Higher Education Commission Interim Report

Health Education and Training Inquiry

March 2026

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

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iheed

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Commissioners:

- Lord Philip Norton of Louth, Conservative peer, Parliamentary Co-chair
- Kevin McKenna, Labour MP for Sittingbourne and Sheppey, Parliamentary Co-chair
- Prof Kathryn Mitchell, Vice Chancellor and Chief Executive of the University of Derby, Academic Co-chair, Inquiry Commissioner
- Rebecca Patterson, General Manager, iheed, Commissioner
- Joe Fitzsimons, Regional Lead Policy and Insights, ACCA, Commissioner

Acknowledgement

The Commissioners wish to formally acknowledge the valuable contributions of all organisations and individuals who have engaged with this inquiry so far. Insights and perspectives were generously shared through our Call for Evidence, focus groups, and interviews. Policy Connect is sincerely grateful to all contributors and endeavours to ensure this report accurately represents the breadth of views received.

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Inquiry Overview

In 2025, the Higher Education Commission (HEC), in partnership with the All-Party Parliamentary Health Group (APHG), launched its inquiry into the role of education and training in supporting the NHS's long-term goals. The inquiry examines how post-16 education systems can best support the recruitment, retention, and development of NHS staff. It identifies the conditions across policy, partnerships, and practice needed to strengthen collaboration between health and education sectors, align provision with workforce needs, and ensure a sustainable pipeline of skilled professionals. Through research grounded in lived experience and best practice, the inquiry aims to provide practical, evidence-based recommendations for national and local government, the NHS, education providers, and education sector partners.

Policy Landscape

The inquiry launched to assess progress and implementation of the NHS Long Term Workforce Plan (June 2023), which set out ambitious targets to train, retain, and reform the healthcare workforce, and ahead of the anticipated NHS 10 Year Health Plan.[1] Since the inquiry's launch, the policy landscape has continued to evolve rapidly, with the publication of the NHS 10 Year Health Plan (July 2025) setting out major commitments to education reform, workforce wellbeing, and career pathway development.[2] The inquiry's work is designed to complement and inform these ongoing policy developments, with findings feeding into the next NHS Workforce Plan expected in Spring 2026. By gathering evidence from students, educators, and sector partners at this critical juncture, the inquiry aims to ensure that policy commitments translate into tangible improvements in healthcare education and training.

[1] NHS England, "NHS Long Term Workforce Plan," June 2023.
[2] Department of Health and Social Care, "Fit for the Future: 10 Year Health Plan for England," July 2025.

Key Policy Announcements

June 2023: NHS Long Term Workforce Plan[1]

- **Train:** Major expansion in training places across healthcare professions
- **Retain:** Focus on inclusive work cultures, wellbeing systems, and modernised employment packages
- **Reform:** Shift to community settings, digital innovation, and flexible course delivery

June 2025: Spending Review[2]

- Significant NHS funding increase
- Enhanced further education and skills investment
- No new core teaching funding for higher education institutions

July 2025: NHS 10 Year Plan[3]

Three major shifts: hospital to community, analogue to digital, sickness to prevention

Key workforce commitments:

- **Education and training reform:** Three-year curriculum overhaul emphasising digital and AI literacy, alongside medical education review addressing bottlenecks and educator capacity challenges
- **Workforce expansion and wellbeing:** New wellbeing standards, expanded flexible working, additional nursing apprenticeships and medical specialty training posts with priority for UK graduates
- **Career pathways and sustainability:** Competency-based skills escalators, improved student funding mechanisms, reduced international recruitment targets, and enhanced widening access initiatives

November 2025: Autumn Budget[4]

- New neighbourhood health centres and health technology investment
- Increased tuition fee caps and frozen loan repayment thresholds
- New maintenance grants for students from low-income families
- International student levy introduction

Spring 2026: Next Workforce Plan *(expected)*

Figure 1: Key Policy Announcements: 1. NHS England, "NHS Long Term Workforce Plan," June 2023., 2. HM Treasury, "Spending Review 2025," June 2025., 3. Department of Health and Social Care, "Fit for the Future: 10 Year Health Plan for England," July 2025., 4. HM Treasury, "Budget 2025," November 2025.

Shaping the Inquiry's Focus

The inquiry formally commenced in June 2025, with a scoping session held in Parliament in July. This brought together key stakeholders from across the healthcare education landscape to define the inquiry's focus and scope. From this session, the inquiry established a steering group of experts, whose ongoing guidance has shaped the inquiry's direction

Through these early consultations, stakeholders identified four key themes to structure the inquiry:

1. **Strengthening Collaboration Between Education Sectors, the NHS, and Other Providers**
   Exploring how partnerships between universities, colleges, Integrated Care Boards, and other providers (including independent and voluntary sector organisations delivering NHS-funded care) can be supported, scaled, and embedded.

2. **Tackling Retention Challenges**
   Investigating how education policy and delivery can enhance learner experience and reduce attrition across healthcare professions.
3. **Aligning Education and Training with NHS Service Needs**
   Assessing how curricula, teaching models, and placements can be adapted to equip students with the clinical, digital, and interpersonal skills needed in a modern NHS.
4. **Resourcing and Sustainability**
   Exploring how funding models, capital investment, and system design can support high-quality, agile, accessible, and future-focussed education and training.

Following the scoping session, the inquiry team conducted a comprehensive literature review, examining over 100 research papers and policy reports. This review set out the context and background to the inquiry, mapping the current evidence base on healthcare workforce development.

The inquiry then launched an open Call for Evidence to gather views, research, and evidence from stakeholders across the healthcare education sector. The inquiry received 36 submissions from a diverse range of contributors, including academics, royal colleges and professional bodies, NHS trusts, and university partners.

Critically, the inquiry grounds its work in lived experience of students and educators. The inquiry team has conducted in-depth interviews and focus groups with learners and staff across multiple healthcare professions, and a student and staff survey was launched to encourage as many people as possible to inform the inquiry's work.

The inquiry team has also visited students directly at Teesside University, Anglia Ruskin University, University College London, and Birmingham University. These visits have provided essential frontline perspectives on the realities of healthcare education and training. Further university visits are planned over the coming months, with close collaboration with student societies and unions ensuring their voices continue to shape the findings.

Purpose of This Interim Report

This interim report synthesises evidence gathered from the literature review, Call for Evidence, and student and staff engagement, providing a high-level overview of the key barriers and challenges facing healthcare education and training. These challenges follow the journey of a healthcare professional, from initial access and selection through to continued professional development, alongside the systemic challenges that cut across all stages. The report also includes a selection of good practice examples and case studies submitted through the Call for Evidence, demonstrating where innovative approaches are already making a difference. The final report will present more comprehensive case studies, detailed recommendations, and supporting statistics.

Evidence Sessions

The findings in the final report will also incorporate insights gathered from three thematic evidence sessions. These sessions brought together key stakeholders from across the health and education sectors to share their perspectives and expertise on critical issues facing healthcare workforce development. These sessions explored different dimensions of the

inquiry, from national strategy and system-level challenges to regional delivery models and educational innovation. Each session brought together policymakers, educators, NHS leaders, and sector partners to identify priorities and inform the inquiry's emerging recommendations.

The three evidence sessions were:

National Strategy and System Leadership
House of Lords
28 Jan 2026

- Strategic workforce planning and demand forecasting
- System coordination and accountability
- Resource efficiency and funding optimisation
- Clinical placement capacity, quality, and funding
- Quality assurance and standards

Regional Delivery and Local Partnerships
Bournemouth University
9 Feb 2026

- Widening participation and diversifying entry routes
- Regional inequalities and targeted interventions
- Local workforce planning and skills matching
- Partnership models and collaboration
- Regional retention strategies

Educational Innovation and Workforce Readiness
University of Greenwich
25 Feb 2026

- Innovations in pedagogy, digital learning, and future-proofing
- Student experience, support, and retention
- Educator workforce recruitment, retention, and capacity
- Assessment and workforce readiness
- Scaling and enabling good practice

The final report and recommendations, launching in summer 2026, will provide guidance for policymakers, education providers, and the NHS on building a sustainable, skilled, and supported healthcare workforce.

Executive Summary

The NHS faces significant workforce challenges with roots in how healthcare professionals are trained, supported, and developed. Demand for healthcare has grown substantially with waiting lists remaining high following the COVID-19 pandemic. These service pressures exist alongside evidence of workforce shortages, declining recruitment, and increasing attrition across professions.

This evidence review, conducted as part of the Higher Education Commission inquiry into healthcare education and training, draws on submissions from universities, NHS employers, professional bodies, regulators, students, and educators across the UK. It examines the full pipeline from access and admissions through to continuing professional development.

The inquiry sits at a timely moment, with the NHS 10 Year Health Plan setting out commitments to workforce expansion and service transformation. The evidence presented here identifies where constraints in the education and training pipeline may limit the delivery of those commitments.

Headline findings

Workforce shortages reflect constraints across the training pipeline, not only pay and conditions. Submissions identified upstream barriers including insufficient training capacity, placement shortages, educator recruitment difficulties, and strategic coordination gaps. Several of these constraints are not addressed in the 10 Year Health Plan's structural reforms, which focus primarily on service delivery.

University financial models for healthcare education face compounding pressures. Declining real-terms tuition fee value, reductions in strategic grant funding, and uncertainty around international student income are placing strain on institutional capacity to deliver and expand healthcare programmes.

Access to healthcare careers remains unequal across socioeconomic background, ethnicity, disability, and geography. Widening participation initiatives demonstrate promise but are inconsistently implemented and inadequately evaluated. Financial barriers at application, during study, and at graduation disproportionately affect students from disadvantaged backgrounds. Several professions also face recruitment shortfalls linked to poor public awareness and misconceptions about the nature of certain healthcare roles.

Student and newly qualified professional wellbeing is linked to attrition across professions. Mental health challenges, financial pressures, variable placement quality, and difficult transitions into employment contribute to losses at multiple points in the pipeline. The 10 Year Health Plan's focus on staff wellbeing does not currently extend to the student pipeline.

Career progression and continuing professional development are inconsistently supported. Structural bottlenecks, fragmented funding, and unequal access to development opportunities across protected characteristics and geographies contribute to turnover and leave gaps in workforce capability.

Implications for policy and system design

The 10 Year Health Plan's workforce commitments and the education pipeline that underpins them require closer alignment. Several of the structural constraints identified in this evidence

review, including placement capacity, educator supply, and institutional financial sustainability, sit outside the Plan's current scope and may limit the delivery of its training expansion ambitions.

Funding models at both institutional and student level require review. Submissions identified that current arrangements do not consistently reflect the cost of delivering healthcare programmes or provide adequate support for students across all professions and training routes.

More effective coordination mechanisms across government, regulators, NHS employers, integrated care systems, and education providers are needed. Submissions identified misalignment at multiple points in the pipeline, suggesting that structural reforms will have limited impact without accompanying investment in shared data infrastructure and cross-system planning.

Widening participation requires a whole-pipeline approach. Evidence indicates that students from disadvantaged backgrounds encounter compounding barriers from application through to career progression, suggesting that admissions-focussed interventions alone are insufficient to achieve equitable outcomes.

Retention at key transition points warrants closer policy attention alongside recruitment. Submissions consistently identified attrition among students, newly qualified professionals, and experienced staff as a significant and recurring challenge, with implications for the overall return on investment in training capacity.

The final report will set out detailed and actionable recommendations across these priority areas, drawing on the evidence gathered through this inquiry.

Evidence Review

Theme 1: System Enablers and Barriers

This section examines the structural and systemic factors shaping healthcare education and training capacity across the pipeline. It explores how workforce shortages, strategic planning gaps, institutional financial pressures, student financial hardship, and educator workforce constraints interact to limit the supply of healthcare professionals.

Key emerging implications for policymakers:

- Workforce shortages are driven by pipeline constraints upstream in training capacity, not only by pay and conditions; policy responses focussed solely on service-level recruitment will be insufficient.
- The 10 Year Health Plan's structural reforms require accompanying investment in shared workforce data infrastructure and cross-sector coordination mechanisms to translate into effective workforce planning.
- University financial models for healthcare programmes face compounding pressures from multiple directions; without intervention, training capacity will contract and widening participation commitments will be undermined by persistent affordability barriers.
- The clinical academic and educator workforce is ageing with insufficient replacement, representing a structural constraint on training capacity that sits outside current workforce planning frameworks.

Workforce shortages affect recruitment and retention across professions

The NHS faces significant challenges that form the backdrop to healthcare education and training. Demand has increased substantially over the last two decades, with waiting lists remaining high following the COVID-19 pandemic. These service pressures exist alongside substantial workforce shortages, with evidence of decreasing recruitment and increasing attrition. Regional inequality compounds these challenges, with rural, remote, and coastal areas facing higher concentrations of ageing populations with complex needs, creating particular workforce distribution challenges.[3]

Workforce shortages relate to both the perception and reality of NHS working conditions. Sustained negative media coverage and limited positive messaging shape perceptions of the NHS as an employer, influencing career decisions from initial applications through to post-qualification choices about private practice or working abroad.[4] Once on placement, students commonly reported witnessing inadequate infrastructure, high workloads, rigid scheduling, and staff feeling overworked and undervalued.[5] These experiences compound poor

[3] Chloe Reeves, Aisha Islam, and Tom Gentry, "The State of Health and Care of Older People in England 2025," Age UK, September 2025.
[4] Ibid.
[5] See for example: Op. cit., O'Donnell; op. cit., Harrison et al.

perceptions of NHS working culture, including reports of hierarchical culture and role protectionism.[6]

NHS Workforce Shortages

- England has 3.2 doctors per 1,000 of the population, compared with the OECD EU average of 3.9. To reach that average, England would need approximately 40,000 additional doctors.[1]
- Nearly one-third of nurses, midwives, and health visitors are over age 50 and a third are expected to retire within 10 years.[2]
- More than 60% of pharmacy teams reported staffing shortages, with over one in five (21%) reporting that their pharmacy had temporarily closed as a result.[3]
- NHS England data, published for the first time in 2024, indicates that as of March 2024, over a fifth of positions (21%) for NHS general dentists were unfilled, with these vacancies amounting to nearly half a million days (495,774) of lost NHS activity.[4]

Figure 2 - NHS Workforce Shortages. 1. British Medical Association, "Medical staffing in the NHS," 27 November 2025., 2. Lucina Rolewicz, Billy Palmer, and Cyril Lobont, "The NHS workforce in numbers," Nuffield Trust, 7 February 2024., 3. Community Pharmacy England, "Pharmacy Pressures Survey 2025." 4. NHS England, "Dental Workforce Statistics," December 2024.

Inadequate data and strategic coordination limit workforce planning

Beyond working conditions, workforce planning challenges affect every stage of the healthcare education pipeline, from determining appropriate student recruitment numbers through to ensuring adequate career progression opportunities for qualified practitioners. While the 10 Year Health Plan addresses inequalities in healthcare provision and plans to redistribute funding to neighbourhood health centres in areas facing the greatest economic and health challenges, it does not address the upstream misalignment of training place locations with workforce need.[7]

Submissions identified persistent tensions between market-driven approaches to higher education and specific training requirements for NHS.[8] Multiple sources identified that insufficient training capacity constrains supply despite clear workforce need.[9] Conversely, potential over-production without matched system capacity in other areas creates the bottlenecks in training posts and cliff edges at graduation.[10]

Contributors identified persistent geographic misalignment between training place locations and workforce needs, with underserved rural and coastal areas facing particular challenges.[11] Some professions have historically relied on international recruitment to address these gaps, but contributors reported that recent policy changes and external factors put these pipelines at risk.[12] The 10 Year Health Plan commits to reducing international recruitment to below 10% by 2035.[13] However, contributors suggested inadequate contingency planning exists for potential workforce depletion, particularly for smaller professions where domestic training

[6] Ibid.
[7] Department of Health and Social Care, "Fit for the Future: 10 Year Health Plan for England," July 2025
[8] Op. cit., British Medical Association; op. cit., Hallwood.
[9] Ibid.
[10] Op. cit., British Medical Association; W. Palmer, L. Schlepper, N. Hemmings, and N. Crellin, "The Right Track: Participation and Progression in Psychology Career Paths" (July 2021).
[11] See for example: Op. cit., Reynolds; op. cit., Hallwood; op. cit., Royal College of Nursing.
[12] Op. cit., Holden; op. cit., Jackson; op. cit., Evans et al.
[13] Department of Health and Social Care, "Fit for the Future: 10 Year Health Plan for England," July 2025

capacity may be insufficient to fill these gaps.[14] Stakeholders also noted that while significant numbers of UK-trained professionals work abroad, research on their exit patterns remains limited compared to the body of evidence on internationally educated practitioners entering the UK workforce.[15]

Gaps in strategic coordination and data compound these workforce planning challenges.[16] Education institutions are reporting that uncertainty around workforce planning and policy changes making it difficult to plan adequately for student numbers.[17] The 10 Year Health Plan commits to merging the Department for Health and Social Care and NHS England to reduce duplication and reduce administrative burden.[18] Alongside this, Integrated Care Boards are to take a stronger strategic commissioning role. However, workforce planning mechanisms across the NHS, government, higher education institutions, and employers are needed to accompany these structural changes.[19]

Without robust workforce data, planning becomes more difficult. Key issues include:

- Insufficient leaver destination data and lack of comprehensive tracking across roles and sectors.[20]
- Workforce projections frequently missing key demographic information such as age profiles, potential reductions in working hours, expected retirements and retire-and-return intentions.[21]
- Predictable staffing pressures such as annual leave, statutory training, sickness and maternity leave not always adequately accounted for.[22]
- High attrition rates among both students and NHS staff further hindering workforce planning.[23]

Professional bodies, associations, regulators and universities sometimes collect in-depth workforce data, but this is not shared and used effectively to identify problems early and learn from successful approaches.[24] These data infrastructure and cross-sector coordination gaps remain unaddressed in the 10 Year Health Plan's structural reforms, despite being fundamental to effective workforce planning that aligns training capacity with service need.

[14] Op. cit., Adhikari; op. cit., Jackson.
[15] Ibid.
[16] See for example: Op. cit., Flack; op. cit., Brown; op. cit., Hallwood.
[17] Op. cit., British Medical Association; op. cit., Hallwood.
[18] Department of Health and Social Care, "Fit for the Future: 10 Year Health Plan for England," July 2025
[19] Op. cit., Flack; op. cit., Hallwood.
[20] Op. cit., Adhikari; op. cit., Jackson.
[21] Op. cit., Flack.
[22] Ibid.
[23] Op. cit., Fielding; op. cit., Royal College of Midwives.
[24] CASE STUDY: HCPC Data Hub from Health and Care Professions Council (HCPC) response to the Higher Education Commission: Health Education and Training Inquiry, November 2025.

CASE STUDY: Health and Care Professions Council (HCPC) Data Hub

Launched in May 2025, the HCPC Data Hub addresses critical workforce planning gaps by providing comprehensive data on all 15 HCPC-regulated health and care professions, representing over 360,000 registered professionals across the UK. Previously, regulators collected significant data about registrants but this information was not systematically available to government, policy makers, workforce planners, and employers who need it for strategic planning.

Current capabilities: The interactive online platform provides stakeholders with centralised access to multiple data streams including registered professions overview and demographics, equality, diversity and inclusion data, pre-registration programme information (numbers and geographic distribution), and retention dashboards showing numbers leaving professions within the first four years of registration. The retention dashboard enables users to drill down by profession, region, and demographic factors.

Planned enhancements: In coming months, the Hub will add programme capacity and fill rate data, pipeline analysis showing conversion rates from graduates to registered professionals, and enhanced leaver insights identifying patterns in workforce departures.

Strategic value: The Hub enables cross-profession comparisons, evidence-based system-wide planning, and proactive risk identification while maintaining regulatory independence. It provides the quantitative foundation for HCPC's annual education reports and insight pages on topics including academic quality and financial sustainability.

Limitations: The Hub covers only HCPC-regulated professions and HCPC states it is "not involved in workforce planning" - the platform provides data but does not make planning decisions. Full functionality is still being rolled out, and partnerships with other data holders are needed to understand the complete student pipeline.

Figure 3 - CASE STUDY: HCPC Data Hub from Health and Care Professions Council (HCPC) response to the Higher Education Commission: Health Education and Training Inquiry, November 2025.

University financial constraints compound workforce training challenges

Higher education institutions delivering healthcare programmes face significant operational, financial, and staffing pressures. The 10 Year Health Plan gives little acknowledgement to these institutional challenges, despite their direct impact on training capacity.

University Financial Pressures

- Recent modelling from the Office for Students suggests that after accounting for key shifts in the financial context, the sector could see a total net reduction in annual tuition fee income of £437.8 million in 2025-26 compared with the sector's forecasts. Without mitigating action, this could result in 124 providers, around 45% of the sector, reporting a deficit.[1]
- A survey of Universities UK members found that the majority of universities are making operational cutbacks, including reducing investment in repairs and maintenance.[2]
- The survey reported 49% have closed courses; 55% have consolidated courses; 46% have removed module options; and 18% have closed departments. 19% of universities have reduced investment in research, with 79% considering future reductions.[3]

Figure 4 - University Financial Pressures. 1. Office for Students, "Financial sustainability of higher education providers in England: November 2025 update," November 2025., 2. Universities UK, "Transformation and Efficiency Taskforce: Towards a new era of collaboration," 2 June 2025., 3. Ibid.

Healthcare education programmes are funded through several mechanisms, but each faces significant constraints or uncertainty:

- **Tuition fees:** The real-terms value of domestic tuition fees has declined substantially. Between 2012-13 and 2025-26, the value fell by 35%, with the 2025-26 tuition fee rate of £9,535 worth only £5,823 in 2012-13 prices.[25] Universities have reported that even with recent increases, tuition fees do not cover the running costs of healthcare courses, which are expensive to deliver.[26]
- **International student cross-subsidisation:** Some universities have used international student tuition fee income to cross-subsidise healthcare courses.[27] Recent policy changes on international student levies are challenging this model.[28] The levy, representing a 6.38% rise in fees, could lead to 16,100 fewer international students in the first year, costing the sector £240 million in the first year and £2.2 billion over five years.[29]
- **Strategic Priorities Grant:** Managed by the Office for Students, this grant supports additional costs that tuition fees cannot cover.[30] However, allocation was cut by 11% between 2024-25 and 2025-26, with some institutions reporting funding cuts of half or almost two-thirds.[31]
- **Placement tariff funding:** Placement provider institutions receive tariff funding rather than higher education institutions.[32] There are also concerns about transparency and accountability in how institutions allocate and use this funding.

[25] Universities UK, "Autumn Budget representation from Universities UK: October 2025," October 2025.
[26] Op. cit., Health and Care Professions Council; op. cit., O'Donnell.
[27] Ibid.
[28] Ibid.
[29] Op. cit., O'Donnell.
[30] Op. cit., Hallwood; op. cit., O'Donnell.
[31] Ibid.
[32] See for example: Op. cit., Education Development Lead; op. cit., Flack; op. cit., Royal College of Nursing.

Healthcare students face acute financial pressures that affect wellbeing and academic success

These institutional financial pressures are mirrored by acute challenges at the individual student level. Rising cost of living significantly impacts healthcare students, who face unique financial pressures including placement-related costs, longer term times, and variable access to financial support.[33] Many students describe taking on employment alongside their studies, which can negatively affect their performance, mental health, and wellbeing.[34]

A range of sources noted that whilst financial support is available, it is often inadequate or not distributed equally across professions:

- Not all healthcare students have equal access to NHS bursaries and student loans, with eligibility varying by profession, geography, training route, and student status (including restrictions for international students).[35]
- Where NHS bursaries are received, evidence suggests they are often insufficient to cover living costs, with the value of financial support not keeping pace with inflation. For some professions, like medicine, moving to the bursary creates a drop in funding often coinciding with their most demanding exams and placement periods.[36]
- In some cases, bursaries interact with the benefits system in ways that can disadvantage students.[37]

The 10 Year Health Plan addresses widening participation, committing to focus medical school expansion on talented students from disadvantaged backgrounds. Yet the Plan does not address how these students will afford to study. Submissions highlighted that rising costs disproportionately impact students from disadvantaged backgrounds, limiting their ability to engage in academic, leadership, or extracurricular opportunities that support career progression.[38] These financial pressures contribute to the high attrition rates discussed earlier and undermine the 10 Year Health Plan's widening participation goals by creating barriers that prevent students from disadvantaged backgrounds from completing their training.

[33] See for example: Op. cit., Sassoon; Rowena Viney, Associate Professor in Medical Education, UCL Medical School, written evidence, November 2025; S. Willis, "Why Are Increasing Numbers of Students Dropping Out of Pharmacy Education?", The Pharmaceutical Journal (30 October 2024).
[34] Op. cit., Harrison.
[35] See for example: Op. cit., Sassoon; op. cit., Hallwood; op. cit., Harrison et al.; op. cit., Royal College of Midwives.
[36] Op. cit., Jackson; op. cit., British Medical Association.
[37] Ibid.; op. cit., Royal College of Midwives.
[38] Op. cit., Iqbal et al.

Educator workforce capacity constraints limit training across professions

Another critical system constraint not addressed in the 10 Year Health Plan is the educator workforce itself. Educator challenges exist across professions, with clinical educators increasingly being pulled into service delivery due to NHS pressures.[39]

Educator Shortages

- A General Medical Council report showed medical educators are more likely to be dissatisfied with their day-to-day work, have worked beyond rostered hours at least once a week and find it difficult to provide sufficient patient care at least once a week.[1]
- Royal College of Nursing data shows 75% universities forced to reduce nursing staffing costs, 33% of nurse lecturers responsible for 80+ students, 25% considering leaving.[2]

Figure 5 - Educator Workforce Shortages. 1. General Medical Council, "The state of medical education and practice in the UK: Workplace experiences 2025," November 2025., 2. Royal College of Nursing, "University financial crisis 'engulfing' nursing courses, RCN warns," press release, June 2024.

Submissions identified multiple barriers preventing practitioners from moving into educator roles or remaining in academic positions:

- Limited availability of dual clinical-academic contracts that would allow practitioners to maintain both clinical practice and teaching roles.[40]
- Misalignment between NHS and higher education institution priorities, policies, and employment conditions.[41]
- Pay differentials, with universities often struggling to match salaries offered in clinical practice.[42]
- Differences in pension schemes and career progression structures.[43]
- Job insecurity driven partly by university financial pressures.[44]

Evidence shows the clinical academic workforce is aging, with replacement not taking place due to perceptions of the career pathway, cliff edges in clinical academic careers, and lack of flexibility in career paths.[45] Practitioners also described difficulties obtaining the Continued Professional Development (CPD) and qualifications required to become educators, with funding models not adequately accounting for costs of mentor training.[46]

These system-level challenges in workforce shortages, strategic planning, financial infrastructure, and educator capacity underpin and compound the difficulties explored throughout this evidence review. Financial pressures limit both institutional capacity and student access, while workforce planning gaps and educator shortages constrain training capacity even where demand exists. Addressing these foundational barriers is essential to creating sustainable improvements across the healthcare education and training pipeline, from widening access through to supporting career progression and workforce retention.

[39] Op. cit., Macdougall; op. cit., General Medical Council; op. cit., Pearce.
[40] See for example: Op. cit., Reynolds; op. cit., Royal College of Midwives; op. cit., Kaunda et al.
[41] See for example: Op. cit., Patel; op. cit., Hallwood.
[42] See for example: Op. cit., Reynolds; op. cit., Patel; op. cit., Hallwood.
[43] See for example: Op. cit., Reynolds; op. cit., Pearce; op. cit., O'Donnell.
[44] See for example: Op. cit., Flack; op. cit., Holden.
[45] Op. cit., British Medical Association; op. cit., Royal College of Midwives.
[46] See for example: Op. cit., Curtis and Smith; op. cit., McKenna.

CASE STUDY: Clinical Academic Internship Model (CAIM)

The Clinical Academic Internship Model addresses limited pathways for clinical academic career progression by creating an innovative bridging programme between NHS Trusts and universities. The model enables NHS clinicians to transition into educational roles through part-time secondment, responding to NHS England's Long Term Workforce Plan identification of the need for more high-quality educators to enhance care quality and outcomes.

Model features: NHS-employed nurses, midwives, and allied health professionals work at Higher Education Institutions on a fractional basis with honorary contracts, teaching while maintaining NHS employment. The part-time secondment structure allows clinicians to collaborate with faculty to support students while gaining educator experience, with a clear Clinical Practice Educator (CPE) career pathway.

Implementation and scale: The pilot ran from 2022-2023 with three experienced nurses from Queen Alexandra Hospital teaching clinical skills at University of Portsmouth one day per week. The programme expanded in 2023-2024 both horizontally (across all South East England regions) and vertically (across nursing, midwifery, and allied health professions).

Outcomes: The model proved effective for workforce development, sustainability, and retention by providing a transparent route into education careers. It created a pipeline for staff transitioning to educational roles while offering a supportive introduction to academic work. The programme generated mutually beneficial relationships between interns, universities, and NHS Trusts, enabling interns to build confidence in supporting the next generation of healthcare professionals.

Sustainability requirements: Continuous national funding is essential for broader expansion to strengthen the healthcare education system across the country.

Figure 6 – CASE STUDY: Clinical Academic Internship Model (CAIM) from Oakley J, Turkistani S, Bell J, "Evaluation of the efficacy of an internship model enabling clinical staff to assume the role of clinical practice educators at universities in the Southeast of England 2023/24," School of Dental, Health and Care Professions, University of Portsmouth, December 2024.

Theme 2: Admissions and Selection

This section examines barriers to entering healthcare programmes, exploring how inequalities in access, poor awareness of certain professions, limitations in widening participation approaches, and underutilised alternative entry routes collectively constrain the diversity and size of the healthcare student pipeline.

Key emerging implications for policymakers:

- Inequalities in access to healthcare programmes persist across socioeconomic background, ethnicity, disability, and geography; financial barriers at the point of application and study mean widening participation commitments cannot be achieved through admissions reform alone.
- Several professions face recruitment shortfalls driven by poor public awareness and negative perceptions of NHS careers; the 10 Year Health Plan does not adequately address this despite its direct impact on supply.
- Widening participation initiatives show promise but require stronger evaluation frameworks focussed on completion and labour market entry, not only admission numbers, alongside broader geographic reach beyond existing training hubs.
- Alternative entry routes including apprenticeships and fast-track programmes remain underutilised due to structural and funding barriers; the forthcoming Alan Milburn review presents a timely opportunity to address these gaps across a wider range of professions.

Access to healthcare programmes remains unequal across intersecting factors

Although there has been significant progress, submissions consistently identified equitable access as a challenge across health professions:

- Students from lower socioeconomic groups remain significantly underrepresented, particularly in highly competitive courses[47]
- Ethnic disparities in admissions persist across professions[48]
- Students with disabilities and neurodivergent students face additional challenges and remain underrepresented across multiple professions[49]
- Regional variation exists in applications, with London and the South East significantly over-represented[50]
- Mature students and students with caring responsibilities can find admissions more challenging[51]

[47] See for example: Kevin Latham, Katherine Woolf, Asta Medisauskaite, and Shaun Boustani, "Unequal Treatment?" (London: Sutton Trust and UCL, 27 February 2025), 30; Dental Schools Council, "Widening Access to Dentistry Careers", 2025.
[48] Op. cit., Letts.
[49] Marcus Shynes, Association of Anaesthetists, written evidence, November 2025.
[50] Op. cit., Latham et al., 30.
[51] Laura Jackson, PhD student University of Strathclyde & Lecturer and Programme Leader Adult Nursing University of the West of Scotland, written evidence, November 2025.

- Gendered differences in applications and admissions persist in some professions - for example, nursing and midwifery experience significant male under-representation[52]

Multiple sources identified challenges around lack of information and guidance, limited confidence, difficulty accessing work experience, and insufficient support networks.[53]

Financial barriers compound these difficulties. Multiple sources identified specific financial barriers including application fees, exam fees, and travel expenses.[54] Submissions also noted that the prospect of significant debt deters some students from applying. Concerns that student finances will not cover living expenses compound this further.[55]

Poor awareness and negative perceptions drive under recruitment in several professions

These access barriers exist alongside a separate but related recruitment challenge across several professions. Whilst some highly competitive courses such as medicine and dentistry face oversubscription where available places cannot meet demand, other professions and courses are struggling to recruit sufficient.[56] Universities link this in part to the negative perceptions of NHS working conditions as outlined earlier, but also misconceptions about the roles and their responsibilities. In professions such as nursing and midwifery, there are gendered perceptions that focus on caring tasks rather than clinical or technical responsibility.[57] There is also a general lack of awareness of Allied Health careers, especially for small and vulnerable professions like Orthoptics, Prosthetics and Orthotics, and several arts therapies.[58] More broadly, we have identified limited awareness of diverse career pathways, including opportunities in research, education, and leadership. [59]

As a result of these challenges, university staff have reported recruiting "right up to the wire" for financial reasons, leaving insufficient preparation time.[60] In some cases, over-recruitment has resulted in student numbers exceeding programme capacity.[61] Although the 10 Year Health Plan acknowledges the negative perception of working conditions within the NHS, it does not address the lack of awareness or misconceptions about individual roles despite their impact on recruitment.

Existing widening participation approaches require refinement to improve reach and effectiveness

[52] Op. cit., Hallwood.
[53] Op. cit., Latham et al., 30; op. cit., Dental Schools Council.
[54] Ibid.
[55] The Sutton Trust, "Reforming Student Maintenance" (London: The Sutton Trust, 21 March 2024).
[56] Op. cit., Hallwood.
[57] See for example: Deborah Harrison, Senior Research Associate, Newcastle University, written evidence, November 2025; Interview with final year postgraduate diploma nursing student, September 2025.
[58] Ibid.
[59] Op. cit., Hallwood.
[60] Interview with senior lecturer in adult nursing, October 2025.
[61] Alex Flack, Clinical Learning Environment Lead, written evidence, November 2025.

Submissions identified a range of successful widening participation initiatives across the sector including:

- Admissions support and early outreach programmes[62]
- Work experience programmes, gateway courses and foundation years[63]
- Mentoring schemes[64]
- Guaranteed interviews, reduced grade offers and contextual admissions[65]

Examples of Good Practice: Widening Participation and Access

Brunel University and Imperial College London Medical Summer School: Free summer programme for up to 50 Year 12 students from widening participation backgrounds aspiring to study medicine or healthcare, helping students build confidence, develop application skills, and connect with admissions teams. The programme removes the financial barrier of typical paid preparatory courses.[1]

St George's University of London Science Stars: GCSE-level science tutoring intervention for widening participation students, with evaluation evidence showing that attainment in science increased more than comparison group pupils, demonstrating positive impact of targeted academic support.[2]

St George's University of London Primary Practice: Programme for Year 6 pupils helping successful transition from primary to secondary school while building knowledge of medicine and healthcare. Evaluation showed positive impact on pupils' resilience, confidence, and interest in science and healthcare careers.[3]

RCN Wales Healthcare Connect Programme: Six-month work-based learning qualification designed for those wishing to study nursing or midwifery degrees who either did not gain full entry requirements or would benefit from further experience before enrolling. Since the pilot began in September 2023, 96% of candidates who successfully completed the course have remained in healthcare.[4]

Figure 7- Examples of Good Practice: Widening Participation and Access. 1-3 Leona Letts, NHS Race and Health Observatory response to the Higher Education Commission: Health Education and Training Inquiry Call for Evidence, November 2025., 4 Ian Mathieson, Health Education and Improvement Wales (HEIW) response to the Higher Education Commission: Health Education and Training Inquiry Call for Evidence, November 2025.

[62] Focus group with medical degree students, UCL, 2025; op. cit., Dental Schools Council.
[63] See for example: Ian Mathieson, Director of Education Strategy and Transformation, HEIW, written evidence, November 2025; S. Curtis and D. Smith, "A Comparison of Undergraduate Outcomes for Students from Gateway Courses and Standard Entry Medicine Courses", BMC Medical Education, 20(4) (2020).
[64] See for example: C. Langford, H. Mozley, R. Bartlett, J. Crispin, and S. Curtis, "From Social Relationships to Social Support: Facilitating Workshops to Enhance Widening Participation Students' Sense of Belonging at Medical School", Widening Participation and Lifelong Learning, 27 (2025), 153-178.
[65] Op. cit., Dental Schools Council.

However, stakeholders also identified limitations in current approaches. Some education providers use single or untriangulated markers of disadvantage that may fail to capture a student's socioeconomic background.[66] Participants from our focus group with medical students noted programmes cluster around large cities and existing training institutions, limiting reach beyond local areas. It was also highlighted that evaluation frameworks focus primarily on admission numbers rather than completion rates and labour market entry.[67]

The 10 Year Health Plan addresses widening participation but does not acknowledge these limitations in current approaches. Submissions suggested that expanding access requires appropriate financial support alongside clear evaluation frameworks and mechanisms.

Alternative entry routes are underutilised due to funding and awareness barriers

Alongside these refinements, submissions highlighted the potential of alternative entry routes to complement existing approaches.

Apprenticeships address financial barriers by providing a salary whilst training. Stakeholders noted they help students avoid significant debt, widening access particularly for mature learners and those from disadvantaged backgrounds.[68] However, some education providers described constraints related to:

- Funding challenges and complex administrative processes[69]
- Limited employer backfill support[70]
- Lack of awareness regarding the apprenticeship pathway[71]

The 10 Year Health Plan acknowledges the potential positive role of apprenticeships, committing to creating 2,000 more nursing apprenticeships over the next three years, prioritising areas of greatest need. However, the Plan does not adequately address the structural barriers identified in the evidence. Additionally, it does not sufficiently address apprenticeships in other professions where they might also be valuable but remain under supported.

The evidence we have gathered from our evidence submissions indicates that fast-track programmes and graduate-entry routes successfully attract career switchers and late-career entrants, offering compressed training routes that can reduce financial costs of extended study periods.[72] However, students and providers have raised concerns about the additional

[66] Ibid.
[67] See for example: T. Cronin, D. Gendy, and J.L. Johnston, "What Impact Does Widening Participation to Medicine Have on the Medical Workforce in the UK: A Scoping Review", Education for Primary Care, 36(1-2) (2025), 6-15; R. Adhikari, "'Widening Access' to Nursing Education in the UK: What Does It Mean in Everyday Practice?", Nurse Education in Practice, 68 (2023), 103588.
[68] Reena Patel, Chartered Society of Physiotherapy, written evidence, November 2025.
[69] See for example: Op. cit., Harrison; Diane Last, Head of Clinical Education, West Suffolk NHS Foundation Trust, written evidence, November 2025; Vanessa O'Donnell, Head of Public Affairs, MillionPlus, written evidence, November 2025.
[70] Op. cit., Harrison.
[71] NHS England and Royal College of Midwives, "Registered Midwife Degree Apprenticeship Evaluation Report" (2023).
[72] Florence Makin, External Affairs Officer, Think Ahead, written evidence, November 2025.

pressures created by condensing course material.[73] Realising the potential of these routes will require addressing the structural and funding barriers submissions consistently identified.

Looking ahead, the forthcoming Alan Milburn review is expected to guide reforms to post-16 health and care career education, which could provide important policy direction in this area.[74] This review could provide important direction on how to address the awareness and structural barriers to alternative entry routes identified in this evidence review.

[73] See for example: Dr Deborah Harrison, Prof Tracy Scurry, Prof Stephen Procter, Prof David Lain, Dr Ana Lopes, Prof Alison Steven, and Prof Marco Tomietto, "Understanding Newcastle's Future Health and Care Workforce 'Pipeline': Pathways, Motivations and Priorities" (Newcastle: Northumbria University, 30 June 2025); op. cit., Fielding.
[74] Department for Work and Pensions, "Alan Milburn calls for a 'movement' to address lost generation of young people not earning or learning as investigation opens," press release, December 2025.

CASE STUDY: Registered Midwife Degree Apprenticeship (RMDA)
The Registered Midwife Degree Apprenticeship demonstrates the potential of apprenticeship routes to widen participation while strengthening workforce supply. Evaluation by King's College London of the first RMDA cohorts (starting January 2020) found:

Widening participation and financial access:

- Over half of apprentices were first generation university students
- All were aged 22+, with nearly one-third from Black/Black British communities
- Almost all were previously maternity support workers
- "I was able to [study] while I've got a family…It gave me the opportunity to do this degree when I thought I would never be able to, ever" (Apprentice)

Workforce benefits:

- Attrition rates of 0-4% compared to 13% on traditional route
- All graduates offered employment by their host employer
- Apprentices contribute productively from day one with existing clinical skills
- No difference in academic proficiency compared to fee-paying students; both routes meet same NMC standards

Barriers to expansion: Despite strong outcomes, wider adoption is constrained by backfill costs, loss of NHS Education and Training Tariff, and lack of understanding about apprenticeships within the profession. In 2023, 49% of NHS Trusts had spent less than 75% of their Apprenticeship Levy, suggesting untapped capacity.

Figure 8 Royal College of Midwives and NHS England, "Registered Midwife Degree Apprenticeship evaluation report," September 2023.

Theme 3: Curriculum, Teaching, and Assessment

This section examines how curriculum design, teaching methods, and assessment approaches shape graduate preparedness for NHS practice. It explores how funding constraints, regulatory complexity, content gaps, and assessment models limit the ability of healthcare education to produce work-ready graduates equipped for a changing health system.

Key emerging implications for policymakers:

- The 10 Year Health Plan's commitment to overhauling healthcare curricula within three years cannot be delivered without adequate funding, educator capacity, and greater regulatory clarity; structural barriers to innovation remain unaddressed
- Persistent gaps in non-technical skills, interprofessional learning, career pathway awareness, and digital literacy mean graduates are entering practice underprepared for the NHS model the 10 Year Health Plan describes; curriculum reform must explicitly target these areas
- Course content does not consistently reflect diverse populations or embed a focus on health inequalities; realising the 10 Year Health Plan's cross-cutting equality commitments will require specific guidance on how this is translated into curriculum design
- A shift towards competency-based and active learning approaches shows promise for developing clinical reasoning, but requires investment in facilities, educator training, and shared infrastructure that current funding models do not support

Funding constraints and regulatory complexity restrict innovation in curriculum design

Despite recognition of the need for innovation and willingness among educators to address curriculum gaps, multiple barriers prevent effective innovation in curriculum design. Across submissions, stakeholders identified three main limiting factors:

1. **Funding and capacity constraints:** Financial pressures make it difficult to embed innovative practices, invest in new technologies, or pilot alternative approaches.[75] These funding challenges compound the educator capacity constraints discussed earlier, with overstretched staff having limited time and resources to develop and test new approaches.
2. **Regulatory complexity:** Regulatory requirements are inconsistently interpreted across institutions, creating uncertainty about what changes are permissible.[76] This inconsistency can stifle innovation as educators face unclear boundaries for experimentation.

[75] Ibid.
[76] Prof Colin Macdougall, Associate Dean, Medical Education, written evidence, November 2025; W. Palmer, S. Reed, N. Hemmings, S. Julian, M. Bodea, R. Oaten, and L. Plotkin, "Practice Learning in Nursing and Midwifery Education: An Independent Rapid Review" (December 2024).

3. **Communication and integration challenges:** Poor coordination between course components, practice partners, and regulators creates confusion and limits the potential for integrated innovation.[77] These communication barriers make it difficult to implement coherent changes across different parts of the education system.

The 10 Year Health Plan commits to overhauling education and training curricula over the next three years to future-proof the NHS workforce. However, the evidence suggests institutions will struggle to deliver this without adequate funding, capacity, and regulatory flexibility.

Theory-practice disconnect and content gaps limit student preparedness

These barriers have resulted in persistent curriculum challenges that affect student preparation for practice. Students report a disconnect between theoretical teaching and clinical realities.[78] They also report unclear communication between different modules, components and staff.[79] Staff perspectives and literature reviews raised similar concerns, noting limited oversight of individual modules and insufficient opportunities for sharing best practice across staff, courses and institutions.[80]

Beyond structural fragmentation, there are concerns about curriculum content representation. It is widely reported that course content does not always represent diverse populations or adequately address health inequities.[81] Specifically, concerns have been raised over stereotyping and lack of diversity in course material.[82] The 10 Year Health Plan addresses health inequalities as a cross-cutting theme and commits to tackling inequalities in both access and outcomes. However, the Plan does not detail how healthcare education curricula will be reformed to embed this focus on health inequalities.

Beyond these structural and delivery challenges, we have identified four key content areas where curriculum gaps limit students' preparation for practice:

1. **Non-technical skills:** Students feel underprepared in communication, prioritisation, situational awareness, organisation, and time management upon entering practice.[83] Numerous government reviews have highlighted leadership as an area of need within the NHS. For example, the Leng Review (2025) called for all doctors to receive formal management and line-management training, built into undergraduate and postgraduate medical education.[84] However, leadership teaching remains informal or is developed later in professional careers.[85]

[77] Ibid.
[78] K. Rajiah, "Integrating Entrustable Professional Activities Using an Integrated Curriculum Design Framework in Pharmacy Education", Current in Pharmacy Teaching and Learning, 17(2) (2025), 102269; Interview with final year postgraduate diploma nursing student, September 2025.
[79] Op. cit., Focus group with medical degree students.
[80] Op. cit., Focus group with medical degree students.
[81] Op. cit., Letts.
[82] Op. cit., Letts.
[83] J. Pollard and M. Tombs, "Teaching Undergraduate Medical Students Non-Technical Skills: An Evaluation Study of a Simulated Ward Experience", Advances in Medical Education and Practice, 13 (2022), 485-494.
[84] Department of Health & Social Care, "The Leng review: an independent review into physician associate and anaesthesia associate professions," 24 July 2025.
[85] Op. cit., Pollard and Tombs; A. Till, J. McKimm, and T. Swanwick, "The Importance of Leadership Development in Medical Curricula: A UK Perspective (Stars are Aligning)", Journal of Healthcare Leadership, 12 (2020), 19-25.

2. **Interprofessional learning:** Many students feel insufficiently prepared for interprofessional communication and integrated care despite these being explicit regulatory outcomes.[86] Barriers to effective interprofessional education include geographical distance and differing pedagogical approaches.[87] The 10 Year Health Plan frames integrated, team-based care as central to its new model, yet does not detail how healthcare education will prepare students for this approach.
3. **Career pathways:** As discussed in the first section, there is a lack of awareness of the range of career pathways available for professional roles. This continues into academic curricula. Certain specialisms receive limited recognition in the curriculum, such as careers in general practice, despite workforce shortages and high demand in these areas.[88] However, careers outside NHS clinical practice, such as in research, were underrepresented. While Band 7 roles and above require basic understanding of research, research content and skills teaching are not consistently embedded in early training programmes.[89]
4. **Digital literacy and AI preparedness:** The 10 Year Health Plan commits to making AI every nurse's and doctor's trusted assistant. However, students have limited training in digital tools and insufficient preparation for AI-enabled healthcare.[90]

These content gaps mean graduates enter practice without key skills the NHS requires, contributing to the workforce pressures outlined in the first section.

[86] Ibid.; op. cit., NHS England.
[87] Ibid.; op. cit., NHS England.
[88] Nicola Fielding, Deputy Programme Lead (Child Health), Lecturer in Child Health Nursing, University of Plymouth, written evidence, November 2025.
[89] Ibid.
[90] See for example: N. Stogiannos, E. Skelton, S. Kumar, S. Ahmed, C. Amedu, C. Vince, M. Schiavottiello, C. O'Sullivan, and C. Malamateniou, "Evaluation of a Customised, AI-Focused Educational Seminar Delivered to Final Year Undergraduate Radiography Students in the UK: A Cross-Sectional Study", Radiography, (2025); M. Banerjee, D. Chiew, K.T. Patel, I. Johns, D. Chappell, N. Linton, G.D. Cole, D.P. Francis, J. Szram, J. Ross, and S. Zaman, "The Impact of Artificial Intelligence on Clinical Education: Perceptions of Postgraduate Trainee Doctors in London (UK) and Recommendations for Trainers", BMC Medical Education, 21(1) (2021), 429.

Examples of Good Practice: Curriculum Innovation

HEARI Project (Healthcare Education to Address Racialised Inequities): NHS Race and Health Observatory-commissioned project led by Canterbury Christ Church University with Melanin Medics and other HEI and NHS partners. The project reviews teaching curricula and existing approaches to improve patient care and reduce racialised health disparities.[1]

DISKPASS Project: Initiative designed to develop foundational digital capability in pre-registration nurses and allied health professionals, equipping learners with essential knowledge in applied digital tools, clinical safety, innovation, data and AI, and digital professionalism. The programme aligns curriculum with national and international digital capability frameworks including JISC, NHS Digital Capabilities, and TIGER 2.0.[2]

Figure 9 - Examples of Good Practice: Curriculum Innovation. 1. Leona Letts, NHS Race and Health Observatory response to the Higher Education Commission: Health Education and Training Inquiry Call for Evidence, November 2025. 2. John McKenna, University of Salford response to the Higher Education Commission: Health Education and Training Inquiry Call for Evidence, November 2025.

Current approaches to teaching and assessment inadequately develop clinical reasoning

In addition to these content gaps, there are concerns about how curriculum is assessed and taught. Online learning enables flexibility and better access, especially for students with disabilities, caring responsibilities, or those balancing work alongside study.[91] However, some stakeholders have raised concerns about variation in the quality of online teaching.[92] Stakeholders also reported barriers in engaging with online material such as low digital literacy, digital poverty, unreliable internet access, and competing family or work responsibilities.[93]

There are also concerns that assessment and teaching methods sometimes incentivise factual recall and memorisation rather than applied clinical reasoning.[94] Multiple professions are exploring a shift towards competency-based training and assessment models. Some stakeholders have suggested these approaches may better reflect the skills and attributes required for clinical practice.[95]

To support this shift, active learning approaches, including case-based learning and simulation, were frequently identified as encouraging deeper engagement.[96] Some evidence suggests that well-designed case-based and simulation learning strengthens clinical reasoning, enables students to follow patient journeys, and supports standardisation of skills across students.[97] However, there are significant costs of training and infrastructure needed to enable simulation.[98] Addressing these challenges would require improved sharing of best practice, increased investment in facilities and educator training, and additional research on effectiveness.[99]

[91] Abbey Holden, University of Huddersfield, written evidence, November 2025.
[92] Interview with first year paramedic student, 2025; C. Bramer, "Preregistration Adult Nursing Students' Experiences of Online Learning: A Qualitative Study", British Journal of Nursing, 29(12) (2020).
[93] See for example: Op. cit., Jackson; John McKenna, Head of Public Affairs, Salford University, written evidence, November 2025; op. cit., Bramer.
[94] Op. cit., Rajiah.
[95] Op. cit., Royal College of Nursing.
[96] Op. cit., Rajiah.
[97] See for example: Op. cit., Reynolds; L. Rossiter, R. Turk, B. Judd, et al., "Preparing Allied Health Students for Placement: A Contrast of Learning Modalities for Foundational Skill Development", BMC Medical Education, 23 (2023), 161; J. Thompson, S. White, and S. Chapman, "Virtual Patients as a Tool for Training Pre-Registration Pharmacists and Increasing Their Preparedness to Practice: A Qualitative Study", PLoS One, 15(8) (2020), e0238226.
[98] Op. cit., Emicke, Shepherd, and Powell.
[99] Ibid.

Theme 4: Clinical Placements and Practice Learning

This section examines the structural and experiential factors shaping clinical placements across healthcare professions. It explores how coordination failures, funding constraints, and communication gaps between education and practice settings limit placement capacity and quality, with direct consequences for student experience and graduate preparedness.

Key emerging implications for policymakers:

- Placement capacity is a critical bottleneck to expanding training places; the 10 Year Health Plan's workforce expansion ambitions cannot be realised without addressing coordination failures, funding adequacy, and the lack of national oversight of placement supply
- Significant variation in tariff funding across professions creates inequitable incentives for providers to host students, risking further capacity constraints in already under-resourced areas of the workforce
- Poor placement experiences, including inadequate supervision, hostile work cultures, and unclear responsibilities, undermine both student wellbeing and the widening participation goals pursued earlier in the pipeline
- Clearer accountability mechanisms are needed to ensure tariff funding reaches frontline placement delivery, alongside improved coordination between higher education institutions and placement providers to reduce operational confusion

Placement capacity gaps stem from inadequate funding, poor planning, and coordination failures

The 10 Year Health Plan builds on previous government announcements calling for an increase in training places to increase the supply of professionals. However, the Plan does not adequately address the shortage of quality clinical placements as a barrier to this expansion. Submissions to our open Call for Evidence identified three interrelated factors constraining placement capacity: lack of national coordination and planning, insufficient and inequitable funding, and poor communication between education and practice settings.

Coordination and planning gaps: Education institutions, providers, and courses often compete for the same placement locations. However, there is no clear national planning, coordination, or monitoring to identify under-utilised or over-subscribed placement locations.[100] This lack of coordination creates additional operational challenges. Providers have noted that academic timetables limit flexibility, preventing placements from being spread across the year.[101] Placement staff have described high student-to-staff ratios, potentially impacting the quality of supervision and learning.[102] Whilst students and education

[100] Op. cit., Macdougall; op. cit., British Medical Association; Alex Flack, Clinical Learning Environment Lead, written evidence, November 2025.
[101] Op. cit., Education Development Lead; R. Pearce, A. Topping, and C. Willis, "Enhancing Healthcare Students' Clinical Placement Experiences", Nursing Standard (2022)
[102] Op. cit., British Medical Association; op. cit., Royal College of Midwives, "State of Midwifery Education 2023".

institutions expressed a desire for a wider range of placement opportunities, capacity constraints and regulatory inflexibility limit these options.[103]

Funding constraints: Submissions widely cited insufficient funding as a barrier to expanding the breadth and quality of practice learning environments.[104] Placement providers receive a tariff based on the number of students, which profession they belong to and how long those students are on placement. However, there is lack of transparency in how institutions spend tariff funding and whether they absorb it into broader budgets.[105] Additionally, significant variation exists in tariff funding per profession. For example, placement providers receive £5,000 per nursing student compared with £30,000 for medical students, meaning lower tariffs may provide less incentive to host students from certain professions.[106] Funding also varies between devolved nations, creating further inconsistencies.[107]

Communication challenges: Communication challenges and misalignment between placement providers and higher education institutions compound these issues.[108] Evidence highlighted how university policies often do not match how practice settings operate, causing confusion for both students and staff.[109] Some stakeholders have reported unclear responsibilities for placement organisation, with competing demands among universities, placement agencies, students, and educators.[110]

Students experience inadequate supervision, poor environments, and limited support on placements

These systemic pressures have direct consequences for students' placement experiences. Frequently reported concerns about placement quality and experience includes:

- **Logistical and organisational challenges:** Students often do not receive enough notice for placements, with locations and timings sometimes changing at short notice. This poses particular challenges for those with caring responsibilities or those who need to arrange accommodation and travel.[111]
- **Student experience and supervision:** Some students feel unwelcome in placement settings.[112] Experiences included arriving at placements where staff had nothing prepared for them, needing to be highly proactive to gain educational value, or being left without adequate supervision.[113] Other students have reported feeling they were used to fill staffing gaps rather than focus on their education.[114]

[103] Op. cit., Harrison; Rosie Pearce, Senior Policy Officer, Dental Schools Council, written evidence, November 2025.
[104] Op. cit., Pearce; op. cit., Makin.
[105] Op. cit., Sassoon; op. cit., Pearce.
[106] Op. cit., Letts.
[107] Op. cit., Association of British Paediatric Nurses.
[108] See for example: Op. cit., Jones; op. cit., Education Development Lead; op. cit., Letts; op. cit., Hallwood.
[109] Ibid.
[110] Ibid.
[111] Op. cit., Jackson; op. cit., Focus group with year 3 nursing students and year 3 midwifery students.
[112] See for example: Op. cit., Focus group with medical degree students; P. Tremayne and L. Hunt, "Has Anyone Seen the Student? Creating a Welcoming Practice Environment for Students", British Journal of Nursing, 28(6) (2019), 369-373; op. cit., Pearce, Topping, and Willis.
[113] See for example: Op. cit., Focus group with medical degree students; P. Tremayne and L. Hunt, "Has Anyone Seen the Student? Creating a Welcoming Practice Environment for Students", British Journal of Nursing, 28(6) (2019), 369-373; op. cit., Pearce, Topping, and Willis.
[114] See for example: Op. cit., Fielding; op. cit., Royal College of Nursing; op. cit., Pearce, Topping, and Willis.

- **Work environment and culture:** Some students and stakeholders reported bullying, harassment, and hostile work cultures in some placement settings.[115] Evidence suggests this can be exacerbated for students from widening participation or minority backgrounds.[116]

Additionally, students expressed concerns about being unable to raise issues whilst on placement, noting that universities lack effective mechanisms to improve placement experiences.[117]

Examples of Good Practice: Innovative Placement Models

Neighbourhood Health Hub: UK's first university-led primary care centre integrating clinical care, education and research in one community setting. The model provides accessible preventative healthcare while offering hands-on student training, with the Health Advice Centre partnering with local charities to deliver health checks to residents experiencing homelessness. This creates the university's own placement capacity while embedding health equity in clinical education and allowing students to experience the NHS's prevention-first model during training.[1]

Bristol Dental School NHS 111 Partnership: New dental school based in city centre to improve public transport accessibility, accepting NHS 111 emergency patients through local NHS collaboration. The partnership provides emergency dental access via the 111 pathway for the public while giving students real patient experience with emergency presentations, demonstrating how dental school location and service design can simultaneously address access gaps and training needs.[2]

King's College London Portsmouth Dental Academy Partnership: Final year King's College London dentistry students spend one week in four of their placement block at Portsmouth Dental Academy throughout their final year. The outreach placement provides students with exposure to different patient populations and experience outside London context, while Portsmouth benefits from consistent student workforce supporting service delivery.[3]

Figure 10 - Examples of Good Practice: Innovative Placement Models. 1. Vanessa O'Donnell, MillionPlus response to the Higher Education Commission: Health Education and Training Inquiry Call for Evidence, November 2025.2-3. Rosie Pearce, Dental Schools Council response to the Higher Education Commission: Health Education and Training Inquiry Call for Evidence, November 2025.

[115] See for example: Op. cit., Fielding; op. cit., Thompson et al.; op. cit., Palmer et al.
[116] Op. cit., Letts; op. cit., Thompson et al.; op. cit., Palmer et al.
[117] Op. cit., Focus group with medical degree students; op. cit., Palmer et al.

Theme 5: Student Wellbeing and Support

This section examines the wellbeing challenges facing healthcare students and the support systems in place to address them. It explores how financial pressures, academic intensity, trauma exposure, and inconsistent access to support contribute to poor mental health and attrition across professions, with particular impact on students from widening participation backgrounds.

Key emerging implications for policymakers:

- Student wellbeing challenges are directly linked to attrition and represent a significant and underacknowledged workforce retention risk; the 10 Year Health Plan's focus on staff wellbeing must extend upstream to the student pipeline.
- Students from widening participation backgrounds face compounding wellbeing pressures, meaning gains made through admissions reform risk being reversed without consistent, targeted pastoral and academic support throughout training.
- Effective interventions exist, including pre-admission programmes, peer support schemes, and embedded wellbeing modules, but inconsistent implementation limits their impact; a stronger national framework for student support is needed.
- Reasonable adjustments for students with disabilities and neurodivergent learners are applied inconsistently across universities and placement settings, contributing to attrition and early workforce exits that undermine investment in widening access.

Healthcare students experience significant wellbeing challenges linked to attrition

The 10 Year Health Plan frames staff wellbeing as important to retention and productivity. However, student wellbeing faces similar challenges. Mental health and wellbeing concerns among healthcare students represent a significant challenge across professions and are consistently linked to attrition.[118] Multiple factors contribute to difficulties:

- **Intense curricula and academic expectations:** High volume of work, examinations, and overlapping deadlines create pressure points.
- **Financial challenges**: As discussed in the system-wide barriers section, students face significant financial pressures including placement costs and inadequate support.
- **Transition periods:** Entering academic life or preparing for placements are linked to elevated stress and burnout.

[118] See for example: Dr Deborah Harrison, Prof Tracy Scurry, Prof Stephen Procter, Prof David Lain, Dr Ana Lopes, Prof Alison Steven, and Prof Marco Tomietto, "Understanding Newcastle's Future Health and Care Workforce 'Pipeline': Pathways, Motivations and Priorities" (Newcastle: Northumbria University, 30 June 2025); op. cit., Fielding.

- **Exposure to trauma:** In some professions, exposure to trauma-related academic content and preparation for distressing clinical work contributes to poor mental health.[119]
- **Isolation and belonging:** Students can feel lonely and isolated.[120] This is particularly acute for those studying primarily online.[121]

Students from widening participation backgrounds may be at greater risk of experiencing mental health difficulties.[122] They may struggle more academically and need support throughout their studies, as well as role models and mentors from similar backgrounds.[123] International students or students from diverse cultural backgrounds may face additional academic challenges including cultural adaptation and communication difficulties.[124] These challenges can be particularly acute when transitioning into clinical learning environments. Personal circumstances including bereavements, health issues, and caregiving responsibilities add pressure.[125]

Because of the educator capacity shortages discussed earlier, students have described personal tutor support as inconsistent.[126] Beyond not knowing how to access support, students may be reluctant to seek help due to stigma or appearing less capable.[127]

We have identified additional challenges when supporting students with disabilities, learning difficulties, neurodivergence, or long-term conditions who require structured support and reasonable adjustments:

- Identifying students who need such support can be difficult, with some students only discovering learning difficulties after experiencing academic failure.[128]
- Even when students are identified as needing reasonable adjustments, these are not always implemented consistently.[129]
- The challenges are particularly acute when coordination is required between universities and placement settings.[130]

[119] See for example: Op. cit., Reynolds; A. Alzahrani, C. Keyworth, K.M. Alshahrani, R. Alkhelaifi, and J. Johnson, "Prevalence of Anxiety, Depression, and Post-Traumatic Stress Disorder Among Paramedic Students: A Systematic Review and Meta-Analysis", Social Psychiatry and Psychiatric Epidemiology, 60(3) (2025), 563-578.
[120] Op. cit., Rich; op. cit., Fielding.
[121] Ibid.
[122] Op. cit., Taylor et al.; L. Hollands, E. McCulloch, J. Scott, J. Hancock, and K. Mattick, "Medical Students' Attitudes Toward a Career in Psychiatry: A Realist Evaluation", Academic Psychiatry, 49(4) (2025), 317-327; op. cit., Cronin, Gendy, and Johnston.
[123] Op. cit., Cronin, Gendy, and Johnston.
[124] Op. cit., Harrison et al.; op. cit., Rossiter et al.
[125] S.N. Iqbal, A. Rekhi, A. James, J.A. Johnson, and A. Trinidade, "The UK Cost-of-Living Crisis and Its Effect on Students at a British Medical School", BMC Medical Education, 25(1) (2025), 791.
[126] Op. cit., Jackson; op. cit., Fielding; op. cit., Thompson et al.
[127] H. Mozley, R. D'Silva, and S. Curtis, "Enhancing Self-Efficacy Through Life Skills Workshops", Widening Participation and Lifelong Learning, 22 (2020), 64-87.
[128] See for example: R. Hill and S. Hardy, "An Evaluative Study on the Impact of Health and Wellbeing Strategies on Preregistration Health Student Retention: A Scoping Review of Published Literature" (Cambridge: Health Education England (East of England), March 2023); C. Crawford, P. Black, V. Melby, and B. Fitzpatrick, "The Academic Journey of Students with Specific Learning Difficulties Undertaking Pre-Registration Nursing Programmes in the UK: A Retrospective Cohort Study", Nurse Education Today, 111 (2022), 105318.
[129] Op. cit., Thompson et al.; op. cit., Crawford et al.
[130] Op. cit., Makin; op. cit., Palmer et al.

Additionally, adjustments made during training are not always reflective of what would be provided in the role after qualifying, potentially contributing to early workforce exits.[131]

Support systems exist but access and implementation remain inconsistent

Despite these challenges, some interventions show promise in supporting student wellbeing and reducing attrition risk when implemented consistently. Examples of effective approaches include:

- **Pre-admission programmes:** These aim to ensure students understand what they are committing to and begin building support structures early.[132]
- **Dedicated support roles**: Examples include Disability and Inclusion Officers and third-party support for neurodiverse learners.[133]
- **Peer support and sense of belonging interventions:** Student buddy and peer support schemes create a sense of community, develop belonging to the profession, and provide an extra layer of support.[134]
- **Wellbeing modules:** Positive impacts from integrating wellbeing support into curricula through dedicated modules, mandatory debrief sessions, and structured reflection.[135]
- **Student voice and feedback loops:** Creating regular opportunities for students to provide feedback on their experiences and visibly acting on that feedback helps identify barriers and improve support systems.[136]

These wellbeing challenges contribute significantly to attrition across healthcare professions and compound the workforce pressures outlined throughout this evidence review. Improving support access and consistency represents a critical retention lever.

[131] Ibid.
[132] Op. cit., Hallwood.
[133] Op. cit., McKenna.
[134] Op. cit., Letts; op. cit., Langford et al.
[135] Op. cit., Reynolds; op. cit., Mozley, D'Silva, and Curtis.
[136] See for example: T. Gale, S. Winter, H. Daykin, J. Tredinick-Rowe, L. Withers, and M. Bryce, "A Qualitative Exploration of Stressors in Anaesthesia Training in the UK and Mechanisms to Improve Resident Wellbeing", Anaesthesia, 80 (2025), 799-811; S. Curtis, H. Mozley, C. Langford, J. Hartland, and J. Kelly, "Challenging the Deficit Discourse in Medical Schools Through Reverse Mentoring-Using Discourse Analysis to Explore Staff Perceptions of Under-Represented Medical Students", BMJ Open, 11(12) (2021), e054890.

Examples of Good Practice: Student Support and Wellbeing

Bridging the Gap Leadership Placement (University of Brighton and Canterbury Christ Church University): Student-led initiative where minoritised healthcare students tackled discrimination experienced on practice placements by creating resources for practice educators, students, and placement partners on race, ethnicity and diversity. The programme empowered students to address systemic issues while providing practical tools for improving placement experiences.[1]

Beyond Barriers Mentoring Scheme (Kingston University): Programme pairing second and third-year healthcare students with practicing healthcare professionals for six months of one-to-one impartial guidance and support. The scheme demonstrated significant benefits to academic achievement, reduced attrition rates, and improved early career support for underrepresented groups.[2]

UCSD Nursing Associate Programme Professional Development and Wellbeing Module: Embedded mandatory module with structured placement debriefs into the curriculum, resulting in improved student confidence in managing workplace stress. The initiative contributed to a cultural shift that now integrates wellbeing considerations into curriculum design and assessment planning.[3]

Reverse Mentoring Scheme: UK university paired underrepresented medical students with senior faculty members, resulting in staff shifting from viewing student challenges as individual deficits to recognising institutional responsibility. The scheme developed deeper understanding among faculty of the barriers faced by minority students.[4]

Widening Participation Student Workshops: UK medical school ran workshops facilitated by staff and widening participation graduates that brought together current widening participation medical students. The accessible and reciprocal peer relationships formed provided emotional support and resources that enhanced participants' sense of belonging through authentic sharing of personal experiences.[5]

Figure 11 - Examples of Good Practice: Student Support and Wellbeing. 1-2. Leona Letts, NHS Race and Health Observatory response to the Higher Education Commission: Health Education and Training Inquiry Call for Evidence, November 2025. 3. Ella Reynolds, University Centre South Devon/South Devon College response to the Higher Education Commission: Health Education and Training Inquiry Call for Evidence, November 2025. 4. Curtis S, Mozley H, Langford C, Hartland J, Kelly J, "Challenging the deficit discourse in medical schools through reverse mentoring-using discourse analysis to explore staff perceptions of under-represented medical students," BMJ Open *11, no. 12 (2021): e054890, doi: 10.1136/bmjopen-2021-054890. 5. Langford C, Mozley H, Bartlett R, Crispin J, Curtis S, "From Social Relationships to Social Support: Facilitating workshops to enhance widening participation students' sense of belonging at medical school,"* Widening Participation and Lifelong Learning *27, no. 1 (2025): 153-178, doi: 10.5456/WPLL.27.1.153.*

Theme 6: Transition to Practice

This section examines the challenges facing students and newly qualified professionals as they move from education into the workforce. It explores how employment uncertainty, geographic allocation pressures, preparedness gaps, and poor working conditions create transition shocks that contribute to early attrition and drive qualified professionals towards private practice or overseas employment.

Key emerging implications for policymakers:

- Employment uncertainty at the point of graduation, driven by budget constraints limiting available posts and narrow recruitment windows, creates a cliff edge that risks losing newly qualified professionals the system has invested significantly in training
- Geographic allocation processes across several professions generate anxiety and instability with significant personal consequences; neither current reform proposals nor the 10 Year Health Plan adequately address the structural causes of this uncertainty
- Inconsistent preceptorship and supervisory support mean newly qualified professionals frequently experience preparedness gaps at the point of independent practice, compounding the curriculum and placement challenges identified in earlier sections
- Poor working conditions, including rigid rotas, insufficient support, and feeling undervalued, are directly driving newly qualified professionals towards private practice or overseas employment; retention at the point of qualification represents an urgent and under addressed policy priority

Geographic uncertainty and employment gaps affect transition for many professions

Transitioning from education to practice represents a critical juncture where students face multiple uncertainties about employment, location, and preparation.

For some professions, such as medicine and dentistry, there are guaranteed foundation years. These are work-based training programmes designed to bridge the gap between academic programmes and independent practice or specialty training. Multiple sources identified challenges with the allocation process.

For example, in medicine, the allocation system recently changed from a criticised ranking system to a computer-generated random allocation process.[137] However, system still creates uncertainty with implications for their daily lives and support systems.[138] There are still issues with the size and scope of deaneries used in allocation systems, with some deaneries

[137] See for example: UKFPO, "UKFP 2024 Applicant Guide to Allocation" (London: UKFPO, July 2023); B. Cook et al., "Medical Students' Insight into Foundation Training (MEDSIFT): A National Cross-Sectional Online Survey Reveals Close to 50% Are Considering a Career Outside the NHS", Postgraduate Medical Journal, 101(1201) (2025), 1202-1210; op. cit., Focus group with medical degree students.

[138] Op. cit., Focus group with medical degree students., "UK foundation programme: Why are some trainees so unhappy with the new allocation system?" *BMJ* 384 (2024), doi: https://doi.org/10.1136/bmj.q722.

covering large areas encompassing diverse settings from cities to remote rural locations.[139] Short notice for foundation placement allocations compounds these anxieties about geographic uncertainty and career opportunities.[140] The first phase of the Medical Training Review also identified how the system disrupts stability and called for greater flexibility. However, models to address these allocation challenges remain absent from both the review and the 10 Year Health Plan.

> "Despite having a wish to move back to Cymru where I think I could really use my Welsh language skills to help patients feel more at ease, understood, and able to communicate with their doctor in their first language, there are still uncertainties that leave me unsure whether to rank it as my top deanery; and even if I did there's no guarantee I will get placed there regardless." - *Welsh Medical Student, Studying in Nottingham.*[1]

Figure 12 - Quote from Welsh Medical Student. 1. Rhiannon Tuckett-Jones, "Training Tomorrow's Doctors: What the UK Can Learn from the US," Policy Connect blog, July 2025.

Students without guaranteed foundation years, and those nearing the end of foundation programmes, have expressed widespread concerns about securing graduate employment.[141] These concerns are heightened by the financial pressures facing NHS trusts discussed earlier. Budget constraints limit available graduate positions in some professions and regions, creating a mismatch between the number of newly qualified professionals and available roles.[142]

Where employment opportunities do exist, recruitment processes themselves create additional challenges. Pooled recruitment processes may prevent students from choosing their preferred specialism or ward.[143] They may also be placed in settings where they had previous negative experiences during placements.[144] Narrow recruitment windows create additional problems for both students and trusts, limiting flexibility and contributing to employment uncertainty.[145]

Preparedness gaps and poor working conditions create transition shocks

Newly qualified professionals reported gaps in their preparedness for independent practice.[146] Equally, educators and clinical staff have highlighted difficulties in standardising pre-registration experiences.[147] This variability makes it challenging to ensure consistent baseline competencies across new graduates. These transition shocks are exacerbated by the poor working conditions discussed earlier.

Working conditions challenges:

[139] Ibid.
[140] Ibid.
[141] See for example: Op. cit., Hallwood; op. cit., Royal College of Midwives; op. cit., O'Donnell.
[142] Allied Health Professions Federation, "Response to the NHSE 10 Year Health Plan Consultation" (London: Allied Health Professions Federation, December 2024).
[143] Op. cit., Harrison; op. cit., Harrison et al.
[144] Ibid.
[145] Op. cit., Flack.
[146] See for example: op. cit., Pollard and Tombs; op. cit., Interview with final year postgraduate diploma nursing student.
[147] Op. cit., Brown; op. cit., Association of British Paediatric Nurses.

- Long, antisocial hours which may contribute to burnout, low morale, and high attrition rates.[148]
- Rotas that are rigid, provided with little notice, changed without consultation, and do not accommodate personal circumstances.[149]
- Feeling undervalued, underpaid, and insufficiently supported.[150]

Formal support gaps:

- Inconsistent preceptorship schemes and clinical supervisors.[151]
- Rushed developmental meetings that become administrative tick-box exercises lacking meaningful developmental feedback.[152]

These challenging working conditions, combined with employment uncertainty and negative media messaging, lead more students to consider working in private practice or abroad upon qualification.[153]

[148] Op. cit., Lock and Carrieri; op. cit., Royal College of Physicians; Royal College of Anaesthetists, "The Anaesthetic Workforce: UK State of the Nation Report" (London: Royal College of Anaesthetists, November 2024).
[149] Op. cit., Lock and Carrieri; op. cit., Royal College of Physicians.
[150] Op. cit., Sassoon; I. McDermott, S. Willis, A. Hindi, and E. Schafheutle, "Why Are Pharmacy Technicians Leaving? Factors Contributing to Turnover Intention and Strategies for Retention", Research in Social and Administrative Pharmacy, 21(2) (2025), 94-103.
[151] Ibid.
[152] B. Hill, T.A. Bruce, D. Simpson, D. Flynn, S. Ban, and D. Porteous, "RePAIRing the Student Nurse Journey: Empowering Interrupted Students Through Innovative Support Strategies", British Journal of Nursing, 33(18) (2024), 884-889.
[153] Op. cit., Hallwood; op. cit., Harrison et al.; op. cit., Jackson.

Theme 7: CPD and Career Development

This section examines the barriers preventing healthcare professionals from accessing career progression and continuing professional development opportunities. It explores how structural bottlenecks, funding constraints, and systemic inequalities in CPD access contribute to high turnover and leave the NHS workforce underprepared for evolving healthcare demands.

Key emerging implications for policymakers:

- Career progression bottlenecks across multiple professions, from nursing band transitions to oversubscribed specialty training posts, drive experienced staff out of the NHS; the 10 Year Health Plan's commitments on personalised career development and new specialty posts do not yet address the structural causes of these barriers
- Insufficient protected time and fragmented funding prevent practitioners from completing CPD even where opportunities exist, with some staff completing mandatory development in their own time; sustainable funding models with clear accountability are needed
- CPD access is inequitably distributed across ethnicity, disability, gender, and geography, meaning existing workforce representation gaps are compounded at every career stage; current reform proposals do not adequately address these equity dimensions
- Reforms to the Growth and Skills Levy and Integrated Care System fund transfers present a timely opportunity to advance the flexible, modularised CPD frameworks stakeholders called for, but implementation detail for healthcare is absent and equity barriers remain unaddressed

Career progression barriers and inadequate CPD access contribute to high turnover

Unclear career pathways and limited development opportunities contribute to high leaver rates within the NHS.[154] This was explicitly recognised in the 10 Year Health Plan, which committed to personalised career development plans for all NHS staff. Despite this commitment, there are significant barriers to career progression and CPD access.

[154] Ibid.; BDA The Association of UK Dieticians, "Strengthening and Diversifying the Dietetic Workforce: Invest. Expand. Improve" (London: BDA).

In some professions, such as allied health professions, CPD is less structured with fewer upskilling hours due to limited opportunities and insufficient governance.[155] Career bottlenecks exist across multiple professions. The Band 4 to Band 5 nursing transition represents a key barrier, along with lack of upward progression for Nursing Associates, healthcare assistants, care workers, and T-Level holders.[156]

Training Bottlenecks

- In 2025 specialty training in medicine received 91,999 applications for 12,833 posts (a 7:1 ratio), marking a 54.1% increase from 2024's 59,698 applications while posts only increased by 0.7%.[1]
- More than 56,000 nurses in England have been at band 5 for more than seven years, representing one in seven of all nurses.[2]
- Band 5 nurses are estimated to be 17% more likely to leave NHS hospital and community services compared to those at band 6.[3]

Figure 13: Training Bottlenecks. 1. British Medical Association, "All-Party Parliamentary Group Health Education and Training Inquiry: BMA submission to the call for evidence," November 2025. 2-3. Royal College of Nursing, "Left Behind: a review of evidence on the career progression of NHS nurses," December 2025.

Doctors need to complete specialty training to achieve a Certificate of Completion of Training (CCT), which allows access to consultant or GP roles. However, these programmes are significantly oversubscribed.[157] Doctors who do not secure specialty training posts often take locally employed doctor (LED) contracts, but may not receive training in the skills that hospitals need.[158] The 10 Year Health Plan acknowledged the specialty post challenge and committed to creating 1,000 new specialty training posts. The Medical Prioritisation Bill also prioritises specialty training offers for doctors who have completed UK training programmes or have significant NHS experience.[159] However, stakeholders questioned whether the expansion will sufficiently address critical shortages and highlighted that LED contributions remain under-recognised.

In other professions, contract structures provide limited incentives for upskilling.[160] For example, dentists and pharmacists have reported being keen to upskill but feeling demotivated.[161] The 10 Year Health Plan committed to working with trade unions and employers on significant contractual changes. However, the Plan does not detail how these contractual changes will address the progression barriers identified in submissions.

[155] Op. cit., McKenna; op. cit., The Chartered Society of Physiotherapy.
[156] Ibid.; R. King, T. Ryan, E. Wood, A. Tod, and S. Robertson, "Motivations, Experiences and Aspirations of Trainee Nursing Associates in England: A Qualitative Study", BMC Health Services Research, 20(1) (2020), 802.
[157] See for example: Marcus Shynes, Association of Anaesthetists, written evidence, November 2025; Katherine Woolf, UCL Medical School, written evidence, November 2025; op. cit., British Medical Association.
[158] General Medical Council, written evidence, November 2025; op. cit., Woolf; op. cit., British Medical Association.
[159] UK Parliament, "Medical Training (Prioritisation) Bill," Government Bill, House of Commons, Session 2024-26, last updated 23 February 2026.
[160] See for example: Op. cit., Brown; D. Evans, I. Mills, L. Burns, M. Bryce, and S. Hanks, "The Dental Workforce Recruitment and Retention Crisis in the UK", British Dental Journal, 234(8) (2023), 573-577.
[161] Ibid.

Examples of Good Practice: Career Pathways and Progression

Allied Health Professional Enhanced Practice Apprenticeship Pilot: Launched in September 2025 in partnership with NHS England, the programme creates structured career progression routes for Allied Health Professionals across four pillars of practice (clinical, leadership, education, and research). The pilot addresses workforce gaps through funded, flexible pathways that improve retention and job satisfaction while embedding inclusivity and digital capability.[1]

Powys Aspiring Nurse Programme: Part-time distance learning degree programme in Powys Health Board undertaken while working as a Healthcare Support Worker. The programme enables existing healthcare support workers to progress to registered nurse status without leaving employment.[2]

Elevate Leadership Development Programme: NHS England programme for ethnic minority neonatal nurses and midwives preparing for senior leadership roles. The programme teaches about allyship and dealing with racism, addressing barriers to leadership progression for underrepresented groups.[3]

Figure 14 - Examples of Good Practice: Career Pathways and Progression. 1. John McKenna, University of Salford response to the Higher Education Commission: Health Education and Training Inquiry Call for Evidence, November 2025. 2. Ian Mathieson, Health Education and Improvement Wales (HEIW) response to the Higher Education Commission: Health Education and Training Inquiry Call for Evidence, November 2025. 3. Leona Letts, NHS Race and Health Observatory response to the Higher Education Commission: Health Education and Training Inquiry Call for Evidence, November 2025.

Insufficient capacity and funding prevent CPD completion

When CPD and career progression opportunities are available, capacity and funding barriers prevent access.

Insufficient protected time and capacity: Service pressures consistently deprioritise education and professional development.[162] Some professionals end up using their own time to complete CPD required to remain clinically safe.[163]

Financial barriers: There are significant financial barriers including hidden costs beyond direct fees, inconsistent CPD budgets across service providers, and lack of dedicated funding streams.[164] Practitioners often rely on competitive grants, scholarships, or loans to access CPD.[165] Funding models overlook costs of mentor training, creating difficulties for practitioners seeking to become educators.[166]

[162] See for example: Op. cit., Brown; op. cit., Holden; op. cit., British Medical Association; Royal College of Midwives, "Position Statement: Advanced Practice in Midwifery" (London: Royal College of Midwives, July 2024).
[163] The Royal College of Speech & Language Therapists, "A Profession Under Pressure: Speech and Language Therapy Retention and Waiting Time" (London: The Royal College of Speech & Language Therapists, July 2025).
[164] Op. cit., Viney; op. cit., Holden; op. cit., Association of British Paediatric Nurses.
[165] Ibid.
[166] Op. cit., McKenna.

Inequalities in CPD access compound representation gaps across professions

Submissions identified inequalities in CPD access and completion across multiple dimensions:

- Ethnic minority staff and those from disadvantaged backgrounds described facing significant barriers to completing CPD.[167] They also reported discriminatory experiences that impact whether practitioners apply for opportunities and whether they succeed.[168]
- Submissions suggested that revalidation and CPD processes disproportionately affect disabled registrants and ethnic minorities.[169]
- Submissions noted staff working less than full time, who are more likely to be women, are less likely to access and complete CPD, contributing to gender-based underrepresentation in career advancement.[170]
- Stakeholders highlighted significant inconsistencies across UK nations in CPD regulation, monitoring, and roles, creating challenges for workforce mobility and equitable access.[171]
- Studies show geographic inequalities between urban and non-urban areas, with London overrepresented in opportunities while some regions and rural areas are underserved.[172]

Introducing more flexible, modularised CPD could support career progression and continuous upskilling.[173] This includes removing barriers to pausing and rejoining training programmes, and facilitating moves between part-time and full-time working.[174]

Some stakeholders suggested moving away from set hourly requirements measuring 'inputs' towards a model based on professional ownership with freedom to tailor learning to individual development needs.[175] It was also suggested that a broader range of activities, like teaching, leadership, and research, could count toward professional development.[176]

[167] Ibid.
[168] Ibid.
[169] Op. cit., Professional Standards Authority.
[170] Op. cit., Shynes.
[171] See for example: Op. cit., Letts; op. cit., Brown; W. Palmer, L. Schlepper, N. Hemmings, and N. Crellin, "The Right Track: Participation and Progression in Psychology Career Paths" (July 2021).
[172] Ibid.
[173] Op. cit., Gale et al.; op. cit., Shynes; op. cit., Royal College of Midwives, "Position Statement: Advanced Practice in Midwifery".
[174] Ibid.
[175] Op. cit., Sassoon; op. cit., Reynolds; op. cit., General Dental Council.
[176] Ibid.

Recent policy developments may provide opportunities to address some of these gaps. The Autumn Budget announced reforms to the Growth and Skills Levy, expanding eligible spending to include modular courses and bootcamps from April 2026, alongside enabling fund transfers across Integrated Care Systems.[177] These reforms could support the flexible, modularised CPD frameworks stakeholders called for and enable more coordinated workforce planning. However, implementation details for healthcare education remain unspecified, and the Budget does not address how these reforms will tackle the equity

Examples of Good Practice: Flexible CPD Delivery Models

University Centre South Devon College-Based CPD with Devon Partnership NHS Trust: Two modular Level 5 CPD pathways designed specifically for mental health workforce, offering flexibility, local access, and practice-centred learning. The programme widens participation and remains agile to changing workforce needs.

Devon Partnership Trust Physical Health Skills Courses: Partnership between Devon Partnership Trust and University Centre South Devon offering two-level course structure (Fundamental and Advanced Physical Health Skills) at Level 5. The programme uses 50% face-to-face simulation with high fidelity simulated patients and 50% remote e-learning, with a train-the-trainer cascade model evaluated using the Kirkpatrick Model.

Figure 15 - Examples of Good Practice: Flexible CPD Delivery Models. Both examples from Ella Reynolds, University Centre South Devon/South Devon College response to the Higher Education Commission: Health Education and Training Inquiry Call for Evidence, November 2025.

barriers in CPD access identified in submissions.

Beyond access and equity challenges, the content gaps identified in initial curriculum - insufficient training in leadership, digital literacy and AI, and research engagement - remain unaddressed through CPD. This means practitioners at every career stage lack critical skills for modern healthcare delivery, from newly qualified staff through to senior positions. These persistent gaps compound workforce challenges and limit the NHS's ability to develop the leadership, digital competencies, and research-informed practice needed for effective healthcare delivery.

Without addressing these structural, financial, equity, and content barriers to career progression and professional development, the NHS will continue to lose experienced staff and fail to equip its workforce with the skills needed for evolving healthcare demands.

[177] HM Treasury, "Budget 2025," November 2025.

Looking Ahead

This interim report surfaces consistent and interconnected challenges across the healthcare education and training pipeline. As the NHS 10 Year Health Plan moves toward implementation, and ahead of the forthcoming final report and detailed recommendations, several cross-cutting priorities demand urgent attention from policymakers and system leaders.

Emerging implications for policy and practice

- The 10 Year Health Plan's workforce expansion ambitions cannot be delivered without addressing upstream constraints in training capacity, placement supply, and educator workforce that this evidence identifies as fundamental bottlenecks
- Widening participation commitments will not translate into meaningful outcomes if financial barriers at application, during study, and at the point of graduation remain unaddressed
- Structural reforms to DHSC, NHS England, and Integrated Care Boards will not improve strategic alignment of training capacity with service need without investment in robust, shared workforce data infrastructure
- As international recruitment pipelines face increasing risk, contingency planning for domestic training capacity is urgently needed, particularly for smaller and vulnerable professions where current supply is insufficient to absorb potential shortfalls
- The NHS cannot retain the experienced professionals it has trained while career progression bottlenecks, CPD inequities, and poor working conditions at the point of qualification continue to drive staff toward private practice or overseas employment

Emerging areas for action

The final report will set out detailed and actionable recommendations. In advance of these, the evidence points to the following priority areas across system actors.

UK Government: Address the financial sustainability of healthcare education at both institutional and student level, and take a more active role in raising public awareness of healthcare careers and the diversity of roles available across the workforce.

Devolved governments: Ensure adequate capacity and infrastructure for workforce mapping, planning, and training coordination within each nation, enabling more responsive and needs-led approaches to healthcare education and workforce development, including the development of regional training pipelines that better reflect local workforce needs.

Regulators: Create the conditions for curriculum innovation by reducing regulatory uncertainty and reviewing proficiency requirements to ensure they reflect the realities of contemporary practice.

NHS England and Integrated Care Boards: Take a stronger strategic role in coordinating placement capacity, aligning workforce planning with training supply, and ensuring equitable access to career development and CPD across regions and professions.

Education providers: Work in closer partnership with NHS employers and system leaders to strengthen widening participation approaches, identify barriers to flexible entry, and ensure curricula reflect the skills and competencies the NHS will require of its future workforce.

All system actors: Establish clearer cross-system governance and coordination mechanisms to align the efforts of government, regulators, employers, and education providers around shared workforce planning goals.

Annex

Acronyms

Acronym	Meaning
AI	Artificial Intelligence
AHP	Allied Health Professions / Allied Health Professionals
APHG	All-Party Parliamentary Health Group
CCT	Certificate of Completion of Training
CPD	Continuing Professional Development
DHSC	Department for Health and Social Care
GP	General Practitioner
HEC	Higher Education Commission
ICB	Integrated Care Board — a statutory NHS organisation responsible for planning and commissioning health services for a defined population area in England.
LED	Locally Employed Doctor
NHS	National Health Service
OfS	Office for Students

Organisations, Programmes and Reviews

Name	Description
Alan Milburn Review	An independent review, commissioned by the UK Government, examining post-16 health and care career education. Its findings are expected to inform future policy on widening access to healthcare careers and reforming career education pathways.
All-Party Parliamentary Health Group (APHG)	A cross-party parliamentary group bringing together MPs, Peers, and external stakeholders to examine health policy. The APHG is co-convening this inquiry alongside the Higher Education Commission.
Department for Health and Social Care (DHSC)	The UK government department responsible for health and adult social care policy in England.
Growth and Skills Levy	A reformed version of the Apprenticeship Levy, announced in the Autumn Budget 2025.
Higher Education Commission (HEC)	An independent cross-party body that conducts evidence-based inquiries into higher education policy and practice. The HEC is leading this inquiry into healthcare education and training in partnership with the APHG.
Integrated Care Boards (ICBs)	Statutory NHS bodies in England responsible for planning and commissioning health services across an integrated care system (ICS).
Leng Review	An independent review lead by Professor Gillian Leng into the physician associate and anaesthesia associate professions.
Medical Prioritisation Bill	Proposed UK legislation that would prioritise specialty training offers for doctors who have completed UK training programmes or have significant NHS experience.
Medical Training Review	A formal review of the medical training pathway in the UK.
NHS 10 Year Health Plan	Published in July 2025, this government plan sets out a long-term framework for transforming NHS services, expanding the workforce, and shifting care toward community and neighbourhood settings.

NHS England	The arm's-length body responsible for overseeing and commissioning NHS services in England.
NHS Long Term Workforce Plan	Published in June 2023, this plan set out ambitions to train, retain, and reform the NHS workforce over a 15-year period.
Office for Students (OfS)	The independent regulator of higher education in England. The OfS manages the Strategic Priorities Grant, which provides funding to universities for activities that tuition fees alone do not cover, including healthcare programme delivery.
Strategic Priorities Grant	A funding stream managed by the Office for Students and allocated to higher education institutions to support activities with strategic value, including the additional costs of delivering healthcare programmes.
T-Levels	Two-year technical qualifications for 16–19-year-olds in England, equivalent to three A-Levels, designed to provide a mix of classroom learning and industry placements.