be done to understand them.
- The adoption of new technology platforms to facilitate healthcare and workforce planning across traditional trust boundaries has the potential to optimise the use of staff time and ultimately, reduce bureaucratic burden. However, as the BMA has repeatedly pointed out, the adoption of a Federated Data Platform from a single supplier, raising questions over the safety of patient data and the oversight of any

company that might potentially seek to exploit that data. The crux of the doctor-patient relationship is trust, and while GPs are supportive of safe and consensual uses of patient data – such as for direct care and legitimate research purposes it must be done in a way that won't damage the confidence that patients have in the profession, and the care they receive. The BMA has called publicly on NHSE and the Department of Health and Social Care to urgently discuss with us how they plan to use confidential patient data within this data platform and what role Palantir will play.

BMA

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