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All-Party Parliamentary Health Group

Higher Education Commission

Trained for Tomorrow

A Plan for the Future NHS Workforce

July 2026

Education & Skills

July 2026

This report was written by Rhiannon Tuckett-Jones.

The views in this report are those of the author and Policy Connect. Whilst these were informed by the contributors to our inquiry, they do not necessarily reflect the opinions of those individuals and organisations.

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Policy Connect
83 Victoria Street
London
SW1H 0HW

www.policyconnect.org.uk

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Foreword

The NHS is the institution that people in this country rely on at the moments that matter most. It is also an institution under considerable pressure. Waiting lists remain high. Workforce shortages are acute and, in some professions, worsening. Rural, coastal, and remote communities face particular difficulties attracting and retaining the staff they need. And the pipeline of skilled professionals that the NHS depends on, trained, supported, and developed through a complex network of universities, further education colleges, NHS trusts, and regulators, is not functioning as well as it should.

This inquiry was grounded in an understanding of the vital and often under recognised role that education institutions play in the development of NHS staff. Universities and colleges are not peripheral to the workforce challenge; they are the foundation on which any sustainable pipeline of skilled professionals depends. A student who cannot access or afford a healthcare degree, a graduate who cannot secure a training post near where they live, a clinical educator who leaves academia because the financial case does not hold, each represents a systemic gap that accumulates over time into the structural shortages now facing the NHS.

Students from disadvantaged backgrounds described the financial pressure of placement costs, longer term times, and the weight of significant debt. Practitioners spoke of wanting to move into education roles but finding pay differentials and a lack of clear pathways too great a barrier. Regional leaders described coordinating workforce planning without the data or institutional mechanisms to support it. Across oral sessions, written submissions, student focus groups, and university visits, a consistent picture emerged: a system with real pockets of innovation and genuine commitment, but without the coordination infrastructure, funding architecture, or strategic direction needed to make those strengths work together at scale.

This report makes a series of ambitious but achievable recommendations. They include a national forum to align workforce planning across regulators, universities, and NHS bodies; regional coordination structures that give integrated care boards the tools to plan for their populations; a student loan repayment scheme modelled on what already works in teaching; formal regulatory recognition for simulation-based learning; and organisation-wide approaches to CPD that distribute development opportunities equitably across the workforce.

This Government has set out an ambitious vision for the NHS: shifting care from hospital to community, modernising the workforce, and building a health service fit for the decades ahead. Education and training sit at the centre of that ambition. Without a well-functioning pipeline of skilled, supported professionals, the structural reforms being pursued cannot be fully realised. We are grateful to everyone who gave evidence, submitted written contributions, hosted site visits, or participated in our oral sessions. Their honesty and generosity in sharing their experience and expertise have shaped every recommendation that follows.

Lord Norton of Louth

Inquiry Co-chair

Professor Kathryn Mitchell

Inquiry Co-chair

Kevin McKenna MP

Inquiry Co-chair

Recommendations

Theme 1: Workforce Planning and Regional Pipelines

1. **The Department of Health and Social Care should establish a National Healthcare Workforce Development Forum to improve strategic coordination across the healthcare education and training system in England.**

a. The Forum should draw its membership from the following, operating on a voluntary and collaborative basis:

- Department of Health and Social Care
- Professional regulators
- Royal colleges
- Office for Students
- Universities and further education colleges
- Professional bodies (including mission groups such as the Council of Deans of Health and University Alliance)
- Private, independent, and voluntary sector providers
- Student representatives
- The Department for Education and Skills England should be invited to participate as collaborators, given their respective roles in further education funding and broader skills economy planning.

b. The Forum should act as a mechanism for regulators and education providers to identify and work through inconsistencies and duplication across the healthcare education system.

c. The Department of Health and Social Care should provide secretariat support and core funding to the Forum to ensure continuity of its work.

d. The Forum should publish an annual report setting out shared priorities and recommendations addressed to government, NHS bodies, regulators, and education providers. The Department of Health and Social Care should publish a formal response to each annual report within three months of its publication.

2. The Department of Health and Social Care and Integrated Care Boards should undertake workforce planning at the regional level.

a. Each integrated care board should undertake robust supply and demand modelling and workforce gap assessment, using consistent data standards across primary, secondary, and tertiary care settings, with findings made publicly available to enable scrutiny and inform national workforce planning.

b. Each integrated care board should develop a 5-year workforce strategy aligned with local health needs and national workforce planning priorities, with explicit consideration of cross-regional graduate flows and workforce redistribution to underserved areas.

c. ICB workforce strategies should be developed through joint planning with universities, further education colleges, and regional skills bodies, with shared responsibility for aligning training capacity, local employment pathways, and regional skills planning frameworks including Local Skills Improvement Plans.

3. The Department of Health and Social Care should develop a national strategy to increase healthcare educator capacity across all professions.

a. The Department of Health and Social Care should make targeted investments in early-career pathways into healthcare education and clinical academic roles across all professions, with protected time for teaching and research built into job planning frameworks.

b. Review the reward and recognition structures for healthcare educators and clinical academics. The review should assess whether current arrangements make education and academic careers financially competitive with purely clinical pathways.

c. Establish clear transition pathways for practitioners to move into education roles. Pathways should include teaching qualifications, mentoring, and induction programmes tailored to profession-specific contexts, with active outreach to practitioners from diverse backgrounds.

Theme 2: Awareness and Access

4. The Department of Health and Social Care should launch a national healthcare careers campaign.

a. The campaign should be sustained across multiple years, with a presence across television, digital platforms, social media, and outdoor advertising.

b. Targeted strands should be developed for professions facing low educational intakes or public awareness deficits, particularly smaller allied health professions, nursing specialities, and pharmacy.

c. The campaign should showcase diverse career pathways and the positive experiences of those working across the NHS.

d. The campaign should include a strand delivered in partnership with the Department for Education, promoting healthcare careers through schools and further education colleges, drawing on existing resources including the NHS Health Careers portal.

5. The Department of Health and Social Care should introduce a student loan repayment reimbursement scheme for NHS healthcare professionals.

a. The scheme should be modelled on the existing teacher student loan reimbursement scheme, enabling healthcare professionals to claim back the student loan repayments they made through PAYE in each year of qualifying NHS service.

b. Priority weighting should be given to those working in underserved geographic areas, shortage specialities, or roles facing the most acute recruitment and retention pressures, with eligible areas and specialities defined by reference to existing indices including NHS workforce shortage data, the Index of Multiple Deprivation, and NHS England rurality classifications.

c. The Department of Health and Social Care should ensure the scheme is actively communicated to prospective students and newly qualified NHS professionals, with clear and accessible guidance on eligibility and the claims process available in one place.

Theme 3: Entry Routes and Flexible Pathways

6. The Department of Health and Social Care, Department for Education, and integrated care boards should expand and improve healthcare degree apprenticeship provision.

a. The Scheme should be modelled on the existing teacher student loan reimbursement scheme, enabling healthcare professionals to claim back the student loan repayments they made through PAYE in each year of qualifying NHS service.

b. The Department of Health and Social Care and NHS England should develop a dedicated funding mechanism to cover employer backfill costs during healthcare apprenticeships.

c. A single accessible information and signposting portal should be developed presenting apprenticeship and university routes to healthcare careers clearly and comparably. The portal could be part of, or integrated with, existing student-facing resources such as Skills England's occupational maps.

d. Clear progression routes should be embedded in all apprenticeship frameworks, from lower-level entry points through to registered professional qualifications, with consistent quality standards across programmes to address misconceptions about apprenticeship routes relative to traditional degree pathways.

7. Universities, further education colleges, and the Department of Health and Social Care should create flexible study pathways across all healthcare professions.

a. Universities should review and reform admissions practices to move beyond traditional academic entry requirements as a proxy for capability, recognising professional experience, vocational qualifications, and alternative route qualifications.

b. Expanded part-time and blended learning options should be developed, combining online delivery with intensive block teaching to enable students to maintain employment or caring responsibilities whilst studying.

c. Modular programme structures should be introduced that allow students to pause, resume, and vary the intensity of study as personal circumstances require, with clear and supported re-entry pathways for those who need to step away temporarily.

Theme 4: Theoretical Teaching

8. Professional regulators should make it faster and simpler for education providers to update their curricula across all healthcare professions, building on reform processes already underway.

a. Regulators should develop and publish a shared framework for curriculum innovation across all healthcare professions, setting out clear expectations for innovative teaching methods, assessment approaches, and programme structures including blended and simulation-based delivery.

b. Where pre-approval processes for curriculum changes exist, these should be streamlined, reducing the time and administrative burden on education providers seeking to implement innovations.

Theme 5: Practice Learning

9. Integrated Care Boards, supported by the Department of Health and Social Care, should establish regional placement coordination networks aligned with national placement and workforce planning requirements.

a. Each integrated care board should undertake a systematic mapping of current placement capacity across all settings, including acute hospitals, primary care, community services, mental health services, social care, public health, voluntary sector, and independent sector providers.

b. Formal placement coordination structures should be established based on that mapping, bringing together universities, NHS trusts, primary care networks, social care providers, voluntary sector organisations, regulators, professional bodies, and student representatives to align placement provision with local service needs and workforce development priorities.

c. Local placement funding allocation decisions should be published, including how tariff funding is distributed across settings and providers within each integrated care board, enabling scrutiny of whether funding reaches the providers bearing the cost of supervision and whether it adequately covers those costs.

d. Regional placement coordination networks should engage with university student support, disability, and hardship services to ensure that financial, wellbeing, and accessibility barriers to placement participation are identified and addressed.

10. Professional regulators should ensure simulation-based learning is formally recognised as a valued and quality-assured complement to clinical placement hours, building on existing outcome-focussed frameworks where these already enable its use.

a. Regulators should formally recognise simulation-based learning in each profession in turn, beginning with those where the evidence base is strongest and extending recognition across all healthcare professions as the evidence develops.

b. Simulation hours that count toward proficiency and practice learning requirements should only be delivered by providers meeting defined quality standards, aligned with those set out by the Association for Simulated Practice in Healthcare (ASPiH).

c. An ongoing evaluation mechanism should be built in to capture data on student outcomes, service pressures, and patient outcomes, informing both the evidence base for regulatory decisions and decisions about where simulation can most effectively complement clinical placement capacity.

Theme 6: Career Development

11. **The Department of Health and Social Care, NHS employers, universities, and CPD providers should address inequity in CPD access across all healthcare professions.**

    a. NHS employers should develop organisation-wide CPD strategies that distribute access equitably across the workforce, moving away from approaches that rely on individual initiative.

    b. The Department of Health and Social Care should commission a review of NHS CPD funding rules, examining how to remove structural barriers to access, and mitigate the impact of recent apprenticeship funding changes including the defunding of leadership and management standards.

    c. CPD providers should expand flexible and online delivery options that enable participation outside standard working hours and reduce the need for travel, with particular attention to professions and geographic areas currently underserved by in-person provision.

Introduction

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, regulation, 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 has produced a series of evidence-based recommendations for national and local government, the NHS, education providers, and education sector partners.

The NHS faces significant challenges that form the backdrop to this inquiry. 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.

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]
- 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]

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.

Policy Landscape

The NHS Long Term Workforce Plan (LTWP) (June 2023) set out ambitious targets to train, retain, and reform the healthcare workforce. The inquiry that informed this report was initially launched to assess the progress of the LTWP, and ahead of the anticipated NHS 10 Year Health Plan.[1] Since then there have been a series of key policy developments, including 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] This report is designed to complement and inform these ongoing policy developments, with findings intended to shape the next iteration of the 10 Year Plan.

Key Policy Announcements

June 2023: NHS Long Term Workforce Plan[1]

- Train: Major expansion in training places across healthcare
- 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:** A three-year programme to update and reform healthcare education curricula, with greater emphasis on digital and AI skills, alongside a review of medical education to address training bottlenecks and educator capacity

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.

- **Workforce expansion and wellbeing:** New wellbeing standards, expanded flexible working, additional nursing apprenticeships and medical specialty training posts for doctors 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

2026: Next Workforce Plan (expected)

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.

Inquiry Overview

This inquiry began in Summer 2025, with a scoping session held in Parliament. This brought together key stakeholders from across the healthcare education landscape to define the inquiry's focus and scope. A steering group of sector experts was established following this session, providing ongoing guidance on the inquiry's direction, reviewing draft recommendations, and contributing to the development of this report. The inquiry gathered evidence through a literature review, a public Call for Evidence, interviews and focus groups with students and staff, and three oral evidence sessions.

This report presents the inquiry's findings and recommendations across six thematic areas, drawing on the full body of evidence gathered. It is intended to provide policymakers, education providers, NHS employers, and regulators with a clear account of the structural challenges facing healthcare education and training, and actionable recommendations for addressing them. The recommendations are addressed to the bodies best placed to act on them, and are intended to be read as a connected set of interventions rather than isolated proposals.

Challenges and Recommendations

Theme 1: Workforce Planning and Regional Pipelines

Top Lines

Gaps in data infrastructure and strategic coordination are a fundamental barrier to effective workforce planning. There is no public, transparent assessment of supply and demand across all regulated health professions.

Regional workforce pipelines are underdeveloped and poorly aligned with local need, leaving rural, coastal, and remote areas chronically underserved.

The educator workforce is a critical and underacknowledged constraint on training capacity. Clinical educators are increasingly pulled into service delivery, and practitioners face significant structural barriers to entering academic roles, including pay differentials and insufficient CPD funding.

1.1 Inadequate data and strategic coordination limit workforce planning

Workforce planning challenges were identified across the inquiry as a fundamental barrier to the recruitment, retention, and progression of NHS staff. The 10 Year Health Plan commits to merging the Department of Health and Social Care (DHSC) and NHS England to reduce duplication and administrative burden, and to giving Integrated Care Boards (ICBs) a stronger strategic commissioning role.[3] We hope these reforms lead to positive changes, but contributors were clear that structural reform alone will not resolve the underlying misalignment between training supply and workforce need without accompanying investment in planning mechanisms that span the NHS, government, higher education institutions, and employers.

3. Department of Health and Social Care, “Fit for the Future: 10 Year Health Plan for England,” July 2025.

Workforce Planning and Regional Pipelines

Submissions identified tensions between market-driven approaches to higher education and the training requirements of the NHS, manifesting at multiple levels:

- Insufficient training capacity constrains supply in professions where workforce need
- Poorly planned training pathways leave graduates without sufficient posts to move into at the point of qualification, and insufficient routes to progress once employed.
- A misalignment between where training places are located and where the workforce is most needed leaves rural, coastal, and remote areas chronically underserved.

Gaps in the underlying data infrastructure compound these difficulties. Workforce projections frequently omit key demographic variables, including age profiles, expected retirements, retire-and-return intentions, and anticipated reductions in working hours. Predictable staffing pressures such as annual leave, statutory training, and sickness are not always accounted for, leaver destination data remains insufficient, and high attrition rates among both students and NHS staff further undermine planning accuracy.

Participants in the first oral evidence session highlighted how organisations such as the Centre for Workforce Intelligence (see Case Study 1) previously fulfilled this coordination function before being disbanded. Though some individual professional bodies, royal colleges, regulators, and universities collect detailed workforce data, as the Health and Care Professions Council (HCPC) Data Hub illustrates (see Case Study 2), this is not shared or used effectively across the system.

Case Study 1: Centre for Workforce Intelligence

The Centre for Workforce Intelligence (CfWI) was established in 2010 to support the Department of Health in evidence-based workforce policy for health and social care in England. Its methodology was transparent and publicly available, using a Delphi process to quantify key workforce variables through successive rounds of expert judgement, producing specialty-by-specialty supply and demand projections accessible to clinicians, planners, and the public.[1]

The CfWI operated from July 2010 until March 2016, when its functions transferred into the Department of Health and Health Education England.[2] As one participant in the inquiry's first oral evidence session observed, no public assessment of workforce supply versus demand has existed since. Work of this kind may continue within government, but it is no longer visible to the professions or the wider public.[3]

1. Pinto, Rodrigo, and others, "Strategic Workforce Planning in Healthcare: A Multi-Methodology Approach," European Journal of Operational Research 267, no. 3 (2018). 2. Lomas, Alexander, and others, "A Retrospective of System Dynamics Based Workforce Modelling at the Centre for Workforce Intelligence," paper presented at the 34th International Conference of the System Dynamics Society, July 2016. 3. Participant, Health Education and Training, Oral Evidence Session 1, 28 January 2026.

Case Study 2: Health and Care Professions Council (HCPC) Data Hub

Launched in May 2025, the HCPC Data Hub provides centralised, publicly accessible data on all 15 HCPC-regulated professions, representing over 360,000 registered professionals across the UK. Whilst regulators have collected significant information about registrants, this has not previously been accessible in a form readily usable for strategic planning.

The interactive platform gives stakeholders access to data on:

- registrant demographics, equality and diversity
- pre-registration programme numbers and
- retention dashboards tracking professionals leaving within the first four years of registration, filterable by profession, region, and demographic factors

Planned enhancements include pipeline analysis showing conversion rates from graduates to registered professionals and detailed leaver insights.

Source: Health and Care Professions Council (HCPC), response to the Higher Education Commission: Health Education and Training Inquiry, November 2025.

Workforce Planning and Regional Pipelines

Alongside gaps in data sharing and coordination, evidence highlights how policy churn creates further instability across the system. Decisions about programme design, student numbers, and infrastructure require timescales that current policy cycles do not support.

The consequences of this misalignment are already visible. The 10 Year Health Plan commits to reducing international recruitment to below ten percent by 2035, yet contributors identified inadequate contingency planning for the workforce depletion that could follow, particularly for smaller professions where domestic training capacity is insufficient to offset the reduction in international recruitment.[4] The Medical Prioritisation Bill, which prioritises UK graduates over international medical graduates in the allocation of specialty training posts, similarly illustrates the consequences of insufficient consultation with education partners.[5] The Bill did not account for students studying at international campuses of UK universities on General Medical Council-accredited qualifications: individuals who hold UK-recognised medical degrees but would not qualify as UK graduates under the Bill's terms, and whose training routes and career prospects were not considered when the policy was designed.

The 10 Year Health Plan signals government appetite for greater coordination between policymakers, employers and education and training providers but it stops short of proposing any institutional mechanism through which this might be achieved. The Higher Education Commission recommends filling that gap through the establishment of a dedicated national forum:

4. Department of Health and Social Care, "Fit for the Future: 10 Year Health Plan for England," July 2025.

5. UK Parliament, "Medical Training (Prioritisation) Bill," Government Bill, House of Commons, Session 2024-26, last updated 23 February 2026.

Recommendation 1: The Department of Health and Social Care should establish a National Healthcare Workforce Development Forum to improve strategic coordination across the healthcare education and training system in England.

a. The Forum should draw its membership from the following, operating on a voluntary and collaborative basis:
   - Department of Health and Social Care
   - Professional regulators
   - Royal colleges
   - Office for Students
   - Universities and further education colleges
   - Professional bodies (including mission groups such as the Council of Deans of Health and University Alliance)
   - Private, independent, and voluntary sector providers
   - Student representatives
   - The Department for Education and Skills England should be invited to participate as collaborators, given their respective roles in further education funding and broader

b. The Forum should act as a mechanism for regulators and education providers to identify and work through inconsistencies and duplication across the healthcare education system.

c. The Department of Health and Social Care should provide secretariat support and core funding to the Forum to ensure continuity of its work.

d. The Forum should publish an annual report setting out shared priorities and recommendations addressed to government, NHS bodies, regulators, and education providers. The Department of Health and Social Care should publish a formal response to each annual report within three months of its publication.

Workforce Planning and Regional Pipelines

The Forum is proposed as an England-level body, reflecting that health and education policy are devolved matters. A standing mechanism for sharing its annual priorities with devolved administrations would allow each nation to draw on shared intelligence while retaining full policy autonomy, with the appropriate channel to be determined by the Forum in consultation with devolved administrations.

The Forum proposed here carries no operational or commissioning functions; its purpose is coordination and strategic intelligence: surfacing inconsistencies, agreeing shared priorities, and publishing recommendations for government, NHS bodies, regulators, and education providers. DHSC secretariat support and core funding are proposed to give the Forum institutional grounding and ensure continuity of its work, including any analytical capacity needed to inform supply and demand modelling; without this, a purely voluntary arrangement risks losing momentum as priorities shift. The requirement for DHSC to formally respond to each annual report within three months provides an appropriate accountability mechanism, ensuring the Forum's recommendations are considered at ministerial level without requiring the Forum itself to have statutory powers.

The Forum should build on earlier precedents including the Health Education National Strategic Exchange and the Centre for Workforce Intelligence, and draw on international models such as Canada's pan-Canadian Health Human Resources Strategy (see Case Study 3).

Case Study 3: Canada's Pan-Canadian Health Human Resources Strategy

Health is a provincial and territorial matter in Canada, meaning no single federal body can direct workforce policy. The Framework for Collaborative Pan-Canadian Health Human Resources Planning was designed to support all jurisdictions in developing a sustainable health workforce, engaging educators, employers, funders, researchers, and providers while respecting each jurisdiction's responsibility for service delivery.[1]

An accompanying Action Plan addressed four areas:

- planning for the appropriate number and mix of healthcare professionals;
- working with employers and the education system on skills and competencies;
- achieving the right provider mix across care models;
- and building a sustainable workforce.[2]

The Government of Canada subsequently funded a Centre of Excellence for the Future of the Health Workforce, in partnership with the Canadian Institute for Health Information, to lead a pan-Canadian approach to data collection, analysis, and policy advice.[3] These mechanisms operate through shared data infrastructure and consensus-based recommendations rather than central direction, offering a directly applicable model for England's challenge of aligning health and education policy across regulators, royal colleges, and providers with different statutory remits.

1. Health Canada, A Framework for Collaborative Pan-Canadian Health Human Resources Planning (Ottawa: Health Canada, 2007). 2. House of Commons of Canada, Standing Committee on Health, Promoting Innovative Solutions to Health Human Resources Challenges, 39th Parliament, 2nd Session, Report 6 (Ottawa: House of Commons, 2008). 3. Government of Canada, Federal, Provincial and Territorial Statement on Supporting Canada's Health Workforce (Ottawa: Health Canada, 2023).

1.2 Regional workforce pipelines are underdeveloped and poorly aligned with local need

Alongside the challenges with national planning frameworks described above, the inquiry identified a lack of coherent regional workforce pipelines as a significant barrier for healthcare students and employers. Contributors across all three evidence sessions agreed that national strategies must be adaptive to regional variation, responding to the specific health needs, demographic pressures, and economic conditions of local areas, with strong emphasis on the

value of place-based partnerships between NHS trusts, universities, and further education colleges. The Hartlepool Health and Social Care Academy was cited as a model of what this can look like in practice (see Case Study 4).

Case Study 4: Hartlepool Health and Social Care Academy

Opened in September 2024 within the University Hospital of Hartlepool, the Hartlepool Health and Social Care Academy operates as a partnership between North Tees and Hartlepool NHS Foundation Trust, Hartlepool College of Further Education, and Hartlepool Borough Council, secured through £1.25 million from the Hartlepool Towns Deal Fund.

The Academy is one of a small number of facilities nationally to feature a purpose-built medical simulation suite, offering training across acute care, specialist clinical procedures, and community care.

Source: Hartlepool Borough Council, "Town Deal: Health and Care Skills Academy," accessed 1 April 2026.

Evidence from submissions and student engagement revealed a clear desire for regional workforce pathways that allow students to work where they trained or where they have existing family ties and support networks. However, current training provision and graduate employment structures do not consistently make this possible.

For professions such as medicine and dentistry, graduates can expect to access a funded postgraduate 'foundation' training post, which provides a structured transition from university into clinical practice. This offers some security at the point of graduation, but significant challenges with how these posts are allocated persist. In medicine, trainees were previously ranked and matched to posts based on their academic performance and preferences. This system has since been replaced by computer-generated random allocation, but this has not resolved concerns that graduates can be placed in training regions, known as deaneries, that cover large geographic areas, potentially far from where they live or have family ties. Short notice for these allocations adds further uncertainty, leaving graduates with limited time to plan around their personal circumstances or explore local career opportunities. The first phase of the Medical Training Review called for greater flexibility, but concrete models to address these challenges remain absent from both the review and the 10 Year Health Plan.[6]

6. NHS England. "The Medical Training Review: Phase 1 Diagnostic Report." October 27, 2025. https://www.england.nhs.uk/publication/the-medical-training-review-phase-1-diagnostic-report/., Department of Health and Social Care, "Fit for the Future: 10 Year Health Plan for England," July 2025.

Workforce Planning and Regional Pipelines

For other healthcare graduates, progression to clinical training posts is less certain and concerns about finding employment are widespread. Unlike medicine and dentistry, many healthcare professions require graduates to secure jobs in an open and competitive market. Financial pressures on NHS trusts have reduced the number of available positions in some professions and regions, making this harder still. Where opportunities do exist, pooled recruitment processes, where multiple employers recruit at the same time through a shared system, and narrow application windows limit flexibility for both students and employers.

Contributors highlighted that regional workforce pipelines must account for the full range of factors shaping where graduates choose to live and work. As evidence from the second evidence session in Bournemouth illustrated, workforce planning alone cannot resolve the challenge of attracting and retaining staff in areas where housing costs are high, transport links are limited, and populations are ageing.

> *"[In Bournemouth, Christchurch and Poole] the pressures we feel across the National Health Service are sharply reflected in our communities in particular because we are a coastal region, we have high housing prices and an ageing population... One of the questions I'm always asking is how do we attract people into healthcare and I think we can't tackle that as an individual organisation and that's why partnership is so important."*
>
> ***Councillor Millie Earl, Oral Evidence Session 2, 9 February 2026.***

Place-based approaches to hiring also carry benefits beyond NHS workforce capacity, with participants noting that enabling young professionals to remain in the regions where they trained or grew up could strengthen regional economies more broadly. The Higher Education Commission accordingly recommends strengthened regional workforce planning at integrated care board level:

Recommendation 2: The Department of Health and Social Care and Integrated Care Boards should undertake workforce planning at the regional level.

a. Each integrated care board should undertake robust supply and demand modelling and workforce gap assessment, using consistent data standards across primary, secondary, and tertiary care settings, with findings made publicly available to enable scrutiny and inform national workforce planning.

b. Each integrated care board should develop a 5-year workforce strategy aligned with local health needs and national workforce planning priorities, with explicit consideration of cross-regional graduate flows and workforce redistribution to underserved areas.

c. ICB workforce strategies should be developed through joint planning with universities, further education colleges, and regional skills bodies, with shared responsibility for aligning training capacity, local employment pathways, and regional skills planning frameworks including Local Skills Improvement Plans.

Both the NHS Long Term Workforce Plan (2023) and the 10 Year Health Plan (2025) identify ICB-level planning as the appropriate vehicle for addressing misalignment between training numbers, speciality distribution, and local health need.[7] Despite this consensus, no existing policy mandates formal five-year ICB workforce strategies with explicit alignment to higher education institution capacity, nor does any existing framework systematically include private, voluntary, and social care providers within regional workforce planning. Recommendation 2 addresses that gap directly.

Requiring ICBs to undertake publicly available supply and demand modelling as a prior step to strategy development ensures workforce strategies are grounded in evidence, enables national scrutiny, and supports management of cross-regional graduate flows toward areas where recruitment pressures are greatest. This regional modelling should feed directly into any national workforce intelligence function, including the kind of body proposed in

7. NHS England, “NHS Long Term Workforce Plan,” June 2023., Department of Health and Social Care, “Fit for the Future: 10 Year Health Plan for England,” July 2025.

Recommendation 1; equally, national supply and demand analysis should inform and calibrate ICB-level planning, creating a two-way relationship between regional and national data.

However, ambition must be grounded in the realities facing ICBs. The King's Fund (2024) found that while ICBs are beginning to build whole-system approaches to workforce development, progress has been slow.[8] Many systems are still developing basic data-sharing and governance infrastructure, and this recommendation therefore takes a phased approach.

Joint planning creates shared ownership of outcomes, with education partners bearing shared responsibility for delivery alongside NHS bodies. Regional pipelines should be designed around the needs of students and graduates, engaging with the full range of factors shaping where people choose to work, including housing, transport, and local economic opportunity, and developed in collaboration with Local Skills Improvement Plan bodies. Where modelling identifies workforce pressures, such as ageing populations in coastal communities or mental health needs in post-industrial areas, that intelligence should also inform curriculum design, a link explored further in Recommendation 9.

1.3 Educator workforce capacity constraints limit training across professions

Another critical system constraint under-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.

Educator shortages

- A General Medical Council report found that medical educators are more likely than other clinicians to be dissatisfied with their day-to-day work, to have worked beyond rostered hours at least once a week, and to find it difficult to provide sufficient patient care at least once a week.[1]
- Royal College of Nursing data paints an equally concerning picture: 75% of universities have been forced to reduce nursing staffing costs, a third of nurse lecturers are responsible for 80 or more students, and a quarter are considering leaving the profession.[2]

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.

8. The King's Fund. Realising the Potential of Integrated Care Systems: Developing System-Wide Solutions to Workforce Challenges. July 2024. https://assets.kingsfund.org.uk/f/256914/x/6709372a21/realising_potential_ics_report_2024.pdf

Workforce Planning and Regional Pipelines

Submissions to the inquiry identified multiple factors preventing practitioners from moving into educator roles or remaining in academic positions:

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

The clinical academic workforce is ageing, with insufficient replacement due to negative perceptions of the career pathway, cliff edges in clinical academic careers, and a lack of flexibility in career structures. Practitioners also described difficulties obtaining the CPD and qualifications required to become educators, with funding models not adequately accounting for the costs of training practitioners to supervise and assess students. There was broad agreement across the evidence sessions that these constraints are not properly acknowledged by government and NHS plans.

The Higher Education Commission recommends the development of a national strategy to address this:

Recommendation 3: The Department of Health and Social Care should develop a national strategy to increase healthcare educator capacity across all professions.

a. The Department of Health and Social Care should make targeted investments in early-career pathways into healthcare education and clinical academic roles across all professions, with protected time for teaching and research built into job planning frameworks.

b. Review the reward and recognition structures for healthcare educators and clinical academics. The review should assess whether current arrangements make education and academic careers financially competitive with purely clinical pathways.

c. Establish clear transition pathways for practitioners to move into education roles. Pathways should include teaching qualifications, mentoring, and induction programmes tailored to profession-specific contexts, with active outreach to practitioners from diverse backgrounds.

Outreach to practitioners from diverse backgrounds is also an important dimension of building educator capacity. An educator workforce that better reflects the diversity of the professions it trains is more likely to support inclusive teaching environments and broaden the range of role models available to students from underrepresented groups, reinforcing the widening participation goals that run throughout this report.

The three elements of this recommendation are mutually reinforcing: investment in early-career pathways creates the pipeline; reformed reward and recognition structures make those pathways financially viable; and clear transition routes with active outreach ensure the pipeline is both accessible and diverse. The strategy must be accompanied by dedicated investment. Previous workforce strategies have accurately diagnosed the challenges facing healthcare educators but have lacked the funding required for effective implementation. The strategy should build on innovative approaches already within the system, such as the Clinical Academic Internship Model, which demonstrates how structured, part-time transitions into education roles can deliver mutual benefit for NHS trusts, higher education institutions, and the students they train (see Case Study 5).

Case Study 5: Clinical Academic Internship Model

The Clinical Academic Internship Model was developed to address the limited availability of structured pathways for clinical staff seeking to move into academic and education roles. Under the model, NHS-employed nurses, midwives, and allied health professionals work at higher education institutions on a fractional basis, teaching clinical skills while maintaining NHS employment through honorary contracts.

The model was piloted between 2022 and 2023, with three experienced nurses from Queen Alexandra Hospital teaching clinical skills at the University of Portsmouth one day per week, before expanding across all South East England regions and across nursing, midwifery, and allied health professions in 2023 to 2024. It demonstrated effectiveness in creating a pipeline for staff transitioning to educational roles, offering a supported introduction to academic work, and generating mutually beneficial relationships between interns, universities, and NHS trusts.

Source: 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: Awareness and Access

Top Lines

- Access to healthcare programmes remains unequal across socioeconomic background, ethnicity, disability, and geography. Awareness of the full range of health careers is limited, particularly for smaller allied health professions, and there is no sustained cross-profession national careers campaign.
- Healthcare students face acute financial pressures beyond those affecting the wider student population, including placement costs, longer term times, and variable access to bursaries. For many students from disadvantaged backgrounds, the prospect of significant debt is itself a deterrent to applying.
- Existing financial support is inadequate and unequally distributed across professions. A student loan repayment reimbursement scheme for NHS professionals, modelled on the existing teacher scheme, would create an annual incentive tied to continued service and targeted at underserved areas and shortage specialities.

2.1 Access to healthcare programmes remains unequal across intersecting factors

Widening participation is not only an ethical imperative but a practical necessity: a healthcare workforce that better reflects the communities it serves is better placed to deliver equitable, high-quality care.

"Widening participation interventions are often framed as optional, 'nice-to-haves', or solely as an ethical/moral imperative rather than critical to financial sustainability, patient safety, and care quality... What we have evidenced repeatedly is that if widening participation interventions are equitably approached and implemented, we all stand to benefit: students, healthcare professionals, and patients."

Rini Jones, Senior Policy and Delivery Manager, NHS Race and Health Observatory, Oral Evidence Session 2, 9 February 2026.

Awareness and Access

Submissions to the inquiry identified multiple factors preventing practitioners from moving into educator roles or remaining in academic positions:

- Students from lower socioeconomic groups remain significantly underrepresented, particularly in highly competitive courses.
- Ethnic disparities in admissions persist across professions.
- Students with disabilities and neurodivergent students face additional challenges and remain underrepresented across multiple professions.
- Regional variation exists in applications, with London and the South East significantly over-represented.
- Mature students and students with caring responsibilities can find admissions more challenging.
- Gendered differences persist in some professions: nursing and midwifery, for example, experience significant male under-representation.

These access barriers exist alongside a separate but related recruitment challenge. Whilst competitive courses such as medicine and dentistry face oversubscription, other professions are struggling to recruit sufficient numbers, with university staff reporting recruiting “right up to the wire” for financial reasons and in some cases over-recruitment resulting in student numbers exceeding programme capacity.

Contributors linked recruitment shortfalls to sustained negative media coverage of the NHS, misconceptions about the nature of healthcare roles, and a lack of awareness of the range of health careers, particularly for smaller professions such as orthoptics, prosthetics and orthotics, and several arts therapies.

Students from widening participation backgrounds described a lack of information and guidance, limited confidence, difficulty accessing work experience, and insufficient support networks:

> *“As a mature student, I felt like there was no information. It was a case of, if I would like to do this I need to go find out how to do that for myself.”*
>
> ***Student, Oral Evidence Session 2, 9 February 2026.***

Awareness and Access

"[In college] I don't think I knew what occupational therapy was or really considered university. I'm the first woman, and the first person in my family for four or five generations to go to university."

Student, Oral Evidence Session 2, 9 February 2026.

Across the inquiry, a range of successful widening participation initiatives were identified:

- Admissions support and early outreach programmes.
- Work experience programmes, gateway courses, and foundation years.
- Mentoring schemes.
- Guaranteed interviews, reduced grade offers, and contextual admissions.

However, access to such initiatives remains uneven, clustering around large cities and a limited number of institutions.

Examples of good practice: widening participation and access

Brunel University and Imperial College London Medical Summer School: A 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: A GCSE-level science tutoring intervention for widening participation students. Evaluation evidence shows attainment in science increased more than in the comparison group, demonstrating the positive impact of targeted academic support.[1]

St George's University of London Primary Practice: A programme for Year 6 pupils supporting 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.[1]

RCN Wales Healthcare Connect Programme: A six-month work-based learning qualification designed for those wishing to study nursing or midwifery 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.[2]

(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) Ian Mathieson, Health Education and Improvement Wales (HEIW), response to the Higher Education Commission: Health Education and Training Inquiry Call for Evidence, November 2025.

Although the 10 Year Health Plan acknowledges the importance of widening participation, it does not address the awareness, information, and misconceptions about individual roles that continue to affect recruitment. The Higher Education Commission recommends that a sustained national careers campaign be established to address this:

Recommendation 4: The Department of Health and Social Care should launch a national healthcare careers campaign.

a. The campaign should be sustained across multiple years, with a presence across television, digital platforms, social media, and outdoor advertising.

b. Targeted strands should be developed for professions facing low educational intakes or public awareness deficits, particularly smaller allied health professions, nursing specialities, and pharmacy.

c. The campaign should showcase diverse career pathways and the positive experiences of those working across the NHS.

d. The campaign should include a strand delivered in partnership with the Department for Education, promoting healthcare careers through schools and further education colleges, drawing on existing resources including the NHS Health Careers portal.

No sustained, cross-profession national careers advertising campaign currently exists. The “We Are the NHS” campaign focusses primarily on nursing and does not adequately cover the breadth of healthcare careers, challenge gender stereotyping, or showcase the full range of available pathways.[9] Existing digital resources, including the NHS Health Careers portal, serve those already interested rather than reaching those who have not yet considered healthcare as a career.[10]

A national campaign would be an outward-facing intervention designed to reach people who have not yet considered healthcare as a career, with centrally developed materials supporting local and regional adaptation by colleges, universities, and health employers. This is an England-level proposal, though learnings should be shared across all four nations through the mechanism proposed in Recommendation 1.

There is domestic evidence that targeted awareness campaigns work, for example the Office for Students’ Strategic Interventions in Health Education Disciplines programme (2018 to 2021), which this recommendation draws on (see Case Study 6).

Case Study 6: Strategic Interventions in Health Education Disciplines

The £3 million Students’ Strategic Interventions in Health Education Disciplines programme focussed on four professions identified as vulnerable following the removal of the student bursary: orthoptics, podiatry, prosthetics and orthotics, and therapeutic radiography.

The programme combined a dedicated marketing campaign and website with a team of outreach officers who engaged over 25,000 young people and 1,500 educational professionals across 470 events. Applications across the four subjects increased by 31% over the programme period, with three of the four subjects recording increases of between 8% and 49%. Evaluators noted that direct attribution was difficult given concurrent factors including the reintroduction of NHS bursaries and the impact of COVID-19 on perceptions of healthcare careers.

Bringing together the Office for Students, Health Education England, professional bodies, and course providers stimulated activity beyond the programme itself. A Challenge Fund supported 15 innovative projects generating evidence on male student recruitment, mature student barriers, and the use of simulation in training. The majority of course leaders reported their courses felt less vulnerable by 2021 than in 2018.

Source: SQW, Evaluation of the Strategic Interventions in Health Education Disciplines Programme, report for the Office for Students, April 2021.

9. Department of Health and Social Care. We Are the NHS. 28 October 2022. https://campaignresources.dhsc.gov.uk/campaigns/we-are-the-nhs/

10. NHS. Take our Careers Quiz. Accessed March 2026. https://www.healthcareers.nhs.uk/FindYourCareer

The proposed campaign should go beyond recruitment messaging to challenge stereotypes and misconceptions, showcase the scientific and technical complexity of undervalued roles, and demonstrate the breadth of career pathways available beyond frontline practice into research, education, leadership, digital, and policy.

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

Improving awareness of healthcare careers cannot be implemented in isolation from the significant financial challenges facing healthcare students. Beyond the pressures facing all students, healthcare students face additional costs specific to their programmes: placement-related expenses, longer term times, and variable access to financial support. Many take on paid employment alongside their studies, with negative consequences for academic performance, mental health, and wellbeing.

Whilst financial support is available, it is often inadequate or unequally distributed 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.
- Where bursaries are received, they are often insufficient to cover living costs, and for some professions, such as medicine, moving onto the bursary creates a reduction in funding that coincides with the most demanding examination and placement periods.
- In some cases, bursaries interact with the benefits system in ways that disadvantage students.

For many students, the prospect of significant financial debt was itself a deterrent to applying.

"My main concern [before applying] was actually being able to afford the degree, and my mortgage and feeding my children at the same time. I knew if the funding wasn't enough or the loan wasn't enough I would have to drop out."

Student, Oral Evidence Session 2, 9 February 2026.

"I work part-time for a mental health facility and they sponsored me to come here; had I not had that sponsorship I'm not sure I would have come to university. It was such a huge amount of debt to take on, and whilst we say that this is a 'good debt', debt is debt, and I worried about it affecting things like getting onto the housing ladder."

Student, Oral Evidence Session 2, 9 February 2026.

Awareness and Access

Stakeholders across the inquiry highlighted that rising costs disproportionately affect students from disadvantaged backgrounds, limiting their ability to engage in the academic, leadership, and extracurricular opportunities that support career progression, compounding the access inequalities described in the previous section.

The 10 Year Health Plan made commitments to widening participation but did not address the cost of healthcare courses or structural challenges within the student loan and bursary system. The 2025 Autumn Budget introduced a number of changes:

- **Tuition fee loan caps rising** to £9,790 in 2026-27 and £10,050 in 2027-28.[11]
- **A maximum maintenance grant of £1,000** in years one and two and £750 from year three onwards for students from households earning at or below £25,000, tapering to £500 and £375 for incomes up to £30,000.[12]
- **Student loan repayment thresholds frozen** from 2027-28 at £28,470, meaning workers earning above that amount will face larger repayments than if thresholds rose with inflation.[13]

The changes to the maintenance grant were broadly welcomed by contributors to this inquiry. However, concerns remain that as minimum wage rates rise, more household incomes will exceed the eligibility thresholds for the grant, meaning some students from low-income families could lose entitlement to support not because their financial circumstances have materially improved, but because earnings have kept pace with wage growth. The combination of higher tuition fees and a frozen repayment threshold raises further questions about the scale of graduate debt and equity of repayment burdens. The forthcoming Treasury Select Committee inquiry on student loans is expected to focus on some of these structural challenges.[14] This inquiry's evidence demonstrates the particular impact of the current system on healthcare professionals, and the Higher Education Commission accordingly recommends introducing a targeted loan repayment scheme for qualified NHS staff:

11. HM Treasury, "Budget 2025," November 2025.

12. Ibid.

13. Ibid.

14. UK Parliament, Treasury Committee. "Student Loans: New Inquiry on Repayment Terms and the Taxation of Graduates Launches." March 12, 2026. https://committees.parliament.uk/committee/158/treasury-committee/news/212575/student-loans-new-inquiry-on-repayment-terms-and-the-taxation-of-graduates-launches/.

Recommendation 5: The Department of Health and Social Care should introduce a student loan repayment reimbursement scheme for NHS healthcare professionals.

a. The scheme should be modelled on the existing teacher student loan reimbursement scheme, enabling healthcare professionals to claim back the student loan repayments they made through PAYE in each year of qualifying NHS service.

b. Priority weighting should be given to those working in underserved geographic areas, shortage specialities, or roles facing the most acute recruitment and retention pressures, with eligible areas and specialities defined by reference to existing indices including NHS workforce shortage data, the Index of Multiple Deprivation, and NHS England rurality classifications.

c. The Department of Health and Social Care should ensure the scheme is actively communicated to prospective students and newly qualified NHS professionals, with clear and accessible guidance on eligibility and the claims process available in one

Debt relief as a means of attracting and retaining NHS professionals has been proposed by a range of organisations and has precedent across several comparable health systems (see example below). International evidence on such schemes shows that while they can be effective in attracting professionals to shortage areas, their impact on long-term retention is less certain, and some have created unintended consequences such as professionals leaving immediately after their service commitment ends, or sharp boundary effects where those just outside eligible geographic areas receive no benefit. Recommendation 5 does not seek to replicate those schemes directly. The case here rests specifically on the reimbursement model, which creates a sustained annual incentive tied to continued service rather than a one-off benefit, and carries more manageable and justifiable fiscal implications than upfront loan forgiveness or write-off.

Examples of existing and proposed debt relief programmes

Nuffield Trust and London Economics (2023): The Nuffield Trust and London Economics modelled a tiered loan forgiveness scheme for nurses, midwives, and allied health professionals, writing off 30% of loan balances after three years of NHS service, rising to 100% after ten years. The estimated cost of approximately £230 million per training cohort compared favourably to the £900 million cost of a 1% NHS pay increase.[1]

US National Health Service Corps Loan Repayment Program: Licensed primary care, dental, and behavioural health providers receive up to $75,000 in loan repayment assistance in exchange for a minimum two-year service commitment in a designated Health Professional Shortage Area, with award amounts weighted by shortage severity and speciality.[2]

Canada Student Loan Forgiveness: Canada's federal programme offers loan relief to healthcare professionals working in rural areas or communities of no more than 30,000 people, with awards tiered by profession from $15,000 to $60,000 over a maximum of five years. Eligible occupations were expanded in December 2025 to include pharmacists, physiotherapists, midwives, and social workers.[3]

NHS Wales Bursary Scheme: The NHS Wales Bursary Scheme covers full tuition fees and contributes to living costs for students on commissioned pre-registration healthcare courses, in exchange for a two-year post-qualification commitment to work in Wales. The model front-loads financial support during training rather than offering debt relief after qualification.[4]

1. Palmer, William, and others, Student Loans Forgiveness, policy proposal (London: Nuffield Trust, September 2023). 2. Health Resources and Services Administration, NHSC Loan Repayment Program, February 2026. 3. Government of Canada, Canada Student Loan Forgiveness, 31 December 2025. 4. NHS Wales Shared Services Partnership, Student Awards Services, 2026.

Recommendation 5 extends to healthcare the mechanism already established in teaching, where professionals in shortage subjects can claim back student loan repayments made through PAYE in each year of qualifying service.[15] Applying the same model to NHS healthcare professionals creates a meaningful annual financial benefit tied directly to continued service: administratively straightforward, fiscally incremental, and politically credible as an extension of existing policy.

15. Department for Education. "Teachers: Claim Back Your Student Loan Repayments." GOV.UK. Published 31 October 2019, last updated 2 March 2026. https://www.gov.uk/guidance/teachers-claim-back-your-student-loan-repayments

Evaluation of the teacher equivalent scheme offers useful lessons for design and implementation.[16] The scheme functioned as a positive factor in retention decisions for around 40% of eligible teachers, though workload and work-life balance were stronger determinants overall, and no statistically significant effect on retention rates was found in the DfE's analysis.[17] Its impact on recruitment was limited, with altruistic motivations consistently outweighing financial considerations. However, there are reasons to suggest greater traction in healthcare: training periods are longer, debt levels are typically higher, and the financial incentive is therefore likely to be more salient for prospective and newly qualified professionals. For the scheme to achieve its potential, it must run alongside the improvements to working conditions, wellbeing, and career development already underway through the 10 Year Health Plan. Financial incentives alone are unlikely to drive recruitment and retention where underlying conditions of service remain a concern.

The evaluation also found that awareness among eligible non-claimants was lower than among claimants, and that key communication channels such as school headteachers had limited knowledge of the scheme throughout the pilot period.[18] A dedicated communication strategy is therefore essential if the healthcare scheme is to reach those it is designed to benefit. DHSC should ensure information about the scheme is embedded in the national careers campaign proposed in Recommendation 4, communicated through university and further education college outreach, and included in standard onboarding materials for newly qualified NHS professionals. The claims process should be designed to be straightforward from the outset, with clear guidance on eligibility, the claims process, and payment timelines readily accessible in one place.

Targeting the scheme using graduated deprivation and rurality indices, rather than hard geographic boundaries, reduces the boundary effects that have undermined similar schemes internationally. Graduated indices produce fairer outcomes but can make it harder for students and graduates to understand at a glance where they would benefit most from the scheme. Clear, publicly available guidance setting out how weighting is calculated and which areas and roles attract higher reimbursement will therefore be essential to ensure the incentive is legible and effective for those it is designed to reach. Design of the scheme should also pay careful attention to professionals in NHS-adjacent roles in social care and the third sector, and to cross-border flows between England and the devolved nations, to avoid exacerbating workforce pressures in Scotland, Wales, and Northern Ireland.

16. CFE Research. The Teacher Student Loan Reimbursement Scheme: Final Evaluation Report. DFE-RR1323. London: Department for Education, 2023. https://assets.publishing.service.gov.uk/media/63ceb003d3bf7f3c4a199574/Teacher_student_loan_reimbursement_scheme_final_evaluation_report.pdf

17. Ibid.

18. Ibid.

Theme 3: Entry Routes and Flexible Pathways

Top Lines

- Apprenticeships have demonstrated strong outcomes for widening participation, workforce retention, and academic performance, yet remain underutilised across most healthcare professions. Funding constraints, administrative complexity, and limited awareness among students and employers all limit uptake, and neither the NHS Long Term Workforce Plan nor the 10 Year Health Plan adequately addresses these structural barriers.
- Flexible entry and study pathways remain underdeveloped across most healthcare programmes, disadvantaging mature students, career changers, and those with caring responsibilities. Universities should move beyond traditional academic entry requirements as a proxy for capability, and expand part-time, blended, and modular options that allow students to maintain employment or caring responsibilities alongside study.

3.1 Apprenticeships are underutilised despite their potential to widen participation

Across the inquiry, apprenticeships were consistently highlighted as having significant potential to widen participation and address the financial barriers described in the previous section. Stakeholders noted that apprenticeship routes help students avoid significant debt, widening access particularly for mature learners and those from disadvantaged backgrounds. Where apprenticeships are already in place, they have demonstrated positive results for student wellbeing and retention, and many students who had not been able to access apprenticeship routes expressed that they would have chosen this pathway had it been available and accessible to them.

"We know that 25% of maternity support workers want to be midwives; this is a wonderful pool of maternity workers that can progress through the apprenticeship route. The first midwifery degree apprenticeship started at the University of Greenwich and we know that this route provides workforce readiness, lower attrition, high motivation and they're a local pool of healthcare workers that will stay local."

Dr Heather Bower, Head of Midwifery Education, Royal College of Midwives, Oral Evidence Session 2, 9 February 2026.

Case Study 7: Registered Midwife Degree Apprenticeship

Evaluation by King's College London of the first Registered Midwife Degree Apprenticeship cohorts, beginning January 2020, found strong outcomes across widening participation, workforce integration, and academic performance. Over half of apprentices were first-generation university students, nearly one third were from Black or Black British communities, and almost all were previously employed as maternity support workers. Attrition rates of between 0% and 4% compared favourably with 13% on the traditional route, and all graduates were offered employment by their host employer. No difference in academic proficiency was found between apprentices and fee-paying students; both routes meet the same Nursing and Midwifery Council standards.

As one apprentice described it: "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."

Wider adoption remains constrained by backfill costs, loss of the NHS Education and Training Tariff during apprenticeship programmes, and limited awareness of the route within the profession.

Source: Royal College of Midwives and NHS England, "Registered Midwife Degree Apprenticeship Evaluation Report," September 2023.

Entry Routes and Flexible Pathways

Apprenticeships across healthcare professions face a common set of constraints:

- **Funding challenges and complex administrative processes:** Apprenticeship funding rules are difficult to navigate, with employers and universities often uncertain about what costs the levy covers and how to access it. The administrative burden of setting up and managing apprenticeship programmes places particular strain on smaller providers and NHS trusts with limited capacity to manage the process alongside service delivery.

- **Limited employer backfill support:** When a member of staff undertakes an apprenticeship, their employer must cover the cost of their absence from the workplace. Unlike traditional university routes, apprentices are employees, meaning trusts must either recruit temporary replacements or absorb the gap in staffing. Without dedicated funding to cover these backfill costs, many employers are reluctant to release staff onto apprenticeship programmes, limiting the number of places available.

- **A persistent lack of awareness:** Prospective students, employers, and school careers advisers often have limited knowledge of apprenticeship routes into healthcare, or hold misconceptions about their quality relative to traditional degree programmes. This limits demand from prospective applicants and supply from employers who might otherwise offer places.

The NHS Long Term Workforce Plan set an ambition to train one in six staff through apprenticeships within a decade, and the 10 Year Health Plan commits to creating 2,000 more nursing apprenticeships over the next three years, prioritising areas of greatest need.[19] However, neither plan adequately addresses the structural barriers identified in the evidence. Both plans also focus primarily on nursing, and do not extend their ambitions to the wider range of healthcare professions where apprenticeship routes exist or could be developed, but remain poorly supported.

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

The Higher Education Commission recommends that healthcare degree apprenticeship provision be expanded and improved:

Recommendation 6: The Department of Health and Social Care, Department for Education, and integrated care boards should expand and improve healthcare degree apprenticeship provision.

a. The Department of Health and Social Care and NHS England should secure the Level 7 health and care apprenticeship mitigation fund beyond its current 2029 end date, and expand its scope to cover all healthcare apprenticeships where Level 7 is a recognised qualifying route and workforce need can be demonstrated.

b. The Department of Health and Social Care and NHS England should develop a dedicated funding mechanism to cover employer backfill costs during healthcare apprenticeships.

c. A single accessible information and signposting portal should be developed presenting apprenticeship and university routes to healthcare careers clearly and comparably. The portal could be part of, or integrated with, existing student-facing resources such as Skills England's occupational maps.

d. Clear progression routes should be embedded in all apprenticeship frameworks, from lower-level entry points through to registered professional qualifications, with consistent quality standards across programmes to address misconceptions about apprenticeship routes relative to traditional degree pathways.

The Post-16 White Paper, released in October 2025, announced that from January 2026, Growth and Skills Levy funding for Level 7 apprenticeships would be restricted to those aged 21 and under.[20] Following intervention from NHS England, DHSC, and sector bodies, a mitigation fund was secured to continue funding five Level 7 healthcare apprenticeships until 2029.[21]

20. Department for Education, Department for Work and Pensions, and Department for Science, Innovation and Technology. "Post-16 Education and Skills White Paper." October 20, 2025. https://www.gov.uk/government/publications/post-16-education-and-skills-white-paper.

21. Department for Education. "The Growth and Skills Levy." GOV.UK. 1 August 2025. https://find-employer-schemes.education.gov.uk/interim/growth-and-skills-levy

While welcome, the fund is time-limited, covers only five professions, and operates outside the levy as a grant. This recommendation calls for it to be made permanent and extended to all healthcare apprenticeships where Level 7 is a recognised qualifying route and workforce need can be demonstrated. Securing this will require cross-departmental agreement, and DHSC and NHS England will need to make a robust costed case within the broader context of workforce development spending.

Backfill costs represent a separate but equally significant barrier. When an NHS employee undertakes an apprenticeship, their employer must cover the cost of their absence, either by recruiting a temporary replacement or absorbing the staffing gap. Without dedicated funding to address this, trusts face a structural disincentive to release staff onto apprenticeship programmes regardless of the availability of levy funding. Any costed case made by DHSC and NHS England should therefore include an assessment of the backfill funding needed to make apprenticeship expansion viable in practice. The design of any backfill funding mechanism should be developed in consultation with the Department for Work and Pensions, given its role in employment support and the potential interactions between apprenticeship participation and the wider benefits system.

On information and signposting, apprenticeships and university places currently operate through different recruitment systems. The immediate goal is ensuring prospective applicants can access clear, comparable information about both routes in one place. Rather than creating a new standalone portal, the most durable approach is to integrate health-specific apprenticeship information within existing national careers resources, particularly Skills England's occupational maps.[22]

Many prospective students, families, and careers advisers still perceive apprenticeships as lower quality than traditional degree programmes, despite evidence to the contrary. Recommendation 6 should therefore be read alongside Recommendation 4, which calls for a national careers campaign that showcases apprenticeship routes as credible pathways into healthcare careers. Steps regulators should take to support curriculum flexibility in apprenticeship contexts are addressed in Recommendation 9, and leadership and management apprenticeships are addressed in Recommendation 11.

22. Skills England. Occupational Maps. Accessed March 2026. https://occupational-maps.skillsengland.education.gov.uk/

3.2 Flexible entry and study pathways are insufficiently developed across healthcare programmes

The evidence also points to the need for greater flexibility within conventional programme structures, in terms of both admissions and course delivery, particularly for mature students, career changers, and those with caring responsibilities or from lower socioeconomic backgrounds.

While professional regulators do not mandate specific academic entry requirements, traditional qualifications have in practice often been used as the primary measure of capability. There was recognition across the evidence sessions that professional experience, vocational qualifications, and alternative route qualifications can be equally valid indicators of potential. Anglia Ruskin University's medical school offers an example of how admissions reform can extend access without compromising programme quality or graduate outcomes (see Case Study 8).

Case Study 7: Anglia Ruskin University Medical School

In 2025, Anglia Ruskin University (ARU) became the first UK university to accept T Level qualifications for entry onto an undergraduate medicine degree, with the first cohort due to start in 2026. Students holding T Levels in Health or Healthcare Science at Distinction level are eligible to apply, with the occupational specialism and industry placement treated as equivalent to traditional work experience. ARU is working with the Medical Schools Council and the Department for Education to advocate for wider adoption, with the admissions lead identifying T Levels as an untapped pool of approximately 7,000 students with no previous direct pathway into medicine.[1]

ARU's Widening Access to Medicine Scheme offers grade reductions and a 5% UCAT score uplift to applicants from disadvantaged backgrounds, including care leavers, recipients of free school meals, and those living in the bottom 20% of the Index of Multiple Deprivation. The scheme also includes a guaranteed interview regardless of UCAT score for eligible candidates and a free residential summer school.[2]

1. Newman, Kim, "Anglia Ruskin University to Accept T Levels for Medicine," Career Development Institute, 8 April 2026. 2. Anglia Ruskin University, "Widening Access to Medicine Scheme," accessed 1 April 2026.

Entry Routes and Flexible Pathways

Alongside admissions reform, evidence sessions highlighted the value of flexible course delivery for students who cannot sustain full-time, campus-based programmes. Mature students, career changers, those with caring responsibilities, and those from lower socioeconomic backgrounds are disadvantaged by models that assume continuous linear progression. Expanding part-time, blended, and modular options enables students to maintain employment alongside study and reduces the financial pressures of intensive full-time attendance, reinforcing the aims of Recommendation 8.

> *"This is the reality of how people will be working in today's world. Young learners don't want jobs for life; they want portfolio careers, they want to be able to choose their hours, and blended learning offers the opportunity to prepare for that. It also offers the opportunity for people coming into healthcare as a second career or people with caring responsibilities."*
>
> ***Henrietta Mbeah-Bankas, previously Head of Education Portfolio, NHS England, Oral Evidence Session 3, 25 February 2026.***

Despite the evidence that flexibility in entry and completion benefits recruitment and retention, such provision remains uneven across institutions and professions. The Higher Education Commission accordingly recommends:

Recommendation 7: Universities, further education colleges, and the Department of Health and Social Care should create flexible study pathways across all healthcare professions.

a. Universities should review and reform admissions practices to move beyond traditional academic entry requirements as a proxy for capability, recognising professional experience, vocational qualifications, and alternative route qualifications.

b. Expanded part-time and blended learning options should be developed, combining online delivery with intensive block teaching to enable students to maintain employment or caring responsibilities whilst studying.

c. Modular programme structures should be introduced that allow students to pause, resume, and vary the intensity of study as personal circumstances require, with clear and supported re-entry pathways for those who need to step away temporarily.

Entry Routes and Flexible Pathways

The Lifelong Learning Entitlement, which allows individuals to access student finance flexibly across their working lives rather than in a single block of study, has the potential to support the kind of modular, pause-and-resume participation this recommendation calls for. However, how it interacts with existing student loan entitlements is not yet straightforward, and some students who have already drawn on their loan allocation may find their access to further funding limited. Programme approval processes, which currently assume continuous linear study, will also need to be updated to accommodate modular delivery. Equally, institutions will need to build in dedicated support structures for students navigating interrupted study from the outset, rather than treating this as an exception to be managed on a case-by-case basis.

To support students who need to pause and re-enter programmes, we must provide financial support, institutional guidance, employer flexibility, and recognition of prior learning. The flexible pathways called for here are also intended to open routes from social care into registered healthcare professions; the coordination infrastructure needed to support placement capacity in those settings is addressed in Recommendation 11.

The scope for universities and colleges to act unilaterally is limited by regulatory hour requirements, programme approval processes, and proficiency standards. Recommendation 7 therefore depends on the regulatory reform called for in Recommendation 9: the shared framework for curriculum innovation should explicitly address flexible delivery, blended models, and recognition of prior learning. The two recommendations should be read and implemented together.

Theme 4: Theoretical Teaching

Top Lines

- Curriculum gaps across healthcare programmes leave graduates underprepared for clinical realities. Content on non-technical skills, interprofessional working, digital literacy, and diverse patient populations remains inconsistent, and course content does not adequately reflect the diversity of the populations students will serve.
- The 10 Year Health Plan commits to overhauling curricula within three years, but funding constraints, regulatory complexity, and poor coordination between course components and practice partners prevent innovation at the pace and scale required.
- Professional regulators should develop a shared framework for curriculum innovation, setting clear expectations for blended, simulation-based, and outcome-focussed delivery across all professions.

4.1 Funding constraints and regulatory complexity restrict innovation in curriculum design

Across submissions, the need to improve and innovate course content was raised as a consistent concern. Students report a disconnect between theoretical teaching and clinical realities, with persistent curriculum gaps affecting how well prepared graduates are for practice.

The need for curriculum reform was particularly highlighted in relation to diversity and representation. Course content does not consistently represent diverse populations or adequately address health inequities, and the 10 Year Health Plan, while committing to tackle inequalities in access and outcomes, does not detail how curricula will be reformed to embed this focus.[23]

23. Department of Health and Social Care, “Fit for the Future: 10 Year Health Plan for England,” July 2025.

Theoretical Teaching

"When we look at clinical curricula or textbooks, symptom descriptions and imagery overwhelmingly depict white skin tones, and this has real impacts on clinical practice. Representative curricula aren't optional, they're operationally necessary. It's a sustainability issue; the cost of racism to the system is staggering: the cost of delayed diagnosis, of culturally incompetent and unsafe care."

Rini Jones, Senior Policy and Delivery Manager, NHS Race and Health Observatory, Oral Evidence Session 2, 9 February 2026.

Beyond representation, four content areas were consistently identified where curriculum gaps limit students' preparation for practice:

1. **Non-technical skills:** Students feel underprepared in communication, prioritisation, and time management upon entering practice. The Leng Review (2025) called for formal management and leadership training built into undergraduate and postgraduate medical education, yet leadership teaching remains informal or is developed later in professional careers.[24]
2. **Interprofessional learning:** Many students feel insufficiently prepared for interprofessional communication and integrated care despite these being explicit regulatory outcomes. The 10 Year Health Plan frames team-based care as central to its new model of service delivery, yet does not detail how education will prepare students for this.[25]
3. **Career pathways:** Awareness gaps identified in Theme 2 extend into academic curricula, with certain specialisms, including general practice, receiving limited recognition despite significant workforce shortages.
4. **Digital literacy and AI preparedness:** The 10 Year Health Plan commits to making AI every nurse's and doctor's trusted assistant, yet students currently receive limited training in digital tools and AI-enabled healthcare delivery.[26]

These gaps mean graduates enter practice without skills the NHS requires, compounding the workforce pressures described in Theme 1. Some providers are already developing innovative approaches to address them (see Case Study 9), but these remain isolated examples rather than system-wide practice.

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24. Department of Health & Social Care, "The Leng review: an independent review into physician associate and anaesthesia associate professions," 24 July 2025.

25. Department of Health and Social Care, "Fit for the Future: 10 Year Health Plan for England," July 2025.

26. Ibid.

Case Study 9: Curriculum Innovation in Practice

HEARI Project (Healthcare Education to Address Racialised Inequities): An NHS Race and Health Observatory-commissioned project led by Canterbury Christ Church University in partnership with Melanin Medics and other higher education institutions and NHS partners. The project reviews teaching curricula and existing approaches with the aim of improving patient care and reducing health disparities.[1]

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

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.

The 10 Year Health Plan commits to overhauling education and training curricula over the next three years, but multiple barriers prevent innovation at the pace or scale that commitment requires.[27] Stakeholders identified three main limiting factors:

1. **Funding and capacity constraints:** Financial pressures make it difficult to pilot and embed new practices, (This compounds the educator capacity constraints described in section 1.3).
2. **Regulatory complexity:** Requirements are inconsistently interpreted across institutions, creating uncertainty about what changes are permissible even where regulators do not formally prohibit them.
3. **Communication and integration challenges:** Universities, placement providers, and regulators often work in isolation from one another. When one part of the system introduces changes, these are not always communicated to or aligned with the others, making it difficult to implement joined-up innovation across the education system as a whole.

27. Department of Health and Social Care, “Fit for the Future: 10 Year Health Plan for England,” July 2025.

The Higher Education Commission recommends that regulators act to accelerate curriculum flexibility across all professions:

Recommendation 8: Professional regulators should make it faster and simpler for education providers to update their curricula across all healthcare professions, building on reform processes already underway.

a. Regulators should develop and publish a shared framework for curriculum innovation across all healthcare professions, setting out clear expectations for innovative teaching methods, assessment approaches, and programme structures including blended and simulation-based delivery.

b. Where pre-approval processes for curriculum changes exist, these should be streamlined, reducing the time and administrative burden on education providers seeking to implement innovations.

Regulatory frameworks governing healthcare education vary considerably in how they approach curriculum innovation. Without a shared framework, providers navigating multiple regulatory relationships face inconsistent expectations and tend toward conservative programme designs even where regulators do not formally prohibit innovation. A shared framework, developed with education providers and professional bodies, would provide the clarity that currently does not exist. It would build on outcome-focussed regulatory models that set standards for what graduates must demonstrate rather than prescribing how programmes must be structured.

Education providers face a further burden in navigating health professionals and education regulators simultaneously. The requirements of the Office for Students (OfS) and bodies such as the Nursing and Midwifery Council (NMC) and HCPC do not always sit coherently alongside one another. The National Healthcare Workforce Development Forum proposed in Recommendation 1 is the appropriate vehicle for working through these tensions systematically.

Several significant reform processes are already underway: the HCPC launched a consultation on revisions to its Standards of Education and Training in 2025; the NMC is reviewing standards

inherited from the EU Directive on practice hours; and the 10 Year Health Plan commits to a three-year programme of curriculum reform.[28] The shared framework called for here is not an alternative to these processes but a mechanism for ensuring their outcomes are coherent, mutually reinforcing, and translatable into practice that education providers can act on with confidence.

Regulatory flexibility alone cannot drive innovation if financial infrastructure is inadequate. Placement tariffs do not function consistently across all settings, and simulation-based placements remain inconsistently recognised and funded. These questions are addressed in Recommendations 9 and 10, but the shared innovation framework should explicitly encompass these modalities so that regulatory and financial enablement develop in step.

28. Health and Care Professions Council. Consultation on Revisions to the Standards of Education and Training. Consultation, 17 November 2025 – 16 February 2026. https://www.hcpc-uk.org/news-and-events/consultations/2025/consultation-on-revisions-to-the-standards-of-education-and-training/, Nursing and Midwifery Council. “NMC Proposes Changes to Standards to Improve Practice Learning.” 20 November 2025. https://www.nmc.org.uk/news/news-and-updates/nmc-proposes-changes-to-standards-to-improve-practice-learning/, Department of Health and Social Care, “Fit for the Future: 10 Year Health Plan for England,” July 2025.

Theme 5: Practice Learning

Top Lines

- Placement capacity is a critical and under addressed barrier to expanding the healthcare workforce. Coordination failures, opaque funding, and significant variation in tariff rates across professions create unequal incentives to host students.
- Some Healthcare students report placements that are poorly organised, inadequately supervised, and in some cases hostile. These experiences disproportionately affect students from widening participation and minority backgrounds, and risk undermining the access gains made at the admissions stage.
- Simulation-based learning has a strong and growing evidence base as a complement to clinical placements, but regulatory recognition is inconsistent across professions and tariff funding covers undergraduate medicine only. Formal recognition should be extended to all healthcare professions in turn, starting with those where the evidence is strongest, and tariff funding should be broadened to match.

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

Practice learning is central to healthcare students' development and transition into clinical practice, but a shortage of quality placements was consistently identified across submissions as a limiting factor in expanding student numbers and retaining staff. The 10 Year Health Plan commits to increasing training places but does not adequately address placement shortage as a barrier to that expansion.[29] The Plan makes reference to some financial support around placements, including reforming the placement tariff in medicine and speeding up reimbursement for travel costs for nursing students.[30] However, the operational details remain unclear, and it is not evident how these measures will adequately address the scale of the shortages identified in the evidence.

29. Department of Health and Social Care, "Fit for the Future: 10 Year Health Plan for England," July 2025.

30. Ibid.

Practice Learning

Submissions identified three interrelated factors constraining placement capacity:

- **Coordination and planning gaps:** Education institutions and courses often compete for the same placement locations with no national coordination or monitoring to identify under-utilised or over-subscribed settings. Academic timetables limit flexibility, high student-to-staff ratios affect supervision quality, and regulatory inflexibility restricts the range of available opportunities.
- **Funding constraints:** Placement providers receive a tariff based on student numbers, profession, and placement length, but there is limited transparency in how this funding is spent and whether it reaches providers bearing the cost of supervision. Funding also varies further between devolved nations.
- **Communication challenges:** Misalignment between placement providers and higher education institutions causes confusion for students and staff, with unclear responsibilities for placement organisation and competing demands among universities, placement agencies, and educators.

These pressures have direct consequences for students. Frequently reported concerns include insufficient notice for placements, locations changing at short notice, arriving where staff had nothing prepared, being used to fill staffing gaps rather than focus on learning, and in some settings bullying, harassment, and hostile working cultures. Evidence suggests these experiences are disproportionately acute for students from widening participation or minority backgrounds.

The Higher Education Commission recommends these challenges be addressed through regional placement coordination networks:

Recommendation 9: Integrated Care Boards, supported by the Department of Health and Social Care, should establish regional placement coordination networks aligned with national placement and workforce planning requirements.

a. Each integrated care board should undertake a systematic mapping of current placement capacity across all settings, including acute hospitals, primary care, community services, mental health services, social care, public health, voluntary sector, and independent sector providers.

b. Formal placement coordination structures should be established based on that mapping, bringing together universities, NHS trusts, primary care networks, social care providers, voluntary sector organisations, regulators, professional bodies, and student representatives to align placement provision with local service needs and workforce development priorities.

c. Local placement funding allocation decisions should be published, including how tariff funding is distributed across settings and providers within each integrated care board, enabling scrutiny of whether funding reaches the providers bearing the cost of supervision and whether it adequately covers those costs.

d. Regional placement coordination networks should engage with university student support, disability, and hardship services to ensure that financial, wellbeing, and accessibility barriers to placement participation are identified and addressed.

No comprehensive picture of available placement capacity exists at regional level, and no formal mechanism currently coordinates provision across the full range of settings within an integrated care system. The NHS and its predecessors have committed to diversifying placements into community and primary care settings, but progress has been limited because we lack the infrastructure to plan, coordinate, and fund placements across sectors. Recommendation 9 addresses that infrastructure gap directly.

Mapping existing placement capacity is the necessary first step, as decisions about coordination structures and funding can only be meaningful if they are grounded in an accurate picture of what capacity currently exists and where the gaps are. Regional decisions about placement numbers, funding allocation, and which settings are used for training must align with national placement and workforce planning requirements. This ensures that local approaches aggregate into a coherent national picture rather than producing inconsistency across integrated care systems.

Across the evidence sessions, stakeholders highlighted existing and proposed innovative placement models spanning community, social care, independent sector, and management settings (see Case Study 10). Regional coordination networks could provide the basis for expanding these approaches, enabling the kind of placement diversification that institution-level initiatives have so far been unable to deliver at scale.

Case Study 10: Innovative Placement Models

Neighbourhood Health Hub: The UK's first university-led primary care centre integrating clinical care, education, and research in a single community setting. The model creates the university's own placement capacity while embedding health equity in clinical education, with the Health Advice Centre partnering with local charities to deliver health checks to residents experiencing homelessness.[1]

Bristol Dental School NHS 111 Partnership: A new dental school located in Bristol 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 while giving students experience with emergency presentations.[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. The outreach placement provides exposure to different patient populations while Portsmouth benefits from a consistent student presence supporting service delivery.[2]

Case Study 10: Continued

College of Optometrists Clinical Learning in Practice (CLiP): Following regulatory change requiring 48 weeks of clinical learning to be integrated into optometry degrees, the College of Optometrists developed CLiP: a standardised programme facilitating, delivering, and assessing 44 weeks of clinical experience in paid employment, designed to be incorporated into any provider's degree. By 2026, 12 of the 15 UK providers and all major employer groups had signed up.[3]

1. Vanessa O'Donnell, MillionPlus, response to the Higher Education Commission: Health Education and Training Inquiry Call for Evidence, November 2025. 2. Rosie Pearce, Dental Schools Council, response to the Higher Education Commission: Health Education and Training Inquiry Call for Evidence, November 2025. 3. Professor Lizzy Ostler, Director of Education, College of Optometrists, response to the Higher Education Commission: Health Education and Training Inquiry Call for Evidence, 2025.

Placement experience must be designed with learning outcomes and student circumstances in mind. For many healthcare students, placements introduce significant financial, wellbeing, and accessibility challenges around travel, accommodation, and caring responsibilities. These compound the cost pressures described in section 2.2 and risk undermining widening participation gains made at the admissions stage.

"Students reach out to me and members of the team directly saying they have a placement and want to engage with their practice learning but cannot afford the upfront travel costs. We must listen to our students to understand their experience and find ways to facilitate and enable them to access their learning opportunities and enable them to have broad, impactful, and diverse career pathways."

Professor Jackie Kelly, Pro Vice-Chancellor and Dean of the Faculty of Health, Medicine and Social Care, Anglia Ruskin University, Oral Evidence Session 1, 28 January 2026.

Engaging university student support, disability, and hardship services within regional coordination structures is a practical means of ensuring these barriers are identified and addressed systematically. The coordination structures this recommendation establishes also create a necessary precondition for addressing wider questions about tariff funding, providing the regional visibility and cross-sector relationships through which a future review of tariff adequacy and eligibility could be meaningfully informed.

5.2 Simulation-based learning can complement clinical placements but is inconsistently recognised and resourced

The case for formally recognising simulation-based learning as a complement to placement hours rests on a growing evidence base. The NMC has permanently incorporated up to 600 hours of simulated practice learning within the 2,300 hours required for pre-registration nursing programmes, with its own evaluation finding that simulated practice learning enhances competence and supports confidence.[31] Internationally, the largest randomised controlled study of simulation in nursing education found no statistically significant differences in outcomes when simulation replaced up to 50% of traditional hours.[32]

Evidence sessions also emphasised that simulation can be co-designed with students, staff, and service users to address specific challenges in healthcare delivery, making it a flexible tool for both education and workforce development.

> *"Simulation-based education does provide really powerful opportunities not only to improve understanding, empathy and decision making, but it's also about how we prepare the workforce for a complicated and rapidly changing healthcare environment. Simulation is most effective when it's co-produced with staff and service users, as it enables professionals to rehearse real care pathways, understand pressures across settings and develop adaptive expertise rather than purely task-based competence."*
>
> ***Professor Jane Harrington, Vice-Chancellor, University of Greenwich, Oral Evidence Session 3, 25 February 2026.***

The ALICE Simulator Project at the University of Greenwich illustrates how simulation can serve not only as a teaching tool but as a platform for research into safety and human factors in high-risk practice settings (see Case Study 11).

31. Nursing and Midwifery Council. Simulated Practice Learning in Preregistration Nursing Programmes. September 2024. https://www.nmc.org.uk/globalassets/sitedocuments/simulated-practice-learning/reports/2024/evaluation-of-simulated-practice-learning-in-pre-registration-nursing-programmes.pdf

32. Hayden, Jennifer K., Richard A. Smiley, Maryann Alexander, Suzan Kardong-Edgren, and Pamela R. Jeffries. "The NCSBN National Simulation Study: A Longitudinal, Randomized, Controlled Study Replacing Clinical Hours with Simulation in Prelicensure Nursing Education." Journal of Nursing Regulation 5, no. 2, Supplement (2014). https://www.sciencedirect.com/science/article/abs/pii/S2155825615300624

Case Study 11: The ALICE Simulator Project, University of Greenwich

The ALICE Simulator Project is a collaborative research and training initiative led by the University of Greenwich, developing a bespoke ambulance simulator in honour of Alice Clark, a 21-year-old paramedic who died in the line of duty three months after qualifying. Blue-light driving under emergency conditions remains one of the least researched areas of paramedic training; the simulator addresses this as both a training tool and a research platform investigating driver behaviour, human factors, and safety risk.

The project brings together researchers, paramedic educators, digital simulation specialists, and industry partners, enabling data capture on decision-making under pressure and systems-level analysis of performance and risk. Development has taken on additional urgency following the introduction of new national regulations on ambulance driving training, and has drawn interest from NHS trusts, ambulance services, and international research institutions.

Source: University of Greenwich, “The ALICE Simulator Project: Advancing Ambulance Safety Through Innovation, Evidence, and Legacy,” 5 November 2024.

Simulation supports more inclusive learning, allowing students to build confidence before entering complex clinical settings, which is particularly valuable for students with disabilities or those who experience anxiety in early practice exposure. Scenarios can be replicated consistently, unusual cases deliberately introduced, and mistakes made and learned from without consequences for patients.

However, high-quality simulation carries significant infrastructure and training costs, and evidence sessions highlighted the need for improved sharing of best practice, increased investment in facilities, and greater educator capacity.

The Higher Education Commission accordingly recommends expanding formal recognition of simulation-based learning:

Recommendation 10: Integrated Care Boards, supported by the Department of Health and Social Care, should establish regional placement coordination networks aligned with national placement and workforce planning requirements.

a. Regulators should formally recognise simulation-based learning in each profession in turn, beginning with those where the evidence base is strongest and extending recognition across all healthcare professions as the evidence develops.

b. Simulation hours that count toward proficiency and practice learning requirements should only be delivered by providers meeting defined quality standards, aligned with those set out by the Association for Simulated Practice in Healthcare (ASPiH).

c. An ongoing evaluation mechanism should be built in to capture data on student outcomes, service pressures, and patient outcomes, informing both the evidence base for regulatory decisions and decisions about where simulation can most effectively complement clinical placement capacity.

Regulatory positions on simulation vary across professions. Some regulators already operate outcome-focused standards that do not prohibit simulation use, while others maintain more prescriptive frameworks. This recommendation addresses those more prescriptive frameworks, while recognising that enabling standards already exist, the priority is ensuring providers have sufficient clarity and confidence to make full use of them.

A differentiated approach to formal recognition reflects the reality that the evidence base is more developed in some professions than others. Rather than claiming universal equivalence prematurely, this recommendation establishes a clear expectation that formal recognition is the destination for all healthcare professions, with the pace of implementation governed by the strength of available evidence and informed by the ongoing evaluation mechanism proposed here.

Simulation tariffs currently cover only undergraduate medicine, meaning nursing, allied health professional, and pharmacy programmes bear infrastructure costs without equivalent financial support. Extending tariff eligibility will require a robust costed business case, but the investment is justified on educational grounds and as a practical response to the placement capacity pressures described in section 4.1. The current inequity in tariff eligibility is unsustainable if simulation is to fulfil its potential across all healthcare professions.

The Regulatory Innovation Office, established to help regulators update their frameworks in response to emerging technologies and new ways of working, is well placed to support this process. Healthcare regulators seeking to revise their standards to formally accommodate simulation-based learning could draw on the RIO's remit to work through the practical and legal barriers to regulatory change, reducing the time and complexity involved in updating frameworks across multiple professions.

Theme 6: Career Development

Top Lines

- Career bottlenecks limit progression and contribute to high leaver rates.
- Where CPD and development opportunities exist, service pressures, hidden costs, and inconsistent employer support can limit access. Inequalities in who can participate compound representation gaps, with ethnic minority staff, part-time workers, and those in rural and remote areas consistently disadvantaged.
- NHS employers should develop organisation-wide CPD strategies that distribute access equitably, moving away from approaches that rely on individual initiative. The Department of Health and Social Care should commission a review of CPD funding rules, including the impact of recent apprenticeship funding changes that have narrowed progression routes available to NHS employers.

6.1 Training bottlenecks and insufficient funding prevent career progression and CPD completion

Unclear career pathways, limited development opportunities, and capacity barriers to CPD completion contribute to high leaver rates and gaps in workforce capability. The 10 Year Health Plan committed to personalised career development plans for all NHS staff, but significant structural barriers to progression and CPD access remain across professions.

In some professions, such as allied health professions, CPD is less structured, with fewer upskilling hours available due to limited opportunities and insufficient governance. Career bottlenecks exist across multiple professions: the Band 4 to Band 5 nursing transition represents a persistent barrier, alongside a lack of upward progression routes for nursing associates, healthcare assistants, care workers, and T-Level holders. Doctors face acute shortages in specialty training posts, limiting access to GP or consultant roles.

Career Development

Training Bottlenecks

- In 2025, specialty training in medicine received 91,999 applications for 12,833 posts, a ratio of seven to one, representing a 54.1% increase in applications from 2024 while available posts increased by only 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 than those at Band 6.[2]

1. British Medical Association, response to the Higher Education Commission: Health Education and Training Inquiry Call for Evidence, November 2025. 2. Royal College of Nursing, "Left Behind: A Review of Evidence on the Career Progression of NHS Nurses," December 2025.

Some providers and NHS bodies are already developing approaches to address these bottlenecks (see Case Study 12), but these remain isolated initiatives rather than system-wide practice.

Case Study 12: 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 designed to improve retention and job satisfaction while embedding inclusivity and digital capability.[1]

Powys Aspiring Nurse Programme: A part-time distance learning degree programme in Powys Health Board, undertaken alongside employment as a healthcare support worker. The programme enables existing support workers to progress to registered nurse status without leaving employment.[2]

Elevate Leadership Development Programme: An NHS England programme for ethnic minority neonatal nurses and midwives preparing for senior leadership roles. The programme addresses barriers to leadership progression for underrepresented groups, including through structured content on allyship and managing experiences of racism in the workplace.[3]

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.

In other professions, contract structures provide limited incentives for upskilling. Dentists and pharmacists have reported being keen to develop their practice but feeling demotivated by the absence of meaningful career rewards. The 10 Year Health Plan committed to working with trade unions and employers on contractual changes, but does not detail how these will address the progression barriers identified in submissions.[33]

Where CPD and career progression opportunities are available, capacity and funding barriers can nonetheless prevent access:

- **Insufficient protected time:** Service pressures consistently deprioritise professional development. Some professionals report completing CPD required to remain clinically safe in their own time, without employer support.
- **Financial barriers:** Significant barriers exist, including hidden costs beyond direct fees, inconsistent CPD budgets, and a lack of dedicated funding streams. Practitioners often rely on competitive grants or loans, and funding models frequently overlook the costs of mentor training.

Inequalities in CPD access compound representation gaps across professions:

- Ethnic minority staff and those from disadvantaged backgrounds reported significant barriers to completing CPD and discriminatory experiences affecting whether they applied for and succeeded in securing opportunities.
- 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.
- Geographic inequalities persist, with London over-represented in available opportunities and rural and remote areas consistently underserved.

33. Department of Health and Social Care, “Fit for the Future: 10 Year Health Plan for England,” July 2025.

The Higher Education Commission recommends these inequities be addressed through a dedicated review and reform of CPD access:

Recommendation 11: The Department of Health and Social Care, NHS employers, universities, and CPD providers should address inequity in CPD access across all healthcare professions.

a. NHS employers should develop organisation-wide CPD strategies that distribute access equitably across the workforce, moving away from approaches that rely on individual initiative.

b. The Department of Health and Social Care should commission a review of NHS CPD funding rules, examining how to remove structural barriers to access, and mitigate the impact of recent apprenticeship funding changes including the defunding of leadership and management standards.

c. CPD providers should expand flexible and online delivery options that enable participation outside standard working hours and reduce the need for travel, with particular attention to professions and geographic areas currently underserved by in-person provision.

No employer framework in England currently treats covering staff absence during CPD as a minimum requirement. A domestic precedent exists: NHS Scotland's 2023/24 Agenda for Change settlement secured protected learning time as an employer obligation for NHS health boards.[34]

The review called for in this recommendation should examine the impact of recent apprenticeship funding changes on NHS employers, including the defunding of leadership and management standards at Level 7. Whilst the Growth and Skills Levy has recently been reformed through Skills England to cover a wider range of training activity, the review should assess whether its current scope adequately supports the CPD needs of the healthcare workforce.

34. Royal College of Nursing. Council's Report to Members on Congress 2024. 2024. file:///Users/rhiannontuckett-jones/Downloads/012-070.pdf

CPD opportunities tend to flow to those most able to advocate for themselves. Strategic, organisation-wide CPD planning, where employers actively map and distribute development opportunities rather than responding to individual requests, is a necessary complement to funding reform. Employers should also be encouraged to draw on training resources beyond NHS and higher education providers, including commercial sector partners, broadening the options available to staff.

Flexible and online delivery reduces dependency on travel and fixed working hours, particularly benefiting staff in underserved areas or with caring responsibilities. Simulation-based CPD, supported by the regulatory changes called for in Recommendation 10, offers a further avenue for delivering high-quality development flexibly across settings (see Case Study 13).

Case Study 13: Flexible CPD Delivery Models

University Centre South Devon and Devon Partnership NHS Trust modular CPD: Two modular Level 5 CPD pathways designed specifically for the mental health workforce, offering flexibility, local access, and practice-centred learning. The programme is designed to widen participation in CPD and to remain responsive to changing workforce needs.

Devon Partnership Trust Physical Health Skills Courses: A partnership between Devon Partnership Trust and University Centre South Devon offering a two-level course structure in fundamental and advanced physical health skills at Level 5. The programme combines 50% face-to-face simulation using high-fidelity simulated patients with 50% remote e-learning, with a train-the-trainer cascade model evaluated using the Kirkpatrick Model.

Source: 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.

Conclusion

The evidence gathered across this inquiry points to a consistent and addressable set of problems. Healthcare education and training in England is delivered by institutions and professionals with genuine commitment and, in many cases, real innovation. What is missing is not effort or expertise but the structural conditions that would allow those strengths to operate coherently: shared data, coordinated planning, adequate funding, and regulatory frameworks that enable rather than constrain.

The consequences of the current system's limitations are already visible. Workforce shortages are deepening in professions where domestic training capacity is insufficient to meet need. Students from disadvantaged backgrounds are deterred from applying, or pushed out before they complete, by financial pressures that comparable professions do not impose to the same degree. Clinical educators are leaving or not entering academia because the career pathway does not make financial sense. Graduates cannot always find posts where they trained or where they have roots. Placement capacity is not growing at the rate training expansion requires. These are not isolated failures. They are the cumulative result of a system in which the education pipeline has not been treated as a strategic priority in its own right.

The government has set out ambitious commitments: expanding training places, reforming curricula, shifting care into communities, and building a workforce capable of delivering a modern NHS. The Higher Education Commission supports those ambitions. This report's argument is that they cannot be realised without sustained, structured attention to the education system that produces the workforce on which all of it depends. Investment in service transformation is diminished in value if the professionals needed to deliver it are not being trained in sufficient numbers, in the right places, or with the skills the reformed NHS will require.

The recommendations set out in this report are ambitious but achievable within existing institutional structures. They do not require new bodies to be created from scratch or existing systems to be dismantled. They ask for a national coordination forum with a clear remit and accountability mechanism; regional planning structures with the data and governance to function properly; a financial support model for students and newly qualified professionals that reflects the particular demands of healthcare training; regulatory frameworks updated to reflect the evidence on simulation and flexible delivery; and CPD systems that distribute opportunity equitably rather than concentrating it among those already well placed.

Progress on these recommendations will require cross-departmental commitment. The Department of Health and Social Care cannot act alone: the Department for Education, Skills England, NHS England, professional regulators, integrated care boards, universities, and further education colleges all have a role to play. The Forum proposed in Recommendation 1 is designed precisely to create the institutional mechanism through which that shared responsibility can be exercised. Without something like it, the coordination failures identified across this inquiry will persist regardless of the ambition of individual policy commitments.

The question before government is whether the current moment, with a new workforce plan expected, a major programme of curriculum reform underway, and public and political attention firmly on NHS performance, will be used to address the structural foundations of the workforce challenge, or whether education and training will again be treated as a downstream consideration rather than the starting point for any serious plan. The Higher Education Commission's view, grounded in the evidence gathered across this inquiry, is that the former is both necessary and achievable. The recommendations that precede this conclusion set out how.

Methodology

Inquiry Timeline

9 July 2025 — Scoping Session. Held in Parliament and co-chaired by Lord Philip Norton of Louth, Kevin McKenna MP, and Professor Kathryn Mitchell. Key stakeholders from across the healthcare education landscape came together to agree the inquiry's scope, priorities, and thematic focus.

Autumn 2025 — Literature Review. Included over 100 research papers and policy reports. The review mapped the current evidence base on healthcare workforce development, providing the contextual foundation for the inquiry's subsequent evidence gathering.

Autumn 2025 — Call for Evidence. Gathered 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.

Autumn 2025 — Student and Staff Engagement. Included in-depth interviews and focus groups with learners and staff across multiple healthcare professions, supported by a student and staff survey. The team visited students directly at Teesside University, Anglia Ruskin University, University College London, Birmingham University, and the University of Salford, gathering frontline perspectives on the realities of healthcare education and training.

28 January 2026 — Oral Evidence Session 1: National Strategy and System Leadership, House of Lords. Brought together policymakers, NHS leaders, and sector partners to examine national-level challenges in healthcare education and training. Discussion focused on strategic workforce planning and demand forecasting, system coordination and accountability, resource efficiency and funding, clinical placement capacity and quality, and quality assurance and standards.

9 February 2026 — Oral Evidence Session 2: Regional Delivery and Local Partnerships, Bournemouth University. Examined how national strategies translate into regional delivery, with a focus on widening participation and diversifying entry routes, regional inequalities and targeted interventions, local workforce planning and skills matching, partnership models, and regional retention strategies.

25 February 2026 — Oral Evidence Session 3: Educational Innovation and Workforce Readiness, University of Greenwich. Explored innovations in pedagogy, digital learning, and future-proofing the healthcare workforce. Discussion covered student experience, support and retention, educator workforce capacity, assessment and workforce readiness, and approaches to scaling good practice across the system.

Spring 2026 — Steering Group Consultation. Sector experts reviewed the inquiry's draft recommendations and contributed to the development of this final report, ensuring findings were grounded in the breadth of expertise and experience represented across the group.

University Visits - Student and Staff Engagement

- University College London – September 2025
- Teesside University – October 2025
- Anglia Ruskin University – October 2025
- Birmingham University – January 2026
- University of Salford – April 2026

Oral Evidence Sessions

Evidence Session 1 - Wednesday 28 January - House of Lords

- Chaired by Lord Philip Norton, Inquiry Co-Chair

Opening remarks from:

- Professor Kathryn Mitchell, Vice-Chancellor, University of Derby, Inquiry Co-Chair
- Kevin McKenna MP, Inquiry Co-Chair
- Jonathan Brash MP, Labour MP for Hartlepool

Structured discussion with:

- Peter Kunzmann, Head of Policy, Royal College of Anaesthetists
- Ed Hughes, Chief Executive, Council of Deans of Health
- Christine Elliott, Chair, Health and Care Professions Council
- Professor Jacqueline Kelly, Pro Vice Chancellor and Dean of the Faculty of Health, Medicine and Social Care, Anglia Ruskin University
- Joe Fitzsimmons, Regional Lead Policy and Insights, ACCA

Evidence Session 2 - Monday 9 February - Bournemouth University

- Chaired by Professor Alison Honour, Vice Chancellor and Chief Executive Officer, Bournemouth University

Opening remarks from:

- Councillor Millie Earl, Leader of Bournemouth, Christchurch and Poole Council

Structured Discussion with:

- Lord Lieutenant for Dorset Professor Michael Dooley, Pro Chancellor at Bournemouth University
- Siobhan Harrington, Chief executive, University Hospitals Dorset NHS Foundation Trust
- Louise Garner, Director of Learning, Bournemouth and Poole College
- Students from Bournemouth University
- Professor Vanora Hundley, Professor in Midwifery, Bournemouth University
- Rini Jones, Senior Policy and Delivery Manager, NHS Race and Health Observatory

Evidence Session 3 - Wednesday 25 February - University of Greenwich

- Chaired by Professor Jane Harrington Vice-Chancellor of the University of Greenwich

Opening remarks from:

- Kevin McKenna MP, Inquiry Co-Chair

Structured discussion with:

- Barbara Coen, Chief Product Officer, iheed
- Henrietta Mbeah-Bankas, Head of Blended Learning, NHS England
- Clare Owen, Director, Medical Schools Council
- Claire Hall, Programme Manager, Health Education Improvement Wales
- Students from University of Greenwich

Call for Evidence Respondents

We received 39 original submissions to our open-ended questionnaire, which was open throughout October-November 2025. We sincerely thank the following organisations and colleagues who submitted written evidence. Those who are not listed below have not given permission to be cited.

- Eli Sassoon, Medical Student, University College London
- Jane Brown, Pharmacy Dean
- Prof Colin Macdougall, Associate Dean, Medical Education, Warwick University
- Isabella Sheila Jones, Practice Experience Facilitation Manager & Education Lead
- Alex Flack, Clinical Learning Environment Lead, NHS
- Deborah Harrison, Senior Research Associate, Newcastle University
- Nicola Brennan, Lead for CAMERa (Centre for Applied Medical Education and Healthcare Workforce Research), Peninsula Medical School, University of Plymouth
- Ella Reynolds, Programme Coordinator and Lead for Nursing Professions, University Centre South Devon, South Devon College
- Diane Last, Head of Clinical Education, West Suffolk NHS Foundation Trust
- Katherine Woolf, Professor of Medical Education Research, University College London
- Dr Antonia Rich, Associate Professor, University College London Medical School
- Dr Rowena Viney, Associate Professor in Medical Education, University College London Medical School
- Laura Jackson, PhD student University of Strathclyde & Lecturer and Programme Leader Adult Nursing, University of the West of Scotland
- Marcus Hynes, Association of Anaesthetists
- Leona Letts, Senior Policy and Delivery Officer, NHS Race and Health Observatory
- Reena Patel, Chartered Society of Physiotherapy
- James Hallwood, The Council of Deans of Health
- Amit Walinjkar, Independent Researcher

- Medical Schools Council
- Rosie Pearce, Senior Policy Officer, Dental Schools Council
- Vanessa O'Donnell, Head of Public Affairs, MillionPlus
- Matthew Peck, Head of Communications, Engagement and Public Affairs, Health and Care Professions Council
- Fiona Smith, Communication Officer, Association of British Paediatric Nurses
- John Mckenna, Head of Public Affairs, University of Salford
- Ian Mathieson, Director of Education Strategy and Transformation, Health Education and Improvement Wales
- Dinah Godfree, Head of Policy, Professional Standards Authority
- Radha Adhikari, University of the West of Scotland
- Professor Dave Clarke, Associate Director for Education, Royal College of Nursing
- General Medical Council
- Amy Wallwork, Policy and Public Affairs Officer, Royal College of Anaesthetists
- Mike Indian, Public Affairs Advisor, The Royal College of Midwives
- Conall Green, British Medical Association
- Emeritus Professor Sally Curtis, University of Southampton
- Nicola Fielding, Deputy Programme Lead, Lecturer in Child Health Nursing (Education), University of Plymouth
- Dr Nicola Brennan, Associate Professor (Research) in Medical Education, Peninsula Medical School (Faculty of Health)

Acknowledgements

Thank you to my colleagues Claudia Jaksch, Robert McLaren and Victoria Zeybrandt for supporting the inquiry to completion. Special thank you to Alyson Hwang for her leadership and support throughout the project.

Acknowledgements

The collective expertise and support of the Commissioners is greatly appreciated, especially for feedback and continuous suggestions throughout the inquiry.

- Kevin McKenna MP, (Labour, Sittingbourne and Sheppey), Inquiry Co-Chair
- Lord Philip Norton of Louth, (Conservative Peer) Inquiry Co-Chair
- Professor Kathryn Mitchell, Vice-Chancellor, University of Derby, Inquiry Co-Chair
- Joe Fitzsimmons, Regional Lead Policy and Insights, ACCA
- Rebecca Paterson, General Manager, iheed

About this Report

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About the Higher Education Commission

The Higher Education Commission is an independent body made up of leaders from the education sector, the business community and the major political parties. The Commission examines higher education policy, holds evidence-based inquiries, and produces written reports with recommendations for policymakers.

About the All-Party Parliamentary Group for Health

The All-Party Parliamentary Health Group (APHG) is an all-party forum dedicated to disseminating knowledge, generating debate and facilitating engagement on health issues amongst Members of Parliament. Policy Connect provides the secretariat for All-Party Parliamentary Group on Health (APHG), supporting the group's activities. We are committed to ensuring our actions and funding are entirely transparent.

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University of Derby

The University of Derby is a public university located in the heart of England, known for its industry connected, research-informed courses and teaching excellence. It is the only university in Derby and Derbyshire, and it was awarded Gold Status in the 2023 Teaching Excellence Framework (TEF). The university focuses on providing practical and relevant education, strong career support, and is engaged in research areas such as low-carbon technologies and the causes of Alzheimer's disease. The University has recently been named the UK University of the Year in 2027 in the Uni Compare rankings.

iheed

iheed is a global leader in online healthcare education, partnering with leading universities, royal colleges and professional bodies to deliver flexible, high-quality postgraduate education for healthcare professionals. Having educated more than 19,000 clinicians from over 110 nationalities, iheed is committed to expanding access to lifelong learning, supporting workforce development, and helping health systems build the skilled, adaptable workforce needed for the future. Through innovative digital learning and strong partnerships, iheed shares the ambitions of Trained for Tomorrow in making healthcare education more accessible, flexible and responsive to evolving workforce needs.

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Glossary

Across the report, a number of phrases, acronyms and abbreviations are used.

ACCA	Association of Chartered Certified Accountants
AHP	Allied Health Professionals
AI	Artificial Intelligence
ALICE	Advancing Ambulance Safety Through Innovation, Evidence, and Legacy (simulator project, University of Greenwich)
APHG	All-Party Parliamentary Health Group
ARU	Anglia Ruskin University
ASPiH	Association for Simulated Practice in Healthcare
BMA	British Medical Association
CAMERa	Centre for Applied Medical Education and Healthcare Workforce Research
CfWI	Centre for Workforce Intelligence
CLiP	Clinical Learning in Practice (College of Optometrists programme)
CPD	Continuing Professional Development
DHSC	Department of Health and Social Care
DfE	Department for Education
DISKPASS	Digital Skills for Pre-registration Allied Health and Nursing Students (curriculum initiative)
DWP	Department for Work and Pensions
GMC	General Medical Council
GP	General Practitioner
HEARI	Healthcare Education to Address Radicalised Inequities
HEC	Higher Education Commission

HEIW	Health Education and Improvement Wales
HEI	Higher Education Institution
HCPC	Health and Care Professions Council
ICB	Integrated Care Board
IMD	Index of Multiple Deprivation
LSIP	Local Skills Improvement Plan
LTWP	Long Term Workforce Plan
NMC	Nursing and Midwifery Council
NCSBN	National Council of State Boards of Nursing
NHS	National Health Service
NHSC	National Health Service Corps (US)
OECD	Organisation for Economic Co-operation and Development
OfS	Office for Students
PAYE	Pay As You Earn
RCN	Royal College of Nursing
RCM	Royal College of Midwives
RIO	Regulatory Innovation Office
SIHED	Strategic Interventions in Health Education Disciplines
T Level	Technical Level qualification (post-16 vocational qualification in England)
UCAT	University Clinical Aptitude Test
UKHSA	UK Health Security Agency

Policy Connect
83 Victoria Street
London
SW1H 0HW

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