# Higher Education Commission Interim Report

*Health Education and Training Inquiry | March 2026*

Policy Connect | Higher Education Commission | appg All-Party Parliamentary Health Group

REPORT SUMMARY

## Context

The Higher Education Commission (HEC), in partnership with the All-Party Parliamentary Health Group (APHG), launched this inquiry in 2025 to examine how post-16 education systems can best support the recruitment, retention, and development of NHS staff. The inquiry was designed to assess progress against the the NHS 10 Year Health Plan (July 2025), with findings intended to feed directly into the next NHS Workforce Plan expected in spring 2026. Evidence was gathered through a literature review of over 100 research papers, an open Call for Evidence receiving 36 submissions from universities, NHS trusts, royal colleges, professional bodies, and regulators, and direct engagement with students and educators through interviews, focus groups, and site visits to four universities.

The inquiry examines the full professional lifecycle across seven themes: system enablers and barriers; admissions and access; curriculum, teaching, and assessment; clinical placements; student wellbeing; transition to practice; and CPD and career development. This interim report synthesises the evidence gathered to date; the final report, due summer 2026, will set out detailed and actionable recommendations for government, regulators, the NHS, and education providers.

## Headline Findings

### 01 | System-level constraints underpin workforce shortages

Workforce pressures cannot be attributed to pay and conditions alone. Evidence identified a set of upstream structural barriers that constrain the training pipeline regardless of funding commitments to expand training places. These include insufficient placement capacity, an aging and diminishing clinical academic workforce, and deep misalignment between NHS employer priorities and higher education institutions in terms of contracts, pay, and career structures.

University financial models for healthcare education face compounding pressures. Declining real-terms tuition fee value, reductions in strategic grant funding, and uncertainty over international student income are placing strain on institutional capacity to deliver healthcare programmes. These financial pressures directly limit the ability of institutions to invest in simulation facilities, educator training, and curriculum innovation. The 10 Year Health Plan's structural reforms focus primarily on service delivery and do not address these upstream education constraints, creating a significant implementation risk for its workforce expansion ambitions.

### 02 | Access to healthcare careers remains unequal

Students from lower socioeconomic backgrounds, ethnic minorities, disabled and neurodivergent students, and those from regions outside London and the South East continue to face compounding barriers at every stage of the pipeline. Financial barriers are particularly acute: application and exam fees, travel costs for placements, and the prospect of significant debt deter entry, while inadequate maintenance support affects retention. Mature students and those with caring responsibilities face additional structural disadvantages in both admissions and progression.

Widening participation initiatives - including contextual admissions, foundation years, mentoring schemes, and guaranteed interview programmes - demonstrate promise but are inconsistently implemented and inadequately evaluated. Evaluation frameworks typically measure admissions numbers rather than completion rates or labour market entry. Several professions, including nursing, midwifery, and allied health, also face recruitment shortfalls linked to poor public awareness and widespread misconceptions about the nature and breadth of clinical roles. The 10 Year Health Plan acknowledges widening participation but does not address the limitations of current approaches or the structural financial barriers that undermine them.

### 03 | Curriculum and placement gaps leave graduates underprepared

A persistent disconnect between theoretical teaching and clinical realities is a recurring concern across professions and institutions. Students and educators alike report fragmentation between course components and placement settings, unclear communication between modules, and limited opportunities for staff to share best practice. Curriculum content does not consistently reflect diverse populations or embed health inequalities as a core theme, despite this being a stated priority of the 10 Year Health Plan.

Four specific content gaps are identified across submissions: insufficient development of non-technical and leadership skills; limited preparation for interprofessional and integrated care working; inadequate coverage of career pathways beyond clinical practice; and weak digital literacy and AI preparedness. The 10 Year Health Plan commits to making AI a trusted tool for all clinical staff, yet students across professions report minimal training in digital tools or AI-enabled healthcare. Clinical placement capacity compounds these gaps, constrained by poor national coordination, inadequate funding, and an educator workforce increasingly diverted into service delivery. The Plan's commitment to expanding training places does not adequately account for the shortage of quality placements as the binding constraint on that expansion.

### 04 | Student wellbeing is a significant attrition driver

Mental health challenges, financial pressures, variable placement quality, academic difficulties, and poor transition support contribute to losses at multiple points across the pipeline. Students from widening participation backgrounds are at heightened risk, as are international students and those with caring responsibilities. Exposure to trauma in clinical and academic settings, geographic dislocation during placements, and stigma around seeking help exacerbate these pressures. Personal tutor and pastoral support is described as inconsistent, partly a consequence of the educator capacity shortages discussed above.

Students with disabilities, learning difficulties, or neurodivergence face additional structural challenges: identification is often delayed, reasonable adjustments are not consistently implemented, and coordination between university and placement settings is inadequate. Adjustments made during training frequently do not reflect what would be provided in post-qualification roles, contributing to early workforce exits. The 10 Year Health Plan's commitments on staff wellbeing do not extend to the student population, leaving a critical retention lever largely unaddressed in national policy.

### 05 | Career progression and CPD are inadequately and inequitably supported

Structural bottlenecks constrain progression across multiple professions. Specialty training posts for doctors remain significantly oversubscribed; many doctors on locally employed doctor contracts do not receive training aligned to NHS workforce needs. The Band 4 to Band 5 nursing transition represents a persistent bottleneck, and Nursing Associates, healthcare assistants, and T-Level students face limited upward progression routes. Contract structures in dentistry and pharmacy provide few financial or professional incentives for upskilling, leaving practitioners keen to develop but systemically discouraged from doing so.

Access to CPD is fragmented and unequal. Service pressures consistently deprioritise protected learning time, and some professionals complete mandatory development in their own time. Funding is inconsistent and opaque, with practitioners often relying on competitive grants or loans. Inequalities in access compound workforce representation gaps: ethnic minority staff and those from disadvantaged backgrounds face discriminatory barriers in applying for and completing CPD opportunities; part-time workers - more likely to be women - are less likely to access career development; and geographic disparities mean London significantly outpaces other regions in available provision. The 10 Year Health Plan's commitment to personalised career development plans for all NHS staff is not yet underpinned by the structural or financial reforms needed to make this a reality across all professions and regions.

## Implications for Policymakers

The evidence presents a consistent picture of a healthcare education pipeline that is under-resourced, insufficiently coordinated, and not adequately aligned with the ambitions set out in the NHS 10 Year Health Plan. Several interconnected priorities emerge for policymakers and system leaders.

- Workforce expansion commitments in the 10 Year Health Plan cannot be realised without addressing upstream constraints in training capacity, placement supply, and educator workforce supply. These systemic bottlenecks fall outside the Plan's current scope and require targeted policy intervention.
- Funding models at both institutional and student level require urgent review. Current arrangements do not reflect the full cost of delivering healthcare programmes, and financial barriers continue to deter students from disadvantaged backgrounds at every stage of the pipeline.
- Widening participation requires a whole-pipeline approach. Admissions-focused interventions alone are insufficient to achieve equitable outcomes; financial support, evaluation frameworks, and post-qualification monitoring must be addressed in parallel.
- More effective coordination mechanisms across government, regulators, NHS employers, Integrated Care Boards, and education providers are needed. Structural reforms to DHSC and NHS England will have limited impact without investment in shared workforce data infrastructure and cross-system planning capacity.
- Retention at key transition points - from student to newly qualified professional, and through early career stages - warrants as much policy attention as recruitment. Evidence consistently identifies attrition as a significant and costly challenge with direct implications for the return on investment in training.
- As international recruitment pipelines face increasing risk, contingency planning for domestic training capacity is urgently needed, particularly for smaller and vulnerable professions.

The final report, due for publication in summer 2026, will set out detailed and actionable recommendations for the UK Government, devolved administrations, regulators, NHS England, Integrated Care Boards, and education providers. These recommendations will be grounded in the full body of evidence gathered through this inquiry and informed by three thematic evidence sessions bringing together policymakers, educators, and NHS leaders.


## Acknowlegement

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- **Lord Philip Norton of Louth**, Conservative peer, Parliamentary Co-chair
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