

NHS England Long-term Workforce Plan: Can this deliver the workforce transformation so urgently needed or is it just more rhetoric?

The long awaited [NHS England workforce plan](#)¹ (the plan) was launched in June 2023 by the Prime Minister (Rishi Sunak) and NHS England CEO (Amanda Pritchard) and heralded as:

*The first comprehensive workforce plan for the NHS, putting staffing on a sustainable footing and improving patient care. It focuses on retaining existing talent and making the best use of new technology alongside the biggest recruitment drive in health service history.*¹

This is a laudable aim, but can this ambitious plan really deliver the actions needed to transform the long term future of this critical workforce?

Workforce planning is crucial to the success of the National Health Service (NHS) and has been notable by its absence in recent decades. The publication of this plan could be seen as a step in the right direction. Workforce planning requires:²

1. Data analysis of the current workforce and projected needs
2. Forecasting estimated future workforce requirements
3. Collaborating with institutions providing education and training
4. Implementing evidence based recruitment and retention strategies
5. Promoting flexibility within the workforce

The plan appears to be '*light on detail*' and the jury seems to out on whether it is fit for purpose, a sentiment echoed by the Royal College of Nursing (RCN) who stated they have:

*"Huge concerns about how realistic the plan is without proper investment in the existing nursing workforce and more financial support for those seeking to join the profession".*³

With 112,00 vacancies in the NHS in March 2023⁴ things clearly need to change. The plan focuses on three key areas to address workforce retention and improve patient care: training, retaining, and reforming.

Education

The plan sets out targets for increasing the number of education and training places over next two years. Domestic education and training needs of healthcare professionals is set to expand by 50-65% in the next 15 years. There is recognition that the current over-reliance on internationally educated nurses and agency staff is costly and unsustainable in the long term. You might think this would be welcomed across the higher education sector, more students equates to more income. However, this is far from the case.

Pressure will undoubtedly be put on educational institutions by NHS England and others to recruit more students to their programmes. This comes at a time when the number of applicants to nursing courses has dropped by 16% across the UK⁵ and universities are already struggling to find placements for existing students. The plan seems to have little understanding of the difficulty of increasing placement capacity. With so many vacancies in the NHS, we ask where will all the staff come from to support and supervise these increased numbers of students effectively? One solution offered in the plan is adopting 'at pace' recent guidance from the Nursing and Midwifery Council's (NMC)⁶ that 600 of the 2,300 placement hours can be undertaken as simulation. However, there is a huge disparity in the availability and quality of skills labs across UK universities and current fees for nursing courses already barely cover the cost of educating a nurse. There is much talk of investment and funding for digital innovation and upscaling of current initiatives, whether this will be enough to develop and maintain the necessary expertise, resources and infrastructure remains to be seen.

The requirement for 2,300 hours of clinical placements for pre-registration nursing courses in the UK has always been hotly debated. Overseas colleagues are often surprised by how many hours UK students do in practice. The plan is supportive of the NMC exploring this issue. If, in due course, the required clinical hours are reduced, we need to learn from countries such as Canada and Australia where students are accompanied to their placements by a clinical tutor who ensures they get appropriate support to learn. UK nursing students are citing poor placement learning experiences as a reason for leaving and raising concerns that they are being used as an 'extra pair of hands'^{7,8}, so we should not rush to reduce clinical hours without addressing the learning environment and culture in which we place our students. Apprenticeship courses may help widen participation and increase numbers. However, apprentices also need clinical placements. This decreases the number available for students on other programmes and some, but not all, of the costs of training apprentices come from the apprenticeship levy. We do not know what these additional costs are or whether it is more cost-effective for organisations to invest in the apprentice route rather than the degree programme.

Retaining

The success of the plan is dependent on addressing what is the immediate and very real problem of high workforce turnover. The reasons staff leave are well known and evidenced; workload, morale, satisfaction, burnout, pay and limited access to continuous professional development (CPD) and career progression⁹. Investing in the pipeline (education) is unlikely to be successful if we cannot retain existing staff who are needed to support, educate,

supervise, assess and develop those entering and remaining in the workforce. The recent Health Education England (HEE) Educator Workforce Strategy¹⁰ makes this clear:

“Delivering our future workforce is ultimately dependent on a sustainable and high quality educator workforce to support education and training, both in practice and in academic settings” (pg. 3).

With workforce deficits in both academic and clinical settings, increasing capacity in the short term is likely to prove challenging.

The plan supports development of a more cohesive and sustained approach to clinical academic pathways, this is long overdue¹¹. There are real opportunities here to invest in lifelong learning, education and training of the workforce – at whichever stage of their career people are at – this is central to staff satisfaction, morale and retention. Recent NHS staff satisfaction scores indicate that more staff are intending to leave (a five year high of 32.3%) and staff were less likely to recommend the NHS as a place to work (a 2 per cent drop since last year, reaching a 5-year-low)¹². NHS staff sickness records are at an all-time high, with 2022 figures indicating the NHS lost the equivalent of nearly 75,000 whole time equivalent staff to illness¹³. This comes at a time when experts are warning of a tsunami of disability associated with Long Covid¹⁴.

Reforming

Reforming the NHS is always a central focus of any NHS plan or strategy, and this one is no different. Some key areas are proposed such as digital and technological innovation, advanced and associate roles. We are pleased to see that increasing the number of advanced practitioners features in the plan. Providing clear career pathways to this route, and advancement beyond, with recognition and reward has been needed for some time. An increase in advanced nurse practitioners may also help to address issues for patients with long term conditions – previously described in this [blog](#)¹⁵ – and through delivery of new models of care such as the [nurse navigators model](#) used in Australia¹⁶. As with the clinical educator workforce, the plan fails to address the age old issue of who will replace these professionals on the “shop floor”.

At a time of low morale and concerns regarding professional identity¹², increasing the number of associate roles may risk de-skilling the workforce and impact patient safety¹⁷. The relationship between nurse education and patient mortality has been apparent for some years; hospitals in which 60% of nurses had bachelor’s degrees had lower mortality rates than that those in which 30% of nurses had a degree¹⁸. Frequent statement from politicians that nurses do not need degree level education appear to disregard the evidence. At a time

of increasing patient complexity and care demand, a highly educated and skilled workforce is crucial. Despite the move to Integrated Care Boards (ICBs), the plan pays scant attention to the social care workforce. With social care also experiencing recruitment and retention challenges and chronic underfunding and poor integration of services will continue to impact patient discharge from hospital in a timely fashion¹⁹.

Digital innovation is a central tenet of any NHS 'reforming' agenda. No-one working in, or being cared for by the NHS would deny that investment in ICT infrastructure and digital innovation is needed²⁰. This commitment is welcomed. However, all too often, previous efforts have been piecemeal, have focused on the technology and not attended to the 'human factors' necessary for successful implementation and adoption²⁰. This has resulted in limited benefits to staff, patients or organisations²¹.

Conclusions

So what are our conclusions? Long term workforce planning is welcomed. An effective workforce plan requires collaboration between policymakers, healthcare providers, education institutions, professional bodies and stakeholders as well as drawing on available data and evidence to inform implementation. However, it is entirely dependent on urgent action and investment in the here and now to be successful. What the plan fails to explain is how this will be achieved with a depleted workforce who are struggling to deliver high quality care and with morale at an all-time low.

Further information and resources to support this editorial can be found on the resources page.

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