

Health and Social Care Committee

Oral evidence: Workforce plan, HC 1712

Wednesday 12 July 2023

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Members present: Steve Brine (Chair); Paul Blomfield; Mrs Paulette Hamilton; Dr Caroline Johnson; Rachael Maskell; James Morris.

Education Committee Member present: Mr Robin Walker.

Questions 1-42

Witnesses

[I](#): Professor Kamila Hawthorne, Chair, Royal College of General Practitioners; Adam Kay, writer and former doctor; Patricia Marquis, England Director, Royal College of Nursing; Charlie Massey, Chief Executive, General Medical Council; and Alex Whitfield, Chief Executive, Hampshire Hospitals NHS Trust.

[II](#): Professor Stephen Powis, National Medical Director, NHS England; and Navina Evans, Chief Workforce, Training and Education Officer, NHS England.

Examination of witnesses

Witnesses: Professor Kamila Hawthorne, Adam Kay, Patricia Marquis, Charlie Massey and Alex Whitfield.

Q1 Chair: Good afternoon. This is the House of Commons Health and Social Care Committee live from the Palace of Westminster in London. This is one of our special one-off topical sessions, and we will be talking about the NHS long-term workforce plan, which I am delighted to say was published only a couple of weeks ago. It was long awaited—"the much-awaited workforce plan" was probably the most overused phrase before it came out—and it is now here. It is a massive document. As I said to the Prime Minister last week at the Liaison Committee, it contains enough announcements to fill the No. 10 grid probably for the next month. There is a lot of stuff in it and it reads very well, but our job is to scrutinise it, to understand it and to see where the challenges are to its implementation.

This is a cross-party Committee. We have all studied the document, and we have asked guests to come before us and help us understand what is in it. The first is Alex Whitfield, the chief executive of Hampshire Hospitals NHS Foundation Trust, which runs Andover War Memorial Hospital, Basingstoke Hospital and the Royal Hampshire County Hospital in Winchester, which is in my constituency—I just put that on the record. We also have Adam Kay with us. Adam is a BAFTA-winning author, TV writer, comedian and former junior doctor. His first book, "This is Going to Hurt", spent over a year at No. 1 on the *Sunday Times* bestseller list and was translated into 37 languages. Welcome to the Select Committee, Adam.

Professor Kamila Hawthorne was a GP for 34 years. She is now president of the Royal College of General Practitioners. Patricia Marquis, England director at the Royal College of Nursing, who is also here in the room—thank you for joining us—qualified as a nurse in her home town of Blackpool, I understand. Down the line, because he has stepped out of a board meeting to join us today and could not make the trip to London, is Charlie Massey, chief executive of the General Medical Council. We are very grateful to you for joining us, Charlie.

I will open it up to colleagues in a minute, but let me start with you, Charlie. The workforce plan is broken down, I suppose, into "train", "retain" and "innovation". Let me ask you about the "train" bit—I suppose that is logical, seeing as you represent the GMC. You put out a statement saying that you warmly welcome the plan, and in particular the doubling of medical school places, so I am going to focus on that with you. What is the risk to this being delivered, as far as you are concerned?

Charlie Massey: Thank you, Chair, for letting me attend virtually. As you said, we very much welcome the plan's ambition and granularity. In terms of the challenges on doubling medical school places, we have actually seen some increases in medical school numbers over recent years, but the thing that we think needs most attention in terms of delivering that ambition is trainers. We see in our data that trainers are among the more stressed, burned-out members of the medical workforce. We very much look forward to working with colleagues across the system on thinking about



how we ensure that we have the training capacity in place to deliver on the ambitions in the plan.

Beyond that, there are issues around clinical placements, and of course the sort of ambition contained in the plan will require new medical schools or satellite campuses alongside leveraging the existing infrastructure. I think that is important, because the plan quite rightly talks about trying to get more places into relatively under-doctored areas. That is really important in terms of having a plan that is strategically coherent. We know that doctors are more likely to stay where they went to medical school, particularly if that is local to where they were brought up, and we know that we have a concentration of medical school places in certain parts of the country.

So there is quite a lot in there. There is also quite a lot of innovation in the “reform” part of the plan, which feeds through to your question about medical school places. Obviously, there is a lot of interest—I am sure we will talk about it—in shorter medical degrees, apprenticeships and so on. One thing that I think will be really important is the fact that from next year we are introducing a medical licensing assessment that will give us, as the regulator, the mechanism to reassure patients and the public that all of those doctors graduating from medical school, whichever route they take, will be meeting the same standard for safe practice.

Q2 Chair: We will come on to the length of degrees in a minute. It says right at the top of the workforce plan, under “Grow the workforce” in the overview: “The first new medical school places will be available from September 2025.” I do not know whether you saw my exchange with the Prime Minister at the Liaison Committee last week about this, but you are obviously aware of that part of the plan. How is that so, when people are chomping at the bit now—and boy do we need them—to get going?

Charlie Massey: There is obviously a question about the profile of the funding, which is not for us at the GMC. Clearly, the £2.4 billion investment is a really significant slug of money, particularly at the current time. We know that medical schools have been able to flex to have more students over recent years, particularly with the bulge at the beginning of the pandemic, when the A-level results were not quite as expected. There is some scope to flex the profile of that increase in medical school places.

From our perspective at the GMC, hitting the 10,000 ambition for 2028 is very achievable. It becomes more challenging to hit the doubling by 2031-32. Again, I think it is doable, but it does require a lot of effort to go in to make sure that the new school provision, in particular, is in place to support the growth.

Q3 Chair: We certainly do not have a shortage of people wanting to do this, do we? It is not like many other parts of the workforce supply chain at the moment, where we have a challenge. We have plenty of people who want to do this.

Charlie Massey: Oh, we do. We have seen medical schools over-subscribed for years. We have seen over 20,000 people applying for many



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fewer medical school places in recent years. The idea in the plan to open up apprenticeships also gives us an opportunity to widen participation in medicine. In the past, we have not seen enough participation in medicine by people from less privileged backgrounds, and I think apprenticeships give us a real opportunity there too.

Q4 Chair: Finally from me to you, you will know that there was a lot of interest in the length of degrees when the plan was published. What is the GMC's view on that? Presumably you will be taking a close interest in medical licensing and making sure that quality and safety remain paramount.

Charlie Massey: Absolutely. As I said, we are introducing a medical licensing assessment from next year. That will mean that all people coming on to our register will need to meet the same standards of clinical knowledge and skill. Our job is to safeguard those standards. Obviously, we want people going into shortened degrees to have every chance to succeed. We do already have some four-year medical degrees in the UK—we have the graduate entry programmes that are four years—and, as I think you have said yourself in the media recently, there are examples elsewhere in the world of primary medical qualifications that we accept that are shorter than five years.

Although it is not our job to design those four-year degrees, our expectation would be that we would sit down with universities to understand their plans. Obviously, as well as safeguarding the standard through the MLA, we have a job in quality-assuring undergraduate education, so we would expect to work with universities to help them make a success of shortened programmes. Ultimately, I think we will have a bit of a mixed economy; we will have four, five and six-year programmes all in existence at the same time.

Q5 Chair: Thank you. Professor Hawthorne, presumably the Royal College of GPs welcomes the 50% increase in the number of GP training places, which is on top of the record number of GPs in training that we have at the moment, but you said, in terms of GPs leaving the profession, that burnout was the detail you were looking forward to seeing in the plan. Now you have seen the plan, what, in your professional opinion, is in there to stop GPs leaving now?

Professor Hawthorne: Thank you for inviting me today. I am actually chair of council at the college, not president.

Chair: Did I promote you or demote you when I said that, out of interest?

Professor Hawthorne: I hope you have promoted me, but you will have to ask the president; I am not sure what she will say.

We have been looking forward to this workforce plan for a long time. We have been asking for it for at least 15 to 20 years. It has not taken a great deal of wit to see that the numbers of GPs were declining over the last couple of decades. We have seen the crisis coming for a long time. We are pleased to see the numbers of GP trainees going up by 50% and the



doubling of medical students, but we are pointing out that that is going to take a certain number of years to come into effect. If we start from now, even, it will be a good 10 to 15 years before we start seeing the increase in GPs coming through from medical schools.

With GP trainees it is also going to take a good few years, although perhaps not quite as long. You have to bear in mind that although our trainee schemes are currently fully subscribed, at least 42% are international medical graduates, not UK graduates. What we really want is to grow our own doctors, not to need to take doctors from other countries that need them too. There is nothing at the moment that would stop a GP wanting to leave other than hope on the horizon.

Q6 Chair: Okay. Well, hope is not an insignificant factor in life.

Professor Hawthorne: No, but what we don't see is enough on retention. We are currently losing GPs faster than we are gaining them. Since I became chair of council last November, we have lost 930 full-time equivalent GPs in England, and that is with GP trainees still coming through at the other end. That is really worrying and dispiriting. We are finding that people are leaving the profession at all stages. There are newly qualified doctors going elsewhere, and there are people leaving in their 30s, 40s and 50s for all sorts of different reasons, but the underlying problem is workload.

Q7 Chair: That is the perfect bridge to Adam Kay. Adam, can I ask you about NHS staff wellbeing and what keeps people working in the NHS? Famously, you do not any more, having trained to be a doctor. Paragraph 15 on page 61 of the plan—I do not expect you to know the reference—reads: "Every staff member should be given the opportunity for regular conversations to discuss their wellbeing and what will keep them in work, including discussions about pension flexibilities, flexible working options, and health and wellbeing." That sounds fantastic. In your experience, is that in any way deliverable?

Adam Kay: I wouldn't have thought so. I think there is a bigger cultural issue within the NHS, particularly within hospital medicine. It is all very well saying that this is timetabled in, but if you are scared of your boss—if your boss insists that you refer to them by their surname—then I just don't see it. Charlie talked about the ambition and granularity of the plan. Particularly in the middle section on retention of staff, I see no ambition, and I see no detail whatsoever. It is achingly vague. I do not know what is realistically being proposed to retain all these doctors. It is all very well running the tap, but the plug is very much out at the moment.

The biggest thing I could see was talk about this emeritus doctor scheme to recruit back retired doctors. That is not retention; that is resuscitation. What are we actually doing to keep the staff in? Wellbeing is a huge part of it, but so is pay. I think it is borderline laughable that pay gets not a single sentence. It needs to be acknowledged as a crucial thing. I know that this is for the Government, the unions and whoever, but you cannot



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have two pages on AI and not a single sentence on pay. You have to respect your staff, and they have to want to stay.

There was an ad in the *BMJ* just over a month ago that I got sent quite a few times, because it had my name on it. It said, "Got that Dr Adam Kay feeling? Come to Australia!" and it offered A&E staff 10 shifts a month for 240,000 Australian dollars. If no one is looking after you, whether in terms of your wellbeing or your pay, why wouldn't your head be turned by that?

Q8 Chair: Finally before I bring in Rachael Maskell, you said that if you drop the grades from A to B, you will get better doctors. You also said that you were surprised by what being a junior doctor involves. We are training lots of new doctors with this plan, but are we training them well? Are we training resilience into them to face what you said was a huge shock when you became a JD?

Adam Kay: We can choose people better and we can train them better. I am not sure resilience is the right term, because that implies you have to be able to deal with whatever is thrown at you. You are taught communication skills, but you are never once taught what that takes out of you as a clinician. There is some mention of that in the report, in all fairness.

I think it is absolutely crucial that we widen access, and dropping the grades does that, but I am not sold on the idea that the way to do that is by having this two-tier scheme with apprentices. I am only sceptical because I was trained as a doctor and I like data, so I want to know in advance that this is the right thing to do for patient safety so we do not end up with some bargain basement, cheapest, easiest version of it—I would say Poundland, but Poundland is good and successful.

When I read the plan, I was worried that it said, "We need apprentices, and this, that and the other, because this will widen participation," but I didn't see, "Why don't we widen participation to the existing medical school model?"

Chair: Thank you. We are going to bring in our other guests and my colleagues, starting with Rachael Maskell.

Q9 Rachael Maskell: I want to continue on that very point, and I will first turn to Charlie Massey. We know that we have a skeletal workforce at many NHS establishments, and apprenticeships are going to put even greater demands on existing clinicians. Is that really realistic? Will we see the quality that is required to practise safely, as we have just heard from Adam Kay?

Charlie Massey: In terms of quality, we should take a lot of assurance from the fact that we are introducing a medical licensing assessment. People will have to pass that, whether they are coming out of a conventional medical school degree, an apprenticeship medical degree, or whichever other route is put in place.



Your broader point about the capacity to do all this while the service is under great pressure is a great question. I come back to my earlier point about trainers being one of the most burned-out, stressed and dissatisfied groups in the medical workforce. I should say that trainers love training. In the survey we published this week, 89% said they enjoy the role of trainer, but fewer than half feel they can use the time allocated for training to actually do the training. One of the things we need to see over the coming years if this workforce plan is going to succeed is a really clear plan that ensures we get the training—the educators—in place. That will require some hard challenges for providers. It will require NHS England and others to think about how we ensure providers give trainers that protected time, and that this is valued as part of their work. If we don't do that, the risk is that we set people up to fail, and none of us wants to see that.

Professor Hawthorne: Can I come in as well? The apprenticeship scheme does not necessarily mean that people will be working as apprentices while they are studying as an apprentice. It means that they will be employed and salaried for part of the time, and then training as a medical student for part of the time. It will take them longer to get to the same place as people who are medical students full time. To begin with, it is quite likely that those people will be nurses, paramedics or pharmacists who wish to gain a medical degree, but eventually it would be very nice to see it widened further to people from other backgrounds.

In my previous life, before RCGP, I was head of graduate entry medicine at Swansea University, and our graduates coming in to read medicine at Swansea had done all sorts of other things. I had two airline pilots, a concert pianist, a professional ballerina—all sorts of people—and they make fantastic doctors. They bring something that perhaps you do not bring when you are 18 and coming straight from school.

Q10 Rachael Maskell: I want to turn to the retention part of the plan, because I thought it was fairly thin. Chair, I should say that I was previously on the NHS staff council, representing the trade union Unite. I have serious concerns about retention in the NHS, and we have heard that it is the biggest issue. Alex, if I can turn to you, what is missing from the retention section of the plan?

Alex Whitfield: The retention section has some really good aspirations. I think there is a level of detail that we need behind it. The conversation that we have just had on apprenticeships is a really important part of retention. At Hampshire Hospitals, nearly 5% of our staff are doing apprenticeships. That is an amazing retention, development and retraining tool for people in the NHS.

I was out on our maternity ward in Winchester last week and the matron said, "Morale is amazing here at the moment." I said, "What's happened?" She said, "Three things. First, we're fully recruited for midwives. That is amazing. I know that, when I turn up to work, I will not be trying to cover two people's jobs. Secondly, we have invested in quality improvement, so every member of the team believes they can change their workplace for



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the better, providing better patient care and a better environment for staff. We've really given them some headspace to look at quality improvement projects, whether really small scale or big. Thirdly, we get the rosters out six weeks in advance, and people know when they're going to be in work."

There are some really basic things that make a fundamental difference to retention, and one of them is people's ability to develop their careers and skills. We want to retain them for 40 years, and they will probably not be doing the same job on day one as they will be 40 years later, so that investment in continuous professional development is really important.

Q11 Rachael Maskell: Patricia, one of the recommendations of this Committee was that childcare should be improved, but that is not really mentioned in the plan. What else should be in there?

Patricia Marquis: I will build on some of the things that have been said already. The absence of any mention of pay is quite shocking. That, obviously, has been a really big issue over recent years. It has gone from being nowhere on our list of why people leave to being very high on it. We have a plan that is trying to solve a retention crisis with recruitment, and that is not really the way to do it. It is like the plug that Adam mentioned.

For us, pay has got to be there, and flexibility. There are some good aspirations in the plan, but they are aspirations that have been around for a long time, and we have not made any progress on them. What is lacking is the detail on how we will make progress on those things, to push employers to be more flexible, and to make better provision for childcare and the arrangements that people need to work their lives alongside their working lives. I don't think that there is granular detail; I think that is what is absent. A plan is absent. We have a nice lofty set of aspirations without any detail as to how we are going to deliver it.

Q12 Rachael Maskell: I concur with that. I can remember over a decade ago talking about flexible working and childcare, and it is yet to materialise.

I want to end on the issue of pay. We know the importance of pay with regards to retention and to morale. The cost of living is real for everyone out there. The pay review body process has been discussed in this Committee, and we have taken evidence on it. To the RCN first and then the Royal College of GPs: how will we handle pay next year? I know the junior doctors and consultants are still in dispute, but how about next year?

Patricia Marquis: We did not participate in the PRB system this year, as you know; we ended up in direct negotiations. We have given evidence as an organisation to the pay review body review that is going on. We will need to assess what happens as that progresses. At the moment, direct negotiation is the only option, because I cannot see how, given where we were this year with the PRB, it will be an option for us unless it changes for next year.

Q13 Rachael Maskell: The Government have not committed even to the



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process in the media over the weekend. What is this going to mean for GPs?

Professor Hawthorne: At the moment, GPs are not showing a particular desire to strike or to think about industrial action. However, all GP trainees are members of our college, so we have to shore them up and support them. We are not a trade union and we do not enter into pay disputes at all, so there is very little I can say other than concurring that it is time for some direct negotiation and getting people around the table so that we sort this out, because it is not good for them or for the public.

Rachael Maskell: I can see everyone nodding.

Q14 **Chair:** And it is not good for the Government's five priorities, because cutting waiting lists is getting more and more challenging; that is where the political pressure comes. Adam, do you concur with Patricia's point that pay has gone from being nowhere to being the No. 1 issue and reason why people leave? Surely pay has always been a challenge, because at the end of the day this is a public service.

Adam Kay: You don't go into it for the pay. There are more efficient ways of converting A-levels to cash than via the route of clinical medicine, so that is not why people go into it. But when I left medicine in 2010, I was earning a quarter more, in real terms, than equivalent staff are earning today. It is not unreasonable to want the equivalent to what there was back then. It feels like such a small demand. And what is plan B? At the moment, everyone is leaving. We have published this big long report about how to keep them there, and one of the big reasons why everyone is leaving is that.

Something that has not been mentioned but occurs to me is this. I would say, from speaking to doctors—which I do a lot and I did an awful lot more, knowing I was coming here—that this plan, with respect to the medics, is profoundly unpopular at the grassroots, frontline level. Who is going to be training the new staff coming through all the new channels? If you are forcing people to train others and to engage in this system when they do not want to, morale will just drop further. Some of these measures, well meaning as they are, may result in even worse retention.

Q15 **Chair:** Alex, does the frontline feel like that?

Alex Whitfield: The thing that strikes me is this. I do a lot of interviewing of would-be consultants, appointing them to the trust, and one of the questions I ask them is, "What are you passionate about, because I want to enable you to do the things that you really care about when you are at work?" Well over half say training. It is something that a lot of medical professionals really enjoy doing, in my experience. The bit about how important it is to protect the time and to give them the ability to do it well is really important, but I think there are a lot of people out there who want to train future generations, and it will help to retain them if we are able to give them the capacity to do that well.

Professor Hawthorne: It is also part of the culture of the profession to train the next generation.

Adam Kay: But if a new generation is being imposed on them and they have had no consultation about these new schemes—I know that all senior doctors want to train their juniors, and juniors want to train the even more juniors, but if you are being told, “Oh, here’s a new wave of people and this is the new way we are doing things,” and you don’t like it, it’s not going to be a nice day at work.

Chair: I am going to move on, because James wants to come in.

Q16 **James Morris:** We are obviously talking about the resolution to short-term pressures, but the workforce plan says: “Growing the NHS workforce, on its own, is not enough to ensure the NHS can meet the changing needs of patients. We need staff to work in different ways”. It also says: “We will...Focus on expanding enhanced, advanced and associate roles to offer modernised careers, with a stronger emphasis on the generalist and core skills needed to care for patients”. What does that mean in the context of what we have been talking about, and is it deliverable?

Alex Whitfield: We have talked a lot about medical professionals, but the workforce plan is much broader than that. I was looking at some of the numbers for apprenticeships. We have apprenticeships at healthcare support worker level, at nursing associate level, for degree-level nursing and at advanced practice level. In having that whole career ladder of opportunities where people can develop their skills, the aspiration is that—we have this phrase: “everyone working at the top of their licence”—if you are an advanced clinical practitioner, you have a healthcare support worker who is doing an amazing job providing the care and enabling you to do your amazing job in advanced care practice. I do believe in transforming the workforce so that you do not have very highly skilled people trying to do absolutely everything but you have a blend of people who have received different elements of training. I absolutely believe healthcare is a team endeavour; it is never an individual sport.

Q17 **James Morris:** Adam, you made a point about change in the NHS, but the proposition in the workforce plan is quite a radical change, isn’t it? It is saying we need more multidisciplinary working and a reform of what we think about core skills as the nature of healthcare changes so rapidly. Are you arguing that that will not happen because there is too much change, and that this is therefore undeliverable?

Adam Kay: I am arguing that this is change for the sake of numbers; it is not change that is doing the best for patients. I just cannot believe that this essentially untested proposition in terms of apprentice doctors—

Q18 **James Morris:** It says, “a stronger emphasis on the generalist and core skills needed to care for patients with multimorbidity, frailty or mental health needs.” Are you saying that is—

Adam Kay: I am not arguing against the multidisciplinary team, which is crucial to looking after staff. I am saying that that exists and it needs

bolstering, and I am just sceptical about throwing all the Scrabble tiles up in the air and starting again.

James Morris: Professor Hawthorne?

Professor Hawthorne: As a generalist, of course I am very much in favour of this, because all too often we see hospital specialists who will see a patient who may say, "I've got this rash, doctor. What do you think?" They will say, "Go back to your GP," whereas, actually, it is a very straightforward rash that could be dealt with very easily. If you had a more generalist approach to the patient, you would probably be able to deal with it within a couple of minutes, instead of making the patient go back.

As we know, we have an ageing population with increased risk of chronic diseases as people get older. It is not uncommon for somebody in their 50s or 60s to have three, four or maybe five chronic diseases all at the same time. If they are going up and down to different clinics, they are wasting a great deal of their own time as well as a lot of NHS time—and from a sustainability point of view as well—and I think that we are going to have to think differently as our population's needs are changing. We need to change with it. We need to flex with it.

Patricia Marquis: From our perspective, it is common to nursing to start as a generalist, and there are less specialisms. But equally, the concern for us is about the associate-type role and substitution. All the evidence shows that registered nurses make the patient safer. There is a lot of evidence that says the more registered nurses there are per patient, the more safe and better quality the care is. There is no evidence around nursing associates, for example.

What I would support is what Alex is saying about a career pathway—that is absolutely right. We need real funding for CPD for nursing staff to be able to progress their careers, but what we have currently—there is no evidence in the plan that this is really going to change—is that nurses have to fund themselves to develop their specialisms or their advanced practice, so there are concerns for us at the CPD end for higher-level practice. At the substitution end, what we see and are really fearful of is people just being used more quickly and cheaply to do a job that will not be done as safely and, actually, will not necessarily deliver good patient outcomes.

Q19 James Morris: I have one other quick question. Adam, I think you said the plan has a couple of pages on artificial intelligence and technology. It is envisaging a health system where technology—AI—is enabled, working with medical practitioners with different skills, to meet patient needs in the future. Do you think that is deliverable, given that a recent report that we did on digital transformation in the NHS suggests that the basic IT infrastructure is inadequate? It is a bit of a challenge to start talking about a tech-enabled workforce. Or am I just being cynical?

Patricia Marquis: No.



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Professor Hawthorne: I think it is happening, but it is happening in a rather stuttering way because of the difficulties that you have already described. It is still possible to do more and more near-patient testing, to monitor patients at home remotely, and to use big data to look at your locality to see what the needs are within your region and where you should put services. All of that sort of thing is happening, and it is very exciting.

Alex Whitfield: I would say that the workforce plan is one of three planks. There is a second one that is about capital investment, and that would include estates, equipment and digital, and there is another bit about social care. On the capital investment, the reality is that each year we sit and look at a capital pot that could be spent 10 times over. We are trying to decide whether we fix the holes in the roof and where the buckets are, or whether we replace equipment. I have radiographers who are younger than some of my X-ray machines. We are investing—the Richards report was amazing, and we are getting loads of brilliant new kit, but there is a lot of catch-up to do on old equipment.

Then there is digital; we could spend millions on electronic patient systems. We were very lucky a year or so ago to be able to give all our junior doctors their own laptops so that they did not have to hang around waiting for computers, but that was only a year or two ago. So a lot of the reform depends on the right level of investment in digital, capital and estates.

Professor Hawthorne: Estates is really important. We are not going to be able to train this number of people if we do not have the infrastructure capacity to train them in.

Chair: We had better move on—time flies. Paul Blomfield is next.

Q20 **Paul Blomfield:** I would like to explore the issues around recruitment in relation to the rest of the health team. Charlie has talked about the type of people applying for medical training places. Talking to the university sector in relation to the rest of health education, what we have seen is a substantial drop in applications, and there were some ambitious targets for nursing and paramedics and so on. What are your reflections on that? I will start with Patricia.

Patricia Marquis: That would be one of our key points around the numbers. What in the plan is there to turn around the lack of applications to the programmes in the first place? We cannot recruit the number of places, and in fact we do not have a mechanism in the NHS from a nursing perspective to set numbers of how many people there will be. We do not commission places in the same way as we used to and as others do. It is all based on whoever applies and what makes it attractive to apply, and the plan does not address that at all. We have been calling for the return not necessarily of the bursary—we have maintenance grants, but they need to be liveable and pay for tuition fees.



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On all of the mechanisms that could be put in place to make it more attractive to join and become a student in the first place, the plan does not—we cannot fill the places that we have now. On how we intend to double that and fill those, there is no evidence there to demonstrate that, so that would be where we say retention is critical. We absolutely have to be able to retain every single person that we have now—if we did get the influx of new students—to be able to support them in placement.

So the big issue for us is supporting people in placement. We do not have the same system of trainers. We have a shortage of educators—those in the university sector providing nursing education—and mentors and supervisors in practice. It is a great aspiration, but there is no evidence of how to make it more attractive, and we have a workforce that is depleting, who we need to be there to be able to support those new students.

One final point on widening participation—we share the same concerns. We have welcomed the apprenticeship route into nursing to widen participation and enable others to join the profession, who in our case would be prevented more because of the finances than because of the academic qualifications. That is not addressing—we would still fear a two-tier type approach, which forces a section of society down only one route when another section have opportunities to access university, higher education and degree programmes in the traditional way. We would seek funding to enable everybody to have the same choice to do a university route or an apprenticeship route—whatever suits their personal circumstances, not their financial circumstances.

Adam Kay: Presumably, apprenticeship means a proportion of students are being paid to train and the remainder are paying to train, so it feels unworkable, doesn't it?

Q21 **Paul Blomfield:** How far do you think the way that you envisage the apprenticeship route operating would be different from what we used to have, in terms of the way that nurses—

Patricia Marquis: The way I trained.

Paul Blomfield: That's what I meant.

Patricia Marquis: Yes. The way I trained all those years ago was, in a way, an apprenticeship. However, the worry with that is that I can speak from personal experience about being put in positions where I was doing things way outside the scope of what I should have been doing with the amount of education and supervision that I had.

It varies because it is different. It is an apprenticeship; it is delivered in a different way. But the risks of people going beyond the scope of what they are supposed to be doing at the particular point of training, especially given the pressures they have got, really increase. And when we are talking about such a significant increase in the number of apprenticeships within the nursing pipeline, that becomes a real worry for us.

Q22 **Paul Blomfield:** Do you think that enough detail, or detailed thinking, has



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gone into the recommendations on apprenticeships to mitigate the risks that you are talking about?

Patricia Marquis: Listen, there is nothing there, and it hardly mentions the concerns that we have around patient safety now, let alone how the lack of the workforce will affect patient safety going forward with these new models, lack of staff and the increase in students. So, no.

Paul Blomfield: I wonder if I could bring Alex in.

Alex Whitfield: Yes, I am desperate to come in, as I really feel I need to speak up for apprenticeships, because what we see is that although the number of people applying for traditional nursing degrees is falling, we are massively over-subscribed on people who want to do nursing apprenticeships. They are often people in their early 30s. They have children and mortgages; they cannot afford to go and spend three years at university. And it does play to the financial difference between both.

The other thing we find with apprentices is that our retention afterwards is much higher, because they are usually people who have been working as care assistants. They know what working on a ward is like; they know what working on a shift is like; and they know what working with patients is like. And so they are then able to combine that academic journey alongside really open eyes as to what the job at the end of it is going to be.

The other thing I would say is that we need to do more on retention during traditional nursing degree programmes. We work really closely with the University of Winchester. It is a really innovative, amazing university, which has been running healthcare programmes for only a few years but really embraced them.

However, when we talk to the university about why students drop out, it is often for financial reasons. It is often because placements are some distance from where they live. We had one story of a student who pitched a tent outside a hospital because their placement was so far from their accommodation and because of the shift times. We are trying to address all those situations and locate placements closer to people's homes and sort out transport, but it is really difficult.

I think one of the quickest wins would be that if everybody who started a nursing degree finished it, we would have a lot more nurses in the workforce, even without expanding the number of placements.

Q23 **Paul Blomfield:** The point you make is interesting and it echoes Patricia's point about diversifying intake, because isn't it probably the case that when we moved from the bursary model, even though there were problems with the bursaries, to the general student funding model, the numbers that we particularly lost were the sort of mature applicants who you are describing?

Alex Whitfield: They were. Sorry, just on apprenticeships, the one other thing that I would say is that the really important part is funding for



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backfill in providers. If I have a matron on a ward and we ask her to take some apprentices, if she says, "But how do I fill my rota on the days they're doing their academic study?" then there is a huge barrier to increasing the number of apprentices. If we say, "Well, that's fine, because we're going to increase your budget and you can employ somebody for those days where your team member is off doing academic study," it takes away that barrier immediately.

I think there is a real risk that if the financial burden for backfill sits within the revenue stream of trying to run a hospital, we will not get the apprenticeship places that we need.

Patricia Marquis: The levy cannot be used for backfill.

Alex Whitfield: Yes, because it is purely for the educational element and not for the backfill, yet we are paying a full-time salary, so we are paying the individual.

Q24 **Paul Blomfield:** I talked to my local teaching hospital about precisely that and they are returning some of the apprenticeship levy that is available to them because of the difficulties in terms of the way that it can be used, because it cannot be used for backfill and it cannot be used actually to pay apprentices. Do you think that some reform of how the apprenticeship levy applies in your context would be helpful?

Alex Whitfield: We have spent all of ours, so if they want to talk to us, we have managed to find a way.

Paul Blomfield: I will tell them to ring you.

Alex Whitfield: But about half of our apprenticeship levy is not on clinical staff; it is on catering, estates, administration—a whole range of things. But yes, more flexibility with the apprenticeship levy would absolutely allow us to train more people.

Q25 **Paul Blomfield:** Can I ask one other question, about retention, which we will come back to in the second panel? I am trying to clarify the ambition. The plan talks at one point about improving the leaver rate by 15%, which I assume means bringing it down by 15%, but it also says that as a result of this plan, 130,000 fewer staff will leave over 15 years. I have worked that out as about 8,600 a year. Last year, 170,000 staff left the NHS. Do you think the ambition is sufficient, even though there are challenges in meeting that?

Alex Whitfield: The NHS employs a lot of people. The expectation is that people will leave—of course they will. They will retire; they will move away. The idea that anyone leaving is a failure is wrong. What the plan does, which is helpful, is support flexible working, particularly at the end of careers, because where we can hold on to people who retire and then come back as bank people or educators and trainers, it is brilliant for people who have years of experience to then be supporting the next generation. They do not want to work full time and they might not want to work night shifts, but we can find ways to keep them as part of the NHS



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family—that is really important. There are some things in here. The pension reforms will help. The childcare changes will help to keep people in the workplace, but there is always more we can do, particularly on that health and wellbeing, stress and burnout reason for leaving. I think there is probably more we can do on that.

Professor Hawthorne: In general practice, we are losing about 1,000 full-time equivalent GPs a year over and above the ones who are coming in, so the numbers are going down, down, down. They are not even levelling off at the moment. I think that on retention, this plan is just not ambitious enough. I refer you to page 123 of the plan, where there is a big table and one row in it for general practice where the modelling suggests there would be plus 700 GPs in retention by 2036. That is just not nearly enough.

Charlie Massey: I just want to reinforce the points around retention. One thing we should welcome is that there is a chapter entitled “Retain” in the plan, and I think we should all take that as an invitation to really work with NHS England and others on actually filling in some more specific actions about how we should address that. But it is a really critical issue for the short and medium term. We have just published data talking about doctors taking hard steps to leave the profession, and we have seen that move from 4% in 2020, to 7% in 2021, to 15% in the latest data we published for 2022. We have seen the numbers taking hard steps doubling every year. There are lots of different reasons for that. When we did a survey on people leaving, a lot of those issues related to burnout and dissatisfaction. Again, our data shows all those numbers have ticked up.

The other point I want to make in relation to retention is that one thing we have not talked about, but I think is really important, particularly for the medical workforce, is attending to equality, diversity and inclusion, which does not yet have enough mention in the rhetoric of the plan around workforce. Over 60% of new doctors are from ethnic minorities, and over half of new doctors actually qualified overseas. It is really important that we enable all those doctors to fulfil their potential, and we know from our data that that is not the case at the moment. I think there is a lot more to do around retention, but we should embrace the fact that there is a chapter in there and take that as an invitation to help fill in the details.

Chair: Adam, I think you wanted to come in.

Adam Kay: It is just the tiniest thing. You mentioned some 160,000 staff leaving last year. The thing that jumped out at me from those numbers was that more people cited their work-life balance as a reason for leaving than retirement.

Paul Blomfield: So it is work-life balance, burnout—

Adam Kay: It is the same thing. Leaving equals burnout in a lot of cases.

Paul Blomfield: And the point you were making earlier was that the pitch to recruit people to go to Australia is not just about salary.

Adam Kay: It's about surfing.

Chair: That's the quote of the day.

Professor Hawthorne: What we need to do is make life for doctors so good that they do not want to leave. That is what we should be doing, rather than punishing the ones who leave, or want to leave.

Q26 **Chair:** Yes, but we do need to be realistic, as Adam said. If money is very important to you, there are other ways to find that than being a doctor.

Professor Hawthorne: It is not about money. It really is not. It is about valuing people and not giving them a workload that is unbearable. Certainly in general practice, it is very difficult to work more than three full days a week, because you are putting in way more than you should.

Chair: This is a good discussion so far.

Paul Blomfield: Patricia, you wanted to come in.

Chair: Very briefly, please.

Patricia Marquis: I was going to make that point—that it is not about money. We talk about nurses and pay, but it is not actually about money. What they are looking for is a solution to the retention problem, because they are burned out and are doing two people's work. The two things go hand in hand. It is not just about the bottom line; it is about the value that is put on the job that people are doing.

Chair: The point has been repeatedly made in the media that the dispute is not just about money. I think everyone has heard that. I will try to close this session shortly. Paulette? I know you have to go to the Chamber soon.

Q27 **Mrs Hamilton:** I am not going to lie, I wasn't going to speak in this bit of the session, but I just have to. I am going to gear this toward nurses. I will ask Alex and Patricia to listen to me carefully. We have missed out completely adult social care. Social care is not involved at all. We have talked about a system. We have spent months and months while I have been on the Committee talking about integrated care systems, integrated care boards and integrated partnerships, and we have talked about working in closer partnership with social care. You have been absolutely clear about retention of staff and having apprenticeships in the system. My issue with all this is that if we worked as a real system, and did not separate health from social care, but put them together, surely to God we could have a development plan for that pipeline of staff you are talking about, so that nurses are not getting burned out.

I know Patricia—hello, it is lovely to see you again—and I want to say that when I came through, it was a two-tier system of nurses, and it was very frustrating. It was a system that absolutely and utterly frustrated us. A lot of nurses left the profession because of it. My question is: do you believe that the way the Government have divided this has not helped? They have talked about a long-term workforce plan, but I do not think that will work



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unless they start to bring things together as a system, instead of looking at everything in individual little boxes. I will put that to you, Alex.

Alex Whitfield: I could not agree more. I said that I think there are three elements. There is the NHS workforce plan, the capital requirements and the social care workforce. We have to join all those up. This is about creating jobs in which people feel that they make a difference to a patient, a citizen, because they can think holistically about their health and social care needs, mental and physical health, and their economic survival—so about the person, not just the condition. If there was a chapter 2 and a chapter 3, they would need to be about the social care workforce. I couldn't agree more.

Patricia Marquis: I agree. It is a complete missed opportunity. We have waited a long time for this and would have hoped it was complete, giving us both health and social care. Around a third to half of nursing staff work outside the NHS, so it misses that entire workforce. Also missing is accountability for delivery of the plan, whether we are talking about health, social care or both. On accountability, we have to have a national plan. We have to have something, and we have to have people—the Government, from our perspective—accountable for delivery. The plan is not clear; it seems like it pushes that down to ICBs, which is probably good, because that is closer to patients, so things can be more joined up, but a lot of the things that need to happen are not necessarily within their control. We need accountability and clarity about who is responsible for the delivery of this plan at the national and local levels, but it certainly has to be joined up. It won't work unless we have social care covered too.

Mrs Hamilton: That was the point I wanted to get across.

Chair: I think we will cover that with the medical director of the NHS, who is next. We have a workforce plan, but our report talked about a health and care workforce plan. That is going up the agenda; people are acutely aware that that is next.

Professor Hawthorne: I think there also needs to be an implementation review to see how this is going. This is big bucks.

Chair: To make the medical director's point for him, there is review of this plan every two years, which will be important. We will explore that with him.

We will draw this panel to a close, if that is okay. Thank you so much to Alex Whitfield, chief executive of Hampshire Hospitals NHS Foundation Trust, Adam Kay, Professor Kamila Hawthorne, Patricia Marquis, and of course Charlie Massie, coming to us down the line, from the General Medical Council up in Manchester. Thank you so much for joining us.

Examination of witnesses

Witnesses: Professor Stephen Powis and Navina Evans.

Q28 **Chair:** We have talked to the Royal College of Nursing, Adam Kay, the



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GMC, the Royal College of General Practitioners and the trust chief executive from Hampshire, and we are now joined by Professor Stephen Powis, who has been before this Committee two weeks in a row. My goodness—you will get a service award at this rate. He is the national medical director of NHS England. He was here last week to talk about end of life care. We are also joined by Dr Navina Evans, who is chief workforce, education and training officer for NHS England. Thank you for being here. We are going to wrap this up within half an hour, which was always the plan as a number of colleagues need to be downstairs for a debate in the Chamber.

Let me start with you, Professor Powis. We have had time to assess the workforce plan. Some 46 organisations welcomed it when it came out; it was long awaited. There is a lot of detail in there—train, retain and innovation. What are the threats to it? If you were to write a risk register for this document, what are the threats to the plan being delivered?

Professor Powis: The first thing to say is that it is long awaited. Our view is that it is a really big moment in the history of the NHS. We had the 75th anniversary last week, and this is the first time in 75 years that we have been asked by the Government to publish a long-term workforce plan. We have published one, and the Government have supported us in it with five years of funding, to the tune of £2.4 billion, which we can come on to. This Committee has long called for the long-term workforce plan, so we should put on the record our thanks for that. That is one of the components that has meant that it has finally come to fruition.

There is a lot of detail in the plan—it is 151 pages, including many pages of references at the end. I am sure we will come on to the fact that there is even more detail to come, because we are now in implementation mode, and a lot of the detail will still need to be worked through. I am very happy to talk about that.

It is a challenging but doable plan. To take one component of it—I know you have had the GMC here this afternoon—the ambition to increase medical school training places by 25% over the next five years is probably towards the top end of what is possible. It will require new places in existing schools, and the development and opening of new schools. That requires infrastructure. It requires an increase in training capacity. All that is something that you cannot do overnight, and will take a number of years. The challenge will be in the operationalisation of it.

What has been de-risked is the funding over the first five years; that is a really important step. Obviously, that funds the educational and training part of the plan. It sets down a marker for future spending reviews. That will need to be translated into the NHS budget as a whole, because clearly there is little point in training an expanded workforce if you do not then employ them. That will require further discussions with future Governments, because this goes beyond a single parliamentary cycle.

The second risk is that the plan gets out of date over the 15 years, but the mitigation and de-risking of that is the pledge to refresh and reiterate it



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every two years. That is something that the Treasury asked us to do, which we welcomed, because frankly it is hard to predict precisely the numbers and skillsets that medicine will require in 15 years, because in 15 years there will be a lot of developments in technology and a lot of advances in medical care.

Q29 Chair: You say that the Treasury asked for the plan to be reviewed every two years; you could read that in one of two ways. You could read it as the Treasury wanting to track progress and increase your ambition, but also a future Treasury may wish to scale back some of the ambition in the plan to meet the fiscal situation.

Professor Powis: Clearly that is a risk, but as I said, I think the fact that we have been asked to plan ahead for 15 years, and we have the first five years of funding, really puts down a very strong marker for future Governments around future funding, and not just in the education and training space; once we have expanded those training places, that will produce an expanded workforce. We know that we need to become less reliant on an international workforce, because every developed country—and not just developed countries—is facing the same underlying demographic changes, which means that they will require a healthcare workforce of their own. We have to become less reliant on international recruitment while, of course, always welcoming people who want to come to the UK because they are very attracted by the training and experience that we can offer.

We also need to become less reliant on temporary and agency staff, which is where a gain in savings might come in future years. Frankly, we are too dependent on them. If you are a ward sister, and you come to a ward that is understaffed on Monday morning, and the staff are agency and temporary staff, it is not a great start to the week. If you come in and you have a fully staffed ward with colleagues whom you know, and work with week in and week out, that is a really good way to start the week. There is much in this that will boost the morale of the workforce.

Chair: We have talked about training. So much of this is about education. We are joined by the Chair of the Education Committee, Robin Walker, who is the MP for Worcester. He is guesting on our Committee today, and he will explore that a bit further.

Q30 Mr Walker: I am grateful to the Committee, and to the Chair in particular, for allowing me to join this session. The plan talks about providing medical school places in the areas that need them most, and that have the greatest shortages. Can you give examples of areas that are crying out for more places?

Professor Powis: The areas where we have difficulties with recruitment and retention are rural areas and coastal areas. I refer you to the chief medical officer's report on coastal communities. As you know, over the last few years, there has been an expansion. The previous Chair of this Committee, when he was the Secretary of State, authorised an expansion, and we have been preferentially expanding through new medical schools



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in places such as Lincoln and Canterbury. Existing medical schools such as Imperial have been working to develop new bespoke medical schools, in Cumbria for instance. We want to continue that policy. Navina might want to come in in a minute. HEE, when it was HEE—it is obviously now part of NHS England—has done work to show that where people put roots down during their training, whether that is undergraduate or postgraduate training, they tend to stay in those places. That is obviously not everybody, because people also move around, but we think that this is the right policy. I fully expect that new schools will be developed in areas of the country—Worcester, for example—where we have difficulties in recruitment and retention.

Q31 Mr Walker: On that point, we have three medical schools that have been approved since 2020 by the GMC to go forward. There has not been a round of allocation of places for those schools. Obviously, HEE held that responsibility; it now sits with NHS England. The plan talks about the first new places under the plan being available for 2025; does that mean that there cannot be an allocation of funded places until then? Or is there some possibility that medical schools that have been given the go-ahead by the GMC can get some funded places before September 2025?

Professor Powis: I might turn to Navina here, if that is okay.

Navina Evans: We have a long history of working very closely with the higher education sector, the Medical Schools Council and the universities. In creating this plan, they helped us, and we did a lot of consultation. They know what is coming, and we continue to work with them to think through where we could do the expansion, and how quickly we could do that. We have set down the ambition for 2025. Of course, we will work with them. The academic year starts in September, and we need to work with them to see how long it will take them to get ready, as they have to look at their facilities and their infrastructure, and we also have to work with the placement providers. There are quite a few moving parts. However, there is nothing to stop us from doing it if we can get it all sorted; we can start the expansion. We want to go as soon as possible, but we have set ourselves 2025 as a must.

Q32 Mr Walker: That is a very welcome clarification. I would say, certainly from the perspective of the Three Counties Medical School, that the placements are there, to the extent that the local health trusts are using their own money, which is supposed to be for patients, to fund places for domestic students. They have been very clear: they can do that only for a single cohort. As we go into future years, no one in the system wants the pipeline of domestic students being turned off, and to have to rely entirely on international students; you described all the reasons for not wanting to internationalise the piece. There is a good argument for that place—and Chester and Brunel, the other two universities that have medical schools—to look at whether that can be brought forward, and whether there is any opportunity to deliver those places before 2025.

More generally, isn't it a matter of some concern that there has not been a formal allocation—a competition, if you like—for funded places since, I



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think, 2016? I understand that there were challenges during the pandemic, and some things had to be postponed, but nine years seems like a very long time to wait for that process to be run.

Navina Evans: There are a number of factors, including the growth and where that growth happens. This is also set over a period of time. We have not had a huge amount of growth in medical school places since 2016, so this is really welcome. The other point is that we must make sure that provision is in line with where the need is. We have had the rural and coastal report, on how we can allocate that way. We always work with the universities to see what they can and want to do and how they can expand. We work with the Department for Education as well, so this is cross-Government, and has all these moving parts. We are really keen to expand where we can, as quickly as we can; that is the rule of thumb.

Professor Powis: The other factor here is the phasing of the funding from Treasury, which you may want to come on to. That phasing is for Government to announce, not us. The fine detail still needs to be worked on a bit and, of course, some of that is around what is possible. However, the funding will be back-loaded into the latter of those five years, to a large extent reflecting the fact that it takes time to get these things established.

Mr Walker: I understand that, and absolutely, the Treasury needs to think about how to make that work most efficiently. I am grateful for the opportunity to come in on that, Chair. One of the other elements that has been mooted as potentially causing some of the delay is getting the structure of the degrees right, so that we can train as efficiently as possible in four-year degrees. Certainly, the Three Counties Medical School is a graduate-entry medical school, delivering four-year degrees anyway. It is important that that is clear, and that there is rapid delivery, which, certainly, our health system seems to be crying out for.

Chair: That is brilliant. Thank you, Robin; and thanks for joining us.

Q33 **James Morris:** If you read this workforce plan, putting the numbers and the analysis aside, it envisages quite a radical change to roles in the NHS, the nature of healthcare, and technological adaptation. It is quite an ambitious plan and a radical change. One of the constraints of making it happen may be the culture in the NHS—that may be a barrier. Between the reality of today and the envisaged future, there is a big gap. What do you think needs to change in the culture of the NHS to make this happen?

Navina Evans: You are absolutely right; it is very challenging. We have given ourselves 15 years to get to where we want to get to, but there are some things that we know we can do now, which are absolutely related to the culture of our organisations, particularly around retention. Everything that we have looked at and put into the plan as potential areas are things that are already happening somewhere in the NHS and delivering results. The task for us is to share that knowledge and to spread the discipline and the outcomes. That is one really important strategy. We now have the

ICBs and the structures in place that can really help that happen. That is the first thing.

Secondly, the NHS leadership has really got the will. It is absolutely clear that the culture relates strongly to how people are willing and able to work. That reflects productivity and then outcomes for patients. I think we have a real will to make that happen.

Thirdly, as a whole system, we need to make sure our systems processes—the digital, the technology, the estate—are aligned so that we can make this a success. From my point of view, it is the right time to tackle that, and there are a number of examples of how that can be successful.

Professor Powis: Of course change is always challenging, but I graduated as a doctor nearly 40 years ago, and looking back over those 40 years, the delivery of medicine and clinical practice is now infinitely more multi-professional and multidisciplinary than it was then. If I take primary care as an example, it is now commonplace in GP practices to have pharmacists, paramedics, physiotherapists and, obviously, nursing colleagues as part of the team-based delivery of clinical care to local communities. In my day, it was predominantly the GP delivering that service.

The professions have adapted to that and welcomed it over the years, so while in one sense, yes, it is radical, in another sense it is evolutionary. In that, there is the introduction of new professional groups, such as physician associates and anaesthetic associates, which have been with us since the early 2000s. Again, they are not completely new, but their numbers have expanded and we want to expand them further. Their roles and skills have also expanded. Physician associates are about to become regulated by the GMC, and allowing them to prescribe is being thought about, so that pharmacists graduating in a few years' time will be able to prescribe. I think this is radical, but it is also an evolution and a recognition that, now and in future, medicine is complex and needs to be delivered by a multi-professional, multidisciplinary team. We need to train the workforce, both in shape and size, to deliver that.

Q34 **Rachael Maskell:** I want to start with the knowledge and skills framework and to see what happened to it. Clearly, it was the jewel in the crown of agenda for change, and it provided tremendous opportunity for workforce development. We heard in the previous session the importance to both retention and reform of being able to utilise that opportunity, but it was never properly funded. What is going to change now?

Navina Evans: We have learned quite a lot from how that was implemented, and from what worked in that and in other developments since. What is important is that we have more and different members of staff and we have skills over roles. We are trying to break down the barriers and really make sure that what we are providing for our patients and the people we serve is up to date with what they need. That is through care pathways incorporating professional expectations and



standards, so I think we are moving on to really embedding some of the work we did then and actually building on it, working towards competencies and credentials and all the different ways in which we can ensure that we get the best out of every professional in the multidisciplinary teams, as Steve described.

Q35 Rachael Maskell: Is the funding going to be invested into it? That was the problem before. It was not the structure; it was the funding issue.

Navina Evans: The funding is around training and education, where we want to ensure we develop our staff through CPD, training, learning and lifelong learning as well. We have plans to be really clear about how we do that. The detail how we phase it over the five years of this particular funding allocation is yet to be worked out.

Professor Powis: The £2.4 billion is a very significant sum, and clearly in the context of the funding that Health Education England has had in recent years, which has been fairly flat—

Navina Evans: Yes.

Professor Powis: —it is also an opportune time for Health Education England to come into NHS England. What has been missing a little bit in having the two separate is the ability to ensure that the requirements of the service and the service developments that we see over the years are absolutely aligned and linked in with the training requirements for the workforce of the future. That also allows us to use the £2.4 billion, but also to support the education and training programmes in a way that probably has not been possible over the last few years.

Q36 Rachael Maskell: I want to drill down into some of the numbers if I can. When we had the inquiry on dentistry, the big thing that was missing was data. Yet there are numbers that appear before us for dentistry—albeit not until 2026—when we have the crisis now. How have you done the modelling? What has been the methodology behind the modelling?

Navina Evans: You are quite right that it has been quite difficult to get absolutely accurate data, but we have got data on the number of dental students we have moved through the system who graduate, and we also have the data on service provision—NHS service provision. We came up with this as a realistic ambition, and we worked with the profession and the training institutions as well to be clear about what we could do and achieve in the timeframe. I agree with you that that number is not ambitious enough, but it is a start. As Steve says, this is an iterative process, so we will want to work further on those numbers.

The other point to make is that this is in the context of an oral health team. Actually, we are growing the dentistry workforce, but we want in this period of time to grow the rest of the oral health team as well—the other professions in oral health care. We want to use this period before the next iteration to work with our integrated care boards and systems to really look at what kinds of service models we will have for oral health care and then, working backwards from that, the workforce that we need.



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This is a start, I would say, for oral health care and making that commitment on dentistry as such. Then there are other models around how we keep dentists and keep the workforce in the NHS, and that is what we need to focus on next.

Q37 Rachael Maskell: I want to touch briefly on three specific professions. One is children's nursing. The data shows that the number of children's nurses will fall. I have gone back to the RCN about that, and they do not recognise the need for that. In fact, they are saying that they need an increase, not least because many people go from that discipline into health visiting, and of course you want to see an increase in the number of health visitors, so I do not think that has accommodated what could happen with the movement between professions.

If I look at health visiting, in 2010 the Government had an ambition to increase the number of health visitors by 4,200. They just scraped over the line with that. At the time, they had 8,000 health visitors; today, there are 6,000 health visitors in the NHS and 1,000 in non-NHS roles. The ambition here will not be anywhere near the number. The practice was unsafe then; it is very unsafe today. Why is there such a lag in ambition on health visiting?

Navina Evans: Again, we did the modelling based on the historical and current data on the workforce for health visiting and children's nursing. We predict that we will continue to grow children's nursing at the same rate as we have done. That might not be sufficient, so we will do more work to look at that in more detail.

You are right that we are keen to explore the connection between children's nursing, health visiting and school nursing with the profession and the services. It is not just NHS services, because some are local authority services. The next piece of work is on delivery: to work out what the service model looks like, to ask where the gaps are across the country for that particular range of children's nursing professionals—health visiting, school nursing and children's nursing, in particular settings—and, working backwards, to refine our predictions and our numbers going forward.

Q38 Rachael Maskell: Briefly, on physiotherapy—I was a physio—the plan makes provision for a 3.3% increase, but the profession says 7% is needed. Again, the modelling needs to be revisited in order to meet the demands and, particularly, the wider ambition on the form of healthcare provided.

Professor Powis: That is one of the reasons for a two-year refresh, and it also the reason why, in all the tables and detailed descriptions of modelling at the end, with the detailed tables, future need is always expressed in a range. That shows that there is some uncertainty, as there always is in modelling, which is why we felt it better to give a range, rather than trying to give a precise number. The iteration every two years will allow us to take account of exactly what you are talking about.

Q39 Paul Blomfield: We are running out of time, so I will try to make this a



quick-fire round. Following up on the issue of dentists and how we keep them, one recommendation is about exploring tie-ins. When I meet my local dental committee, they say that they want to stay in the NHS, but that the contract does not make it work for them. How will you tie people to an unworkable contract?

Professor Powis: The dental contract is important. As you know, the UDA component of that has been in place for two decades. We have put in recent reforms, but I think there is agreement that further work is needed. The workforce component is only one component of what we need to do in dentistry; the way the contract works, or how we target those UDAs or the commissioning of dentistry are part of it as well. Other work is going on with colleagues in DHSC and other parts of Government on further dental reform. The workforce is one component of that, not all of it by any means.

Q40 Paul Blomfield: We clearly also have a problem with young doctors leaving. Was any consideration given to tie-in following medical training to keep doctors working in the NHS?

Professor Powis: When we looked at the data for how many doctors were still in the NHS five years, say, after graduation, the figure for those who had left was in single-digit percentages. Also, it was a snap survey, including people leaving temporarily for a host of reasons. We felt—our advice to Government was—that a tie-in scheme in medicine was not at this point worth it. That is why you will not see it there.

Navina Evans: We are working with our trainees on incentives and what would help them to want to build a career. The other thing that we are working with them on is their ability, if they want to move out, to come back to suit their lifestyle and other choices people want to make. Quite a lot of work is going on to explore options to make people feel committed in the way that we were to stay in the NHS.

As for the oral health professions and the dentists, again, we are working with our ICBs. They now commission those services in their local areas, so they understand the local needs of the population but also what the service models are going to look like. Through that, we are offering incentives for people so that they want to stay in the NHS. Those are not just related to the contract or pay. That is where we want to do the work.

Professor Powis: Frankly, we believe it is better to create the environment where people want to stay, rather than focus on a scheme that makes them stay through time.

Q41 Paul Blomfield: I think that reflects some of the comments we had in our earlier session. I would like to explore that further. There are ambitious targets to increase training places for the rest of the health team, not just doctors. We know the problem we have at the moment: people are not applying for the places that already exist. Universities are telling me that there is a significant drop-off in nursing applications, paramedical applications and so on. How are you going to turn that round?



Navina Evans: The rates went up, but we have seen the drop-off. We are doing quite a lot of work to attract people into higher education in health and care professions. Again, I come back to local initiatives. Many people, when we work with them, are telling us that some of them cannot afford it, so widening access is really important. The apprenticeship route has become very popular, as are having new roles that attract people into the non-traditional professions and allowing for career pathway movement—from, say, physician associates and other roles.

The other thing is addressing other aspects of people's lives—housing and all those other factors that are really important to them. We are getting that local intelligence and working with local further and higher education bodies to attract students into our sector. There is quite a big drive to do that at the moment.

Q42 **Paul Blomfield:** I would like to explore that further, but I am conscious of time. Can I ask one last question? We spent the morning at the Crick Institute, which is clearly doing fantastic work from which patients in the NHS are going to benefit enormously. One of the points that was made to us was the benefit of having clinician scientists, but the pressures on clinicians militate against those opportunities. When you were preparing the workforce plan, did you give any consideration to how to create the capacity to enable clinicians to be involved in the sort of work that they are doing at Crick?

Professor Powis: Yes, and there was a paragraph in the workforce plan about clinical academics and medical academics. As somebody who did a seven-year Medical Research Council clinical fellowship scheme back in the day, you would not expect me to say anything other than that I am entirely supportive of ensuring that we have a clinical academic workforce that can drive forward the life science and clinical science agenda, which this country does so well.

There are two bits to that. There is the work that we do with the universities around the university-employed clinical academics. I think that there is an opportunity to re-look at that and to make sure that we have the right pipeline, all the way through from undergraduate training. We have talked about a four-year curriculum, but I am very keen that the opportunities to do intercalated BSc degrees remain, because they are an important first part of enticing people into academic clinical medicine. We also need to look at fellowships and how they are provided by research bodies and charities, through to new-blood lectureships and senior lectureships in universities, so that people have a career that they can aim towards. That is one component.

The other component is how we encourage NHS staff and ensure that NHS staff who are not employed by universities but who want to conduct clinical research or get involved in academic activity have the space and time to do that. That is a more complex question, because there are lots of competing pressures, but when it works—there are lots of places where it works well—there are lots of fruits. We saw that particularly with the various trials in the pandemic, including the recovery trial, which was the



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big set of trials that was done on therapeutics during the pandemic. Recruitment into those trials was probably greatest in district general hospitals, which do not traditionally have the same sort of academic base that the teaching hospitals have.

So there is plenty of opportunity, and I am personally very passionate about it. I will give a commitment that we will, as the next stage of this plan, work hard with our academic colleagues to see how we can ensure that that academic workforce is there for the future.

Navina Evans: Can I just add that the healthcare scientists—

Chair: We are actually going to end there, because we need to go downstairs, but thank you very much. As they always say when we are on the radio, we are out of time, but this is a subject we will be returning to—and boy will we do that. We have given it a real old canter today, and thank you so much to Professor Stephen Powis and Dr Navina Evans from NHS England for your time.