Educating our future NHS workforce

Universities as partners to expand training and secure a pipeline of clinical educators that can help the NHS succeed

The Government's Plan for Change[1] sets out an ambitious approach to delivering an NHS fit for the future as part of its decade of national renewal. Delivering three big shifts will be core to government's wider 10 Year Health Plan: from hospital to community, analogue to digital, and sickness to prevention. A highly skilled and motivated workforce, backed by a sustainable pipeline of trainees and upskilling of existing staff, will be critical in delivering success.

Our briefing *Education for a healthy future* outlines how our universities are already working in partnership with the NHS, further education colleges and professional bodies to train the nurses, doctors, dentists, technicians, researchers and other professionals the NHS needs to cut waiting lists and bring advanced technologies and treatments into everyday use. **With political consensus on the need to increase the number of healthcare workers, our universities are ready to work with government to refresh the long-term workforce plan and expand training further.**

However, a properly coordinated approach is needed, underpinned by consistent engagement between the higher education and health sectors, to maximise opportunities for efficiency and effective delivery. That is why **we are calling for the creation of a new Ministerial Taskforce on NHS workforce planning**. This Taskforce could report to the NHS Mission Board and be chaired by a minister with joint accountability across DfE and DHSC to ensure coordination between departments. Drawing on advice from NHS England's newly-formed Clinical Expansion and Reform Stakeholder Advisory Group, the Taskforce would ensure all stakeholders are informing progress and identifying barriers and solutions to workforce growth.

Challenges to transforming healthcare education

Expanding training places

Growth in demand for NHS services has not been matched by increased capacity in the workforce and education pipeline. The UK only trains 13 medical graduates per 100,000 population, less than half of that in top OECD countries.[2] This is partly because the desire to increase student numbers has not been supported by long-term funding which would enable universities to consider options for training expansion. For example, recent rounds of medical and dental expansion have been intermittent and unpredictable, and the process opaque. This has not been conducive to long-term planning for either the NHS or training institutions.

Shortages in the number of educators

The proportion of clinical academics has stagnated, and with more than 50% now over the age of 50 there are serious concerns about long-term sustainability.[3] Clinical academics lead the UK's health research and were vital in our fight against COVID, with breakthroughs like the AstraZeneca vaccine and the RECOVERY trial that identified affordable, life-saving treatments. They are also widely recognised for their role in training future healthcare professionals.

Clinical educators face unique challenges in balancing their teaching responsibilities with clinical duties, and often experience pressures related to workload, career development and remuneration. In turn, some clinical professionals may hesitate to enter education roles because they fear it might hinder their career progression. Without addressing these challenges, we will be unable to expand training in universities to the levels needed to secure our future healthcare workforce.

Restrictions in clinical placement capacity

Clinical placements are a crucial part of healthcare education. If we are to increase healthcare training across the UK, then placement capacity will need to support this. The shift from hospitals to community care will require student healthcare workers to gain early exposure to primary care settings as part of their training, but there are financial and planning challenges to the diversification of clinical placements and the establishment of innovative practice. For example, NHS secondary care (hospitals or community services) tariff funding is awarded directly to trusts, not universities. A lack of transparency, and variability in approaches taken, can mean ineffective use of funds for clinical placement delivery and a lack of clarity as to whether funds can be accessed to support simulated practice.

Universities do receive funding directly via the NHS primary care tariff for clinical placements in primary care settings, such as GP surgeries. However, to make a shift from hospitals to community, there needs to be greater support and alleviation of pressures on these health services to increase capacity for training.

There are already efforts being made by the HE sector to relieve pressure on placement capacity. For example, some Russell Group universities are partnering with other institutions to establish medical schools in under-doctored areas and where there is greater capacity for placements. Our universities are also opening simulation units and sharing clinical teaching spaces with other local training providers, giving students access to cutting-edge facilities.

Degree reform

Discussions of degree reform have been prompted by a desire to relieve student debt and train healthcare professionals, specifically doctors, quicker. The NHS workforce plan developed under the previous government[4] set out plans for an accelerated four-year undergraduate degree to train doctors in England. However, there are concerns about the impact this would have on the depth of academic study and access opportunities for disadvantaged students. The number of students from lower socioeconomic backgrounds entering medical school in the UK more than doubled over the past decade.[5] Any reform to degree structure should not risk the progress being made in breaking down barriers to opportunity.

Options to increase access and speed up the delivery of trained doctors, include:

(a) **Supporting graduate entry medicine**. Graduate entry medicine allows individuals from various disciplines and socioeconomic backgrounds to enter the field, thereby attracting students with diverse experiences, educational history and skills.[6,7] . Yet students on graduate entry programmes are largely self-funded, with only partial tuition fee and maintenance loans available. This serves as a significant barrier to entry.

(b) **Revisiting proposals to move the point of registration**. With the appropriate safeguards in place, graduates would be allowed to work as fully registered doctors sooner. This can only be achieved if graduates are supported, trained and assessed in a way that prepares them to practise. This would require universities to review their curricula and skills assessments and for this to be supported by the regulatory authorities.

Research-intensive universities are ready to work with government to explore the merits and limits of these approaches in order to meet ambitions of training doctors more efficiently.

International recruitment

Expanding the NHS workforce will require measures to grow our domestic workforce alongside support for training and recruitment of healthcare workers from abroad. We should not disregard the significant and valuable contribution that international staff make to the NHS: accounting for one in every five employees and 35% of doctors.[8]

International students have enabled universities to expand and continue delivering high-quality courses despite falling per student income for the teaching of home undergraduates. This has been particularly true for high-cost subjects such as medicine and dentistry. International students make important contributions to university campuses across the UK, to our NHS and, as graduates, to healthcare systems globally. In England and Wales[9,10], there is a 7.5% cap on medical and dental student numbers which remains unchanged since its introduction in 2017. This is in comparison to international students representing 25% of all students studying at UK universities across all subjects.[11] There is also a lack of parity across the sector with some medical schools seemingly operating outside of the cap, which should be addressed.

Student demand and training pathways

Whilst medical and dental degrees have historically been competitive, applications for other types of healthcare degrees have declined or stagnated in recent years. In 2024, there was just a 1% increase in placed applicants on nursing courses at UK universities compared to 2023, and a 1% decrease in placed applicants on undergraduate midwifery courses.[12] The apparent undesirability or lack of awareness of these careers needs to be addressed to recruit and retain students who will go on to work in healthcare.

To encourage uptake, a diverse range of pathways will need to be available to students. For example, continued access to healthcare apprenticeships at all levels of study, and flexible modular courses in nursing, midwifery and Allied Health Professions (AHPs) that can be funded by the Lifelong Learning Entitlement (LLE). Level 7 apprenticeships play a critical role in the primary care and advanced practice workforce, as well as addressing management and efficiency challenges in the NHS. Planned reforms to the apprenticeship levy threaten the ability to gain access to on the job learning and opportunities to upskill, which are invaluable to retaining and increasing productivity in the NHS workforce.

Achieving government's ambitions for the NHS workforce

Government's plan for a future workforce should promote a more strategic approach to training expansion. Any plan should account for costs, clinical placement capacity and regional demand for healthcare professionals. It should also promote join-up with other government agendas. For example, delivering the skills needed for the industrial strategy and the work of Skills England, to help drive economic growth by building a skills system fit for the future. **To deliver this, we recommend:**

(a) The 2025 Spending Review is used as an opportunity to set funding milestones to deliver the 10-year Health Plan and workforce ambitions. Long-term certainty of funding is needed to enable universities, working with partners, to consider options for expanding provision.[13]

(b) Government further collaborates with the devolved nations. Health is a devolved matter but challenges such as an ageing population, increased demand for services, and healthcare staff burnout are shared across the UK. Any workforce plan should assess its impact on cross-border movement and ensure an equitable distribution of the workforce between the four nations.

(c) Integrated Care Boards (ICB) appoint at least one higher education representative from the local area.[14] Only a small number of ICBs have university leaders represented, limiting the sector's opportunity to engage in regional workforce planning.[15] Greater representation of university leaders on ICBs would enable closer collaborative working and better support the diversification and expansion of clinical placements.

(d) **The OfS establishes a multi-year allocation process for additional medicine and dentistry places.** The process should have transparent criteria and sufficient lead time to encourage regional coordination of bids.

(e) **Government – alongside regulatory bodies, research funders and the NHS – better promotes portfolio careers between practice, academia and research to existing NHS staff and healthcare students.** The Academy of Medical Sciences has made recommendations to better integrate academia and the NHS, which we support.[16] Our universities commit to increasing the value and attractiveness of the educator role and setting out clear career pathways that incentivise retention of talent. We look forward to engaging with government, NHS and wider sector to consider the findings of the Office for Strategic Coordination of Health Research Task and Finish Group [17], and take steps to secure the UK's clinical research capability.

(f) **Government should guarantee that HEIs will receive a proportion of NHS tariff funding (including secondary care).** Whilst our universities will continue to help find solutions to placement capacity constraints, including through partnership approaches, this would support diversification of clinical placements and investment in simulation. A broader range of clinical placements can also relieve capacity constraints, support the ambition to move more care from hospitals to communities[18], and expose students to a broader range of career pathways.

(g) **Government and relevant funding bodies review the cap on international medical and dental places.** The review should ensure consistency across providers and look to increase the proportion of places for international students.

(h) **Government and the General Medical Council look to revisit recommendations from the Greenway review[19] to enable full registration at the point of graduation.** Consideration of alternatives to 4-year undergraduate programmes should also include **further investment in graduate entry medicine, including a review of NHS bursaries,** to help remove financial barriers for talented individuals to pursue careers in medicine.

(i) **Government supports expansion of training pathways for upskilling and retraining,** by protecting apprenticeship levy funding for Level 7 apprenticeships for NHS workers.

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[1] Plan for Change: Milestones for mission-led government (2024)

[2] Health resources – medical graduates, OECD (2022)

[3] 'Transforming health through innovation: Integrating the NHS and academia', Academy of Medical Sciences (2020)

[4] NHS Long Term Workforce Plan, NHS England (2023)

[5] This includes the proportion of entrants from non-selective state schools increasing from 47% to 54%, while the proportion from independent schools has decreased from 29% to 24%, Fostering Potential, Medical Schools Council (2024)

[6] 'Examination performance of graduate entry medical students compared with mainstream students', Journal of the Royal Society of Medicine (2009)

[7] 'Comparing the academic performance of graduate-entry and undergraduate medical students at a UK medical school', Education for Health Change in Learning & Practice (2017)

[8] 'NHS workforce in a nutshell', Kings Fund (2024)

[9] Medical and dental maximum fundable limits, Office for Students (2024)

[10] In Northern Ireland, 10% of places are available to international students. In Scotland only 5.5% of places were available to international students for 2024 entry.

[11] % of all undergraduate and postgraduate students, Higher Education Student Data, HESA (2024)

[12] Daily clearing analysis, UCAS (2024)

[13] In England, the percentage of NHS budget spent on health education has been steadily falling from 5% in 2006-7 and not stands at roughly 2.8% of the annual £181.7bn budget, The NHS budget and how it has changed, King's Fund (2023)

[14] At the local level, all 42 Integrated Care System have plans around workforce and have an ICB responsible for managing budgets and working with local partners to deliver local care strategies.

[15] 'How are ICSs tackling workforce challenges?', The King's Fund (2023)

[16] 'Transforming health through innovation: Integrating the NHS and academia', Academy of Medical Sciences (2020)

[17] 'Clinical Research in the UK: reversing the decline', Office for the Strategic Co-ordination of Health Research (2025)

[18] There are already examples of good practice, with efforts from our universities to diversify healthcare education placements to GP clinics, community health centres, mental health teams and palliative and hospice settings.

[19] 'Securing the future of excellent patient care', Independent Review by Professor David Greenaway (2013)