Education Strategy

Horizon Scanning and Strategy Mapping

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Health Education and Improvement Wales (HEIW)

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SECTION A: Wales

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A1	NHS 10+ Wales (NHS Wales) Published September 2023 Accessed August 2025	Produced by the Science Evidence Advice (SEA) Division for the Health and Social Services Group on behalf of the Chief Scientific Advisor for Health (Welsh Government) to inform long-term planning; it is evidence advice, not Welsh Government policy. Conditions growing faster than demography: Projections indicate atrial fibrillation, dementia, heart failure, COPD, osteoporosis, CHD, IBD, PVD, asthma, hypertension, anxiety disorders and diabetes will outpace demographic change, implying broader skills across cardiac, respiratory, metabolic and mental health. Inequalities are decisive: The most deprived spend ~9 more years in less-than-good health than the least deprived; prevention and equitable access must permeate curricula and placements. Economic inactivity & LTC link: As of 2022, 466,000 people (16–64) in Wales were economically inactive, 159,000 due to long-term sickness, connecting health, work and rehabilitation skills needs. Prevention first: Modifiable risk factors (smoking, obesity, poverty-linked determinants) mean earlier diagnosis, lifestyle change and public-health action can bend the curve; education should emphasise behaviour change, screening, and community interventions. Shift care out of hospital: Efficiency depends on strong primary/community care and social care integration, with improved access and diagnostics nearer home; placements must reflect this shift. Workforce demand despite tech: Even with shorter hospital stays, Wales will still need significantly more FTE staff by 2030–31 (order-of-magnitude scaling from England), plus extra capacity in GP, community and social care. Digital, data & AI capability: Delivering value requires continued investment in digital medicine and AI and upskilling the workforce to use them safely and effectively (ethics, bias, governance). Genomics mainstreaming: Genomics is expected to reshape prevention, diagnosis and personalised care in Wales; it needs education, infrastructure and ethical frameworks across professions.

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		Measure what works: The paper urges robust, joined-up data and impact evaluation with controls to know which interventions deliver outcomes and value—skills educators should embed. Productivity & value: Tackling waits and optimising care pathways can yield economic gains; education should link competencies to productivity (e.g., pathway redesign, appropriate use of tech).
A1	A Healthier Wales - Action refresh 2024-25 Published December 2024 Accessed August 2025	Updates and sharpens the actions delivering *A Healthier Wales*, following Cabinet support in summer 2024, with clear signals on prevention, community care, digital, workforce and value. Prevention & population health (core shift). Scale early intervention, screening and immunisation; build robust all-hazards health protection (pandemics included); emphasise rehabilitation, reablement and recovery in community settings. Curricula need stronger behaviour-change, public health, rehab and outbreak skills. Person-centred, place-based care. Integrated Community Care becomes the design principle; explicit plans for women's and children's health; commitment to age-friendly Wales; access in people's preferred language/format. Training should reflect personalised care, family approaches, safeguarding, and bilingual practice. Sustainability, value & performance. Embed climate action; drive value-based healthcare via the Value & Sustainability Board; recover/reset/transform planned care; use performance, oversight and escalation to hold gains; "one Welsh public service" collaboration. Educator content should connect skills to value, productivity and decarbonisation. Quality & safety priorities. Standardise pathways and models "once for Wales"; reduce unwarranted variation; explicit focus on antimicrobial resistance (AMR); NHS Executive used to drive quality improvement; progress towards a National Care and Support Service. Map competency frameworks to standardised pathways; include AMS/IPC as core.

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		Digital & data (system backbone). Deploy proven clinical systems, EHRs and med-tech; complete national capabilities (diagnostics, specialist systems, Wales NHS App, e-prescribing); establish national enterprise architecture; boost data maturity (cyber, UX, data sharing/recording, clinical safety); put analytics at the core and mitigate digital exclusion. Education must uplift digital, data, clinical safety and informatics skills across all professions. Workforce (capability, culture, deployment). Implement the Workforce Strategy to grow an inclusive, flexible, multi-professional workforce working across boundaries; embed compassionate leadership and positive culture; plan effective deployment to maximise skills and technology. Priorities for HEIW: supervision capacity, educator time, multiprofessional learning, and deployment literacy. Research, innovation & life sciences. Strengthen research capacity, funding partnerships and adoption; use genomics/personalised treatments and modern innovations to deliver value and sustainability; set a life-sciences vision linked to health and wealth. Build scholarly/innovation capability and genomics literacy into programmes. Co-production & partnership. Elevate citizens' voice; support people and carers to co-produce and own care plans; align national–regional–local planning and commissioning to maximise assets. Educator development should include co-production, service design and partnership working.
A1	Genomics Delivery Plan for Wales Published February 2022 Accessed September 2025	Published by Welsh Government with Genomics Partnership Wales (GPW) it sets the vision, delivery themes and concrete commitments to embed genomics across NHS Wales services, with a strong patient/public involvement model and clear workforce ambitions. Workforce is a pillar. Plan commits to "develop skills of our existing workforce" so clinicians across specialties can use genomics safely and effectively; it references growing STP/HSST posts (genetic counselling, bioinformatics, genomic science, microbiology, molecular pathology) and clinical geneticist training. Education must mainstream genomics literacy for all professions and scale specialist pathways.

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		Service growth → skills demand. Explicit targets: up to 3,000 whole genomes/year (rare disease & selected cancers), ~5,000 cancer genomic profiles/year, and strengthened pathogen genomics for public-health surveillance. This drives needs in sample logistics, consent, triage, variant interpretation, MDT working, data governance and counselling. 'People, Clinical Services, Research & Enablers' delivery themes. • People: three-tier co-production architecture (Patient & Public Sounding Board; alumni; wider public) to shape services and evaluation. Learners and educators should be trained in co-production and public communication (including bilingual materials). • Clinical services: embed genomics across cancer, rare disease, paediatrics, mental health (All-Wales Psychiatric Genomics Service) and screening, aligned to redesigned diagnostic pathways. Curricula should map competencies to each pathway. • Research & innovation: strengthen links with HEIs and clinical services; learners need research literacy and data/biobank awareness. • Enablers: secure data & sample storage, governance, infrastructure (incl. new Cardiff Edge facility and regional delivery "nodes"). Education should cover IG, cyber, clinical safety and informatics basics for all. Diagnostics alignment & evaluation discipline. The plan ties to the Diagnostics Recovery and Transformation Strategy and requires a programme-level evaluation/monitoring strategy co-produced with the Sounding Board. Educators should teach measurement for improvement and contribute to service-linked evaluation. Equity & access. Commitment to inclusive, accessible services and outreach to under-represented communities; education should prepare staff to deliver equitable, culturally competent, Welsh- and English-medium genomic care. Downstream workforce planning is underway. One action was a Strategic Genomics Workforce Plan, delivered by HEIW + GPW in November 2024 — use as the operational workforce spine for curricula, placements and CPD.
A1	Health Professional Education Investment Review	Welsh Government commissioned an independent review chaired by Mel Evans OBE, to provide a comprehensive review of education and training investment for health professionals in Wales,

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	Published March 2015 Accessed October 2025	commissioned by Welsh Ministers to assess whether funding, commissioning and governance arrangements were fit for purpose. The review followed concerns about sustainability, equity, and alignment between workforce planning and service need, and made 34 recommendations to modernise commissioning, education models, and cross-sector working. A single strategic commissioning framework. The review found fragmented commissioning across professions and recommended creating a single, centralised national framework for planning and funding all health professional education, linked directly to workforce modelling and NHS service priorities. This became the foundation for HEIW's later role. Clearer accountability and governance. Recommended a national body (with ministerial accountability) to align workforce intelligence, education investment, and service redesign, to overcome siloed departmental control and lack of shared metrics. Investment principles. Emphasised transparency, value for money, and return on investment in education spending, with performance indicators linked to recruitment, retention, service quality and patient outcomes, not just training volumes. Strengthen workforce intelligence and forecasting. Called for a robust evidence base to guide commissioning, including long-term demand/supply modelling, population health trends, and productivity assumptions, rather than relying on historic training numbers. Integration with service transformation. Recommended aligning education funding with service modernisation programmes (primary care, community health, mental health, prevention), ensuring curricula evolve alongside new models of care and prudent healthcare principles.

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		Inter-professional education (IPE). Argued for stronger multi-professional learning, joint placements, and shared skills training to reflect integrated team-based care; urged regulators and HEIs to embed IPE systematically. Access, inclusion, and Welsh language. Advised removing barriers for Welsh-domiciled students (bursaries, hardship, travel costs), embedding Welsh-language capability, and improving equality of access to education across regions, including rural placement incentives. Post-registration and CPD alignment. Recommended integrated funding and policy for continuing professional development, with equitable access across professions and employment sectors, and shared evaluation of outcomes. Partnership with education providers. Proposed longer-term (5–10 year) partnership agreements with universities and colleges to ensure stability, flexibility to meet service demand, and clearer expectations on quality, supervision and Welsh policy delivery. Leadership and system capability. Highlighted the need for stronger workforce planning capability across NHS Wales, and a coordinated approach to developing clinical educators, mentors and supervisors. The report's recommendations directly informed the creation of Health Education and Improvement Wales (HEIW) in 2018, designed as the single national body for workforce intelligence, education commissioning, and leadership development. It sits historically as the turning point between distributed HEI commissioning and the integrated workforce-education-service model now used in Wales.
A1	Strategic Vision for Nursing & Midwifery Chief Nursing Officer, Wales	A five-year strategic vision (2025–2030) for the nursing and midwifery professions in Wales. It sets out how nurses and midwives will "lead, innovate and influence" across the health and care system with the aim of transforming care delivery, strengthening professional identity and aligning

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	Published November 2025
	
	Accessed December 2025
		workforce development to population, system and societal needs.
		
		The "Strategic Vision for Nursing and Midwifery 2025–2030" is built around six inter-connected themes, each with ambitions and guiding principles, many of which have direct implications for education, training and workforce planning.
		
		• Valued, Respected & Empowered Workforce
		  ○ Aim: By 2030, nurses and midwives are recognised for excellence; supported to lead, grow across diverse careers; and work in safe, inclusive, flexible environments that support wellbeing, retention and workforce diversity.
		  ○ Education implication: Commission flexible career-pathway frameworks (undergraduate → early-career → advanced / portfolio careers), embed wellbeing, psychological safety, inclusive practice and Welsh-language capability into curricula and CPD; design flexible working models to support retention and attractiveness.
		• Empowered Leadership & Professional Identity
		  ○ Aim: Nurses and midwives to lead at every level — policy, system change, community care — influencing decision-making, co-producing services, and championing equality, governance, sustainability and Welsh-language care.
		  ○ Education implication: Build leadership development pathways (undergrad → senior leadership), embed service-design, policy, governance, strategic thinking, and sustainability into pre- and post-registration training; recognise leadership competencies as core outcomes.
		• Expertise through Education, Research & Data
		  ○ Aim: By 2030, nursing and midwifery practice will be evidence-driven, research-active, data-literate, and continuously improving. Career-long learning is embedded; specialism and innovation encouraged.
		  ○ Education implication: Expand post-registration CPD, specialisation and advanced practice pathways; strengthen academic-practice links (universities, HEIW, NHS) to embed research, evaluation, data-use and improvement science in curricula; commission micro-credentials for genomics, digital health, data, sustainability.
		• Population-Focused & Preventative Care

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		○ Aim: Nurses and midwives will deliver equitable, person-centred care across the life course; lead prevention, early intervention, community-based & population-health-oriented care; reduce inequalities; support inclusive and accessible care (including via Welsh language and culturally safe care). ○ Education implication: Increase community, primary care and public-health placements; embed public health, health inequalities, social determinants, population health and bilingual care competencies in pre-/post- registration curricula; develop prevention-focussed skill-mix and team-based practice training. • Innovation in Care & Workforce Models ○ Aim: By 2030, nursing and midwifery will drive agile, multi-professional, digitally enabled, value-based, and sustainable models of care. New technology, digital health, automation and integrated care models will be standard. ○ Education implication: Embed digital health, data literacy, AI/technology, informatics and sustainability into curricula and CPD; prepare workforce for new roles (multi-professional, advanced, hybrid) and team-based working; ensure training in new models (virtual care, continuity, community-based integrated care). • Global Leadership & Partnerships ○ Aim: Wales' nursing and midwifery professions contribute internationally — sharing best practice, influencing global health policy, and collaborating across borders while embedding sustainability and ethical global health values. ○ Education implication: Foster international collaboration, exchange, research partnerships, global health training; build curricula with global health, equity, sustainability lenses; support mobility and mutual learning as part of career development. Additionally, the Vision emphasises co-production (involving service users, communities, staff), sustainability and climate-aware practice, and inclusion and Welsh-language care as cross-cutting principles. The document commits to convening theme-based summits (led by Executive Nursing Directors) and producing annual work-plans with actions, milestones, and responsibilities to operationalise the vision.

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A1	National Patient Safety Plan for NHS Wales 2026 – 2031
	
	Publisher: NHS Wales Performance and Improvement
	
	Date: March 2026
	
	This document sets out a five-year, all-Wales framework for improving patient safety across the healthcare system. It establishes, for the first time, a unified national approach to reducing avoidable harm, strengthening safety culture and embedding continuous learning across primary, community, secondary and social care.
	
	Link: National Patient Safety Plan for NHS Wales 2026 – 2031
		Overall purpose and ambition
		• The Plan establishes a national, system-wide approach to patient safety, moving away from fragmented, compliance-driven activity towards coordinated improvement.
		• Its central aim is to reduce avoidable harm and build a culture of learning and improvement across NHS Wales.
		• It positions patient safety as fundamental to healthcare quality, integrated with statutory duties such as the Duty of Quality.
		
		System context and rationale for action
		• The Plan responds to a lack of a single national patient safety framework, resulting in disjointed and reactive approaches.
		• Current challenges include:
		  ○ Persistent safety risks in a system under pressure
		  ○ Limited system-wide learning
		  ○ Over-reliance on incident reporting rather than proactive risk management
		• It highlights health inequalities, rising demand and workforce pressures as compounding safety risks.
		• Financial impact is emphasised, with £114.6 million in claims and redress linked to unsafe care (2023–24).
		
		Core aim and conceptual approach
		• The Plan is built around the aim:
		"Listening, leading and learning for safer care in Wales."
		• It is structured around three foundational pillars:
		  ○ Listening – incorporating patient, staff and partner insight into safety improvement
		  ○ Leadership – visible, accountable leadership embedding safety as a priority
		  ○ Learning – continuous, system-wide learning from data and experience
		• These pillars underpin the development of a learning health system focused on prevention, not just response.
		
		Quality Management System (QMS) approach

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		• A central feature of the Plan is the introduction of a national Quality Management System (QMS) for patient safety.
		• The QMS integrates four core functions:
		  ○ Planning
		  ○ Improvement
		  ○ Control
		  ○ Assurance
		• As illustrated in the *diagram on page 16*, these elements operate together to create a continuous, system-wide safety framework linking leadership, data, culture and improvement activity.
		• The approach shifts responsibility from individuals to system design and organisational processes, embedding safety into everyday care delivery.
		
		National clinical safety priorities
		• The Plan identifies a focused set of national clinical safety priorities, selected through data triangulation and system insight.
		Key priority areas include:
		• Acute deterioration and sepsis
		• Deconditioning and frailty in the community
		• Healthcare-associated infections
		• Mental health safety in secondary care
		• Care for people with learning disabilities and neurodivergence
		• Maternity and neonatal safety
		• Medicines safety (identified as a developing priority)
		• These priorities are intended to focus national effort on areas of highest risk and harm, enabling coordinated improvement.
		
		Whole-system scope
		• The Plan applies across all sectors of NHS Wales, including:
		  ○ Primary care
		  ○ Community services
		  ○ Secondary care

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		○ Social care • It explicitly includes independent contractor services (e.g. general practice) within a national safety framework. • Emphasis is placed on integration across organisational and professional boundaries, ensuring consistency in safety standards. Six key enablers of patient safety The Plan identifies six system enablers required to deliver improvement: 1. Leadership 2. Workforce 3. Culture 4. Information and insights 5. Learning, improvement and research 6. Whole systems approach • These enablers represent the core conditions required to sustain safety improvement, including workforce capability, data infrastructure and organisational culture. Five-year implementation approach • The Plan sets out a phased delivery model (2026–2031): ○ Phase 1 (2026–27): Establish foundations (governance, systems, frameworks) ○ Phase 2 (2027–31): Deliver enhancements (culture, data integration, research) ○ Phase 3 (post-2031): Sustain and continuously improve • Actions are organised across the six enablers, with defined objectives, timelines and expected impacts. Governance and delivery model • Delivery is led by NHS Wales Performance and Improvement, working with: ○ Welsh Government ○ Health boards and trusts ○ National organisations • Oversight is provided through national governance structures aligned to the Clinical Governance Framework.

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		• The Plan emphasises clear accountability, system alignment and coordinated national oversight.
		
		Measurement and evaluation
		• Impact will be measured through:
		  ○ The Quality Outcomes Framework (QOF)
		  ○ Quantitative and qualitative indicators
		  ○ Two-yearly reviews to reassess priorities
		• Measurement is intended not only to assess outcomes but to feed learning back into the system, reinforcing continuous improvement.
		
		Overall conclusion and direction
		• The Plan sets a clear national direction for improving safety across NHS Wales, focusing on:
		  ○ Reducing harm
		  ○ Strengthening safety culture
		  ○ Improving use of data and learning systems
		• It emphasises collaboration across organisations and the role of patients and staff in shaping safer care.
		• The overarching goal is to deliver safe, effective and equitable care for all people in Wales.

A1	Barriers to higher education in Wales: evidence review Publisher: Welsh Government Date: March 2026 Barriers to higher education in Wales: evidence review synthesises existing research and data to identify the key factors that influence access to, participation in, and progression through higher education for learners in Wales. The report brings	Purpose and scope • The review aims to provide a comprehensive synthesis of evidence on barriers affecting participation in higher education in Wales. • It supports understanding of who is less likely to access higher education and why, drawing on quantitative and qualitative studies. • The report covers the full learner journey, from pre-entry through to progression and completion. Conceptual framing of "barriers" • Barriers are understood as multi-dimensional and interacting, rather than isolated factors. • The report distinguishes between: ○ Structural barriers (e.g. socio-economic context, geography)

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	together national and international evidence to provide a comprehensive overview of structural, financial, educational and social barriers. Link: Barriers to higher education in Wales: evidence review	○ Institutional barriers (e.g. admissions, support systems) ○ Individual-level factors (e.g. aspirations, attainment, confidence) • It emphasises that barriers often accumulate across the life course. Socio-economic disadvantage • Socio-economic background is identified as a primary determinant of participation. • Learners from lower-income households are less likely to: ○ Enter higher education ○ Attend higher-tariff institutions ○ Progress successfully once enrolled • Financial concerns, including fear of debt and cost of living, are highlighted as significant deterrents. Prior attainment and school experience • Educational attainment prior to higher education is a strong predictor of participation. • Differences in school performance, access to subject choices, and educational support contribute to inequalities. • The report notes that attainment gaps often reflect wider socio-economic inequalities. Information, advice and guidance (IAG) • Access to high-quality, timely information and guidance is identified as uneven. • Learners from disadvantaged backgrounds are less likely to receive: ○ Tailored advice about higher education pathways ○ Support with applications and decision-making • This contributes to lower confidence and reduced likelihood of applying. Aspirations, expectations and cultural factors • The review highlights the role of aspirations and perceptions of higher education. • Some learners perceive higher education as: ○ Financially risky ○ Not culturally aligned with their background ○ Unnecessary for their intended career

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		• Family, community and school environments strongly influence expectations.
		
		Geographic and regional factors
		• Geographic location affects access through:
		  ○ Distance from higher education institutions
		  ○ Transport and accommodation costs
		  ○ Availability of local provision
		• Rural learners and those in certain regions face additional logistical and financial challenges.
		
		Financial barriers
		• Financial considerations are a consistent theme, including:
		  ○ Living costs
		  ○ Availability of maintenance support
		  ○ Perceived and actual levels of student debt
		• Even where financial support exists, perceptions of affordability remain a barrier.
		
		Under-represented groups
		The report identifies several groups with lower participation rates, including:
		• Learners from low-income backgrounds
		• Care-experienced individuals
		• Disabled learners
		• Ethnic minority groups (with variation between groups)
		• Mature learners
		• Each group faces distinct and overlapping barriers, requiring nuanced understanding.
		
		Transitions and progression
		• Barriers do not end at entry; the report highlights challenges in:
		  ○ Transitioning into higher education
		  ○ Continuing and completing courses
		  ○ Progressing to employment or further study
		• Academic, financial and wellbeing pressures can affect retention.

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		Intersectionality of barriers
		• A key finding is that barriers are intersectional: individuals often experience multiple disadvantages simultaneously.
		• For example, socio-economic status may interact with geography, ethnicity or disability to compound disadvantage.
		
		Evidence base and methodology
		• The review draws on:
		  ○ Academic literature
		  ○ Policy reports
		  ○ Administrative and survey data
		  ○ UK and international comparisons
		• It adopts a narrative synthesis approach, integrating findings across multiple sources rather than generating new primary data.
		
		Limitations of the evidence
		• The report acknowledges:
		  ○ Gaps in Wales-specific data in some areas
		  ○ Variability in definitions and measures across studies
		  ○ Challenges in isolating causal relationships
		• It highlights the need for ongoing research and improved data linkage.
		
		Overall conclusions
		• Participation in higher education in Wales is shaped by a complex interplay of socio-economic, educational, financial and cultural factors.
		• Barriers are persistent and often cumulative, affecting both access and progression.
		• Addressing these barriers requires a holistic understanding of the learner journey, rather than focusing on single points of intervention.

A1	Routes into post-16 education and training	Purpose and scope of the inquiry

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	Publisher: Senedd Cymru – Children, Young People and Education Committee
	
	Date: July 2024
	
	Routes into post-16 education and training presents the findings of a Senedd committee inquiry into the pathways available to young people in Wales after compulsory education. The report examines the accessibility, clarity and effectiveness of routes into further education, apprenticeships, training and higher education, and identifies key issues affecting learner choice, progression and outcomes.
	
	Link: Routes into post-16 education and training
		• The inquiry was undertaken to understand how effectively the post-16 system in Wales supports young people to access, navigate and progress through education and training pathways.
		• It considers routes including:
		  ○ Further education (FE)
		  ○ Apprenticeships and work-based learning
		  ○ Sixth form provision
		  ○ Higher education pathways
		• The report draws on written and oral evidence from stakeholders, including education providers, learners, employers and policy bodies.
		
		Complexity and fragmentation of pathways
		• A central finding is that the post-16 system is complex and fragmented, making it difficult for learners to understand available options.
		• There is no single, coherent framework that clearly sets out progression routes across FE, HE and vocational pathways.
		• This complexity can lead to confusion and suboptimal decision-making.
		
		Information, advice and guidance (IAG)
		• The report highlights variability in the quality and availability of careers advice and guidance.
		• Some learners receive comprehensive, impartial support, while others experience limited or inconsistent guidance.
		• Concerns are raised about:
		  ○ Timeliness of advice
		  ○ Awareness of vocational and apprenticeship routes
		  ○ Bias towards certain pathways (e.g. academic routes)
		
		Perceptions and status of different pathways
		• Academic routes are often perceived as more prestigious than vocational or technical options.

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		• Apprenticeships and FE pathways are sometimes viewed as secondary choices rather than equal alternatives.
		• These perceptions influence learner choices and may limit uptake of certain routes.
		
		Transitions and progression
		• The report identifies challenges in transitions between stages, including:
		  ○ Moving from school to FE or apprenticeships
		  ○ Progressing from FE to HE
		  ○ Switching between pathways
		• There are gaps in clear progression routes and recognition of prior learning, which can hinder mobility.
		
		Access and equity
		• Access to post-16 opportunities varies by:
		  ○ Geographic location
		  ○ Socio-economic background
		  ○ Availability of local provision
		• Learners in rural areas or disadvantaged communities may face additional barriers, including travel and limited course availability.
		
		Availability and capacity of provision
		• The report notes variation in the availability of courses and training opportunities across Wales.
		• Some regions have limited access to certain vocational or specialist programmes.
		• Capacity constraints can restrict learner choice.
		
		Apprenticeships and work-based learning
		• Apprenticeships are recognised as an important route but face challenges including:
		  ○ Limited availability in some sectors
		  ○ Competition for places
		  ○ Variability in employer engagement

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		• The report highlights the need for clearer pathways into and through apprenticeship programmes.
		
		Role of employers
		• Employer engagement is identified as a key factor in effective post-16 pathways.
		• However, involvement is inconsistent, and opportunities for work-based learning vary across sectors and regions.
		
		Data, tracking and system understanding
		• The report identifies limitations in the availability and use of data on learner journeys and outcomes.
		• There is a lack of comprehensive tracking of progression across different pathways.
		• Improved data integration is seen as important for understanding system performance.
		
		Welsh Government reforms and Medr
		• The report references ongoing reforms to the post-16 system, including the establishment of Medr.
		• It considers how these reforms aim to create a more joined-up tertiary education system.
		
		Key findings and conclusions
		• The post-16 education and training system in Wales is characterised by:
		  ○ Complexity and fragmentation
		  ○ Variable access to guidance and provision
		  ○ Unequal perceptions of different pathways
		  ○ Gaps in progression and data
		• The report concludes that while there are multiple routes available, they are not always clearly understood, equally valued or easily navigable by learners.

A2	Review of Health Professional Education and Training Across Wales Produced by KPMG on behalf of HEIW	This report, commissioned by Health Education and Improvement Wales (HEIW) and prepared by KPMG LLP, was published in October 2019. It presents a comprehensive review of undergraduate and postgraduate health professional education and training across Wales, with the aim of

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	Published October 2019 Accessed August 2025	informing future commissioning decisions to support the development of the health and care workforce. The review was undertaken to support HEIW's upcoming education commissioning process. It focused on: • The quality and responsiveness of current education provision • Access to education across Wales, particularly in rural areas • The extent and effectiveness of inter-professional education • The Welsh language provision within health education programmes Stakeholder engagement was central to the review, involving over 130 individuals from education providers, Health Boards, Trusts, government bodies, professional organisations, and students. Key Findings • Quality of Education: Generally viewed positively by stakeholders, with students well-prepared for practice. However, concerns were raised about placement experiences and support for newly qualified professionals. • Access to Education: Limited provision in rural areas was noted, with calls for more flexible delivery models such as satellite campuses and distance learning. • Inter-professional Education: Delivery was inconsistent across institutions. A siloed approach was identified, with recommendations for more collaborative and integrated learning. • Welsh Language Provision: While full Welsh-medium programmes were not widely demanded, there was strong support for bilingual education and the development of Welsh language skills among healthcare professionals.
A2	Strategic Workforce Plan for Primary Care Published May 2024 Accessed August 2025	HEIW produced a five-year Strategic Workforce Plan for Primary Care (2024/25–2029/30) to deliver sustainable, multi-professional workforce models aligned to *A Healthier Wales* and the Primary Care Model for Wales; launched 15 May 2024. Clear case for change & vision. Rising demand/complexity, ageing, multimorbidity, and tech shifts require team-based, prevention-first, digitally enabled primary care; the vision emphasises equitable services matched to local need, attractive careers, and broader skills.

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		Twenty-six actions across eight themes (education-heavy). Highlights include: • Excellent education & learning (Actions 13–14): Structured CPD via Primary Care Academies; core skills in SDM, QI, MECC, mental health; inclusion-health training (incl. prison health competency framework); remote clinical decision-making; urgent care competencies; expand pre- and post-registration training in primary care (more placements for pharmacists, nurses, AHPs, healthcare scientists, more foundation doctors in primary care, expanded GP specialty provision); equitable transition programmes (e.g., GPN Foundation, new AHP programmes); Advanced Training Practice model in optometry; educator development plan to value and standardise the educator workforce. • Workforce supply & shape (Actions 8–12): Simplified primary care workforce planning methodology; scenario-based demand modelling that explicitly factors supervisory capacity; embed enhanced/advanced/consultant practice framework; retention taskforce and tailored schemes; apprenticeships expansion; GP workforce solutions (partnership/salaried levers, reduce locum reliance; review GP retainer); feasibility of a specialist staff bank. • Engaged, healthy, motivated workforce (Actions 1–4): Bespoke experience & wellbeing measurement for all contractor settings; preceptorship/mentorship for new starters (GPNs, GPs incl. in areas of deprivation, urgent primary care, dental roles); induction modules for non-clinical staff (population health/inequalities); supervision guidance and upskilling for multiprofessional teams; explore parity of staff benefits. • Seamless workforce models (Actions 5–7): Public communication on primary care team roles; toolkits on scope/regulatory/supervisory needs; embed new roles (e.g., physician associates, non-registered roles such as community health workers, care navigators, social prescribers) with standardised job descriptions and education pathways. • Attraction & recruitment (Actions 15–17): Rotational/portfolio/flexible roles; review incentive schemes; strengthen careers outreach via Careersville and an all-age careers strategy. • Leadership & succession (Actions 18–21): Equitable access to national leadership programmes; bespoke development for cluster/collaborative leads; Clinical Fellowship in health inequalities/population health to inform pre-/post-registration curricula; professional management & leadership pathways.

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		• Digitally ready workforce (Actions 22–24): Primary care digital roadmap with training implications; roll-out of HEIW digital competency tool; immersive technologies access during education and development. • Additional actions (25–26): Welsh language training offer (More Than Just Words) and widening access for under-represented groups into primary care careers. Benefits expected: More high-quality placements, clearer career pathways, improved recruitment/retention, time released for teaching/training/QI—framed within the quadruple aim.
A2	heiw.nhs.wales/files/all-wales-simulation-strategy-mg-draft-6pdf/ Published 2022 Accessed August 2025	HEIW's five-year All-Wales Simulation-Based Education and Training Strategy, 2022–2027 setting vision, principles and delivery aims to make high-quality, interprofessional simulation accessible across Wales; created through national engagement to guide IMTP delivery and quality assurance. Vision & mission (what "good" looks like). HEIW will lead development of a highly trained workforce delivering safe, sustainable care; SBET is positioned as integral to workforce development, cost-effective, interprofessional, and focused on patient/service-user outcomes. Four strategy domains with 12 workstreams. Engaging People & Partnerships (communications & networking; collaborations across Wales/UK/global & with industry; digital platforms to share resources and showcase best practice). Promoting Quality (faculty development; standards & QA; evaluation). Supporting Simulation Delivery (accessibility; interprofessional development; CPD & performance review for SBET faculty). Designing Future Directions (immersive technologies; research; evidence-based practice translation). Faculty development – tiered, equitable, multiprofessional. Commitments to a standardised faculty programme so educators gain the skills, knowledge and behaviours to deliver consistent, safe SBET; flexible access; explicit support for interprofessional SBET. Standards & quality assurance (ASPiH-aligned). Promote and embed ASPiH standards (and relevant professional/regulatory standards) into faculty development and routine SBET

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		design/delivery; foster a culture of learning from success/failure to improve safe learning environments. Evaluation that reaches outcomes. Evaluate all phases of SBET and reinforce assessing impact on patient, service-user and learner outcomes; provide equitable access to evaluation tools and support. Access & capacity across Wales. Improve accessibility, deliverability and utilisation of facilities, equipment, technicians/actors and faculty; strive for equitable access to SBET for the whole workforce (registered and non-registered). Interprofessional development as default. SBET is framed as fundamental to interprofessional education across the continuum (undergraduate → postgraduate → CPD), with clear definitions of IPE. Protected educator contribution. Recognise and support SBET faculty through CPD and performance review so education isn't crowded out by service pressures. Immersive technologies roadmap. Identify priorities/benefits/challenges; co-create a vision for XR (AR/VR/MR) that is equitably accessible; promote sharing of innovation and best practice. Research & evidence translation. Build a research culture (linking with HEIW ERIIC), encourage projects on SBET's impact, and translate literature into everyday practice. Cross-cutting commitments. Equality & diversity, Welsh language, and sustainability are embedded (EIA and sustainability impact assessment referenced).
A2	HEIW Genomics Workforce Plan Published November 2024 Accessed September 2025	A three-year roadmap with 33 actions to develop a sustainable genomics workforce for NHS Wales, both the *specialist* laboratory/clinical workforce and the *wider* workforce's "genomic literacy" in line with the Genomics Delivery Plan for Wales and UK Genome UK commitments.

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		Mainstreaming genomics beyond specialists. The plan's central premise is to embed genomic testing and decision-making into routine pathways (cancer, rare disease, infection control, pharmacogenomics), which requires targeted education for non-specialists and clearer role definitions across MDTs. Expect curricula and CPD to prepare clinicians, nurses, pharmacists and AHPs to *offer* tests appropriately, consent, interpret decision-support outputs, and escalate to specialist services. Two workforce lenses for education design. 1. Specialist genomics workforce (AWMGS, PHW pathogen genomics, clinical scientists, bioinformaticians, clinical geneticists, genetic counsellors) with actions on structured career pathways, accelerated training pipelines, and support for professional registration. 2. Wider NHS workforce — with actions to lift "genomic literacy" across primary, community and secondary care so testing and results are used at the right point in care. Curriculum and pathway redesign (specialist). Actions include reviewing/shortening training time in healthcare science specialisms; leveraging the Genomics Training Academy; using learning pathway reviews (e.g., Assistant/Associate roles) to widen entry and progression; and ensuring apprenticeship and degree routes align to service need. Clearer, multi-professional models. The plan promotes "T-shaped" skills and introduces/extends associate/practitioner support roles within specialist services; mapping career frameworks across healthcare science to improve attraction and retention; and growing the number of registered genomic biomedical scientists. Education and competency frameworks need to reflect these redesigned teams. Pharmacogenomics as a priority use-case. Specific actions task HEIW with identifying education, training and competency requirements for *multi-professional* delivery of pharmacogenomics (including extended/advanced/consultant roles), and scoping prescriber competency expansion across Wales. This will require UG/PG content and CPD micro-credentials for prescribers and pharmacists.

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		Primary & community capability. Actions point to working with Primary and Community Care Academy and CPD leads to expand practical education resources for GP teams and community pharmacy; and with secondary-care training departments to ensure resources for staff in hospitals. Higher education partnership & commissioning levers. The plan calls for HEIW to: embed genomics in *all* undergraduate and/or foundation curricula where relevant; require appropriate genomics education within post-registration training (contractual where possible); and collaborate with universities on programme updates and supervised practice capacity. Digitally ready workforce. Priorities include bioinformatics capacity, digital infrastructure to enable flexible work/learning, and practical training in data quality, pipelines and cybersecurity — acknowledging that technology and generative AI will increasingly support interpretation and joint decision-making. Wellbeing, supervision & attraction/retention. The plan addresses workload, vacancy and progression challenges; promotes flexible/remote options (enabled by lab information systems); and encourages non-management clinical progression routes (e.g., consultant-level roles in bioinformatics). Supervision capacity and quality of placements are flagged as enablers for retention. Implementation and benefits tracking. A programme-managed approach will prioritise the 33 actions and develop a benefits framework to measure outcomes (care quality, population health, staff engagement, recruitment/retention, and intelligence-led workforce planning).
A2	HEIW Workforce Plan A STRATEGIC MENTAL HEALTH WORKFORCE PLAN FOR HEALTH AND SOCIAL CARE Published November 2022	A national plan setting out 33 actions across seven themes to secure a sustainable, skills-fit mental health workforce for health and social care in Wales, aligned to the 10-year Workforce Strategy and *Together for Mental Health*. An implementation plan followed in 2023, with government funding to support delivery. Mental health is "everybody's business": baseline literacy for all staff. The plan calls for *all* health and social care professionals to have a core mental health component in education and training,

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	Accessed September 2025	with advanced training for groups such as GPs and ED teams, and access for third-sector partners and contractors. Co-production with people with lived experience is expected. Excellent education & learning (theme). Actions include: • Redesign psychiatry education & training to improve recruitment/retention and flexibility, aligned with Future Doctor recommendations. • Review quality frameworks for commissioned programmes and placements (to tackle attrition and improve experience), widening multi-professional placements in mental health settings. • Strengthen social work pathways (greater undergraduate exposure/specialism and a post-qualifying framework for mental health). Digitally ready workforce (theme). Build a network of digital champions across organisations to drive safe uptake of technology in mental health services; ensure workforce models and curricula reflect digital opportunities (remote care, data use). Seamless workforce models (theme). Expand capacity in community and primary care teams (e.g., cluster-level resources and consistent role specs); systematically capture lived-experience insights to shape skills and competencies for integrated care. Workforce supply & shape (theme). Increase commissioning in priority areas; use scenario planning to shape specialist supply (nursing, pharmacy, psychiatry, social work, psychological therapies); develop new roles (e.g., peer workers) within MDTs. Attraction, recruitment, and retention (themes). Strengthen career pathways, widen entry routes, and make mental health a more attractive choice — responding to engagement findings on perceived popularity, feeling valued, and service navigability. Leadership & succession; wellbeing and inclusion. Promote compassionate and collective leadership, improve wellbeing culture, and ensure the workforce reflects Welsh language and population diversity.

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		Delivery & governance. The plan is co-owned by HEIW and Social Care Wales, with a published implementation plan (May 2023) and Welsh Government funding (£3.3m in April 2023) to accelerate delivery of the 33 actions.
A2	HEIW Strategic Pharmacy Workforce Plan Published June 2023 Accessed September 2025	A national plan to stabilise and grow the pharmacy workforce across all sectors in Wales, aligning to *Pharmacy: Delivering a Healthier Wales* and the Workforce Strategy for Health & Social Care; it responds to new GPhC education standards, growing demand, wellbeing concerns and service transformation (digital, manufacturing, primary care expansion). Implement new pharmacist & pharmacy technician education standards. The plan is built around the GPhC Initial Education & Training Standards (IETS): all new pharmacists will register as independent prescribers from 2026, with training and placements redesigned accordingly; technician standards (2017) underpin expanded safe delegation and skill-mix. Education must prioritise "day-one" clinical capability, prescribing supervision, and quality of training capacity. Protected learning time & educator capacity. Recurrent workplace pressure limits training capacity; actions call for protected development time, more Designated Supervisors, tutors and mentors, stronger quality management/assurance and improved access to centrally funded resources — to make programmes deliverable in practice and improve retention. Career frameworks & credentialling. A Wales-wide, competency-based pathway is set: RPS Foundation → Advanced → Consultant level for pharmacists (from 2026 cohorts), plus mapped pathways for pharmacy technicians, trainees and support staff, with clear entry, progression and multi-professional opportunities. Commissioning and CPD should explicitly align to these steps Multi-sector, multi-professional learning. Expand multi-sector training (including for pre-registration pharmacy technicians) and embed multi-professional placements/learning so pharmacists and pharmacy technicians train alongside GP, hospital, community and social care teams; this supports seamless models and "work-readiness" across settings. Digital medicines & informatics skills. Priorities include building a digitally ready workforce (e-prescribing, electronic records, automation, LIS), appointing informatics leadership, and

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		developing practical competencies in digital workflows and safety — tightly coupled to the Digital Medicines Transformation Portfolio. Immersive and simulation-based education. Scale immersive technologies and simulation to support complex problem solving and teamworking across the pharmacy career pathway; ensure this sits within the HEIW digital education vision. Genomics & advanced therapies literacy. Develop education and CPD so pharmacists and technicians can support genomics and advanced therapy medicinal products in mainstream practice (consent, test ordering, interpretation, MDT roles). Wellbeing, inclusion & Welsh language. Education and placement design should foster compassionate cultures and wellbeing (including rest breaks and supportive supervision), address attainment gaps for ethnic minority learners, widen routes into pharmacy, and recognise Welsh-language capability to meet population need. System alignment to service change. Education must reflect five strategic drivers shaping roles and curricula: *Pharmacy: Delivering a Healthier Wales*, A New Prescription (community pharmacy contract reform), TrAMs (centralised manufacture), the hospital clinical pharmacy review, and the Digital Medicines programme.
A2	Strategic Workforce Plan for Primary Care 2024/25-2029/30 Published May 2024 Accessed September 2025	A five-year plan (2024/25–2029/30) setting 26 actions to stabilise, renew and transform the primary care workforce across Wales, aligned to *A Healthier Wales* and the Primary Care Model for Wales. It focuses on multi-professional teamworking, wellbeing/retention, digital capability and clearer pipelines into, and through, primary care. Make primary care multi-professional by design. The plan centres on holistic, team-based care at practice/cluster footprint, with consistent service offers and skills matched to local need. Education and placements should therefore be multi-professional by default, with exposure across GP, community pharmacy, dental, optometry, nursing, AHPs and inclusion health services.

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		Access to education & training (action 13). Improve access to CPD and formal education for the *current* workforce, removing practical barriers (funding release, space, scheduling) so more staff can upskill in-role. Tie provision to service priorities and quality assurance. Grow education & training *in* primary care (action 14). Expand provision and placement capacity within primary care (not just in acute settings) so learners are "work-ready" for community models; scale HEIW's hub-and-academy approach and multi-sector rotations. Structured supervision at scale (action 3). Produce multi-professional supervision guidance and upskill supervisors; prioritise protected time and a consistent standard across contractors and HB-employed teams to improve learner experience and retention. Onboarding and early-career support (action 2). A national support offer for people new to primary care (including newly qualified staff) — e.g., induction curricula, mentorship and core skills — to reduce early attrition and accelerate safe autonomy. Career pipelines, apprenticeships and new roles (actions 7, 10, 11, 15–17). Embed and evaluate roles that support prevention and prudent care (e.g., social prescribing, PA/ANP roles, extended pharmacy technician roles); increase apprenticeships; promote portfolio/rotational models; and develop sustainable GP workforce solutions (partnership/salaried routes, reduced reliance on locums). Education pathways and micro-credentials should map to these roles. Leadership for primary care (actions 18–21). Ensure equitable access to national leadership programmes, sustain bespoke offers for cluster/collaborative leads, and introduce a Clinical Fellowship in health inequalities/population health to influence UG/PG curricula. Digital capability (actions 22–24). Align curricula with the primary care digital roadmap, roll out HEIW's digital competency tool to identify training needs, and improve access to immersive technologies for education and development (simulation/VR). Wellbeing, inclusion, Welsh language (actions 1, 4, 25–26). Measure staff experience/wellbeing; explore extending benefits for primary care staff; promote Welsh-language training; and widen

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		access for under-represented groups into primary care careers — all of which should be reflected in learner support and widening-participation objectives.
A2	HEIW Dental Strategic Workforce Plan Published May 2024 Accessed September 2025	A five-year plan (2024/25–2029/30) to stabilise, renew and transform the primary care dental workforce in Wales. It sits as a companion to the Strategic Workforce Plan for Primary Care and includes six dental-specific actions in addition to the cross-primary-care actions. Make dental education primary-care-centred. The plan focuses on General Dental Services (GDS) and aims to ensure breadth of skills and competencies for community delivery; placements and curricula should therefore be designed and quality-managed *in* primary care settings, not only in acute or school environments. Scale educator capacity & supervision quality. A core action is to develop an educator development plan to recognise, train and support supervisors/tutors across sectors, backed by multi-professional supervision guidance and protected time (linked to the Primary Care plan actions). Education commissioning should require consistent supervision standards across contractor and Health Board settings. Retain early-career dentists through innovative training offers. HEIW will develop targeted early-career training models (e.g., longitudinal schemes, fellowships, incentive/tie-in offers) to keep trainees in Wales; UG, DFT/VT and post-grad pathways should integrate these options with clear competencies and mentorship. Grow therapy skills and flexible progression routes. Concrete supply actions include increasing BSc Dental Therapy places by 60% and commissioning a 1-year top-up conversion for Level 5 Dental Hygienists to BSc Dental Therapists — so curricula, placement capacity and supervision for therapists must expand accordingly. Strengthen data literacy and digital practice. The plan prioritises digital and technological capability, workforce data improvement (e.g., WNWRS for dental practices) and collaboration with DHCW; programmes should include informatics, safe digital workflows, and data stewardship linked to service transformation.

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		Wellbeing, inclusion and fair access to development. Low morale, stress and retention challenges are prominent; onboarding support for people new to primary care, access to CPD, and equitable benefits/support are emphasised. Learning design should build psychologically safe supervision and flexible access (time, funding, modality). Link education to contract reform and skill-mix. Engagement highlighted contract mechanisms and employment models as major drivers of workforce behaviour; curricula should prepare teams to work at the top of scope, deploy effective skill-mix, and operate within evolving GDS models and prevention-first care. Clear governance & benefits tracking. Delivery will prioritise actions, costings and a benefits framework; education teams should align quality assurance, commissioning levers and metrics with this framework for accountability.
A2	HEIW National Diagnostics Programme Workforce Plan Published January 2024 Accessed September 2025	A short-to-medium-term plan that consolidates actions across the national diagnostics programmes into a single, focused workforce plan for Wales. It responds directly to the Welsh Government's Diagnostics Recovery and Transformation Strategy (2023–2025) and sets out 25 actions intended to have the greatest near-term impact while regionalisation and digital transformation gather pace. Design education around a whole-system diagnostics model. The plan shifts from siloed modalities to a *combined approach* across imaging, pathology, endoscopy and healthcare science — curricula and placements should therefore emphasise cross-modal pathways, shared competencies and MDT working rather than single-discipline training alone. Prioritise "fast-impact" skills and roles. Because this is an accelerative plan (not a long-term strategy), focus education and CPD on skills that quickly add capacity: reporting radiographers, reporting biomedical scientists, advanced/consultant clinical scientist roles, and prudent multi-professional models. (These role directions are also reinforced in the Government strategy.)

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		Grow placement capacity in regional and community settings. As services regionalise and move suitable diagnostics closer to home, education should expand supervised practice in regional hubs and community/primary care diagnostics (e.g., community imaging, endoscopy networks, POCT environments), with consistent quality standards. Embed digital & data capabilities as core literacy. The plan's context expects digital test requesting/reporting on national platforms, cross-HB reporting, AI adoption, and national LINC lab systems. Programmes must cover data stewardship, informatics workflow, AI-in-practice (limits, bias, supervision) and cyber hygiene, with assessment in real clinical tasks. Adopt the 'academy' model for training at scale. Building on the National Imaging Academy, extend academy-style simulation, protected training lists, and educator pipelines across other diagnostic disciplines to accelerate competence and relieve service pressure. Quality, safety and accreditation awareness. Education should align to the plan's emphasis on accreditation, decontamination standards, safe asset management and value-based procurement — so graduates understand how service quality frameworks shape daily diagnostic practice. Future-proof with flexible, modular CPD. Because technology and regional models are evolving, create modular micro-credentials that can be updated rapidly (e.g., AI-assisted reporting, digital cellular pathology, PET-CT expansion, POCT governance), linked to the 25 actions and usable across sectors. Equity, Welsh language and inclusion. The Government strategy foregrounds reducing inequalities; education and supervision should include inclusive communication (including Welsh-language capability where needed) and equitable access to training/CPD across Health Boards and contractor sites.
A2	HEIW Strategic Nursing Workforce Plan: 2025 – 2030 Published March 2025	he first all-Wales Strategic Nursing Workforce Plan: 2025–2030, setting out 32 national actions to grow, transform and support the nursing workforce across primary, community, secondary and independent sectors; underpinned by workforce modelling, engagement ("Our Big Conversation") and alignment to national policy.

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	Accessed September 2025	1) Grow domestic supply & placement capacity (reduce reliance on international recruitment over time). Actions include: strengthen supply/demand modelling for the Education & Training Plan; targeted retention (aim to reduce turnover to 5%); introduce and integrate the Registered Nursing Associate (Band 4) role with flexible routes to registration; refreshed Train Work Live marketing; improve workforce data quality; broaden placements into primary/community, public/population health, independent & third-sector; expand Practice Education Facilitators; and grow the clinical educator workforce with a national role descriptor, competency framework and career pathway. Also expand Return to Practice. 2) Curriculum modernisation: digital, data, AI & genomics. Mandate digital capability across undergraduate and postgraduate programmes; use the Digital Capability Framework to diagnose needs and create a digital competency passport; develop a Genomics Workforce Development Toolkit & Capability Framework; review curricula with HEIs to strengthen genomics, public health, digital requirements and automation; and support safe expansion of independent/supplementary prescribing with refreshed pathways. 3) Prevention and population health at the core. By 2030, nurses should demonstrate stronger capability to influence social determinants of health and reduce inequalities. Education priorities include life-course public health, epidemiology and data use, with expanded/prepared Specialist Community Public Health Nursing (SCPHN) routes and exploration of a Public Health Nurse (PHN) role; education must support upstream prevention and community-anchored practice. 4) Shift education and learning to community-centred, team-around-the-person models. Training should support place-based, multi-professional care (e.g., Wales' Enhanced Community Care and Primary Care Model for Wales) and new community roles (e.g., Community Matron) — with rotation, supervision, and methods that reflect community demand and productivity. 5) Advanced & consultant practice pathways. Commission Level 7 Advanced Practice education; fund PhD learning and development; scale

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		training for remote/advanced decision-making and motivational interviewing; extend work-based learning for integrated, preventive and enhanced community care. 6) Virtual care and new models of delivery. Scope skills and education to implement virtual nurse roles; build capability for telehealth, remote monitoring, health informatics and clinical data use; ensure digital literacy for HCSWs and nursing registrants (with accredited units/qualifications). 7) Educator, supervision and CPD infrastructure. Strengthen preceptorship, clinical supervision and mentoring (including restorative approaches); publish a CPD Strategy to standardise access; grow the clinical educator workforce and leadership; develop career frameworks (including portfolio careers) from HCSW through consultant nurse; and improve access to wellbeing resources (to tackle sickness/turnover). 8) Leadership, culture and talent. Expand leadership programmes (senior nurse/matron and aspiring leaders), formal succession planning & talent management, including targeted diversity pipelines (e.g., Black, Asian and Minority Ethnic Future Senior Leader Talent Pool) and compassionate leadership development; align to NMC's review of The Code and Revalidation. 9) Welsh language capability. Promote and provide Welsh language training to improve person-centred care and outcomes; embed access via a proactive "Active Offer" culture. 10) Outcomes, benefits and implementation. Benefits to be tracked via PROMS/PREMS, workforce measures (vacancies, fill rates, turnover/sickness), education fill rates and leadership access; actions categorised as initiate/accelerate/underpin with business-case gating and use of existing HEIW commissioning cycles.
A2	HEIW Strategic Perinatal Workforce Plan 2025-28	A multi-professional perinatal workforce plan (2025–2028) for maternity and neonatal services in NHS Wales. It sets national actions across four themes, growing the workforce; education &

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	Published April 2025 Accessed September 2025	training; leadership & culture; and workforce transformation, to recruit, retain, train and digitally enable teams, and to address safety, quality and equity priorities highlighted in national reviews. Multi-professional by design (who the Plan covers). Education and placements should reflect the full perinatal team — midwives; neonatal, peri-operative and enhanced-care nurses; obstetricians, neonatologists and obstetric anaesthetists (incl. SAS and locally-employed doctors); sonography/obstetric radiology; AHPs (e.g., psychologists, SLT, OT, physio, dietetics); healthcare scientists; pharmacists; and physician associates. Structured support for locally-employed (LE) doctors. Create a Wales-wide package (tutors, induction, supervision, study leave and e-portfolio access) to improve parity of training and progression for LE doctors — a fast-growing segment in perinatal rotas. Support-worker career pathways (Bands 2–4). Develop an all-Wales competency and progression framework, commission work-based learning for L2–L4, and train assessors so competencies can be signed off locally and safely. Standardise and expand priority clinical training. • Neonatal nursing "Qualified in Specialty (QIS)" course standardised across Wales. • Work-based, multi-professional education for transitional care, special care, neonatal outreach, peri-operative and enhanced maternity care. • Prioritise commissioning of a university-accredited Enhanced Maternity Care module for midwives and ultrasound education for HCPC/NMC/RCT-registered staff. • Build genomics literacy into perinatal education. Digital capability as core literacy. Develop a Digital Education & Training Plan (pre- and post-registration), roll out the HEIW Digital Capability Framework to diagnose needs and commission targeted CPD, and stand up digital leadership offers in readiness for Digital Maternity Cymru. Maternal Medicine workforce model. Scope the workforce and training requirements for a Maternal Medicine Network, including the Obstetric Physician role, with education aligned to rising complexity and regional models.

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		Perinatal Academy (options appraisal). Test an academy model to coordinate simulation, protected training lists and educator pipelines across perinatal teams, building on academy approaches used elsewhere in Wales. Equity and inclusion in learning. Develop training/resources to reduce inequalities for Black and ethnic minority women, birthing people and babies; ensure access to development for all staff groups. Sonography capacity. Collaborate with the NHS Executive National Imaging Programme to stabilise and grow sonography capability, with aligned training routes and supervision capacity. Workforce intelligence driving commissioning. Build scenario-based modelling, a multi-professional perinatal workforce dashboard, and use outputs to shape HEIW's Education & Training Plan (including increases in specific training programmes, placements and specialty strategies such as O&G, Neonatal GRID and Obstetric Anaesthesia SIA).
A2	heiw.nhs.wales/files/workforce-trends-report-march-2025/ NHS Wales Workforce Trends Report Health Education and Improvement Wales (HEIW) Published March 2025	The report presents a detailed analysis of workforce data across NHS Wales, highlighting trends in workforce size, composition, and distribution over time. It shows that the overall NHS Wales workforce has grown in recent years, reflecting efforts to expand capacity and respond to increasing service demand. However, this growth is uneven across staff groups and regions. A key theme in the report is the continued presence of workforce shortages and vacancies. While recruitment has increased in some areas, vacancy rates remain high in several professional groups, including nursing, certain medical specialties, and some allied health professions. These shortages are described as persistent and, in some cases, worsening. The report identifies variation in workforce distribution across health boards and regions. Some areas experience greater challenges in recruitment and retention, particularly in rural or less densely populated regions. This contributes to unequal workforce availability and service pressures across Wales.

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		Workforce demographics are explored in detail. The report highlights an ageing workforce in several professions, with a significant proportion of staff approaching retirement age. This creates future supply risks and underscores the need for succession planning. At the same time, there is an increasing number of younger entrants in some professions, reflecting recent expansion in training pathways. Retention is identified as an ongoing challenge. The report notes patterns of staff turnover, including movement within the NHS, exits from the workforce, and reliance on temporary staffing. Issues such as workload, wellbeing and career development are referenced as factors influencing retention, although the report focuses primarily on describing trends rather than analysing causes in depth. The report also examines the use of temporary staffing, including agency and bank staff. It notes continued reliance on temporary workforce solutions to fill gaps, which has implications for continuity of care and cost. International recruitment is identified as an important component of workforce supply in some areas. The report describes trends in recruitment from outside the UK and highlights its contribution to workforce growth, while also noting variability across professions. Skill mix and workforce roles are discussed, with evidence of changes in the composition of teams. There is growth in certain roles, including support staff and advanced or extended roles, reflecting changes in service delivery and workforce models. The report includes analysis of training and education pipelines, linking workforce supply to student numbers and training outputs. It highlights the importance of aligning education commissioning with workforce demand, although detailed analysis of this relationship is limited. Data on working patterns is also presented, including full-time and part-time employment. The report notes increasing flexibility in working arrangements, which affects overall workforce capacity when measured in whole-time equivalents.

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		Overall, the report provides a comprehensive statistical overview of the NHS Wales workforce, identifying key trends in growth, vacancies, demographics, and workforce composition. It highlights a system experiencing both expansion and pressure, with ongoing challenges in recruitment, retention, and distribution of staff.
A3	Advanced Therapies Wales Delivery Plan Published January 2025 Accessed September 2025	Co-ordinated by ATW and endorsed by WG, it's the first national plan of its type in the UK to coordinate NHS Wales, HEIs and partners to ready services, workforce and infrastructure for advanced therapy medicinal products (ATMPs), covering ecosystem development, delivery pathways, research capacity and a central point for information and engagement. System readiness requires role-specific training across the ATMP pathway. The ATTC NHS Readiness Toolkit sets out the competencies and artefacts providers need for safe delivery: governance, business/financial planning, QA & risk management, operational delivery, clinical practice, education & training, long-term follow-up, and clinical trials. Education should mirror these sections with mapped learning outcomes and competency sign-off (e.g., SOP literacy, chain-of-identity/custody, apheresis and infusion workflows, pharmacy handling, data capture and follow-up). Clinical trials and adoption skills. The UK pipeline indicates ~36 ATMPs across 34 indications expected within three years, making trial delivery and adoption skills (set-up speed, governance, metrics, outcomes-based agreements) essential. Build modules on trial readiness, performance management & metrics, and real-world outcomes for ATMPs. Patient/public involvement (PPIE) and equitable access. MW-ATTC emphasises raising public awareness, equity of access to ATMP trials, and a Patient Charter—education should develop plain-language communication, informed consent in novel therapies, and community engagement skills (including Welsh-medium resources). Service pathway skills: from referral to long-term follow-up. Training must cover pathway mapping, logistics, infusion & monitoring, toxicity management, and extended follow-up obligations unique to ATMPs (regulatory requirement). Embed this in interprofessional simulation and assessment.

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		Workforce and educator development. The plan's ecosystem aims require educator capacity (clinical educators, pharmacy, apheresis, cellular processing, research nurses, data managers). Create joint HEI–NHS educator roles and CPD in GxP (GCP/GMP/GDP), supervision for novel roles, and outcomes evaluation. (Inference grounded in ATTC sections on QA, trials, and education.) Data and outcomes literacy. Wales is building an ATMP outcomes programme; curricula should include data stewardship, registry participation, outcomes-based contracting literacy, and methodologies for real-world evidence. Policy alignment and strategic intent. The delivery plan advances the Welsh Government's Advanced Therapies Statement of Intent (equitable access, economic opportunity). Educators should connect learning to value-based healthcare and Welsh industrial strategy.
A3	Unpacking Welsh regional migration: A deep dive into higher education progression across the Welsh parliamentary regions | UCAS Published July 2023 Accessed August 2025	Uses UCAS applications/acceptances to examine who studies where across the five Senedd regions, and what this means for participation, widening access and local supply. Participation varies widely by region (supply matters). 18-year-old entry rates range from 37.9% in South Wales Central to 29.7% in South Wales East (gap 8.2pp). South Wales East lacks a resident HE provider (aside from campuses), reinforcing the role of local provision in progression. Strong preference to study locally within Wales. Applicants commonly apply to and are placed within their own region, driven by proximity and transport links; South Wales Central attracts the largest numbers (e.g., 5,605 placements, including 1,470 from neighbouring South Wales East). Cross-border patterns differ. When Welsh students go to England, geographical proximity weakens: e.g., North West England takes 2,345 Welsh acceptances (vs 810 to West Midlands). From Wales, North Wales → North West England is the largest regional flow (1,535). Wales attracts most students from South West England into South Wales Central.

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		Subject demand aligns with NHS needs. Nursing & midwifery and business & management are the top choices across all regions; health subjects have broad appeal, implying latent clinical pipeline if barriers are reduced. Apprenticeships interest is highest where HE access is lowest. South Wales East shows the highest interest in apprenticeships (36%) vs 34% Wales average, aligning with its lower HE entry rate and provider gap. Rural–urban pattern is distinctive in Wales. Rural entry rates exceed urban in all regions (e.g., North Wales: 35.6% rural vs 28.0% urban), the reverse of England; material deprivation in urban areas likely depresses urban progression. Targeting urban WIMD Quintile 1 areas is advised. Welsh language & international. Demand for courses with "Welsh" in the title is concentrated in North Wales and Mid & West Wales; South Wales Central has the highest international acceptances (notably from China/India), suggesting differentiated regional branding.
A3	Universities Wales and Chairs of Universities Wales joint response to the Finance Committee of the Senedd's call for information on Welsh Government Draft budget proposals for 2025/26 Published November 2024 Accessed October 2025	Written by Universities Wales (UW) and Chairs of Universities Wales (ChUW), this response outlines the higher education sector's position (representing Welsh universities) on the budget proposals for 2025-26. It makes the case that Welsh universities are national assets, outlines financial pressures facing them, and sets out key asks for investment and policy support. Economic and social value of universities. The submission highlights that Welsh universities deliver substantial value (e.g., an estimated £10.97 billion annual economic impact) and play a role in skills, innovation and place-based development. Financial sustainability concerns. The document sets out that many Welsh universities face deficits, rising staff and operating costs, infrastructure/maintenance pressures, and feel fee-income and funding no longer cover costs. Participation gap and future workforce needs. It draws attention to under-participation in higher education by Welsh domiciled students (30.0 % entry rate, gap of 7.0 percentage points with England) and argues this is a challenge in addressing future jobs and workforce supply.

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		Key asks for funding and policy action. Among the key recommendations/asks: • Align the fee Welsh universities can charge with the recent uplift in England (to £9,535) to maintain competitiveness. • Explore transformative additional support (resource or capital) for higher education to enable universities to adapt and grow. • Consider mitigating costs such as employer pension scheme increases, National Insurance contributions, etc. Alignment with service, skills and innovation policy. The response emphasises that higher education is a key part of delivering Wales's economic, societal and skills ambitions, and that budget decisions should safeguard the sector's capacity to contribute. Access, Widening Participation & Equity. The document refers to the need to act now to improve access, particularly from under-represented groups, and to reverse the widening participation gap. Governance and long-term planning. The sector asks for a sustainable funding model, clarity on future policy change (fees/funding), and recognition of the long-lead time for universities to plan and respond to budget changes. This is a consultation/response document rather than a strategic plan, but it sits within the budget-setting process of the Wales Government and is directed to the Senedd Finance Committee. The document serves as a sector voice to influence budget allocations, funding frameworks and policy decisions for higher education in Wales for the academic and financial years ahead. It highlights the interplay between Welsh Government budget decisions, university financial models (fees, funding, cost pressures), and broader economic and workforce outcomes in Wales.
A3	Strategic Plan 2025-30 MEDR Published 25/02/25	MEDR are the arm's length body now responsible for all tertiary education in Wales. Their vision is "we will work in close collaboration with our partners to enable a tertiary education and research system that is centred around the needs of learners, society and the economy with excellence, equality and engagement at its heart".

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	Accessed 28/04/25 MEDR strategic plan	The plan set out 5 strategic aims plus a foundation aim relating to the new organisation. The 5 strategic aims are: 1. To focus the tertiary education sector around the needs of the learner 2. To create a flexible, joined up tertiary system where everyone can acquire the skills and knowledge they need for a changing economy and society 3. To ensure learners receive the highest quality provision in a tertiary education sector that strives for continuous improvement 4. To grow internally acclaimed research and inspire innovation throughout the tertiary education sector 5. Encourage greater use of the Welsh language, increasing demand for and participation in learning and assessment through the medium of Welsh. The plan is split into founding commitments (areas that will be a focus in the first 2 years) and growth commitments (long term delivery). The plan sets out 8 long term ambitions - Better learner experience and outcomes - More equitable outcomes - Improved learner engagement and well being - Greater alignment of knowledge and skills with needs of Wales - Growth in excellences and impact of Welsh research and innovation - More learning in Welsh - Increased participation in tertiary education - More coherent learning pathways. The plan stresses the need to increase participation rates in tertiary education which are too low whilst the number of young people not in education or employment is too high. The Aim is to increase more pre 16 learners to transition to tertiary education and reduce NEET. There are some useful statistics in the plan: - Proportion of working age adults without qualifications is estimated at 7.9% against a WG target of 5% in every local authority area

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		- Only 67.4% of people in Wales are qualified to Level 3 against a target of 75% - Proportion of NEET = 14% (young people) - Economic inactivity rate of 20.^5 - Employers report 22% skills shortage vacancies and 14% skills gap in existing workforce There are regional disparities in these figures.
A3	Medr Statistics: Students in Higher Education, 2024/25 Publisher: MEDR Date: January 2026 Students in Higher Education, 2024/25 presents official data on student enrolments at Welsh higher education providers. It covers total numbers, domicile, mode of study, subject areas, demographic characteristics and trends over time. The publication provides the core evidence base for tertiary education planning, funding allocation and workforce supply analysis in Wales. Link: Students in Higher Education, 2024/25	1. Overall enrolment trends • Reports total higher education enrolments across Welsh institutions for 2024/25. • Identifies trends compared with previous years (growth/decline by level and mode). • Tracks undergraduate vs postgraduate proportions. 2. Welsh-domiciled participation • Breaks down numbers of Welsh-domiciled students studying in Wales and elsewhere. • Highlights trends in participation rates and cross-border flows. 3. Subject-level data (including health disciplines) • Provides enrolments by broad subject group (e.g., medicine & dentistry, subjects allied to medicine, nursing & midwifery, biological sciences). • Enables identification of growth or contraction in health-related programmes. 4. Mode of study (full-time / part-time / postgraduate) • Reports the balance between full-time and part-time study. • Tracks postgraduate taught and research enrolments. • Education implication: Part-time and postgraduate pathways are critical for CPD, advanced practice, and workforce upskilling aligned to HEIW IMTP 2025–28. 5. Demographic characteristics • Data on age, sex, ethnicity and other equality characteristics. • Insights into widening participation and representation in higher education. 6. International student patterns • Reports numbers and proportion of international students.

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
		• Important for institutional sustainability but less directly linked to domestic health workforce supply. 7. Trends in postgraduate research • PhD and research enrolment data support analysis of research capacity and academic pipeline. This statistical release is part of Medr's new role as the integrated tertiary education regulator for Wales, following the Tertiary Education and Research (Wales) Act. It replaces and consolidates previous HESA/Welsh Government statistical reporting streams into a unified regulatory dataset. Forms a critical input to funding allocations, regulatory oversight and strategic commissioning.
A3	Financial sustainability of the higher education sector in Wales 2024/25 Publisher: Medr Date: March 2026 Financial sustainability of the higher education sector in Wales 2024/25 provides a comprehensive assessment of the financial position, risks and outlook of Welsh higher education providers. It analyses institutional financial data, sector trends and forecast positions to evaluate the sustainability and resilience of the sector.	Purpose and scope • The report assesses the financial health of higher education providers in Wales, using both historic data and forward-looking forecasts. • It aims to identify system-level risks, institutional pressures and emerging trends affecting sustainability. • The analysis covers all regulated Welsh higher education providers. Overall financial position of the sector • The report identifies a deteriorating financial position across the sector, with increasing numbers of institutions forecasting deficits. • Operating surpluses have reduced significantly, with some providers reporting negative margins. • Financial resilience varies across institutions, but pressures are widespread rather than isolated. Income trends

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	Link: Financial sustainability of the higher education sector in Wales 2024/25	• Total income has increased in nominal terms but has not kept pace with rising costs, leading to real-terms pressure.
		• Key income streams include:
		  ○ Tuition fees (home and international students)
		  ○ Research income
		  ○ Other commercial and operational income
		• There is a growing reliance on international student fee income, which introduces volatility and risk.
		
		Expenditure pressures
		• The report highlights significant cost pressures, including:
		  ○ Staff pay and pension costs
		  ○ Inflationary increases in energy and estates costs
		  ○ Investment requirements for digital infrastructure and facilities
		• These pressures are identified as structural and ongoing, rather than temporary.
		
		Operating surpluses and deficits
		• Many institutions are forecasting declining or negative operating surpluses, reducing their ability to invest or absorb shocks.
		• The report notes that sustainable operating margins are increasingly difficult to maintain under current funding conditions.
		
		Liquidity and cash flow
		• Cash reserves and liquidity positions are under pressure for some providers.
		• Reduced cash flow flexibility limits institutions' ability to respond to unexpected financial challenges.
		• The report identifies varying levels of liquidity across the sector.
		
		Balance sheet and borrowing
		• Some institutions have increased borrowing to finance capital investment or manage cash flow.
		• Rising debt levels, combined with higher interest rates, create additional financial risk.

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		• Balance sheet strength varies between institutions, influencing resilience.
		
		Capital investment constraints
		• Financial pressures are limiting the ability of institutions to invest in:
		  ○ Estates and infrastructure
		  ○ Digital systems
		  ○ Specialist facilities
		• Deferred investment may have longer-term implications for quality and competitiveness.
		
		International student dependence
		• The report highlights increasing dependence on international student recruitment as a source of income.
		• This introduces exposure to:
		  ○ Policy changes (e.g. visa rules)
		  ○ Global competition
		  ○ Geopolitical and economic factors
		• This reliance is identified as a key systemic risk.
		
		Workforce-related impacts
		• Financial pressures are influencing staffing decisions, including:
		  ○ Recruitment freezes
		  ○ Restructuring
		  ○ Reductions in staff numbers in some areas
		• Workforce costs remain the largest expenditure category.
		
		Institutional variation
		• There is significant variation between providers in:
		  ○ Financial performance
		  ○ Exposure to risk
		  ○ Income diversification
		• Some institutions are more vulnerable due to size, subject mix or dependence on specific income streams.

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		Forecast outlook
		• The forward outlook suggests continued financial pressure, with limited short-term improvement expected.
		• The report indicates that without changes to funding or cost structures, financial challenges are likely to persist.
		
		System-level risks
		The report identifies several key risks to sector sustainability:
		• Structural imbalance between income and costs
		• Dependence on volatile income streams
		• Reduced capacity for investment
		• Potential impact on provision and institutional stability
		
		Data and methodology
		• The analysis is based on:
		  ○ Institutional financial returns
		  ○ Forecast submissions
		  ○ Sector-wide financial indicators
		• It includes both retrospective analysis and forward projections.
		
		Overall conclusions
		• The report concludes that the Welsh higher education sector faces significant and sustained financial challenges.
		• While institutions continue to operate, financial resilience is weakening, and risks are increasing.
		• The issues identified are systemic and affect the sector as a whole, rather than being confined to individual providers.

SECTION B: United Kingdom

1. UK Government/Four nations NHS organisations

2. Professional & Regulatory Bodies

3. Other



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B1	The Leng review: an independent review into physician associate and anaesthesia associate professions - GOV.UK Published July 2025 Accessed July 2025	This review into the role of Physician Associates (PA's) and Anaesthetic Associates (AA's) proposes 18 recommendations that have been accepted by Government. The review followed a period of intense scrutiny following high profile cases and statements by professional bodies. The roles which were introduced in 2002 and 2004 respectively as a response to significant workforce challenges and this remains a key driver. The review was established to consider what modifications may be required to improve confidence in the roles. The review acknowledges the key drivers in the NHS as being demographic changes, increasing complexity of care and rapid advances in technology. The review concluded that evidence of the safety and effectiveness of these roles is weak due to the absence of RCTs specifically focussing on these roles. It highlighted the significant issues raised by resident doctors and the difference in perception between the way in which PA's and AA's view their roles compared to resident doctors who expressed concerns about the impact of these roles on their training and development. The recommendations propose changes to job titles and identification; changes to the deployment of roles including proposals that will restrict PA's and AA's being able to see patients who are undifferentiated; strengthened team working and oversight and professional development. There are wide system recommendations around regulation and accountability; safety and reporting; redesigning medical team working models and supporting doctors as leaders and managers. Welsh Government have made a statement accepting the recommendations in principle.
B1	NHS England RePAIR Report 2025_FINAL.pdf Published February 2025 Accessed August 2025	Produced on behalf of Health Education England (now part of NHS England), the RePAIR (Reducing Pre-registration Attrition and Improving Retention) Report 2025 is one of three outputs from a large-scale programme begun in 2015 in response to a Department of Health mandate to cut unnecessary attrition from pre-registration programmes. It synthesises national data, a student survey, focus groups, case studies and an economic evaluation to propose practical actions across the student journey.

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		Define attrition consistently; track it properly. RePAIR calls for standard definitions and measurement. Using available data, 33.4% did not complete on time (2013/14–2014/15); observed trends show ~50% improvement in years 2–3 attrition 2009/10→2016/17, but definitions remain inconsistent. Wales should adopt a single approach with partners. Four critical "Steps" in the pipeline. RePAIR frames action across: (1) Pre-enrolment; (2) During the course; (3) the "Flaky bridge" (final year → first job); (4) Early clinical career. This creates a shared structure for interventions and accountability between AEIs and providers. Where/why students struggle (survey insights). High placement quality reported (86% agree), but travel cost/time pressures (86% say money is tight for placement travel), feeling used as "an extra pair of hands" (67%), confusion around assessment (e.g., PAD) and some lack of respect on placement (34%). Many persist because of the goal (97%) and feel well supported in career development (89%). Highest risk points. The first clinical placement is the most attrition-prone moment; targeted preparation of students and mentors reduces exits. What works (illustrative interventions). • Buddying (student-to-student; final-year ↔ NQ staff). • "Keeping warm" communications and onboarding before start dates. • Retention officers and mindful placements (reasonable adjustments, travel burden). • Structured preceptorship/foundation programmes (e.g., dedicated facilitators; rotations). One site cut preceptee attrition from 17% to 4% over two years after introducing a preceptorship facilitator. Value for money (economic evaluation). York Health Economics Consortium estimated benefit per student retained in HEI: £13,875; per Band 5 retained in provider: £63,980. Transition and preceptorship programmes showed positive net

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
		benefits across sites (e.g., preceptorship net benefit £2.33m at one site), with results robust to sensitivity tests. A RePAIR cost calculator was produced. Headline recommendations. • R1–2: National bodies + AEIs/providers to standardise definitions and evaluate cost-effectiveness of interventions. • R3: Expand hardship support, especially for mature students. • Actions mapped to each Step (pre-enrolment through early career).
B1	Fit for the future: 10 Year Health Plan for England Published July 2025 Accessed August 2025	Sets out the government's 10-year plan to "reimagine" the NHS in England around three shifts - Hospital → community, - Analogue → digital, - Sickness → prevention following public and staff engagement via Change NHS; positioned as the route to restore performance, modernise care and underpin economic growth. Three system shifts to design education around. The Plan describes care model change to: 1) Neighbourhood Health Service with neighbourhood health centres (12h/day, 6d/week), more urgent care in community, expanded community pharmacy roles, and thousands more GPs; 2) Digital-by-default access via the NHS App as a full front door by 2028 and a single patient record; 3) Prevention including tobacco/vape legislation, obesity measures (healthy food sales reporting; access to weight-loss medicines), mental health teams in schools, and a new genomics population health service (e.g., newborn genomic testing). Education pathways will need to reflect this model. Education & training reform. Over the next 3 years, curricula will be overhauled with: comprehensive AI and digital skills; renewed emphasis on generalist capabilities for neighbourhood care; a digitally-led education platform; skills escalators for career progression; personalised career coaching for every member of staff; and regulator-aligned moves to real-time feedback, appraisal and revalidation.

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		Workforce model implications. England proposes a new workforce model that reduces reliance on international recruitment (currently c.34% of new recruits non-UK nationality), recruits locally, and expects fewer staff than the 2023 Long Term Workforce Plan projected but with higher productivity through skills, AI enablement and role redesign. Education supply, supervision capacity and role boundaries will be rebalanced accordingly. Operating model & governance context. Centre reforms include combining NHS England HQ with DHSC (aiming to reduce central headcount by 50%) and making ICBs strategic commissioners with stronger capability — which shifts where education, placement and workforce commissioning conversations in England will sit. Productivity & value. A new value-based approach and 2% annual productivity target frame skills, deployment, and technology adoption as education outcomes, not just service metrics.
B1	nes_learning_and_education_strategy_2023-2026.pdf Published March 2024 Accessed August 2025	The Learning and Education Strategy 2023–2026 from NHS Education for Scotland (NES) sets NES's vision, principles and priority themes for a high-quality, inclusive, technology-enabled learning system across Scotland's health and social care workforce; it operationalises NES's wider Strategy (People, Partnerships, Performance). Purpose & vision anchored in outcomes and rights. NES frames learning as the route to *better, rights-based quality care and outcomes* through a skilled, resilient workforce; it positions NES as a collaborative, innovative learning organisation serving health and social care. Seven principles to govern learning quality. Prioritise quality and impact; co-design with people who use services; reduce duplication with "Once for Scotland" approaches; embed inclusivity, widening access and climate sustainability; adapt for

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		innovation (AI, simulation, VR/AR); and measure quality, value and impact systematically across public, organisational and individual "value lenses". Four priority themes for 2023–26 (with outcomes & KPIs). 1) Integrated approach to quality: transform educational governance, policies, processes and systems into a coherent "ecosystem". 2) Future-focused learning pathways — co-produce career & learning frameworks, consolidate offers into a NES "prospectus", align commissioning with workforce and population needs, widen access (incl. apprenticeships/internships). 3) Learner-centred delivery: refresh Turas to personalise learning and create portable records, streamline mandatory learning, and strengthen educator capability. 4) Working in partnership: deepen collaboration across NHS boards, HE, regulators, local government and social care to align learning with service needs and innovation. Progress tracked via Strategic KPIs (e.g., learner experience/scale, quality of clinical training environment, digital skills, sustainability, efficiency/value). Inclusivity, equity, language and sustainability built in. The strategy emphasises accessibility, diversity and equity across learning, plus sustainability-focused education; it is profession-neutral and spans health and social care, reflecting whole-system workforce needs. Digital and data as enablers. Explicit commitment to AI-ready curricula and educator development; Turas becomes the personalised front door, with improved data flows and portability to cut duplication and recognise prior learning.
B1	NHS England » Educator Workforce Strategy Published March 2023 (updated August 2024) Accessed August 2025	The Educator Workforce Strategy from NHS England sets priorities to secure sufficient, high-quality educators across all professions and settings so the NHS can grow, retain and upskill its workforce; it was co-designed with educators, learners, regulators, patients and partners, and will be supported by an implementation plan and a repository of good practice.

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		Why an educator strategy now: Demand is rising; education is central to workforce supply, retention and productivity, yet educator capacity is constrained by service pressure, an ageing educator demographic, unclear pathways and squeezed development time. Who counts as an "educator": An umbrella term spanning supervisors, assessors, faculty and practice educators across pre- and post-registration education in all settings (regulated and non-regulated). Co-design & evidence base: Built through stakeholder engagement, an Oct 2022 multi-professional webinar, literature review and call for evidence; aligned to England's Long Term Workforce Plan. Seven strategic priorities: 1) Integrate educator workforce into system planning: educator capacity must be explicit in integrated workforce–service–finance plans ("all levers, all levels"), from support workers to advanced practice. 2) Protect educator time & resources: build education into job plans, recover "lost" training, and use the Quality Framework standard (4.2); 55% of GMC-surveyed trainers couldn't use their allocated training time due to workload. 3) Career frameworks for all professions: define clear educator career pathways with continual development, academic opportunities and digital delivery capability; collaborate across professions. 4) Development & wellbeing: enable educators to prioritise education (not be crowded out by service), tackle burnout (52% moderate/high risk; yet 90% enjoy the role), and provide coordinated support and CPD. 5) Common standards & principles: set multi-professional principles of "what good looks like", reduce duplication, and draw on existing standards (e.g., supervision fundamentals for advanced practice). 6) Equality, diversity & inclusion: address disparities (NHS workforce 22.4% from minority ethnic backgrounds; EDI concerns in training environments reported by 12% trainees/18% trainers); equip educators to lead culture change.

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
		7) Evolving, innovative models: scale interdisciplinary learning, digital/blended delivery, simulation and evidence-based ed-tech with clear governance and regular evidence review. Implementation support: An educator survey, communities of practice, and a live repository of examples will underpin delivery.
B1	Training the Future GP Published March 2023 Accessed August 2025	Published by Health Education England (now NHSE Workforce, Training & Education, it sets out a reform vision and action framework to modernise GP specialty training. Themes include generalism, equity, technology, planetary health, population health and leadership, alongside a shift to 24 months in practice within the 36-month programme to better prepare GPs for changing models of care. Ten reform themes (curriculum spine): Enhancing generalism; Equity in training; Social accountability/serving all communities; Improving quality of training; Wellbeing & mental health; Earlier cancer diagnosis & referral; Population health; Technology in practice; Planetary health; Leadership/management/strategy. Use as organising pillars for programme outcomes, placements and assessment. Practice-based emphasis: Trainees now spend 24 of 36 months in general practice, creating headroom to re-shape supervision, community experiences and assessment in primary care settings. Technology & blended learning: Explicit call to build digital care, decision-support, remote monitoring and data use into training, delivered via blended (face-to-face + digital) models that teams and trainees support. Innovative placements & population need: Encourages non-traditional/third-sector placements (e.g., charities, CAMHS), population-health modules, and teaching on over-diagnosis/harms and earlier cancer detection.

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		Equity, wellbeing, planetary health: Embed health inequalities, psychological safety & wellbeing, and sustainability in practice into the learning design, with clear actions for local delivery. From report to implementation: NHSE signals local implementation and matching doctors in training to population need, implying commissioning levers, supervision capacity and QA must move with the education vision.
B1	The state of medical education and practice in the UK. Workforce report 2025 Y Cyngor Meddygol Cyffredinol (GMC) Cyhoeddwyd ym mis Tachwedd 2025	Mae'r adroddiad blynyddol hwn yn rhoi trosolwg cynhwysfawr o weithlu meddygol y DU, gan ddefnyddio data'r GMC a thystiolaeth ehangach i ddadansoddi tueddiadau o ran cyflenwad, dosbarthiad, hyfforddiant a phatrymau gweithio. Mae'n archwilio cyflwr addysg ac ymarfer meddygol, gan ganolbwyntio ar gynaliadwyedd y gweithlu, lles a phwysau system. Mae'r adroddiad yn cyflwyno darlun manwl o weithlu meddygol y DU, gan dynnu sylw at dwf parhaus yn nifer y meddygon trwyddedig, ochr yn ochr â phwysau parhaus a chynyddol ar y system. Er bod niferoedd cyffredinol y gweithlu wedi cynyddu, mae'r adroddiad yn pwysleisio nad yw'r twf hwn wedi cyd-fynd â'r galw cynyddol am wasanaethau, gan arwain at straen parhaus ar y gweithlu. Un thema allweddol yw'r newid yng nghyfansoddiad y gweithlu. Mae'r adroddiad yn nodi amrywiaeth gynyddol o ran oedran, rhyw a gwlad y cymhwyster, gyda chyfran gynyddol o feddygon yn cael eu hyfforddi y tu allan i'r DU. Mae graddedigion meddygol rhyngwladol bellach yn cynrychioli cyfran sylweddol a chynyddol o'r gweithlu, yn enwedig mewn rhai arbenigeddau a rhanbarthau.

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
		Mae dosbarthiad meddygon yn parhau i fod yn anghyson ar draws arbenigeddau ac ardaloedd daearyddol. Mae rhai arbenigeddau, gan gynnwys ymarfer meddygol cyffredinol a rhai arbenigeddau ysbyty, yn parhau i wynebu heriau recriwtio a chadw staff. Mae gwahaniaethau daearyddol hefyd yn amlwg, gyda rhai rhanbarthau'n profi mwy o brinder gweithlu nag eraill. Mae'r adroddiad yn tynnu sylw at dueddiadau mewn addysg a hyfforddiant meddygol, gan gynnwys niferoedd cynyddol o fyfyrwyr a hyfforddeion meddygol. Fodd bynnag, mae hefyd yn nodi pwysau yn y system hyfforddi, gan gynnwys cystadleuaeth am swyddi hyfforddi, amrywioldeb mewn profiadau hyfforddi, ac effaith gofynion gwasanaeth ar gyfleoedd dysgu. Mae cadw staff yn bryder canolog. Mae'r adroddiad yn nodi, er bod llawer o feddygon yn aros yn y proffesiwn, bod niferoedd cynyddol yn ystyried gadael neu leihau eu horiau. Mae'r ffactorau sy'n dylanwadu ar hyn yn cynnwys llwyth gwaith, cydbwysedd rhwng bywyd a gwaith, gorflinder a bodlonrwydd swydd. Mae'r adroddiad hefyd yn tynnu sylw at batrymau o feddygon sy'n cymryd seibiant gyrfa, yn gweithio llai nag amser llawn, neu sy'n stopio ymarfer yn y DU. Mae lles yn ffocws sylweddol, gyda thystiolaeth o lefelau uchel o straen a gorflinder ymysg meddygon. Mae'r adroddiad yn defnyddio data arolwg sy'n dangos bod llawer o feddygon yn teimlo nad ydynt yn gallu ymdopi â gofynion llwyth gwaith ac yn wynebu heriau o ran cynnal eu lles.

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
		Mae patrymau gweithio'n newid, gyda mwy o feddygon yn dewis trefniadau gweithio hyblyg neu ran-amser. Mae hyn yn effeithio ar gapasiti cyffredinol y gweithlu o'i fesur mewn termau cyfwerth ag amser llawn, hyd yn oed wrth i nifer y staff gynyddu. Mae'r adroddiad hefyd yn edrych ar gynnydd gyrfa a symud o fewn y gweithlu. Mae'n nodi tueddiadau o ran meddygon yn symud rhwng arbenigeddau, yn gadael rhaglenni hyfforddi, neu'n gweithio mewn rolau nad ydynt yn ymwneud â hyfforddi. Mae mwy a mwy o symud hefyd rhwng gwledydd, i mewn ac allan o'r DU. Mae data ar ddiogelwch cleifion ac ansawdd gofal yn gysylltiedig â phwysau ar y gweithlu. Mae'r adroddiad yn awgrymu y gall prinder staff a phwysau llwyth gwaith effeithio ar y gallu i ddarparu gofal diogel ac effeithiol, er ei fod yn canolbwyntio'n bennaf ar dueddiadau'r gweithlu yn hytrach na chanlyniadau uniongyrchol. Mae'r adroddiad yn defnyddio ystod o ffynonellau data, gan gynnwys data cofrestru'r GMC, arolygon a setiau data gweinyddol eraill, i ddarparu dadansoddiad cynhwysfawr sy'n seiliedig ar dystiolaeth. Mae'n tynnu sylw at bwysigrwydd parhau i fonitro a chasglu data er mwyn deall deinameg y gweithlu. Yn gyffredinol, mae'r adroddiad yn dod i'r casgliad, er bod gweithlu meddygol y DU yn parhau i dyfu a datblygu, ei fod yn wynebu heriau sylweddol sy'n ymwneud â galw, dosbarthiad, cadw staff a lles. Disgrifir y pwysau hyn fel rhai parhaus a chymhleth, sy'n gofyn am sylw parhaus i sicrhau sefydlogrwydd ac effeithiolrwydd y gweithlu meddygol.

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B1	Trained for Tomorrow: A Plan for the Future NHS Workforce
	
	Published July 2026
	
	Accessed July 2026
		Trained for Tomorrow: A Plan for the Future NHS Workforce presents the final recommendations of Policy Connect's Health Education and Training Inquiry. The report examines the future sustainability of the NHS workforce, focusing on how education, training and workforce planning can better respond to changing population needs, workforce shortages and service transformation. It draws on evidence from universities, NHS organisations, professional bodies, regulators and other stakeholders.
		
		Purpose and scope
		• The report examines the current health education and training system and considers how it can better support future NHS workforce requirements.
		• It reviews evidence relating to:
		  ○ Workforce supply and demand
		  ○ Education and training pathways
		  ○ Clinical placements
		  ○ Workforce planning
		  ○ System governance
		• The report presents a series of recommendations intended to strengthen the long-term sustainability of the NHS workforce.
		
		Workforce demand and future pressures
		• The report identifies growing workforce pressures driven by:
		  ○ An ageing population
		  ○ Rising demand for healthcare
		  ○ Increasing prevalence of long-term conditions
		  ○ Workforce retirements
		• It argues that these trends require long-term workforce planning rather than short-term responses.
		
		Education and training capacity

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		• The report highlights concerns regarding the capacity of the education system to meet future workforce demand.
		• Areas identified include:
		  ○ University capacity
		  ○ Availability of clinical placements
		  ○ Educator workforce capacity
		  ○ Financial sustainability of education providers
		• It notes that expansion of training places alone is insufficient without corresponding increases in placement and supervision capacity.
		
		Clinical placements
		• Clinical placements are identified as one of the principal constraints on expanding workforce supply.
		• The report discusses:
		  ○ Limited placement availability
		  ○ Pressures on clinical supervisors
		  ○ Variability in placement quality
		  ○ Workforce pressures affecting educational capacity
		• Practice learning is described as a critical component of professional education.
		
		Workforce planning
		• The report calls for a more strategic approach to workforce planning.
		• It highlights the importance of:
		  ○ Long-term forecasting
		  ○ Improved workforce intelligence
		  ○ Better alignment between education commissioning and service need
		• Workforce planning is presented as requiring closer integration between education providers, healthcare organisations and policymakers.
		
		Collaboration across organisations
		• A recurring theme is the need for stronger collaboration between:

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
		○ Universities ○ NHS organisations ○ Professional regulators ○ Government departments ○ Employers • The report suggests that effective workforce development depends on coordinated planning and shared responsibility. Workforce retention • Alongside recruitment and education, the report identifies retention as a major factor influencing workforce sustainability. • Issues highlighted include: ○ Wellbeing ○ Career development ○ Working conditions ○ Professional support • Retention is discussed as an important element of maintaining workforce capacity. Innovation in education • The report explores opportunities to modernise education and training through: ○ Digital learning ○ Simulation ○ Flexible learning pathways ○ Technology-enabled education • Innovation is presented as a means of enhancing educational delivery while maintaining quality. Equity and widening participation • The report discusses the importance of widening access to health professions. • Areas highlighted include:

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
		○ Fair access to education ○ Flexible routes into healthcare careers ○ Supporting learners from diverse backgrounds • Widening participation is considered alongside workforce supply objectives. Funding and system sustainability • Financial sustainability is identified as a recurring challenge. • The report considers: ○ Funding for higher education providers ○ Clinical placement funding ○ Investment in educator capacity ○ Long-term workforce investment • It notes that sustainable workforce development requires stable and coordinated funding arrangements. Governance and accountability • The report examines governance arrangements across health education and workforce planning. • It highlights the involvement of multiple organisations with responsibilities for: ○ Workforce planning ○ Education commissioning ○ Professional regulation ○ Service delivery • The report considers the need for clearer coordination and accountability across the system. Overall conclusions • The report concludes that the NHS workforce faces significant long-term challenges relating to workforce demand, education capacity, clinical placements and retention.

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		• It presents workforce sustainability as dependent on stronger integration between education, workforce planning and service delivery. • Overall, the report advocates a coordinated, long-term approach to planning and developing the future NHS workforce through collaboration between education providers, healthcare organisations and national bodies.
B1	Government workforce planning – lessons learned Publisher: National Audit Office (NAO) Date: July 2026 Link: Government workforce planning – lessons learned	A cross-government lessons-learned report examining where workforce planning succeeds or fails and what senior leaders need to do differently. Drawing on previous NAO audits and examples of good practice, it identifies eight lessons covering productivity, future skills, resilience, workforce modelling, affordability, integrated planning, planning capability/data and cross-system coordination. • Plan for skills, not just numbers: Workforce planning should identify the future skills and capabilities required, rather than relying on professions, grades or current establishment. • Upskilling and reskilling: Technological and service change will require continuous development of the existing workforce alongside recruitment of new staff. • AI and automation: Digital transformation will change tasks and roles, creating demand for skills in AI, data, cyber security and oversight, while potentially removing some traditional opportunities for on-the-job learning. • Experience and productivity: New staff take time to become fully productive; retention of experienced staff, supervision and structured early-career development therefore matter. • Scenario-based planning: Long-term workforce and education decisions should test different assumptions around demand, technology, workforce supply and service models rather than rely on a single forecast. • Integrated planning: Workforce, education, service and financial planning should use common assumptions and operate together. • Better workforce intelligence: Current data often describe roles and professions but not actual skills. Better skills data and common taxonomies are needed to understand capability gaps.

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		• System-wide planning: Workforce decisions should consider shared labour markets and population need, with national coordination alongside local flexibility. Education should not simply produce more people for today's workforce model. It should be one of the main mechanisms through which NHS Wales deliberately creates the skills, experience and adaptability required for future models of care.
B2	How long do new HCPC registrants stay registered for? An analysis of first-time HCPC registrations: 2013 to 2020 Published September 2025 Accessed October 2025	A quantitative analysis of first-time HCPC registrants from 2013 to 2020, tracking how long they remained on the register and identifying patterns of attrition and retention by profession, gender, and route to registration. It aims to support workforce planning, education design and regulatory policy by providing an evidence base on career longevity post-registration. Published by Health and Care Professions Council (HCPC). Study scope and data. Examines 243,000 first-time registrants across 15 HCPC professions (2013–2020 cohorts). Retention was measured over up to eight years, defining "retained" as still registered at the end of each follow-up year. Data exclude those joining via restoration or readmission. Overall retention patterns. • Across all professions, around 90 % remained registered one year after first registration, but retention drops to roughly 70 % after five years. • Variation between professions is marked: Clinical Scientists, Radiographers and Physiotherapists show high long-term retention, while Operating Department Practitioners (ODPs), Arts Therapists and Prosthetist/Orthotists show lower persistence. Early-career exits. The steepest attrition occurs within the first three years post-registration, suggesting transition-to-practice support is a key determinant of long-term retention.

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		Gender differences. • Women make up about 76 % of new registrants, and their overall retention rate is slightly higher than men's, though differences narrow by year 8. • In some male-dominated professions (e.g., ODPs, Orthotists), attrition rates were higher. Route to registration. UK-educated registrants show higher five-year retention (≈72 %) than those registered via international routes (≈65 %), highlighting potential onboarding or adaptation challenges for overseas recruits. Cohort stability and service risk. HCPC notes that consistent early-career attrition equates to significant workforce churn and "lost investment" in education and induction, directly impacting service continuity and productivity. Policy implications. The report encourages regulators, education commissioners and employers to target transition-to-practice, supervision and CPD as key retention levers, and to embed retention monitoring in workforce planning. HCPC will continue to produce "Insights" series workforce analytics (biannual). Findings are intended to inform DHSC, HEIW and equivalent bodies across the UK on education commissioning, regulation and professional support models. The dataset complements HEE/HEIW long-term workforce models by adding real-world retention after registration, not just student completion.
B2	Perspectives on a Common Code of Conduct for Health and Care Professionals | PSA	Published by the Professional Standards Authority for Health and Social Care (PSA), it explores public, service-user and professional views on a possible common code of

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	Professional Standards Authority (PSA) Published April 2024 Accessed August 2025	conduct spanning the 10 statutory regulators, accredited registers and (optionally) non-clinical senior managers, to inform PSA's wider 2024/25 scoping work. It is research to inform policy, not a code or decision. Starting perceptions & "code literacy". The public largely assume everyone in health and care is regulated and works to a code; both public and professionals expect broad similarity across codes with profession-specific nuance. There is discomfort about unregulated roles and the absence of clear accountability. Education should surface the regulatory landscape and goal of codes explicitly. Perceived benefits of a common code (consistency, trust, transparency). Participants see upside in consistent behavioural standards, easier recognition of breaches, stronger confidence to complain/whistleblow, and better MDT culture (collaboration, shared goals). EDI is viewed as part of a respectful culture and consistent behaviours. Education can translate these into shared cross-professional learning on conduct. Challenges to address (heterogeneity, wording, risk of "blandness"). Bringing diverse professions under one code risks being too generic to matter or too stringent for some roles. Differences in wording (e.g., "should" vs "must") create ambiguity. A principles-led approach with room for profession-specific detail is favoured. Learners need to understand regulatory language and its consequences. What a common code would likely cover (content themes). Core, cross-cutting topics: communication; patient safety culture; confidentiality/GDPR; record-keeping; respect & non-discrimination; empathy; integrity, candour & honesty; accountability. Additional themes raised: social media, civility, and sustainability. These map well to curriculum outcomes and assessment rubrics. Implementation & accountability (education is pivotal). For impact, a common code would need whole-system adoption, integration into training from the outset, and inclusion in induction so it becomes cultural "muscle memory". Concerns centre on how it aligns with existing profession-specific codes/NHS values, who enforces it, and

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		the cost/overheads of rollout. Education should build the how (teaching, supervising, evidencing) as well as the what. Managers and accredited registers. Many respondents support inclusion (or parallel standards) for non-clinical senior managers and those on accredited registers, to close accountability gaps and improve trust — but emphasise the need for clear oversight. Scenarios using high-profile cases were used to test whether a common code might have made a difference. These translate well into scenario-based learning and simulation.
B2	National Training Survey 2025 results Published July 2025 Accessed August 2025	*National training survey 2025 results, a* UK-wide report from the General Medical Council (GMC) that provides an annual snapshot of the quality of postgraduate medical education and training and the training environment across the UK, used for quality assurance and system improvement. Scale & headline experience. 50,637 trainees and 21,289 trainers responded. 87% of trainees rated clinical supervision good/very good; 84% rated overall experience good/very good; 63% felt their post offered leadership-skills development. Burnout remains high. 61% of trainees and 47% of trainers are at moderate/high risk of burnout. Although down from the 2023 peak, trainee high-risk burnout has doubled since 2019; 50% report high/very high emotional exhaustion. Rota gaps harm training. 26% of trainees and 29% of trainers say training is adversely affected because rota gaps aren't handled appropriately. Escalation hesitancy (new metric). 21% of trainees feel apprehensive about escalating to a supervisor; 23% out-of-hours. Higher in surgery (29%), O&G (27%), medicine & emergency medicine (26%). Workload pressure varies by specialty. 42% overall report heavy/very heavy workload, rising to 70% in emergency medicine, 63% in O&G and 48% in surgery.

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		Discrimination & speaking up. 28% experience micro-aggressions/negative behaviours; 39% don't feel confident reporting discrimination without fear. The burden is higher for some groups (e.g., 45% of bisexual and 39% of gay trainees hear discriminatory comments; 34% of UK-educated ethnic-minority trainees report micro-aggressions vs 25% of white peers). Induction & mentoring. Induction quality improved to 76% rating good/very good, but 56% report no mentor; formal mentoring remains limited outside GP. Flexibility trends. In 2025, 30% of female and 15% of male trainees reported LTFT working; most doctors step out after F2 (around 65% in 2023). The GMC flags the need for flexible training models.
B2	State of Medical Education (GMC) Workforce Report 2024 The state of medical education and practice in the UK Workforce report 2024 General Medical Council Published November 2024 Accessed September 2025	Published by the GMC, it analyses 2012–2023 register trends and pipeline dynamics across all four UK nations to inform workforce planning, training capacity and inclusion priorities. Fastest workforce growth on record, driven by non-UK joiners. From 2022→2023, licensed doctors grew +6% (vs 2.6% average since 2011); 68% of joiners were non-UK graduates and ~9% of the 2023 workforce had only just gained a UK licence that year — heightening the need for robust induction, supervision and inclusive learning environments. Locally Employed (LE) and SAS growth reshapes training needs. LE doctors in England & Wales grew +75% (2019→2023) to 36,831; 66% of LE and 81% of SAS doctors had non-UK PMQ. LE leaving rates have fallen (7%→4% since 2017), indicating LE roles are more long-term and require structured development and recognition of competence gained. Post-F2 detours now the norm. 75% of the 2022 F2 cohort did not enter core/specialty training in 2023; 11,757 licensed doctors had completed F2 in the

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		previous 12 years but never entered training — signalling demand for flexible pathways, recognition of LE learning, and career support outside formal programmes. Trainer capacity is the binding constraint. Clinical/educational supervisors report unsustainably high workloads and rising numbers of trainees/LE doctors they oversee; without protected time and more trainers, the planned increase in UK medical school places will not convert into trained specialists/GPs. Diversity has increased; equity must follow. Ethnic-minority doctors now outnumber white doctors; the workforce is near gender parity (49% female). Persistent differential attainment and progression barriers require targeted educator development and equitable access to training opportunities (especially for IMGs/LE/SAS). Leavers steady overall, but pressure points exist. 4% of licensed doctors left in 2023 (stable vs 2022); higher leaving among doctors on neither register/not in training; some new specialists show higher early leaving (e.g., ophthalmology 28% within five years). Education and supervision quality are central to retention. Future mix: more non-UK graduates, esp. in GP. Planning must integrate inclusive induction, progression routes and trainer capacity to support a more internationally trained, more diverse future workforce.
B2	State of Medical Education (Workplace Experiences) The state of medical education and practice in the UK Workplace experiences 2025 General Medical Council Published August 2025	Published by the GMC, a UK-wide analysis based on the GMC Barometer survey 2024 plus interviews, setting out where workplace pressures, culture and training conditions aid or hinder patient care and retention across all four nations. Gradual improvements but persistent strain. For a second consecutive year doctors report better experiences, yet the system remains under severe pressure; 40% witnessed patient safety being compromised in 2024 (little change), so education must prioritise safe escalation, prioritisation, and teamwork under pressure.

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	Accessed August 2025	GP pressure is acute. 61% of GPs struggled to provide sufficient care weekly; 44% reported struggling with workload and 46% were dissatisfied — threatening ambitions to shift care into communities. Programmes should strengthen generalist/primary care skills, triage, digital access, and team-based models, with more community placements and supervisor support. Trainer capacity is the binding constraint. 1 in 10 doctors stopped or reduced trainer activity due to workload (new 2024 response option). Without protected trainer time and educator development, rising student/trainee numbers won't translate into safe learning. Build job-planned education time, supervision ratios, and educator CPD into commissioning. Locally employed (LE) doctors need development routes. LE doctors were least likely to feel able to progress and only 44% reported sufficient access to learning/development. Education strategy should provide RPL/APE (recognition of prior learning/experience), modular bridging, and clear routes into training or credentials. Burnout trending down but workload barriers remain. High-risk burnout fell to 18% (from 25% in 2022); inadequate staffing is still the top barrier (72%). Education must include workload literacy, efficient teamworking, delegation/scope clarity, and digital skills to reduce friction. Equity and inclusion gaps. Disabled doctors and ethnic-minority UK-qualified doctors report poorer experiences; fairness must be taught, practised and measured in learning environments (anti-discrimination, civility, psychological safety, mentoring). Nation picture. Experiences in Wales broadly mirror the UK but Welsh doctors were more likely to identify multiple barriers to providing care, reinforcing the need to tailor rural/bilingual support and placement design.

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B2	Academy of Medical Royal Colleges The_future_is_out_there_161024.pdf Published October 2024 Accessed August 2025	Published by Academy of Medical Royal Colleges (AoMRC), convened UK system leaders to identify practical levers to deliver the long-promised shift to home and community-based care, clarifying the national vision, culture, funding, metrics and delivery conditions needed. Three system "big shifts". From analogue → digital, hospital → community, and sickness → prevention, education must prepare the workforce for new settings, tools and preventive models. Four enablers to deliver the shift (what to teach for). 1. Priorities & culture: make community care a first-class norm; co-design services with people; broaden to a bio-psycho-social model and earlier intervention. → Teach co-production, behaviour change, social determinants, asset-based approaches. 2. Flow & discharge to home: improve discharge decision-making, standardise MDT working, and reduce avoidable bed days. → Train in flow science, discharge-to-assess, intermediate care, shared decision-making. 3. Scale & quality of home/community care: invest in primary/community infrastructure, diagnostics closer to home, technology-enabled care, and a professionalised care-sector workforce; enable teams to manage risk in the community; use virtual wards. → Build community diagnostics, remote monitoring, risk stratification, virtual-ward operations into curricula/CPD. 4. Change where the money goes & what we measure: align funding and metrics with community activity; create permissive national frameworks and out-of-hospital provider networks. → Teach population-health outcomes, commissioning & contracting literacy, improvement measurement. Illustrative cases to emulate in learning. Examples show virtual wards cutting readmissions (−35%) and improving experience; discharge choice programmes reducing bed occupancy (−42%). → Use as simulation/scenario content and assessment cases.

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		Workforce implications. Emphasises MDT/cross-organisational working, community diagnostics, IT/estates readiness, and using the next workforce plan to reinforce the shift—education must hard-wire these competencies.
B2	Independent report finds varied learning experiences for nursing & midwifery students - The Nursing and Midwifery Council Published December 2024 Accessed October 2025	An Independent research report / review into practice-learning for nursing and midwifery students by the Nursing and Midwifery Council (NMC) in partnership with Nuffield Trust and Florence Nightingale Foundation. A review of how practice-learning (placements, supervision, simulation) is delivered for pre-registration nursing, midwifery and nursing associate students across the UK, commissioned to identify variation in experience, gaps in supervision and evidence, and to inform the NMC's upcoming regulatory review of practice-learning requirements. Variation in student learning experience. The report found that although regulatory requirements for practice-learning are comprehensive, there is "highly varied learning experiences and supervision" across institutions and placements, which may undermine the consistency of student preparation. Supervision, assessor roles and workload pressures. One of the key findings is that the pool of qualified practice supervisors/assessors is under pressure, leading to variability in support and assessment of students. The report recommends expanding support, protected time and training for these roles. Clarity of standards and expectations. The report emphasises inconsistent interpretation of practice-learning standards (hours, settings, birth numbers for midwives etc), and calls for clearer guidance and better coordination between education institutions and practice-learning partners. Growing importance of simulation & alternative settings. While simulation is a growing part of practice learning, the report identifies limited evidence on its impact, cost-effectiveness and how it should be integrated; it suggests more research and clearer guidance on when simulation can substitute or complement clinical placements.

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		Expansion of community-based placements. The report highlights that many students still have placements heavily hospital-based; it calls for more exposure to community, primary care and non-acute settings to reflect service transformation and future models of care. Equity, diversity and access. The review observed that variation in placement experience may disproportionately affect students from under-represented backgrounds or those in smaller/remote institutions; it recommends improved support and monitoring of equity in practice-learning opportunities. Linking student experience to workforce readiness. The underlying implication is that if practice-learning is inconsistent, then new graduates may be less "work-ready" for the reality of care settings, especially as models shift (community, prevention, digital). This links directly into workforce strategy and commissioning of education. Governance and accountability. The NMC has published a consultation on changes to practice learning education standards in April 2026 which will close in July 2026. (See separate document)
B2	NHS England » The Medical Training Review: Phase 1 diagnostic report Published October 2025 Accessed December 2025	The first comprehensive review in over 15 years of medical (postgraduate) training in England. It assesses whether incremental adjustments are sufficient or whether systemic reform is required, in light of changing population health needs, workforce demographics, evolving medical practice, and shifting career expectations. The Report diagnoses strengths and weaknesses in the current system and advances 11 recommendations, anchored around four key priorities. Four key priorities identified: 1. Training must become more flexible.

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		2. Build on excellence beyond formal training routes, including SAS (Specialty & Associate Specialist) and locally employed doctors — recognising their growing role. 3. Urgently address damaging training bottlenecks that block progression, convergence to service need, or impede retention and morale. 4. Rebuild inclusive, supportive team structures so that doctors at all career stages feel valued and supported, addressing wellbeing, supervision, career stability and fairness. More broadly, the report identifies: • A misalignment between the current model of postgraduate training and evolving demand, population need, disease burden, and workforce demographics have changed sharply, but training structure has not kept pace. • Growing competition and bottlenecks: many newly qualified doctors (foundation / early career) do not secure training posts immediately, leading to reliance on service-type roles, locum or local-employed posts; this undermines predictable career progression and workforce planning. • Variability in training quality and supervision, especially outside formal programmes, raising concerns about consistency, equity and support for training. • Need to evaluate and enable portfolio careers, flexible working patterns, and broader definitions of "training" vs "service" to reflect diverse career aspirations, changing demographics and the wider role of non-traditional doctors (SAS, LED, non-consultant career paths). • A call for robust educator infrastructure and transparent funding/support for clinical educators, trainers and supervisors, acknowledging that effective training requires protected time and investment, not just goodwill. • Emphasis on equity and geographical distribution, reforms should consider social need across regions (incl. rural, underserved), not just trainee preference or metropolitan convenience. • Recognition that digital skills, generalist training, the shift towards community, population and prevention-centred care require adaptation of

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		curricula and training models, not just specialism-focused hospital-centric training. The Review (Phase 1) involved an extensive engagement programme: over 8,000 responses received, including more than 6,000 from resident doctors, as well as input from medical students, SAS/LED doctors, educators, regulatory bodies, patients and services. The report does *not* itself prescribe a full reform blueprint, rather, it lays out diagnostic findings, principles and recommendations. The next phase will involve collaboration among royal colleges, postgraduate deans, regulators, government and other stakeholders to design a detailed reform package. It marks a shift away from piecemeal incremental adjustments and signals a call for a system-wide, evidence-based, strategically guided reform of medical training. Phase of the Review is now underway and this will be taken forward on a 4 nations basis focussing initially on 8 key priority areas.
B2	https://www.gatsby.org.uk/app/uploads/sites/2/2025/11/towards-a-skills-first-scotland-final.pdf Towards a Skills-First Scotland: Pathways to Prosperity Organisation: Gatsby Foundation Published November 2025	This report explores how Scotland can transition towards a "skills-first" approach to education, employment and economic development. It examines how skills are developed, recognised and utilised across the system, and proposes a more coherent framework to improve pathways into skilled employment and support economic prosperity. The report argues that Scotland's current education and skills system is too focused on traditional academic routes and does not sufficiently recognise or prioritise skills development across all pathways. It suggests that a shift towards a "skills-first" approach would better align education and training with labour market needs and improve outcomes for individuals and the economy.

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		A central theme is the need to place skills at the core of how pathways are designed and valued. The report highlights that skills are developed through multiple routes, including further education, higher education, apprenticeships and workplace learning, but these routes are not always equally recognised or clearly connected. This can create fragmentation and limit progression opportunities. The report identifies issues with how qualifications and pathways are structured, noting that the system can be difficult for learners and employers to navigate. It points to a lack of clarity around progression routes and the transferability of learning between different parts of the system. This complexity can lead to inefficiencies and underutilisation of talent. Employer engagement is a key focus. The report notes that while employers are critical to defining skills needs, their involvement in the design and delivery of education and training is inconsistent. It argues that stronger and more systematic engagement is required to ensure that provision reflects current and future workforce demands. The report also discusses the importance of high-quality technical and vocational education. It highlights that these routes are often undervalued compared to academic pathways, despite their importance in meeting skills needs. Improving the status and quality of vocational education is presented as an important element of a skills-first system. Flexibility in learning is another key theme. The report emphasises the need for more flexible, modular and lifelong learning opportunities that allow individuals to develop skills throughout their careers. It notes that traditional linear education pathways are not well suited to changing labour market conditions. Data and information are identified as areas requiring improvement. The report highlights the need for better labour market intelligence, improved data on skills

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		supply and demand, and clearer information for learners and employers. This would support better decision-making and system planning. Governance and system coordination are also examined. The report notes that responsibilities for skills policy and delivery are spread across multiple organisations, which can lead to fragmentation and a lack of coherence. It calls for clearer leadership and stronger coordination across the system. The report includes examples and comparisons with other countries to illustrate different approaches to skills systems and highlight potential lessons for Scotland. Overall, the report presents a vision of a more coherent, flexible and employer-informed skills system in which skills are recognised and valued across all pathways. It emphasises the importance of aligning education, training and employment systems to support both individual progression and economic development.
B2	NMC consults on improving nursing and midwifery practice learning Publisher: Nursing and Midwifery Council (NMC) Date: April 2026 NMC consults on improving nursing and midwifery practice learning announces a public consultation on proposed changes to the NMC's approach to practice learning within nursing and midwifery education. The consultation follows an independent review of practice learning experiences and seeks views on how standards and guidance could be strengthened to improve consistency, quality and learner support. Link: NMC consults on improving nursing and midwifery practice learning	Background to the consultation • The consultation was launched following concerns identified through research and stakeholder engagement regarding the variability of practice learning experiences. • It builds on findings from an independent review that explored the experiences of nursing and midwifery students during practice learning. • The NMC recognises that practice learning is a critical component of professional education and plays a significant role in preparing students for registration. Purpose of the proposed changes • The consultation seeks feedback on measures intended to improve the quality, consistency and effectiveness of practice learning. • It aims to ensure that students are supported in environments that facilitate learning, professional development and safe practice.

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		• The proposals are designed to strengthen existing standards rather than replace the overall framework for nursing and midwifery education.
		
		Student experience in practice learning
		• The announcement highlights evidence that student experiences vary considerably across learning environments.
		• Areas identified through previous review work include:
		  ○ Access to support and supervision
		  ○ Quality of learning opportunities
		  ○ Inclusion and belonging within teams
		  ○ Exposure to inappropriate behaviour and workplace culture challenges
		• The consultation acknowledges the importance of creating positive and supportive learning environments for all students.
		
		Practice learning culture
		• A key focus is the culture of practice learning environments.
		• The NMC notes that learning experiences are shaped not only by educational structures but also by workplace behaviours, relationships and organisational culture.
		• The consultation explores how standards and expectations can better support positive learning cultures.
		
		Supervision and support
		• The proposals consider the role of practice supervisors, assessors and educators in supporting students.
		• The consultation recognises the importance of:
		  ○ Effective supervision
		  ○ Clear responsibilities
		  ○ Appropriate support structures
		• It also reflects wider concerns about workforce pressures affecting the capacity of staff to undertake educational roles.

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		Equality, diversity and inclusion
		• The consultation places emphasis on ensuring that practice learning environments are inclusive and equitable.
		• Particular attention is given to the experiences of learners from different backgrounds and the need to address differential experiences and outcomes.
		• The NMC highlights the importance of fostering environments where all learners feel respected, supported and able to succeed.
		
		Quality assurance and consistency
		• The NMC is seeking views on how greater consistency in practice learning experiences can be achieved across settings.
		• The consultation explores whether additional guidance, expectations or quality mechanisms may be required.
		• It acknowledges that learning environments vary significantly and that maintaining consistent quality can be challenging.
		
		Stakeholder engagement
		• The consultation invites responses from:
		  ○ Students
		  ○ Educators
		  ○ Practice supervisors and assessors
		  ○ Education providers
		  ○ Employers
		  ○ Professional bodies
		• The NMC positions the consultation as an opportunity to gather a broad range of perspectives before any changes are implemented.
		
		Relationship to existing standards
		• The proposed changes are intended to complement the NMC's existing education and training standards.

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		• The consultation focuses specifically on strengthening the practice learning component of professional education. • Any changes resulting from the consultation would sit within the wider regulatory framework governing nursing and midwifery education. The consultation reflects the NMC's view that practice learning experiences are central to the quality of nursing and midwifery education. It acknowledges evidence of variation in learner experiences and seeks to identify ways to improve support, inclusion, supervision and consistency. The overall aim is to ensure that practice learning environments provide high-quality educational experiences that support students throughout their professional preparation.
B3	Independent report on the regulation of advanced practice in nursing and midwifery | Nuffield Trust Published May 2023 Accessed August 2025	Led by the Nuffield Trust, this independent report was commissioned by the Nursing & Midwifery Council (NMC) to review whether and how advanced practice in nursing and midwifery should be regulated across the UK. It synthesises literature, job advert analysis and UK stakeholder input (including Wales) to set out risks and regulatory options. Growth of advanced practice; regulation gap. Advanced roles are expanding; there is no specific additional regulation of advanced practice in the UK—assurance currently rests largely with employers and non-mandatory course accreditation/credentialling. Variation in education & entry. Marked variation in master's-level AP courses (clinical content, entry experience) and limited external assurance; portfolio recognition routes exist (England and a similar route in Wales). Risk areas. Latent risks around diagnosis/intervention tasks; public understanding is limited; risks can be higher in some non-NHS settings; scope of practice not always clear. Options for regulation. Three main routes: (1) keep current framework for now; (2) annotate the NMC register for AP qualifications/equivalence

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		(prospective/voluntary/compulsory); (3) create a second-tier register based on assessed competencies. Each has trade-offs on cost, burden and speed. Principles & consistency. Any change should meet PSA principles (proportionate, consistent, targeted, transparent, accountable, agile); too much divergence across UK nations risks workforce mobility.
B3	Practice learning in nursing and midwifery education Nuffield Trust on behalf of Nursing & Midwifery Council (NMC) Published December 2024 Accessed August 2025	This review examines evidence and stakeholder insight on practice learning for pre-registration nursing and midwifery, covering hours and the births requirement, simulation, placement settings, supervision/assessment and equity, to inform NMC standards and support quality and capacity improvements across the UK. Led by the Nuffield Trust, in partnership with the Florence Nightingale Foundation, this independent rapid review was commissioned by the Nursing & Midwifery Council (NMC). • Practice learning hours (incl. births requirement) - evidence is limited; quality matters most. The review finds *no conclusive empirical evidence* for an "optimal" number of in-person practice hours for safe, effective pre-registration training. Stakeholders agreed that quality of the learning environment outweighs sheer volume of hours. Midwifery's "40 births" standard is increasingly hard to achieve given service patterns; flexibility is used but generates anxiety and unintended consequences (e.g., task-list culture). • Simulation — valuable but variably permitted and resource-intensive. Up to 600 hours of simulation can currently count toward nursing practice hours (retained post-pandemic), while midwifery can only count simulation for hard-to-achieve proficiencies. Evidence supports simulation as a bridge to practice and confidence-building, but not yet as a wholesale substitute for clinical hours; expansion is limited by staff expertise, time and kit. International approaches vary widely. • Interpretation and implementation problems. Widespread confusion about what "counts" (e.g., simulation settings; breaks;

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		mixed messages since Covid flexibility); supernumerary status sometimes not upheld; inconsistency in signing off proficiencies. These discrepancies create anxiety and undermine assurance. • Placement settings and models — expand beyond hospitals. There's headroom to broaden placements into community, primary care, independent and third sector settings, but barriers include supervision/assessment capacity and student worries about meeting proficiencies. Internationally, models include hub-and-spoke and coaching-based models; no single model is "optimal". Staging of placements across the programme matters. • Funding and incentives — misaligned and insufficient. Hosting placements carries real costs (time for supervision, training). The report notes tariff disparities (e.g., £32,552 per medical undergraduate vs £5,343 for nursing/non-medical in 2023/24 in England). Wales is piloting funding for GP placements; promising but requires scale and consistency. • Supervisory infrastructure — Wales has strengths to build on. HEIW funds c.60 WTE Practice Education Facilitators (PEFs) providing support and QA for placement learning — a notable asset that could be deepened and standardised. • Equity and inclusion — explicitly called out. The review frames equitable and inclusive practice learning as core to safe, high-quality preparation (e.g., tackling variable experiences, ensuring safe, respectful environments and consistent support). The review also sets out "specific areas for action" for regulators, AEIs and practice partners (clarity on rules, proportionate QA, better data, expanded settings, stronger supervision capacity, and student support).
B3	Waste not, want not: Strategies to improve the supply of clinical staff to the NHS | Nuffield Trust Published September 2023	This research report was led by the Nuffield Trust and examines the UK's "leaky" domestic clinical training pipeline and sets out a 10-point plan to improve supply and early-career retention of clinical staff in the NHS. It was published to inform policy

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	Accessed August 2025	amid growing reliance on international recruitment and concerns about value for money from education spend. Leakages across the pathway: Notable student attrition (e.g., ~13% in nursing/radiography cohorts 2014–20) and early-career exits (≈17–21% of several AHPs and nurses leaving NHS H&C settings within two years). Only 52% of new NMC joiners and 39% of GMC joiners were UK-trained in the latest data. Drivers & risks: Financial pressure, placement experience and lack of support contribute to attrition; policy shifts (faster routes, apprenticeships) may help but carry risks if poorly implemented. Investment & value: Around £5bn pa spent on clinical education/training in England; stronger assurance on outcomes and placement quality is urged. Incentives & routes: Calls to: review degree-level apprenticeships; consider student loan forgiveness (nursing, midwifery, AHPs; options for doctors/dentists); evaluate models like Irish/Australian preceptorship and the Welsh bursary tie-in. Pay & careers: Analyse starting/early-career pay competitiveness; tackle career progression inequalities between professions; plan for more diverse career paths (e.g., SAS/LE roles, portfolio). GP supply & data: Urgent rethink of GP pipeline policies; improve attrition/participation/retention data and early-career destination tracking.
B3	Healthcare Horizons KPMG Published January 2023	Produced by KPMG International, *Healthcare Horizons* (Jan 2023) is a thought-leadership report describing three possible futures for health systems and a route to an inclusive model that blends technology, empowered communities and an enabled workforce. It was published to help leaders plan beyond crisis response and redesign care over the next 5–10 years.

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	Accessed August 2025	Three futures; aim for "Inclusive". KPMG sets out Impoverished, Alienated and Inclusive scenarios. Inclusive systems use tech and community assets to enable the workforce; over-reliance on hospitals, or on "big tech", creates risk and inequity. Education should be designed to *create* the inclusive future (not default to the other two). Five trend categories to build into curricula. Technology & data: Decentralised health data (personal online data stores), AI and cognitive tech free staff from routine tasks; digital twins support prediction and planning. Consumerism: Seamless, personalised, omnichannel experiences and platform-based access. Workforce: Top-of-practice working with new skill mixes; tech-enabled roles. Communities: Patients and communities as active custodians, co-designing care. ESG: Systems judged on social and environmental impact as well as outcomes. Data stewardship & literacy. Prediction: health data becomes decentralised and coveted; individuals and communities gain control. This needs workforce skills in data ethics, interoperability and safety. Shift of care settings. Expect less spend on estates and a shift to community & virtual care, with integrated neighbourhood models and virtual wards; placements and competencies must follow. Ecosystem roles & micro-credentials. Future systems feature health data centres, global specialist hubs, community services and micro-credentialled participants (including carers and non-registered workers) integrated with primary/community teams. Future care pathways. Inclusive pathways become Predictive, Personalised, Proactive, Preventative; examples show AI coaches, remote monitoring, VR rehab, and community peer support, implying new competencies across the pipeline.

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		5–10 year agenda. The transition agenda includes building population-health data platforms, redesigning roles, and re-engineering incentives towards prevention and value. Education and regulation must move in step.
B3	In the balance: Lessons for changing the mix of professions in NHS services | Nuffield Trust Published January 2025 Accessed August 2025	Published by Nuffield Trust in January 2025 and Commissioned by NHS Employers to distil lessons from UK and international evidence on introducing and integrating new and emerging roles (e.g., PAs, NAs, ACPs, ARRS roles) and changing skill-mix safely and productively. Changing skill-mix is not automatically better care or lower cost. Poorly designed/implemented shifts can increase demand, add cost, threaten standards and fragment care; robust triage, pathway design and clear task allocation are essential. Design roles from first principles. Build roles around work analysis, staff skills and patient needs; plan for service redesign capacity (org. development, leadership, estates/space) to make multi-professional teams work in practice. Education & training capacity is a major constraint. Delivering expansion requires agreed standards/competencies, growth in intakes (notably nursing, medical, ACP/NA), and realism about provider and placement capacity and competition for learning opportunities across professions. Preparation for practice gaps. Evidence shows some new starters (e.g., clinical pharmacists, PAs) lack sufficient patient-facing experience, creating support/training deficits; ACP trainees can struggle to complete competencies when training is added onto full roles in overstretched services. Supervision is pivotal, and uneven. Ongoing clinical supervision, mentoring and peer support are critical, yet access is inconsistent (e.g., a quarter of ACPs without clinical supervision in one study); some practices employed PAs without necessary supervision.

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		Funding design shapes behaviour. Schemes like ARRS salary reimbursement can distort local skill-mix decisions (e.g., £0 direct cost for ARRS roles/GP registrars vs c. £106k salaried GP, £49k practice nurse), so relative costs must be considered alongside need and quality. Regulation, scope and safety. Clarify scope of practice, indemnity and governance before scaling roles; UK lessons echo international work (e.g., Australia's scope-of-practice review). Public awareness & consent are low. Limited understanding of new roles risks confidence and experience; proactive communication and transparent boundaries are needed. Acceptance by other professions matters. Attitudes from doctors and other staff are a major constraint (e.g., 76% of respondents in emerging roles cited doctors' views on PAs); role blurring fuels friction (e.g., NA vs RN). Exposure and clarity improve acceptance. Progression, wellbeing & retention. Emerging-role staff leave when they don't feel part of a team or their role is misused; structured progression, preceptorship and belonging are part of safe integration. Evaluate change. Adopt a systematic approach with real-time evaluation to avoid repeating past failures; learn from prior initiatives before scaling.
B3	How will your decisions today shape the future for generations to come - MCA Ernst & Young Published January 2025	Published by EY, this article provides long-form insight by *Elisabeth Bolshaw* on how today's leadership choices shape a multi-generational workforce and wider society. Five-generation workforce is the "new normal". For the first time, five generations are working together; employers that rethink old structures can unlock growth through cross-generational collaboration and learning. Ageing populations and lower birth rates will tighten talent supply to 2050, making every generation's contribution

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	Accessed August 2025	critical. Education should design multi-age learning and knowledge-transfer by default. Gen Z realities: finances, purpose, portability. Gen Z shows low financial security, strong purpose orientation, and rising portfolio careers/side hustles; programmes must be flexible (stackable routes, paid placements, recognition of prior learning) and connect learning to mission/impact to boost engagement and retention. Trust & transparency matter. Trust in "big" institutions is weak for Gen Z; transparency on data use grows trust (e.g., most consumers will share health data electronically if protections are clear). Educators should build data stewardship, consent and clinical safety into every pathway. AI optimism + skills gap. Gen Z expects to use more AI, valuing time-saving and error-reduction, but skills are overestimated and uneven. Curricula must raise AI literacy (prompting, oversight, bias, governance, patient safety) alongside human skills (judgement, empathy, teamwork). Digital-first work & career expectations. Younger cohorts expect digitally enabled, creative work with rapid progression and global exposure; learning needs blended delivery, micro-credentials and experiential projects aligned to real NHS problems. Sustainability & social equity are non-negotiable. Decisions today must address decarbonisation and equity; learners expect organisations (and education) to act on both, so sustainability, inclusion and community impact should be embedded as competencies and assessment themes.
B3	Health Equity in England_The Marmot Review 10 Years On_full report.pdf Published February 2020	Commissioned by the Health Foundation to assess what changed since the 2010 Marmot Review and to set an agenda to reduce widening health inequalities. Stalling life expectancy & widening gaps. Since 2011, life-expectancy gains slowed sharply; women in the most deprived areas saw declines. Years lived in ill-health

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	Accessed August 2025	increased, with a steep deprivation gradient. Implication: every programme needs explicit equity outcomes, not just overall quality. Social determinants through the life-course (the 6 domains). The report re-affirms the 2010 framework: (1) best start in life; (2) capabilities and control; (3) fair employment/good work; (4) healthy standard of living; (5) healthy, sustainable places; (6) prevention. It also stresses proportionate universalism (universal offers, scaled by need). Use these domains to organise curricula and placement experiences. Child poverty & early years. Child poverty rose back to pre-2010 levels; after housing costs it reached ~30% (2017/18) and exceeds 4 million children, with higher rates for lone-parent and larger families. Early-years spending grew for childcare hours but equity-focused family support shrank. Education should embed poverty-aware, trauma-informed, family-centred practice. Education system context since 2010. The review links funding cuts and persistent attainment gaps to long-term health equity impacts; the early-years workforce faces low pay and recruitment challenges, affecting quality. Future clinicians need skills to work with education and local services on school readiness, SLC (speech, language & communication), and inclusion. Places left behind & regional inequality. The North–South divide widened; affluent areas did well wherever they are, but deprived areas' outcomes depend heavily on region. Training must prepare staff for place-based practice, with exposure to high-deprivation/rural placements and community partnerships. Work, income, and healthy living standard. Rising in-work poverty, insecure work and household debt undermine health; the review calls for minimum incomes for healthy living, better wages and good work. Clinicians need capability in social welfare navigation, MECC, occupational health and rehabilitation to work.

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		Prevention, data and accountability. Stronger prevention and joined-up data are required to target need and evaluate impact; local systems need capability to run equity-sensitive improvement and report outcomes transparently.
B3	Four-nations-report-2023-2024-V3.pdf Published July 2025 Accessed August 2025	A report published by Skills for Health (part of The Workforce Development Trust), it synthesises current workforce challenges and opportunities across England, Scotland, Wales and Northern Ireland, with case studies and actionable best practice to inform better planning and delivery. Converging workforce pressures across the UK. The report flags skills shortages, shifting service demand and the need for innovative role design as common issues across all four nations, framed not just as problems, but as opportunities to redesign teams, routes and supervision. End-to-end, needs-based planning. It emphasises aligning the size, shape and distribution of the workforce to population health need, "the right mix of skills, in the right place, at an effective cost" which pulls education commissioning, placements and educator capacity into the centre of workforce planning. Four devolved-nation case studies to learn from. Featured examples cover: Mental health workforce planning with HEIW (Wales); junior doctors optimisation at University Hospitals Sussex (England); NHS Greater Glasgow & Clyde (Scotland); and building workforce planning capability for Health & Social Care Northern Ireland—practical illustrations of how planning, training capacity and role design connect. From insight to action: best-practice toolkit. The companion material highlights proven practices and practical steps organisations can take now—useful prompts for curriculum design (e.g., scenario planning, service and role redesign, capabilities frameworks) and for educator workforce development. Data, modelling and transparency. Evidence collated alongside the report stresses the need for robust modelling, clearer assumptions and better communication of

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		uncertainty when translating national projections into local education numbers, supervision capacity and placement plans. Whole-system alignment (health–social care–education). The four-nations lens underlines that effective planning depends on joined-up action between NHS bodies, social care and education partners, with local case studies showing how this supports retention, wellbeing and progression.
B3	From zoomers to boomers, training workers on AI is a multigenerational challenge Published July 2025 Accessed August 2025	Published by *People Management* (CIPD), this article explores why AI upskilling is a multigenerational challenge and what HR/L&D should do so *all* age groups can adopt AI productively and safely. Big training gap, high demand. The article highlights that only ~16% of employees report receiving AI training, while success depends on *every* generation integrating AI into daily work. Broader evidence shows workers want formal training, access to pilots/sandboxes, and incentives to adopt AI. Generational access & opportunity are uneven. Older cohorts report fewer AI skilling opportunities than younger ones, so design must level access rather than assume "digital natives" are already competent. Some studies even find millennials self-report higher AI expertise than Gen Z, underlining the need to assess skills, not stereotypes. How people actually learn AI at work. Workers often skip formal modules and learn via experimentation and peers, so programmes should blend microlearning, cohort practice, peer/reverse mentoring, and on-the-job tasks. Make room for informal/social learning as a first-class method. Inclusive design principles. Use Universal Design for Learning and multiple formats (asynchronous, live, simulation) so different ages, roles and confidence levels can succeed; ensure accessibility and varied pacing.

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		Trust, safety and governance are core content. Training must cover data stewardship, consent, clinical safety, bias and explainability, aligned to UK government guidance (AI Opportunities Action Plan; HMG AI Playbook). Public-sector lessons warn that AI can magnify poor data-permission practices without strong governance—teach *safe use* as much as *clever use*. Link learning to real work and value. Provide approved tools in sandboxes, tie learning objectives to specific tasks/workflows, and measure transfer to practice (quality, safety, productivity). Employers are planning automation + augmentation + upskilling together; curricula should mirror that mix.
B3	Five Factors Impacting the Public Sector Skills Landscape Published January 2025 Accessed August 2025	A short, evidence-led report from *TrainingZone* in partnership with The Open University (OU), setting out five factors shaping public-sector skills and practical actions for L&D and workforce leaders; it builds on findings from the OU Business Barometer 2024. AI & technology adoption (skills and safety). Public-sector organisations face both opportunities and risks from AI and automation; the Barometer finds low confidence applying AI/green tech (64%), signalling a need for baseline AI/data literacy and safe-use governance alongside role-specific upskilling. Persistent skills shortages → workload & wellbeing pressure. Skills gaps are more acute in the public/third sector (66%) than overall (62%); 78% say shortages increase workload on existing staff, undermining quality, retention and time for education. From reactive to proactive training. The report urges moving beyond ad-hoc, compliance-only learning to planned, capability-led development tied to service outcomes and career pathways (pre- to post-registration).

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		Recruitment headwinds (demography & shocks). Ageing workforce, post-pandemic dynamics and Brexit complicate recruitment—calling for widening access, apprenticeships and mid-career conversion routes. Regional disparities & place-based need. Geography matters: uneven skills and access to development require regional targeting of education/placements and support for rural/remote services. Capacity & capability for modern challenges. Success hinges on joined-up action across government, local systems and providers to build educator/supervisor capacity, digital infrastructure and evaluation capability.
B3	Council of Deans of Health – Strategy 2030 Published August 2025 Accessed August 2025	The strategy from the Council of Deans of Health (CoDH) sets their vision and priorities to 2030 to support members (100+ universities educating c.200,000 current/future nurses, midwives and AHPs), build a connected leadership community, and drive system-level change across UK health education and research. Core values: inclusion, impact, collaboration, integrity. Three strategic aims with clear levers for HEIs and systems. 1) Empower members as system leaders (excellence in education/research; navigating external pressures). 2) Build a strong, connected leadership community (amplify voice; collaborate). 3) Drive system-level change through evidence, policy and external affairs. These frame how universities partner with governments, regulators and employers. Priority themes reflected in CoDH groups (what the strategy operationalises). Pedagogy & innovation (ed-tech, curriculum change), Equality, diversity & inclusion (including anti-racism), Regulation (assurance, standards portability), Research (capacity, impact), plus reference groups for Simulation and Generative AI in healthcare education, and thematic groups for Advanced practice and Workforce. These signal national priorities for curriculum, educator capability and quality.

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		UK-wide, nation-aware delivery (relevant for Wales). CoDH Wales convenes Welsh HEIs around student/educator recruitment and retention, workforce development, innovation and research, working with Welsh Government, HEIW, MEDR, Universities Wales and regulators — a ready vehicle for "once-for-Wales" co-ordination. Partnership and pipeline focus. Strategy signposts collaborations (e.g., Skills for Care, AHP Educator Career Framework, Student Leadership, Funding Clinic) that can be harnessed for widening access, educator development and placement quality.
B3	The Future of Medical Education: Learning Healthcare in the Digital Age Published April 2025 Accessed August 2025	A blog insight from Care Learning that summarises key trends reshaping medical education, integration & IPE, digital/online learning, simulation & immersive tech, AI & analytics, competency-based/personalised pathways, global collaboration, and wellbeing/ethics, to guide education leaders in the digital age. Integrated & interprofessional learning (IPE) as default. Curricula are moving away from silos, blending basic science with clinical practice from the start and normalising IPE to build collaboration skills. Map early clinical exposure and multi-professional teamwork into programme design. Digital & e-learning platforms for access and flexibility. Online platforms, virtual classrooms, on-demand video/podcasts and interactive modules widen access and let learners study at their own pace — important for LTFT and rural learners. Build high-quality asynchronous components with strong pedagogy, not just content upload. Simulation & immersive training to practise safely. VR/AR and high-fidelity manikins create risk-free environments for procedures and clinical decision-making, improving hands-on competence while protecting patients; continue scaling SBET across Wales with clear QA.

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		AI & data analytics in curricula and assessment. AI/ML are being taught for data interpretation, diagnosis support and real-time, personalised feedback via AI-enabled assessment tools; learners must also grasp limits of AI. Prioritise AI literacy (safety, bias, explainability, governance). Personalised and competency-based education (CBE). Progression based on demonstrated mastery, not time served; analytics and AI enable individualised pathways focusing effort where gaps exist. Align assessments and e-portfolios to observable competencies. Globalisation, collaboration & inclusion. More international partnerships, exchanges and efforts to widen participation diversify the pipeline and spread innovation; use this to benchmark Welsh offers and open outward routes. Wellbeing, ethics, cybersecurity & privacy. Mental health support is rising in importance, alongside explicit teaching of digital ethics, cyber hygiene and data protection as digital tools proliferate. Bake psychological safety and professional conduct for digital practice into learning environments.
B3	Final-CoDH-Nursing-and-Midwifery-Educator-Workforce-Report.pdf Published July 2025 Accessed August 2025	A UK-wide survey and qualitative study (Oct–Nov 2024) of nursing and midwifery academic educators on recruitment, retention, progression and leadership; published in 2025 to inform national action on educator capacity. • Recruitment picture (last 2 years). 84% of teams recruited; mainly early-career academics (1–3 years HE experience). 60% did not recruit senior academics. Learning disability nursing faced the toughest recruitment, then adult nursing. Midwifery reported more positive recruitment. Drivers of difficulty: salary gaps NHS↔academia and lack of appropriate experience. Some Welsh respondents cited easier recruitment due to close health-board partnerships and being the sole local HE provider.

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		• Vacancies: 34% reported unfilled posts (mostly 1–6 early-career roles), raising workload and student-experience risks. Contracts, capacity & what doesn't work. • Joint/split contracts exist but are uneven; very short part-time/one-day contracts were widely viewed as ineffective, adding planning burden and limiting ability to run modules or support students. Shifting staff profile & skill mix. • Majority report more early-career staff (notably in adult, mental health and midwifery; South East strongest trend). Concern about losing the "top slice" of experience in both HE and practice • Team composition: Clinical staff (58%) are common in teams, with researchers (43%), advanced clinical staff (38%), clinical academics (35%), learning technologists (17%) and technicians (20%) variably present; midwifery most likely to include clinical staff (62%). Retention & progression pressures. • Reasons for leaving: Retirement (38%), return/move to clinical practice (30%), career progression elsewhere (21%), career change (20%). Financial pressures on HE (cuts, VS schemes) and staffing gaps compound attrition. • Progression bottlenecks (beyond SL): Frozen promotions, limited senior posts/flattened structures, rigid criteria privileging research profiles, insufficient protected research time or PhD support; promotion routes often unclear. Leadership representation & gaps. • Highest role held by someone of the same profession: Head of school/department (28%); Dean (18%); Pro-VC (7%). Nursing/midwifery generally better represented at exec level than some AHPs, yet many teams still feel under-championed and call for leaders who can bridge university and practice priorities.

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		What's helping (emerging practice). • Development offers (mentoring, coaching, networking), inclusive recruitment, strong induction/transition support for clinicians entering academia, flexible roles (e.g., lecturer-practitioner, secondments/rotations), knowledge-capture from senior staff, and reviewing pay to narrow NHS–HE gaps. In Wales, an associate lecturer scheme (clinician secondments 2 days/week) was highlighted. Twelve recommendations (headline areas). Promote academic careers; structured progression pathways; transition training for clinicians; formal mentoring; targeted skills development (curriculum, simulation, advanced practice, assessment/supervision, research, evaluation/impact, cultural competence, IPE); multiprofessional leadership skills; leadership development; portability/recognition between HE & practice; HEI–practice partnership models (rotations, flying faculty, internships, reciprocal contracts); funded routes to higher qualifications; realistic workload policies/boundaries; streamline/regulatory alignment across health & education.
B3	Final-CoDH-Allied-Health-Professions-Educator-Workforce-Survey-Report.pdf Published July 2025 Accessed August 2025	UK survey and qualitative study of AHP academic educators (Oct–Nov 2024; 143 unique responses) on recruitment, retention, progression and leadership, using the AHP Educator Career Framework (2023) to define career stages; published 2025 to inform national action on educator capacity. Recruitment picture & where Wales sits. Most teams recruited within the last two years; early-career hires (1–3 years' experience) dominate; London reported the lowest recruitment rate, while Wales 87% reported recruiting (regional breakdown). Positive experiences were noted in larger AHPs (physio, paramedic, dietetics, OT), and Welsh providers highlighted strong partnerships with local health boards and being the sole local HE provider in underserved areas as enablers.

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		Recruitment challenges (what and where). Widespread difficulty recruiting Operating Department Practice (ODP) educators; London most challenged. Top causes: lack of applicants and pay gaps vs clinical practice. Smaller AHPs (orthoptics, osteopathy, podiatry, dietetics, SLT) reported limited applicant awareness of the profession. Creative arts therapies were least likely to have recruited. Applicants often lacked experience/qualifications for posts, especially in AHPs newer to HE. Vacancies & workload risk. Most providers didn't see unfilled vacancies as a "major" concern overall, but ODP (53%), paramedic (50%) and SLT (44%) educators did; Midlands most likely to report unfilled posts (58%). Concern centres on workload on remaining staff. Staff profile is skewing junior. Teams report more early-career staff and little/no increase in senior staff, risking loss of expertise/institutional memory—exacerbated by early retirements and financial constraints limiting senior recruitment. Some professions saw diversity increases (e.g., osteopathy 67%, prosthetics & orthotics 60%). Clinical background & setting-specific expertise. Clinically qualified proportions were broadly flat (dietetics/osteopathy had variance). Osteopathy (67%) and ODP (42%) struggled to recruit staff with specific setting expertise (acute/hospital, peri-op, theatres, critical care, surgical first assistance). Urban institutions were more likely to struggle with specialist skill recruitment than remote ones. Skill gaps in educator capability. Difficult-to-recruit educator skills include research, curriculum development, simulation, advanced practice, assessment & supervision, cultural competence and IPE. This points to a targeted faculty-development need. Money matters (and apprenticeships add admin). Financial pressures are reducing programme resourcing and raising staff–student ratios; growth in apprenticeships increases admin burden (multi-regulator compliance) and placement pressures, with funding shortfalls also blocking staff progression.

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		Retention: workload is the common story. Across AHPs, retention is "neither easy nor hard", but dietetics had most difficulty (41%). Main reasons: excessive workload, growing pastoral/administrative load (especially in new/apprenticeship programmes), and unclear expectations for clinicians entering academia—many return to practice quickly. Top leaver reasons: workload and retirement (plus restructures). Paramedic and OT teams particularly cite moves back to clinical practice. Early-career academics are hard to retain. Progression & leadership. Pathways look clear on paper but barriers bite: frozen promotions, research-output criteria hard to meet for teaching-focused/clinical-background staff, limited protected scholarship time; Wales had the highest proportion reporting no promotions in 2 years (60%). Smaller AHPs are under-represented in university leadership and sometimes misplaced (e.g., arts therapies assessed on non-clinical metrics); decisions can skew towards nursing priorities. What helps (emerging practice). Flexible contracts, PhD/qualification opportunities, internships, guest lecturing, joint clinical-academic practice, and structured induction for new academics support recruitment/retention. The report spotlights Welsh commissioning & health-board partnerships as facilitators. Recommendations (headline set). 13 actions include: promote academic careers, structured progression, mentoring, faculty-skills training (curriculum, simulation, assessment/supervision, research, evaluation/impact, cultural competence, IPE), multiprofessional leadership, mutual recognition & portability between HE and practice, flexible/joint models (rotations, "flying faculty", secondments), funded routes to PG quals, workload policy & staffing principles, and a cross-sector review of regulatory oversight to reduce duplication.
B3	KPMG and Mills & Reeve Radical Collaboration: A Playbook	Produced by KPMG and Mills & Reeve, for Universities UK's Transformation & Efficiency Taskforce, it provides Practical guidance on how UK universities can

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	Published July 2025 Accessed August 2025	collaborate or consolidate, with models, governance options, toolkits and conditions for success to address sector sustainability and improve outcomes. Why collaboration, why now. The playbook links financial pressure, demographic shifts, technology and policy changes to a need for medium–long-term structural solutions, not just efficiencies. Education planning should assume shared services, shared faculty, and joint provision across institutions. Guiding principles (North Star → Who → How). Start with clear purpose (benefit to students, staff, local economy), then ensure leadership & governance, cultural compatibility, wide stakeholder engagement, and long-term integration plans with due diligence and early engagement with government/regulator. These become design criteria for joint education ventures. A spectrum of collaboration models. Options run from Contractual Alliances (retain independence; share services / placements / executives) through Federations and Education Corporate Groups (parent entity with shared brand/services) to merger variants and future Multi-University Trusts (MUTs). Each has distinct governance, branding, finance, staff and student implications that map to different education use-cases (e.g., joint curricula or clinical education hubs). Operational detail that matters for education. • *Contractual Alliance:* institutions stay autonomous but can share student support, facilities, placements, and even executive roles; secondments are enabled. Useful for shared simulation centres, joint PEF (Practice Education Facilitator) teams, or co-badged modules. • *Education Corporate Group:* a parent body oversees strategy and shared services; students can study across the group; academic governance remains at level-specific councils (HE/FE/schools). Good for end-to-end pathways (FE→HE→CPD) and all-Wales content libraries. • *"Newtown" worked example:* shows a regional, multi-entity group with shared ownership, data/analytics, and back-office platforms (e.g., CRM, HRIS, VLE) to

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		enable skills pipelines aligned to local need—directly transferable to Welsh regions. Conditions for success. System-level change needs sector leadership, student bodies, regulators, funders and regional partners to align; structural/regulatory barriers to collaboration must be addressed collectively - important for cross-provider education models. Collaboration Toolkit. A phased approach from strategic intent and options long-list through business case, implementation roadmap and post-merger integration—useful as a template for multi-institution education projects (e.g., unified e-PAD, shared simulation network).
B3	Student Academy Experience Survey Student Academic Experience Survey 2025 - HEPI, HEPI/Advance HE Published July 2025 Accessed August 2025	UK annual survey by HEPI and Advance HE of 10,232 full-time undergraduates on teaching, workload, wellbeing, money and value; core barometer used by policymakers and providers. Paid work is now the norm — and shapes learning. 68% of students work in term-time; mean hours ≈ 8.9/wk across all students and 13.1/wk among those who work. Commuters, carers and later-year students are most likely to work. Education models must assume widespread employment. Independent study time has fallen sharply. Average independent study ≈ 11.6 hrs/wk (2025), now lower than contact hours attended in most subjects; suggests a structural time squeeze. Contact hours steady; satisfaction dipped, especially for working students. Typical contact attended ~13 hrs/wk; satisfaction with contact hours fell, and is lower for students who work than for those who don't. Assessment getting faster. 61% of assignments returned within two weeks (up from 45% in 2024), a notable quality gain to lock in.

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		Value for money and expectations. 37% rate value as good/very good vs 29% poor/very poor; 26% say their experience exceeded expectations (up from 22% in 2024). However, 11% would choose a non-HE route if deciding again (up from 6%). Wellbeing and mental health support. Mental health remains the top reason for considering withdrawal, with financial difficulties second; 40% want universities to offer comprehensive mental-health services, and 41% want robust preventative + counselling with NHS handling complex cases. Belonging pressures. A small but significant decline in reported belonging / on-campus relations; free-text calls for more personalised support and one-to-one interactions. Total weekly load. For students who work, combined study + work averages 44.3 hrs/wk, consistent with time scarcity affecting engagement. Fees/finance trade-offs. Students split between keeping fees flat (accepting some quality reductions) and small inflationary rises to maintain quality; knowledge of fees systems varies. (Useful for Wales funding comms.)
B3	JISC - Collaboration for a sustainable future Published October 2024 Accessed October 2025	Published by JISC and KPMG, this is a sector-wide blueprint arguing that UK higher education can unlock value and long-term sustainability by collaborating on shared, standardised approaches to digital, data and technology. It sets out five collaboration themes (from common models and shared skills pipelines to whole-service sharing) and stresses that the main barriers are inconsistent processes and culture, not technology. The call to action is for leadership-backed, "adopt-don't-adapt" standardisation and coalitions of the willing. Standardise first, then share. The report identifies the biggest technical obstacle as the lack of standardised processes, data structures and operating models across institutions. It proposes sector-wide adoption of common models/definitions (e.g.,

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		via reference architectures) and an "adopt, don't adapt" mindset to enable interoperability and shared platforms. Five collaboration themes to design around: 1. Greater central coordination on models and definitions; 2. Central provision of DDaT (digital, data & technology) skills and shared resource to counter high demand/low supply; 3. Shared procurement/implementation/management of applications across teaching & learning, research and professional services; 4. Sharing or commissioning whole services (largest benefits, longest lead times); 5. Co-building technology with vendors (prefer extending existing tech over building from scratch). Business case realities. For shared services, cases should assume 10–30-year horizons and address VAT treatment to realise savings at scale. Leadership & governance conditions. Success needs visible backing from senior leaders (VCs), incentives to collaborate or clear direction from government, trust between institutions, and a neutral convener to progress initiatives. Why standardisation matters (beyond tech). Many institutional activities do not create competitive advantage (e.g., commodity back-office capabilities). Standardising and sharing them frees up resource for value-adding education and research. Operating constraints to design for. Any digital education strategy must contend with: legacy estates and technical debt; complex integrations; cyber risk; data quality/reporting burdens; transition to SaaS/cloud and the shift from capital to recurrent costs; and national shortages/competition for technical skills.

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		Culture over tooling. The foreword underscores that technology isn't the main barrier; willingness to standardise practice and drive culture change is.
B3	Student Demand to 2035, HEPI Student-Demand-to-2035.pdf Published October 2024 Accessed August 2026	Published by Higher Education Policy Institute (HEPI), it projects young, full-time undergraduate demand to 2035 in England and explores factors behind the recent stall in participation, with implications for institutions and policy. (Scope excludes part-time, postgraduate and international students.) Scope & limits . The report models domestic young undergraduates in England only, not the whole UK; it notes post-18 demand beyond 18-year-olds (mature, apprenticeships) could partially offset trends but isn't modelled. Demography turns after 2030. The 18-year-old cohort rises to 2030, then falls ~7% (2030–35) and ~12% (2035–40) — ~17% down from the 2030 peak to 2040. If participation does not improve, overall demand would reduce substantially after 2030. Participation has stalled. After two decades of steady increases, application/participation dipped in 2023–24, putting prior demand projections "too high" unless the decline proves a temporary blip. Equity trends mixed. Long-term widening-participation gaps narrowed (most vs least privileged), but progress stalled in the last two years. The male participation gap remains large; HEPI estimates it would take a ~37% increase in male participation to match female rates. Cost signal is about living costs, not fees. Real-terms fees have fallen since 2012, but maintenance support hasn't kept pace, likely deterring some applicants — a student cost-of-living issue for widening access. Market dynamics risk provider fragility. "Higher-tariff" universities have grown applications (+40% since 2013) while lower-tariff declined (–13%), intensifying

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		competition and risk for some providers. The report moots number controls / stronger system stewardship to avoid destabilisation. Possible drivers of the stall. HEPI cites COVID after-effects, a hostile public narrative about HE, and economic factors; school attainment trends do not clearly explain the dip.
B3	Transformation and Efficiency Taskforce: Towards a new era of collaboration Published June 2025 Accessed December 2025	A sector-wide call to action setting out how UK universities can respond to financial, demographic and technological pressures through collaboration, shared services, digital transformation and new operating models. It follows extensive engagement across institutions and proposes practical "starting points" that universities can adopt collectively to reduce costs, improve resilience and maintain quality. The report presents six core *collaboration priorities:* 1. Digital transformation with shared approaches • Calls for collaboration on sector-wide digital infrastructure, shared procurement, joint implementation teams, and interoperable systems. • Recommends collective use of data architecture, shared cyber-security capability and co-ordinated digital investment roadmaps. Education implication: For health-professional training, this enables a shared Wales-wide digital learning ecosystem: simulation, VR/AR, digital assessment, data-driven curriculum analytics and a unified e-portfolio spine. 2. Shared services to reduce duplication • Opportunity for "deep" shared services across finance, HR, L&D, procurement, estates, digital, and student services. • Focus on standardisation, consolidation and economies of scale. Education implication: Supports standardised, cross-institutional placement administration, QA, supervisor training, CPD management, and shared back-office capability for Welsh health education.

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		3. Collaborative academic provision and flexible learning • Suggests joint curriculum development, cross-institution modules, micro-credentials, and shared delivery models between institutions. • Greater focus on lifelong learning and stackable qualifications. Education implication: Aligns to HEIW's ambitions for pan-Wales micro-credentials, common core curricula (digital, AI, generalism, genomics), and shared simulation-based modules. 4. Data-enabled decision-making • Strengthens the case for shared intelligence dashboards, sector benchmarking, workload analytics, resource optimisation and scenario modelling. Education implication: Enables Wales-wide workforce–education intelligence, linking HEI delivery, placement capacity and workforce demand 5. Place-based collaboration • Universities should collaborate with local services, businesses, and civic partners to support regional economic and workforce needs. Education implication: Reinforces the importance of Health Boards, HEIs and Regional Partnership Boards jointly planning placements, workforce pipelines and community-based training hubs. 6. Stronger cross-sector partnerships • Encourages partnership with public services, NHS bodies, local government, FE and industry for innovation, skills and inclusion. Education implication: Supports multi-sector training in health, care, digital health innovation, community care, and preventative practice, with co-delivery between NHS and HE providers. The report was commissioned by UUK after mounting concerns about sector-wide financial pressures, aging estates, digital cost escalation, skills shortages and rising regulatory burdens.

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		It emphasises "collaboration before cuts", and warns that fragmented, institution-by-institution measures will not address structural issues. Provides practical "starting points" and case studies to support immediate implementation. Encourages a cultural shift to a shared-infrastructure mindset, with national or regional coordination.
B3	Delivering a joined-up post-16 skills system Universities UK (UUK) Published October 2025 Accessed December 2025	*Delivering a joined-up post-16 skills system* sets out UUK's proposals for a more coherent and collaborative post-16 skills landscape across the UK. It identifies fragmentation between FE, HE, employers, and government as a barrier to tackling skills shortages and calls for a system in which qualifications, funding, data and progression pathways are easier to navigate. The paper outlines practical proposals for a more flexible, accessible, employer-responsive and high-quality skills system. 1. A unified, interoperable post-16 skills ecosystem • The report argues that the skills system is currently complex and hard to navigate for learners and employers, with duplication and inconsistent progression routes. • Calls for shared frameworks, qualification pathways and aligned standards across FE, HE and apprenticeships. • Emphasises the importance of employer-led but nationally coordinated provision. 2. Lifelong learning and flexible pathways • Supports credit-based, modular learning, stackable qualifications and mixed modes (online, blended, work-based). • Proposes greater portability of credits across institutions to enable learner mobility.

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		• Stresses the need for alignment with the UK-wide Lifelong Learning Entitlement (LLE). 3. Better coordination between FE, HE and employers • Highlights the need for place-based partnerships to meet regional workforce needs. • Encourages co-designed curricula and collaborative delivery between FE colleges, universities and employers. • Calls for integrated careers guidance and transition support. 4. Employability, productivity and economic growth • Links a joined-up skills system to improved productivity and local economic development. • Encourages embedding future-skills (digital, green, data, AI) across the curriculum. • Promotes work-integrated learning, industry placements, and employer co-investment. 5. Simplification of policy and funding • Identifies funding complexity as a major constraint on collaboration and learner flexibility. • Calls for longer-term, more stable funding arrangements to enable strategic planning. • Advocates for incentives to encourage FE-HE collaboration. 6. Data, evaluation and quality • Recommends enhanced skills intelligence and labour-market data that is shared across FE, HE, government and employers. • Calls for clearer outcome measures linked to progression, employment, and regional workforce needs. • Suggests developing shared digital infrastructure for credit-tracking and learner records.

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		7. Working with the devolved nations • Although UK-wide, the report explicitly recognises that devolved skills systems (including Wales) require close alignment to avoid fragmentation and to maximise labour-market agility. • Encourages cross-border learning while respecting devolved governance. Part of UUK's broader agenda for reforming tertiary education and responding to skills shortages, demographic change, and employer demand for agility. Aims to influence UK Government policy and devolved approaches by providing a collaborative, partnership-first framework. Reinforces the role of universities as central actors in regional skills ecosystems, not just providers of academic degrees.
B3	Rethinking Placement: Increasing Clinical Placement Efficacy for a Sustainable NHS Future - HEPI Higher Education Policy Institute (HEPI) Published November 2025 Accessed December 2025	*Rethinking Placement: Increasing Clinical Placement Efficacy for a Sustainable NHS Future* examines the clinical placement crisis across healthcare disciplines in the UK. It diagnoses structural pressures (capacity, supervision, culture, funding, productivity) and proposes a new strategic model for efficient, high-quality, multiprofessional, digitally enabled placements. It is aimed at policymakers, HEIs, regulators, and NHS workforce leaders. The report responds to national debates on workforce shortages, the Long Term Workforce Plan (England), and widening recognition that the UK cannot expand health education without fixing the placement ecosystem. It brings together evidence from HEIs, NHS providers, regulators, students, professional bodies and workforce planners. 1. The placement system is at breaking point

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		• Demand for clinical placements has grown sharply (nursing, AHPs, medicine, midwifery, pharmacy), yet capacity, supervision time, space and staff availability have not kept pace. • Placement shortages now constrain education expansion, workforce supply and service transformation. • Pressure falls disproportionately on overstretched clinical teams; variation in quality and student experience is widening. 2. Reframe placements as a core strategic asset • HEPI argues that placements must be treated as a strategic, funded, system-level function, not dependent on goodwill. • Calls for national and regional planning, with clear objectives linked to workforce modelling and service need. 3. Expand capacity through a multiprofessional, team-based model • Proposes shifting from the traditional 1:1 supervision model to team-, hub- and coaching-based supervision, enabling one educator to support multiple learners. • Recommends expanding interprofessional placements (nursing, AHPs, medical, pharmacy learners in shared settings) as default practice. 4. Invest in the educator workforce • Calls for protected time, formal recognition, career pathways and development for practice supervisors, assessors and clinical educators. • Proposes national standards for educator capability, wellbeing support, and ratio expectations. 5. Scale simulation strategically, not simply more hours • Supports evidence-based simulation, aligned with competencies and service models, to relieve pressure on placement sites. • Warns against using simulation as a simplistic “placement substitute” without evidence or pedagogical design.

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		6. Use digital innovation and virtual placements • Highlights opportunities for virtual wards, remote monitoring, AI-supported learning environments, remote supervision, and digitally enabled placement matching and allocation tools. • Advocates for a national digital infrastructure to track capacity, quality and learner progress. 7. Better data and intelligence to plan capacity • Notes a lack of basic, consistent data on placement capacity, quality, attrition, supervision workload and learner outcomes. • Recommends developing a national placement intelligence system integrated with workforce modelling. 8. A transparent, sustainable funding model • Calls for ringfenced, transparent, multi-year funding for placements, educator time, simulation, infrastructure and digital systems. • Suggests moving away from activity-only metrics (e.g., hours) towards outcomes- and quality-linked funding. 9. Align regulation and assurance • Recommends regulators provide more flexible, outcomes-based requirements, reduce burdensome bureaucracy, and harmonise expectations for multiprofessional learning and simulation.
B3	jobs-of-the-future.pdf Universities UK (UUK) Published November 2025 Accessed December 2025	*Jobs of the future* sets out how economic, technological and demographic shifts will transform the UK labour market. It identifies the fastest-growing job families, the skills that will be most in demand, and the role of universities in preparing a future-ready workforce. It argues that higher education must adapt to AI, automation, green transition, digitalisation and new models of work, and that skills shortages will intensify without major system redesign.

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		1. Six major drivers reshaping the labour market • AI and automation transforming professional, administrative, clinical and analytical roles. • Digitisation of services, including health, public services and education. • Ageing population increasing demand for health, care and preventative services. • Net-zero transition shifting skills needs in all sectors, including health estates and green operations. • Global competition for talent, especially in STEM, health and digital roles. • Evolving work patterns: portfolio careers, hybrid work, flexible professional routes. 2. Jobs of the future: high-growth areas • Advanced digital roles (AI, data science, cybersecurity, informatics). • Health and life sciences: genomics, diagnostics, digital therapeutics, biotech. • Mental health, community health, ageing and care-coordination roles. • Green and sustainability roles across every sector (including public services). • Interdisciplinary jobs that blend technical, clinical and behavioural skills. 3. Skills of the future UUK identifies a core set of cross-cutting essential skills: • Digital fluency & data literacy • AI-assisted judgement and critical decision-making • Systems thinking & problem-solving • Interpersonal skills, teamwork and communication • Creativity & innovation • Management, leadership and change navigation Strong emphasis is placed on *generalist* and *meta-skills* as automation reshapes specialist tasks. 4. Universities' role in a future-ready workforce • Provide flexible, modular, stackable learning across a lifetime.

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		• Build stronger industry and public-sector partnerships, including co-delivery. • Invest in digital learning infrastructure, simulation and AI-enabled pedagogies. • Strengthen careers, employability and transitions into emerging job areas. • Expand cross-disciplinary programmes that break down subject silos. 5. Equity and access • Warns that technological change risks widening regional and socio-economic gaps. • Calls for inclusive digital access, fair pathways, and widening participation in future-skills programmes. • Emphasises the need for accessible upskilling for in-work adults. 6. Policy recommendations • A coherent national skills strategy to integrate FE, HE, employers and government. • Incentives for lifelong learning, micro-credentials and rapid upskilling. • Investment in digital infrastructure, innovation capability and applied research. • Labour-market intelligence to guide regional provision and workforce planning. Positioned within the policy debates on productivity, net-zero, skills shortages, and innovation. Framed as a forward-looking call to action, encouraging universities and governments to anticipate rather than react to future workforce demands.
B3	Financial sustainability of higher education providers in England: November 2025 update Publisher: Office for Students (OfS), England.	1. Widespread financial fragility • The update confirms a material deterioration in the financial position of many providers since earlier assessments.

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	Date: November 2025 An updated assessment of the financial sustainability and resilience of higher education providers in England, drawing on providers' latest financial forecasts and risk returns. It evaluates short, medium and long-term viability, highlights systemic pressures, and sets out the OfS's regulatory response. Although England-focused, the findings are highly relevant to Wales given shared cost drivers, labour markets, and the interdependence of HE and public-service workforce supply (including health). Link: Financial sustainability of higher education providers in England: November 2025 update	• A significant proportion are forecasting deficits, with reduced liquidity and thin operating margins. • Risks are systemic rather than isolated, driven by structural funding constraints rather than poor local management. 2. Core cost pressures • Pay and pensions (including employer contribution increases). • Inflationary pressures on estates, energy and digital infrastructure. • Rising regulatory and compliance costs. • Capital constraints, limiting ability to invest in estates, simulation, digital platforms and specialist facilities. 3. Income volatility and concentration risk • Continued real-terms erosion of home undergraduate fee income. • Heightened reliance on international student recruitment, increasing exposure to geopolitical, visa and market shocks. • Smaller and specialist providers are particularly exposed, including those delivering high-cost subjects. 4. Implications for provision and capacity • Providers are already responding through course closures, restructuring, staff reductions, and capital deferrals. • High-cost, placement-intensive subjects (e.g. health, clinical sciences, nursing, AHPs) are at disproportionate risk without targeted support. • OfS flags a real risk of reduced regional provision, with implications for local workforce pipelines. 5. Workforce impacts within universities • Recruitment freezes and redundancies are affecting academic, clinical and professional staff, including those critical to placement coordination, supervision, simulation and educator development.

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		• Growing risks to staff morale, wellbeing and retention mirror challenges seen in the NHS workforce. 6. Regulatory stance and intervention • OfS signals increased regulatory engagement, including enhanced monitoring, requirements for recovery plans, and potential intervention where viability is threatened. • Emphasises that providers must demonstrate credible, sustainable business models, not short-term fixes. 7. Long-term structural challenge • The report is clear that short-term mitigations will not resolve underlying sustainability issues without policy change on funding, fees, or system design. • Highlights the need for system-level solutions, collaboration and transformation rather than institution-by-institution retrenchment. The update sits within the OfS's statutory duty to protect students and the stability of the English HE system. It informs OfS risk-based regulation, ministerial advice and sector dialogue. While regulatory powers differ in Wales, the financial ecosystem is interconnected: Welsh providers face similar pressures and compete in the same labour and student markets.
B3	Plan B: What the forthcoming NHS workforce strategy should not ignore Publisher: Nuffield Trust Date: May 2023	1. Retention matters more than recruitment alone The paper stresses that retention has a far bigger short-term impact on workforce capacity than training more staff. High turnover, sickness absence and burnout undermine the benefits of expanded education pipelines.

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	Plan B: What the forthcoming NHS workforce strategy should not ignore is a challenge paper published ahead of NHS England's Long Term Workforce Plan. It argues that while workforce strategies often focus on headline staff numbers, they risk failing unless they address retention, productivity, job quality, skill-mix and system constraints. The paper sets out the "blind spots" that any credible workforce strategy must confront. Link:	Workforce plans that ignore working conditions, morale and workload will struggle to deliver. 2. Productivity and skill use are central, not optional The Trust argues that the NHS cannot train its way out of workforce gaps without improving how staff time and skills are used. Issues include under-utilisation of skills, rigid role boundaries, and lack of investment in enabling infrastructure (digital, estates, admin support). 3. Training expansion is constrained by placement and educator capacity The article highlights that plans to expand training numbers are often not matched by capacity in placements, supervisors or educators. Without addressing these constraints, growth targets risk being unachievable. 4. Early-career experience is a critical risk point Newly qualified staff are particularly vulnerable to leaving due to stress, poor support and lack of development opportunities. Failure to improve early-career experience wastes education investment. 5. International recruitment is not a substitute for system reform While recognising the role of international recruitment, the paper warns against over-reliance without ethical consideration or domestic system improvement. Poor retention of internationally recruited staff reflects underlying system issues.

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		6. Workforce wellbeing and job quality are strategic issues Burnout, stress and workload are framed as system-level failures, not individual resilience problems. Ignoring wellbeing undermines long-term workforce sustainability. 7. Workforce strategies must align with service transformation The paper cautions that workforce plans often assume service models remain unchanged, despite ambitions for community care, prevention and digital delivery. The article was published as part of the Nuffield Trust's role as an independent health policy think tank, influencing debate ahead of the NHS Long Term Workforce Plan (England, June 2023). Although England-focused, its critiques are systemic and structural, and therefore highly transferable to other UK systems, including Wales.
B3	Future Medical Workforce Project Publisher: Scottish Government Date: December 2025 The Future Medical Workforce Project – Draft Phase 1 Report sets out Scotland's early findings on how medical roles, training structures and service models must evolve to meet future demand. Phase 1 focuses on diagnosis: examining demographic change, service redesign, role distribution, training bottlenecks and workforce	1. Align medical workforce planning with population need • Recognises rising complexity, multimorbidity and an ageing population as fundamental drivers of workforce redesign. • Emphasises strengthening generalist capability and community-based practice alongside specialist expertise. • Suggests medical workforce planning must move beyond simple headcount modelling to role-based forecasting. 2. Rebalance generalist and specialist training

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	sustainability. It prepares the ground for Phase 2 implementation recommendations. Link:	• Identifies imbalances between hospital specialisms and generalist/community provision. • Suggests exploring greater flexibility in specialty training, modular elements, and clearer pathways between generalist and specialist roles. 3. Address training bottlenecks and transition gaps • Highlights limited specialty training posts relative to foundation completions. • Recognises growth in locally employed doctors and service posts outside formal training. • Signals need for better recognition, supervision and progression routes for these groups. 4. Strengthen supervision and educator infrastructure • Notes pressure on consultant trainers and supervisors. • Suggests formal recognition, job-planned time and leadership pathways for educators. 5. Enhance workforce flexibility and retention • Calls for improved flexibility in working patterns and career breaks. • Emphasises improving morale, wellbeing and career satisfaction to stabilise supply. 6. Integrate digital, AI and new service models • Recognises digital health, AI-supported diagnostics and remote care as reshaping medical roles. • Training must reflect changing scope of practice and technological integration.

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		7. Improve data and modelling capability • Identifies gaps in workforce intelligence and forecasting accuracy. • Recommends improved data integration between education, workforce planning and service delivery. 8. Promote multi-professional and team-based care • Encourages stronger integration between doctors and advanced practitioners, pharmacists, AHPs and nurses. • Recognises task-shifting and new roles as necessary for sustainability. The Project is a Scottish Government initiative responding to workforce shortages and service transformation pressures. Phase 1 is diagnostic and consultative; further phases are expected to set implementation plans. Operates within Scotland's devolved workforce planning system but reflects common UK-wide pressures.
B3	Student Working Lives Publisher: Higher Education Policy Institute (HEPI) Date: November 2025 Student Working Lives examines the extent, nature and consequences of paid work undertaken by students during higher education. It analyses trends in term-time employment, financial pressures, wellbeing impacts and implications for academic outcomes. The report highlights how financial strain and rising living	1. Rising levels of term-time employment • A growing proportion of students are undertaking paid work during term-time, often for significant hours per week. • Financial necessity — rather than career development — is the primary driver. • Cost-of-living pressures are cited as a structural cause. 2. Impact on academic performance and wellbeing • Long working hours correlate with fatigue, stress and lower academic engagement.

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	costs are reshaping the student experience and, in some cases, undermining progression and performance. Link:	• Students in placement-heavy or professionally regulated programmes report particular strain due to limited flexibility. • Concerns raised about burnout before entry to professional practice. 3. Inequality of impact • Students from lower-income backgrounds are disproportionately affected. • Regional cost variations and commuting burdens compound inequity. • The experience differs between disciplines, with healthcare courses less compatible with flexible working. 4. Placement-intensive programmes face particular pressure • Health, nursing, midwifery and clinical science students often have full-time placements with limited capacity for paid work, yet still face living-cost pressures. • Students sometimes take on work in addition to placement hours, increasing exhaustion risk. 5. Student employment and employability • While some work enhances transferable skills (communication, time management), this benefit is secondary when employment is driven by necessity. • The report cautions against assuming term-time work is universally positive. 6. Policy and institutional recommendations • Improve maintenance support, hardship funds and financial advice. • Ensure timetabling and placement models acknowledge student employment pressures. • Strengthen pastoral support and wellbeing provision. • Enhance transparency about the true cost of study. The report contributes to the wider HE sustainability and cost-of-living policy debate.

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
		Links to funding discussions, maintenance loans and regional disparities. Relevant to devolved systems where financial support arrangements differ.
B3	Higher education student numbers – Research Briefing (CBP-7857) Publisher: UK Parliament – House of Commons Library Date: January 2026 Higher education student numbers is an official statistical briefing providing an overview of trends in UK higher education participation. It presents data on total student enrolments, entry rates, demographic characteristics, subject areas, domicile, mode of study and international student trends. The briefing supports parliamentary scrutiny, debate and policymaking by providing accessible, up-to-date statistical evidence. Link: Higher education student numbers	Overall student numbers • The briefing reports total UK higher education enrolments across undergraduate and postgraduate levels. • It identifies long-term growth in participation since the 1990s, with fluctuations linked to policy reforms (e.g. tuition fee changes) and demographic shifts. • It distinguishes between students studying at UK higher education institutions and alternative providers. Entry rates and participation • Provides data on entry rates of young people into higher education, including the proportion of 18-year-olds entering university. • Highlights trends in widening participation, including increasing participation among disadvantaged groups. • Shows variation across UK nations (England, Wales, Scotland, Northern Ireland). Undergraduate vs postgraduate study • Breaks down numbers between undergraduate and postgraduate students. • Notes growth in postgraduate taught (PGT) provision in recent years. • Tracks changes in postgraduate research (PGR) enrolments. Domicile and cross-border flows • Distinguishes between UK-domiciled students and international students. • Provides analysis of where students from each UK nation study (e.g. Welsh students studying in England). • Tracks patterns of international recruitment and the increasing share of non-UK students.

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
		International students • Identifies significant growth in international student enrolments over the past decade. • Highlights the financial importance of international students to universities. • Notes policy changes affecting recruitment (visa rules, post-study work rights). Subject areas • Provides enrolments by broad subject group (e.g. STEM, social sciences, business, health-related subjects). • Tracks changes in subject popularity over time. Mode of study • Distinguishes between full-time and part-time study. • Notes a long-term decline in part-time undergraduate enrolments since the early 2010s. Demographic characteristics • Provides breakdowns by age, sex and socio-economic background. • Highlights increasing participation by women over time. • Presents data on mature students and trends in their enrolment. Regional and institutional variation • Notes differences between institutions in size, subject mix and student profile. • Identifies variation between nations in funding arrangements and participation patterns. The briefing forms part of the House of Commons Library's statistical series, designed to inform MPs and peers.

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
		It draws primarily on data from Higher Education Statistics Agency (HESA), UCAS and Department for Education datasets. It is updated periodically to reflect the latest official statistics. The document is descriptive rather than analytical; it does not propose policy changes but summarises evidence.

B3	Independent prescribing in the UK
	
	Publisher: Nuffield Trust
	
	Date: April 2026
	
	Independent prescribing in the UK provides an overview and analysis of the development, current use and future potential of independent prescribing across healthcare professions. The report examines how prescribing rights have expanded beyond doctors and dentists, evaluates how these roles are being used in practice, and explores the implications for service delivery and workforce utilisation.
	
	Link: Independent prescribing in the UK
		Background and policy development
		• Independent prescribing was originally restricted to doctors and dentists but has been progressively extended to other professions over the past two decades.
		• Professions now able to independently prescribe include:
		  ○ Nurses
		  ○ Pharmacists
		  ○ Some allied health professionals (e.g. physiotherapists, podiatrists, radiographers)
		• The policy intention has been to improve access to care, increase efficiency and make better use of workforce skills.
		
		Definition and scope of independent prescribing
		• Independent prescribing is defined as the ability of a qualified professional to:
		  ○ Assess patients
		  ○ Diagnose conditions
		  ○ Make clinical decisions
		  ○ Prescribe medicines autonomously
		• It is distinct from supplementary prescribing, where prescribing occurs within a clinical management plan agreed with a doctor.
		
		Growth in independent prescribing

Ref	Strategy Document	Key Reference points and areas of focus for education strategy

		• The report documents substantial growth in the number of non-medical prescribers, particularly among nurses and pharmacists.
		• Expansion has occurred unevenly across professions and regions.
		• Uptake is influenced by:
		  ○ Workforce roles
		  ○ Service models
		  ○ Organisational support
		
		Variation in use and implementation
		• Despite policy expansion, the use of prescribing qualifications varies widely.
		• Some professionals with prescribing rights do not use them regularly or at all.
		• Variation exists between:
		  ○ Settings (primary care, community, hospital)
		  ○ Professions
		  ○ Local service configurations
		• This indicates a gap between qualification and practical utilisation.
		
		Barriers to effective use
		• The report identifies several barriers limiting the use of independent prescribing:
		  ○ Lack of organisational support or clear role design
		  ○ Limited access to supervision or mentorship
		  ○ Governance and regulatory constraints
		  ○ Confidence and experience levels among practitioners
		  ○ IT systems and prescribing infrastructure
		• These barriers contribute to underutilisation of prescribing capability.
		
		Role in service delivery
		• Independent prescribing is described as having the potential to:
		  ○ Improve patient access to medicines
		  ○ Reduce delays in treatment
		  ○ Support new models of care (e.g. multidisciplinary teams)

Ref	Strategy Document	Key Reference points and areas of focus for education strategy

		• It is particularly relevant in:
		  ○ Primary care
		  ○ Community services
		  ○ Long-term condition management
		
		Workforce implications
		• The report highlights that prescribing capability enables professionals to work more autonomously and take on extended or advanced roles.
		• It supports task-shifting and redistribution of workload within healthcare teams.
		• However, effective integration depends on clear role definitions and service design.
		
		Patient safety and governance
		• The report emphasises the importance of:
		  ○ Robust training and competency frameworks
		  ○ Clinical governance arrangements
		  ○ Ongoing professional development
		• Safety is presented as dependent on both individual competence and system-level support.
		
		Training and professional development
		• Independent prescribing requires completion of an accredited training programme and ongoing competence maintenance.
		• Access to training and opportunities to practise prescribing skills varies across professions and regions.
		
		Data and evidence gaps
		• The report identifies limitations in available data on:
		  ○ How many prescribers are actively prescribing
		  ○ The impact on patient outcomes
		  ○ Variation across settings

Ref	Strategy Document	Key Reference points and areas of focus for education strategy

		• Improved data collection and evaluation are highlighted as necessary to better understand effectiveness.
		
		Future considerations
		• The report discusses potential further expansion of prescribing rights to additional professions.
		• It emphasises the need for:
		  ○ Better integration into service models
		  ○ Improved workforce planning
		  ○ Enhanced data and evaluation
		
		Overall conclusions
		• Independent prescribing has expanded significantly and is now an established feature of the UK healthcare workforce.
		• However, there is considerable variation in its use, and much of its potential remains unrealised.
		• The effectiveness of independent prescribing depends on system design, organisational support and integration into clinical roles, rather than qualification alone.

B3	Higher Education Commission Interim Report - Health Education and Training Inquiry
	
	Publisher: Policy Connect – Higher Education Commission
	
	Date: March 2026
	
	The Higher Education Commission Interim Report – Health Education and Training Inquiry presents early findings from an inquiry into the current state of health education and training in the UK. It examines pressures on the system, including workforce shortages, placement capacity, funding constraints and the alignment
		Purpose and scope of the inquiry
		• The inquiry explores how effectively the current system of health education and training supports workforce needs.
		• It considers the full pipeline, including:
		  ○ Undergraduate and postgraduate education
		  ○ Clinical placements
		  ○ Workforce entry and progression
		• The interim report presents initial findings ahead of a final set of recommendations.
		
		Workforce demand and supply pressures

Ref	Strategy Document	Key Reference points and areas of focus for education strategy

	between higher education and NHS workforce needs. The report draws on evidence from universities, NHS organisations, professional bodies and other stakeholders.
	
	Link: Higher-Education-Commission-Health-Education-Training-Interim-Report-03.2026 (1).pdf
		• The report highlights ongoing and increasing workforce shortages across health professions.
		• Demand for healthcare services is rising due to demographic change, complexity of need and system pressures.
		• The current education and training pipeline is described as struggling to keep pace with demand.
		
		Clinical placement capacity
		• Placement capacity is identified as a major constraint on expanding training numbers.
		• Challenges include:
		  ○ Limited availability of supervisors
		  ○ Workforce pressures in clinical settings
		  ○ Variability in placement quality
		• The report notes that placement availability directly limits the number of students that can be trained.
		
		Funding and financial sustainability
		• The report highlights concerns about funding models for health education, including:
		  ○ The cost of delivering high-quality programmes
		  ○ Financial pressures on universities
		  ○ The adequacy of funding for clinical placements
		• It notes that funding arrangements can influence the viability of certain programmes.
		
		Alignment between education and workforce needs
		• Evidence suggests that there is not always clear alignment between:
		  ○ Education commissioning
		  ○ Workforce demand
		  ○ Service delivery models

Ref	Strategy Document	Key Reference points and areas of focus for education strategy

		• The report highlights the need for better coordination between health systems and education providers.
		
		Role of higher education institutions
		• Universities are identified as central to delivering health education and training.
		• The report notes pressures on institutions, including:
		  ○ Financial constraints
		  ○ Workforce challenges
		  ○ Increasing student numbers
		• It also highlights the importance of collaboration between universities and healthcare providers.
		
		Workforce experience and retention
		• The report references challenges related to:
		  ○ Staff wellbeing
		  ○ Workload
		  ○ Retention of newly qualified professionals
		• It notes that training alone is insufficient to address workforce shortages without improvements in retention.
		
		Variation in training quality and experience
		• The report identifies variation in:
		  ○ Student experience
		  ○ Access to learning opportunities
		  ○ Quality of supervision
		• These differences are influenced by local service pressures and organisational factors.
		
		Data and workforce intelligence
		• The report highlights limitations in data and workforce planning systems, including:

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
		○ Incomplete understanding of workforce demand and supply ○ Challenges in linking education data with workforce outcomes • Improved data is seen as important for planning and decision-making. System complexity and fragmentation • The health education system is described as complex and fragmented, with multiple organisations involved in: ○ Commissioning ○ Regulation ○ Delivery • This complexity can create challenges in coordination and accountability. Emerging themes and direction of inquiry • The interim findings point towards key areas for further exploration, including: ○ Workforce planning and modelling ○ Placement capacity and innovation ○ Funding and sustainability ○ System integration and collaboration • These themes are expected to inform the final report. Overall conclusions • The report concludes that the current health education and training system faces significant structural and operational challenges. • While it continues to deliver training at scale, pressures related to demand, funding, placement capacity and workforce sustainability are increasing. • The interim findings highlight the need for a more coordinated and sustainable approach to health education and workforce development.
B3	What Matters Most? 20 Years of the Student Experience	Purpose and scope • The report reviews twenty years of evidence on the student experience across UK higher education.

Ref	Strategy Document	Key Reference points and areas of focus for education strategy

	Publisher: Higher Education Policy Institute (HEPI)
	
	Date: May 2026
	
	This report reflects on two decades of evidence about the higher education student experience in the UK. Drawing on historical survey data, policy developments and changing student expectations, it examines how students' priorities, concerns and perceptions of higher education have evolved over the past 20 years. The report aims to identify the factors that students consistently value most and how these have changed over time.
	
	Link: What-Matters-Most-20-years-of-the-student-experience.pdf
		• It examines changing attitudes, expectations and experiences of students over time.
		• The analysis draws on a range of sources, including student surveys, sector research and policy developments.
		
		Evolution of student expectations
		• The report highlights significant changes in what students expect from higher education.
		• Students increasingly view higher education through multiple lenses, including:
		  ○ Academic development
		  ○ Career preparation
		  ○ Personal growth
		  ○ Value for money
		• Expectations have become more complex as participation in higher education has expanded and the policy environment has evolved.
		
		Teaching and learning
		• High-quality teaching remains one of the most important factors influencing student satisfaction.
		• Students consistently place value on:
		  ○ Engaging teaching
		  ○ Subject expertise
		  ○ Accessibility of academic staff
		  ○ Meaningful feedback
		• The report notes that while delivery methods have changed, the importance of teaching quality has remained consistent.
		
		Employability and career outcomes
		• Employment prospects have become increasingly important in students' perceptions of higher education.
		• Students place significant emphasis on:

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
		○ Graduate employment outcomes ○ Work-related learning opportunities ○ Development of transferable skills • Career preparation is identified as a growing component of the overall student experience. Student wellbeing and mental health • The report highlights a substantial increase in attention given to student wellbeing over the past two decades. • Mental health support is now considered an important aspect of the student experience. • Students increasingly expect institutions to provide accessible wellbeing services and supportive learning environments. Financial pressures and affordability • Financial concerns have become increasingly prominent. • Areas highlighted include: ○ Tuition costs ○ Living expenses ○ Accommodation costs ○ Student debt • The report notes that financial pressures influence both student experience and decision-making. Digital transformation • Technology has fundamentally changed how students engage with higher education. • Developments include: ○ Virtual learning environments ○ Online learning resources ○ Hybrid and blended learning models

Ref	Strategy Document	Key Reference points and areas of focus for education strategy

		• The report notes that digital provision has become an expected component of higher education delivery.
		
		Sense of belonging and community
		• Students consistently value opportunities to feel part of an academic and social community.
		• Factors influencing belonging include:
		  ○ Relationships with peers
		  ○ Engagement with staff
		  ○ Participation in university life
		• The report highlights belonging as an important contributor to student success and satisfaction.
		
		Diversity, inclusion and representation
		• The report notes increased attention to equality, diversity and inclusion across the sector.
		• Students increasingly expect learning environments that are:
		  ○ Inclusive
		  ○ Representative
		  ○ Supportive of diverse backgrounds and identities
		• Issues relating to accessibility and fairness are identified as increasingly important aspects of the student experience.
		
		Student voice and partnership
		• There has been growing emphasis on involving students in decision-making.
		• The report highlights the development of approaches that position students as partners in shaping their educational experience.
		• Student feedback mechanisms have become more prominent over the period reviewed.
		
		Impact of policy and sector change
		• The report explores how changes in:

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
		○ Funding systems ○ Tuition fee arrangements ○ Regulation ○ Quality assurance frameworks have influenced student expectations and experiences. • It notes that wider policy developments have shaped perceptions of higher education and value. Changing perceptions of value • The concept of "value" has become increasingly significant in discussions of higher education. • Students assess value through multiple dimensions, including: ○ Teaching quality ○ Graduate outcomes ○ Personal development ○ Overall experience • The report suggests that perceptions of value are influenced by both educational and financial considerations. • The report concludes that while many aspects of higher education have changed significantly over the past twenty years, several factors remain consistently important to students: ○ High-quality teaching ○ Supportive learning environments ○ Strong relationships with staff ○ Opportunities for future employment • It finds that newer priorities, including wellbeing, digital provision and affordability, have become increasingly prominent. • Overall, the report presents the student experience as evolving and multifaceted, shaped by changing societal expectations, policy developments and economic conditions.

Ref	Strategy Document	Key Reference points and areas of focus for education strategy

B3	Evaluating the Legacy Mentor Role Introduced Across North-East & Yorkshire
	
	Publisher: University of Huddersfield (School of Human and Health Sciences)
	
	Date: July 2024
	
	This report evaluates the implementation and impact of the Legacy Mentor role introduced across the North East and Yorkshire region. The role was developed to support nursing students undertaking practice learning experiences and to enhance the quality of clinical learning environments. The evaluation explores the effectiveness of the role from the perspectives of students, mentors, educators and healthcare organisations.
	
	Link: LegacyMentorFinalReport.pdf
		Background to the Legacy Mentor role
		• The role was introduced in response to concerns regarding:
		  ○ Placement capacity pressures
		  ○ Student support needs
		  ○ Workforce shortages affecting supervision and learning environments
		• Legacy Mentors were experienced practitioners employed to support students within practice settings and help strengthen learning experiences.
		• The initiative was implemented across multiple organisations in the North East and Yorkshire region.
		
		Purpose of the evaluation
		• The evaluation aimed to assess:
		  ○ How the role was implemented
		  ○ The contribution of Legacy Mentors to student learning
		  ○ The impact on practice learning environments
		  ○ Perceptions of students, staff and stakeholders
		• The study examined both intended and unintended outcomes of the initiative.
		
		Student support and experience
		• Students generally reported positive experiences of the Legacy Mentor role.
		• The report found that Legacy Mentors provided:
		  ○ Additional support during placements
		  ○ Increased accessibility for advice and guidance
		  ○ Enhanced pastoral and professional support
		• Students described feeling more confident and better supported during their practice learning.
		
		Practice learning environment
		• The role was found to contribute positively to placement environments.
		• Legacy Mentors supported:
		  ○ Integration of students into clinical teams
		  ○ Facilitation of learning opportunities

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
		○ Development of positive learning cultures • The report suggests that the role helped create more structured and supportive placement experiences. Supervision and educational support • Legacy Mentors provided an additional layer of support alongside existing practice supervisors and assessors. • They often acted as a bridge between: ○ Students ○ Clinical teams ○ Education providers • The role helped address some of the challenges associated with workforce pressures and limited supervisory capacity. Impact on staff and clinical teams • Staff reported that Legacy Mentors contributed to: ○ Improved coordination of student support ○ Reduced pressure on some clinical staff ○ Greater focus on learning within practice settings • However, the extent of impact varied between organisations and settings. Professional development and transition support • The role supported students' professional development through: ○ Coaching and guidance ○ Reflection on practice experiences ○ Development of confidence and professional identity • Particular value was identified in supporting students through challenging placements and transitions. Implementation challenges • The evaluation identified several challenges, including: ○ Variability in role implementation

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
		○ Differences in organisational understanding of the role ○ Uncertainty about role boundaries in some settings • Some organisations integrated the role more effectively than others. Stakeholder perceptions • Stakeholders generally viewed the role positively. • Benefits identified included: ○ Enhanced learner support ○ Improved communication ○ Greater visibility of educational activity within clinical settings • There was broad recognition of the role's contribution to practice learning quality. Sustainability and future development • The report considers issues relating to the sustainability of the role, including: ○ Funding arrangements ○ Workforce availability ○ Integration into existing educational structures • Stakeholders highlighted the importance of clarity regarding future investment and long-term planning. Evaluation methodology • The evaluation used a mixed-methods approach, including: ○ Surveys ○ Interviews ○ Stakeholder engagement activities • Evidence was collected from: ○ Students ○ Legacy Mentors ○ Clinical staff ○ Practice education leads

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
		○ Partner organisations The report concludes that the Legacy Mentor role was viewed positively by students and stakeholders and contributed to enhancing practice learning experiences. The role provided additional educational and pastoral support, helped strengthen learning environments, and supported student development during placements. While implementation varied across settings, the evaluation found evidence that the role added value to practice learning and addressed some of the pressures affecting clinical education environments.
B3	Healthy ageing: what can England learn from Japan and Sweden about meeting the challenge of an ageing society? Publisher: The King's Fund Date: September 2025 This report examines how Japan and Sweden are responding to the challenges of population ageing and considers lessons for England. Drawing on international evidence and policy analysis, it explores how both countries have adapted their health, care and wider social systems to support older populations, maintain independence and manage increasing demand for services. Link: What Can England Learn From Japan and Sweden About Meeting the Challenge of an Ageing Society? | The King's Fund	Purpose and scope • The report explores the implications of population ageing for health and care systems. • It compares approaches adopted in: ○ Japan ○ Sweden ○ England • The analysis focuses on policies, service models and system characteristics that support healthy ageing and long-term sustainability. Demographic context • The report highlights that population ageing is one of the most significant societal changes facing developed countries. • Japan is identified as having one of the oldest populations in the world. • Sweden is presented as another country with extensive experience of responding to demographic change. • England is described as facing similar trends, including: ○ Increasing life expectancy ○ Growth in the number of older people ○ Rising prevalence of long-term conditions Healthy ageing as a policy objective

Ref	Strategy Document	Key Reference points and areas of focus for education strategy

		• Both Japan and Sweden place strong emphasis on enabling people to:
		  ○ Remain healthy for longer
		  ○ Maintain independence
		  ○ Participate in society as they age
		• The report notes that healthy ageing is viewed as extending beyond healthcare to include housing, employment, social participation and community support.
		
		Prevention and public health
		• Prevention is identified as a major feature of both countries' approaches.
		• The report highlights efforts to:
		  ○ Promote healthy lifestyles
		  ○ Reduce risk factors for ill health
		  ○ Delay the onset of frailty and dependency
		• Public health interventions are positioned as an important component of managing future demand.
		
		Community-based care
		• Both Japan and Sweden have developed systems that emphasise care closer to home.
		• The report describes a focus on:
		  ○ Community services
		  ○ Integrated support
		  ○ Local coordination of care
		• Hospital care is only one part of a broader system designed to support older people in their communities.
		
		Integration of health and social care
		• The report highlights different approaches to integrating health and social care services.
		• Sweden is noted for strong local government involvement in care provision.

Ref	Strategy Document	Key Reference points and areas of focus for education strategy

		• Japan's system includes extensive coordination between healthcare providers, community services and long-term care programmes.
		• Integration is presented as an important feature of supporting people with complex needs.
		
		Long-term care systems
		• A significant part of the analysis focuses on long-term care arrangements.
		• Japan's long-term care insurance system is discussed in detail, including:
		  ○ Universal eligibility arrangements
		  ○ Funding mechanisms
		  ○ Service access
		• Sweden's publicly funded care system is also examined.
		
		Workforce challenges
		• Both countries face workforce pressures associated with ageing populations.
		• The report notes challenges including:
		  ○ Recruitment and retention
		  ○ Growing demand for care workers
		  ○ Increasing complexity of care needs
		• Workforce shortages are presented as a common international issue.
		
		Technology and innovation
		• Japan is highlighted for its investment in:
		  ○ Robotics
		  ○ Assistive technologies
		  ○ Digital solutions
		• These technologies are used to support independence and address workforce constraints.
		• Sweden is also described as using digital innovations to support service delivery.
		
		Housing and age-friendly environments

Ref	Strategy Document	Key Reference points and areas of focus for education strategy

		• The report emphasises the role of housing and community design in supporting healthy ageing.
		• Examples include:
		  ○ Accessible housing
		  ○ Age-friendly communities
		  ○ Adaptations that enable independent living
		• Healthy ageing is presented as a whole-system issue extending beyond health services.
		
		Social participation and wellbeing
		• Both countries place importance on reducing social isolation and supporting community participation.
		• The report highlights initiatives that encourage:
		  ○ Social connection
		  ○ Volunteering
		  ○ Community engagement
		• These are viewed as important contributors to wellbeing in later life.
		
		Governance and system leadership
		• The report examines how national and local government structures influence policy implementation.
		• Long-term planning and sustained policy commitment are identified as features of both countries' approaches.
		• The importance of coordination across sectors is emphasised.
		
		The report concludes that Japan and Sweden have developed different but complementary approaches to responding to population ageing.
		• Common themes include:
		  ○ Prevention and healthy ageing
		  ○ Community-based support
		  ○ Integration of health and social care
		  ○ Investment in long-term care

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
		○ Use of technology and innovation ○ Attention to housing, wellbeing and social participation • The report presents ageing as a societal challenge requiring coordinated action across health, care, housing, communities and public policy rather than a challenge for healthcare services alone.
B3	Demographic Decline and Predatory Recruitment: The Twin Threats to English Higher Education into the 2040s Publisher: Higher Education Policy Institute (HEPI) Date: May 2026 This report examines two major long-term challenges facing higher education institutions in England: projected demographic changes affecting the supply of prospective students and increasingly competitive student recruitment practices. The report explores how these factors may affect the sustainability, behaviour and structure of the higher education sector over the coming decades. Link: Demographic-decline-and-predatory-recruitment.pdf	Purpose and scope • The report analyses the future outlook for English higher education through to the 2040s. • It focuses on two interconnected challenges: ○ Demographic decline in some parts of England ○ Intensifying recruitment competition between institutions • The report considers how these pressures may affect student numbers, institutional sustainability and sector behaviour. Demographic trends and future student demand • A central focus is the changing demographic profile of the population. • The report notes that while some regions may experience growth in younger populations in the short term, longer-term projections indicate demographic decline in several areas. • These shifts are expected to alter the size and distribution of the potential student population. • Regional variation is a key theme, with demographic change affecting institutions differently depending on location. Geographic disparities • The report highlights significant differences between regions in projected population change. • Some areas are expected to experience reductions in the number of young people entering higher education age groups. • Other regions may continue to see growth or relative stability.

Ref	Strategy Document	Key Reference points and areas of focus for education strategy

		• These demographic patterns are presented as likely to influence institutional recruitment prospects.
		
		Recruitment competition
		• The report argues that competition for students has intensified across the sector.
		• Institutions increasingly compete for applicants through:
		  ○ Marketing activities
		  ○ Financial incentives
		  ○ Admissions practices
		  ○ Student experience offers
		• Competition is expected to increase further as demographic pressures emerge.
		
		Predatory recruitment practices
		• A major theme is concern about what the report describes as "predatory recruitment".
		• This term is used to describe recruitment approaches that prioritise institutional survival or growth over student interests.
		• Examples discussed include:
		  ○ Aggressive recruitment tactics
		  ○ Unconditional offers and inducements
		  ○ Practices that may encourage unsuitable enrolment decisions
		• The report argues that such approaches can distort decision-making and undermine confidence in the sector.
		
		Marketisation of higher education
		• The report links recruitment pressures to broader trends associated with the marketisation of higher education.
		• Institutions are described as operating within an increasingly competitive environment where student recruitment is closely tied to financial sustainability.

Ref	Strategy Document	Key Reference points and areas of focus for education strategy

		• This creates incentives that may influence institutional behaviour.
		
		Financial sustainability concerns
		• The report highlights the relationship between student recruitment and institutional finances.
		• Reduced student numbers can create significant financial challenges, particularly for institutions that rely heavily on tuition fee income.
		• The report notes that demographic change may increase financial pressures across parts of the sector.
		
		Institutional vulnerability
		• Not all institutions are equally exposed to future demographic decline.
		• Factors affecting vulnerability include:
		  ○ Geographic location
		  ○ Recruitment profile
		  ○ Dependence on specific student groups
		  ○ Financial resilience
		• The report suggests that some institutions face greater risk than others.
		
		International student recruitment
		• International students are discussed as an increasingly important source of enrolment and income.
		• The report notes that some institutions have become highly dependent on international recruitment.
		• While international recruitment may offset domestic demographic pressures, it introduces additional risks related to:
		  ○ Government policy
		  ○ Global competition
		  ○ Economic and geopolitical change
		
		Impact on student choice and decision-making

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
		• The report examines how recruitment practices can influence student behaviour. • It raises concerns about the quality and transparency of information available to prospective students. • Ensuring informed decision-making is identified as an important consideration within a competitive recruitment environment. Regulatory and policy considerations • The report discusses the role of regulators and policymakers in overseeing recruitment practices. • It considers whether existing arrangements are sufficient to ensure that competition operates in the interests of students. • Questions of accountability, transparency and sector oversight are explored. Long-term sector outlook • The report argues that demographic and recruitment pressures are likely to shape the future structure of the higher education sector. • It suggests that institutions will need to adapt to changing patterns of demand and increased competition. • The analysis focuses on long-term trends extending into the 2040s rather than short-term fluctuations. The report concludes that demographic change and increasingly competitive recruitment practices represent two of the most significant long-term challenges facing English higher education. It highlights the interaction between population trends, institutional sustainability and recruitment behaviour. The report presents these issues as structural challenges that will influence the future development of the sector over the coming decades.

SECTION C: Global Insights / Research



Ref	Strategy Document	Key Reference points and areas of focus for education strategy
C	Education Strategy for Capital Region Denmark Published March 2023 Accessed August 2025	Sets out a comprehensive education strategy for all healthcare-related education levels and professions across the Capital Region in Denmark. It aims to address workforce shortages, improve education quality, and align learning with evolving healthcare needs. The strategy is built around four strategic objectives and three guiding principles (practical, holistic, data-based) and is intended to influence national policy and support regional healthcare transformation. 1. Strategic Objectives to Design Education Around • Shared priority in daily work: Education must be embedded in everyday clinical practice, not treated as a separate or competing task. Managers and staff must co-own the educational mission, supported by inclusive learning environments and efficient use of resources. • High-quality basic education: Emphasis on practical, interdisciplinary training with strong supervision, simulation-based learning, and integration into the working community. Students must feel part of the team and be supported physically and socially. • Systematic lifelong competence development: Education must span the entire career lifecycle, from induction to advanced specialization. Includes peer learning, digital tools, and tailored support for returners and internationally trained staff. • Future forms of learning: Innovation in pedagogy and technology, including mandatory simulation, blended learning, digital certification, and evidence-based evaluation. Learning must be close to patients and rooted in real-world practice. 2. Education Infrastructure & Data • Develop a coherent regional education data infrastructure to monitor quality, outcomes, and individual progress. • Explore digital educational books to document competencies and support mobility across roles and organisations. 3. Workforce Model Implications • Increase student and apprentice placements across regional hospitals and community settings.

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
		• Strengthen career pathways, especially for roles close to clinical care, and ensure visibility of progression opportunities. • Equip managers to lead education effectively and integrate training into service delivery. 4. Placement & Supervision Capacity • Expand simulation-based training and ensure high-quality supervision across all education levels. • Collaborate with municipalities and general practitioners to support community-based education and continuity across sectors. 5. Digital & Blended Learning • Introduce video-based teaching, e-learning, and digital certification for clinical skills. • Ensure digital learning respects clinical time and is aligned with patient outcomes. 6. Evidence-Based Education • Invest in educational research and use evaluation data to continuously improve learning environments and methods.
C	The future of work in the health sector wcms_669363.pdf International Labour Organisation (ILO) Published February 2019 Accessed September 2025	A sectoral analysis by the International Labour Organization (ILO) of how demography, technology, globalisation, and environmental/geopolitical change will reshape work in health services, and what that means for decent work, education & training, and social dialogue. It highlights the need for gender-responsive policies across the workforce. Megatrends → skills shift, not just job counts. The paper frames the future of health work through four megatrends (demography, technology, globalisation, environmental/geopolitical change) and focuses their effects on working conditions, education/training and workforce voice—signalling curricula must adapt to these drivers, not simply expand numbers. Decent work as a quality & retention lever. Education should embed safe staffing culture, fair work principles and social dialogue competencies (e.g., speaking up, negotiation, civility) because working conditions shape learning, supervision and retention. (Derived from the paper's "decent work/working conditions" lens.)

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		Gender-responsive design. The ILO stresses gender equity in policy and workforce planning. Programmes need gender-aware pedagogy, tackling harassment/violence, flexible/part-time training routes, and pathways into leadership. Technology + globalisation reshape skills mix. With digital tools and cross-border knowledge flows accelerating change, curricula must build digital literacy, informatics, telehealth teamwork, and data stewardship across professions; lifelong learning and CPD are pivotal. Education & training are central to the 'future of work'. The ILO makes education & training one of three focal areas (with working conditions and social dialogue), reinforcing the need for continuous upskilling and skills-anticipation linked to service models. Social dialogue and workforce voice. The report emphasises tripartite collaboration (employers–workers–government) to co-design changes. Programmes should teach co-production and change leadership so graduates can participate effectively. Environmental/geopolitical shocks. Education must prepare for resilience, emergency/public-health response, and sustainable practice, reflecting the paper's recognition of environmental and geopolitical pressures on work.
C	Global consensus statement on simulation-based practice in healthcare | Advances in Simulation | Full Text Published May 2024 Accessed August 2025	Produced through an international collaboration of 50 simulation societies across 67 countries, facilitated by SESAM and SSH, to set shared priorities and a call-to-action for adopting high-quality simulation in health education and services. Publisher: BioMed Central. What simulation is for (beyond teaching): Evidence and expert consensus link simulation to better safety culture, processes and outcomes, cost-effectiveness, team performance, and workforce resilience; it supports rare, high-risk skills and system redesign, not just skills drills. Integrate across the whole continuum: Make simulation a routine part of undergraduate, postgraduate and in-service learning and of quality improvement—not a bolt-on. Emphasise interprofessional delivery and practical application in teams.

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
		Access & equity first: Tackle inequities of access (between geographies, professions, institutions). Use low-cost/high-impact methods, telesimulation and "pack-and-go" kits to reach rural/remote settings; ensure contextually relevant scenarios and inclusive participation. Standards, quality assurance & faculty: Use recognised best-practice standards (e.g., INACSL, ASPiH, ASPE) with faculty development, evaluation, and accreditation/credentialling/certification (and re-certification) to assure quality and safety, including psychological safety. Ethics, safety & sustainability: Treat global availability of high-quality simulation as an ethical imperative; protect learner/patient information; remove "blame and shame" from feedback; embed diversity, equity, inclusion and accessibility; be environmentally responsible in how simulation is designed and delivered. Technology with judgement: Use XR/VR/AR, digital and telesimulation where they add value, but evaluate for unintended effects and ensure staff digital skills keep pace. Funding & policy commitment: Secure institutional and governmental support (political, strategic, financial) to sustain facilities, equipment, space and staff; advocate consistently for simulation's benefits for patients, staff and organisations. Research & scholarship: Renew emphasis on simulation research and on integrating simulation within wider healthcare research and innovation agendas. Explicit substitution rules: Be clear where simulation may augment or replace clinical experience (pre-licensure/residency) and state this explicitly in policy and curricula.
C	Reports | World Economic Forum WEF Future of Jobs Report 2025 Published January 2025 Accessed August 2025	Produced by the World Economic Forum (WEF), this report synthesises views from 1,000+ employers (14m workers; 22 industries; 55 economies) on how macro-trends (AI/tech, green transition, demographics, geoeconomics, economy) will reshape jobs, skills and workforce strategies to 2030. Scale of change: Employers expect 39% of workers' core skills to change by 2030 (down from 44% in 2023 as firms get better at L&D). 50% of the workforce has already completed training as part of long-term learning strategies (vs 41% in 2023). Prioritise continuous upskilling system-wide.

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		Jobs outlook to 2030: Net +78m jobs globally (170m created; 92m displaced). Care roles (e.g., nursing professionals, personal care, social work) grow on ageing/demographics; clerical roles decline with automation/AI; software, data and security roles rise strongly. Automation vs augmentation (healthcare nuance): Work splits by 2030 into roughly thirds: human-only, tech-only, and human-machine collaboration. In Medical & Healthcare Services, a much larger share of change comes from augmentation (working alongside AI/tools) than pure automation—so curricula must build "working with AI" competence, not only task replacement. Fastest-rising skills (priorities for curricula): AI & big data, networks & cybersecurity, technological literacy; plus creative & analytical thinking, resilience/flexibility, curiosity & lifelong learning, leadership & social influence, talent management, and environmental stewardship (aligns to decarbonisation/planetary health). Core skills today (baseline everyone needs): Analytical thinking remains #1; resilience/flexibility, leadership & social influence, creative thinking, motivation & self-awareness, with technological literacy and empathy/active listening close behind. Map these to generic outcomes across professions. Growing vs declining roles — skill gaps to bridge: Skills that most distinguish growing jobs: resilience/flexibility, technological literacy, programming, resource/operations management, quality control. Target these in transition pathways (e.g., admin → digital care navigation). Workforce strategies employers will use: Upskilling (85%) is top; process/task automation (73%) and tech augmentation (63%) also rise; 70% will hire for emerging skills, 51% will redeploy internally, 41% foresee some reductions due to skills obsolescence. Education must both grow supply and support redeployment. What improves talent availability: Biggest movers are employee health & wellbeing (64%), effective upskilling/reskilling (63%), progression/promotion (62%), higher wages (50%), and tapping diverse talent pools (47%). Build educator capability to deliver wellbeing-aware, inclusive learning. Public-policy levers employers want: Funding (55%) and provision (52%) of reskilling/upskilling, and improving public education (47%). Signals strong mandate for Once-for-Wales action via HEIW/MEDR/AEIs.

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
C	Equipping Health Workers with the Right Skills (EN) Organisation for Economic Development & Cooperation/International Labour Organisation Published December 2022 Accessed September 2025	Comparative review by OECD & ILO of 16 countries' methods to anticipate future health workforce skills and how the intelligence is used (education, labour, migration policy). Offers a practice guide and policy recommendations for building mixed-method, governance-led skills anticipation. Purpose-built skills anticipation beats generic forecasting. Start with clear policy objectives, then choose scope, method and time horizon accordingly; sectoral (health) lenses provide more actionable detail than whole-economy exercises. Mixed methods are best practice. Combine quantitative forecasts (numbers/flows) with qualitative techniques (surveys, Delphi, expert panels) to reveal changing skill requirements within occupations; mixed methods are costlier but more robust. Focus on skills (not just qualifications/occupations). Skill needs shift with technology and service models; exercises that target skills directly are rare but most useful for curriculum updates and CET/CPD. Plan across appropriate time horizons. Training pipelines are long (often 7–10 years); many systems run 5–15 year cycles, sometimes longer, with biannual/regular refresh to stay current. Ageing workforce & automation realities. The share of doctors aged 55+ has increased since 2000; automation risk in health is lower than other sectors, and AI is more likely to complement high-skill clinical work than replace it—so plan for augmentation skills. Use cases for skills intelligence. Results are used to set education intakes, shape curricula, inform migration policy, and reallocate tasks across roles; scope-of-practice rules can block productive task redesign if not updated. Barriers & enablers. Common blockers: funding, data quality/availability, weak coordination/governance, limited stakeholder involvement. Strong governance and user-oriented design increase policy uptake. Policy recommendations (OECD/ILO). (1) Design with explicit objectives; (2) mix methods; (3) focus on skills; (4) involve social partners; (5) co-operate internationally (e.g., bilateral agreements, knowledge transfer).

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
C	Artificial Intelligence and the health workforce (EN) Organisation for Economic Development & Cooperation (OECD) Published November 2024 Accessed September 2025	A survey-led analysis (via the World Medical Association) by OECD of medical associations' views on AI: opportunities, risks, barriers and actions for policy-makers and the health workforce. Overall stance on AI in healthcare. 72% of medical associations believe benefits outweigh risks, and 70% say physicians remain central; none thought AI will replace doctors. Education should focus on augmentation, not replacement. Where the value is (and isn't). AI can improve operational efficiency and free clinician time, but results are inconsistent and depend on data quality, governance and workflows. Train teams to integrate AI into care pathways, not just use tools. Barriers to adoption. Top obstacles: data accessibility and operational infrastructure (74%), ethics/liability (94% concerned; 71% expect higher clinician liability), and low digital/health literacy among staff and the public. Education must cover data stewardship, safety and legal literacy alongside skills. New roles & capability needs. Anticipated roles include AI data analysts, AI model developers, telemedicine specialists, "prompt engineers"; the report urges internal AI units/leadership in provider organisations. Curricula and CPD (continuing professional development) should develop clinical–data translator capabilities. Three priority actions for systems/workforce (education-relevant). 1. Develop skills for the AI age - continuous learning for current staff and curricular integration for students; keep pace with standards like FHIR (data) and ISO 42001 (AI management). 2. Invest in the workforce that supports frontline AI - redesign workflows and define new roles so clinicians can use their highest skills. 3. Safely manage AI introduction - embed clinicians through the full AI lifecycle (design → deployment → monitoring) to build trust and usability. Trust, governance & safety. Providers worry less about job loss and more about AI built "without them"; programmes must teach risk management, bias mitigation, privacy, security and accountability models and practise escalation/override.

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
C	Office of the European Union Study on the deployment of AI in healthcare - Publications Office of the EU Published July 2025 Accessed August 2025	Mixed-methods assessment (literature, consultations, surveys) of barriers, accelerators and monitoring/indicator options for scaling AI safely and effectively in European healthcare. Four barrier domains to target in learning. The study groups obstacles into: (1) technological/data (e.g., data standardisation & interoperability); (2) legal/regulatory (complex, overlapping frameworks); (3) organisational/business (financing, reimbursement, local value assessment); and (4) social/cultural (trust, literacy, workforce concerns). Education should map curricula and CPD to each domain. Deep dive: data & interoperability. "Data heterogeneity" and poor interoperability repeatedly block deployment; programmes must build data quality, curation and interoperability literacy for clinicians, managers and informatics leads. Workforce acceptance factors. Reported concerns include lack of trust, low digital-health literacy, job security fears/over-reliance on AI, and impact on the doctor–patient relationship—all require explicit teaching (ethics, bias, communication, shared decision-making). What successful hospitals did (accelerators). Good-practice sites implemented AI deployment strategies, clear roles/responsibilities, dedicated budget, targeted training for staff & managers, metrics/benchmarks, community outreach, and phased roll-out with incentives for innovation. These are directly translatable into education QA and commissioning conditions. Monitoring & indicators. The report proposes an indicator framework and highlights the need to identify available/missing data sources to track the effectiveness of recommended actions—implying education KPIs must link learning to safe deployment and service outcomes. Use-case focus. While AI's promise spans efficiency, admin burden and clinical pathways, the study stresses slow clinical adoption and the need for skills + governance rather than tool-specific training.
C	A Guide To The Future For Medical Students - The Medical Futurist	A practical "one-stop" orientation for medical students about how medicine will work over the next 5–10 years, highlighting the culture shift toward empowered patients, data-rich care and AI-enabled clinical work.

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	Published March 2025 Accessed August 2025	Culture & patient partnership. The guide frames a *cultural transformation* where students must learn to work *with* empowered patients; co-decision making, digital etiquette, and communication across app- and portal-based journeys are core capabilities. Build simulated consultations that include shared decision tools and remote-first interactions. AI as a colleague. Emphasis on AI literacy: knowing use-cases (triage, imaging, summarisation, decision support), limits (bias, explainability), and "human-in-the-loop" safety. Curricula should cover prompt discipline, output critique, dataset provenance, and governance — not coding per se — with assessment in authentic tasks. (This aligns with broader scoping work on AI competencies in UGME.) Data fluency & interoperability. Graduates need working knowledge of EHRs, FHIR-style interoperability, patient-generated data (wearables, home diagnostics) and *how to use data at the point of care* (dashboards, registries, risk tools). Education should include data stewardship, cybersecurity hygiene and consent-by-design. Digital front doors & remote care. Routine care shifts to asynchronous messaging, telemedicine, remote monitoring and community diagnostics; students should experience "virtual ward" workflows, escalation protocols, and team-based remote supervision. Simulation with VR/AR & synthetic cases. Practical exposure to VR/AR simulation, digital twins and synthetic images/cases to build procedural skill and diagnostic reasoning safely; embed scenario design and debrief skills for faculty and learners. Genomics & personalised care. Baseline literacy in polygenic risk, pharmacogenomics and consent/ethics for genomic services; ability to interpret decision support outputs rather than perform wet-lab tasks. Digital biomarkers & continuous monitoring. Understanding validation, clinical thresholds and workflow integration for continuous signals (cardio-metabolic, mental health, respiratory), and how to escalate from home to community to acute settings. New professionalism & ethics. Modernise professionalism to cover online identity, algorithmic accountability, data justice and equitable access; practice recognising and mitigating bias in datasets and tools.

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		Futures methods as a core skill. The piece sits in a wider TMF agenda advocating formal *futures* skills (horizon scanning, scenarios, back-casting) so clinicians can navigate fast-moving tech. Consider a short core module on futures methods within UGME/CPD. Lifelong learning infrastructure. Expect micro-credential pathways, digitally-led platforms and personal learning plans mapped to changing scopes of practice; assessment shifts from time-served to competency and real-time feedback. Audience & tone. Written for students but equally useful to educators and clinical supervisors planning curricula *for the next decade* of practice. It's positioned in TMF's *Medical Education* stream alongside AI-skills primers and technology trend pieces used by many faculties.
C	Australia: National Medical Workforce Strategy 2021–2031 Published March 2022 Accessed September 2025	A national plan to ensure Australia has a sustainable, well-distributed medical workforce. It sets five priorities: plan & design collaboratively; rebalance supply & distribution; reform training; build generalist capability; build a flexible, responsive workforce, underpinned by cross-cutting themes on Aboriginal and Torres Strait Islander workforce & cultural safety; supporting new models of care; and doctor wellbeing. Reform training pathways (Priority 3). • Expand regional/rural training posts and supervision models (including quality remote supervision and networked training). • Coordinate training numbers and places nationally (incl. a training "pool" and better alignment of Commonwealth/jurisdiction funding). • Introduce programmatic/modular assessment to recognise prior learning and enable flexible progression; create a national portal with transparent entry/selection data. Build generalist capability (Priority 4). • Ensure GPs/generalist specialists have significant roles in curriculum design, delivery and assessment. • Embed generalism and cultural safety across medical school; quarantine a share of placements for generalist pathways and rural-interested trainees; progress a two-year transition-to-practice to strengthen early generalist skills.

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		• Require demonstration of generalist skills before specialty entry; reward generalist experience at selection; support Fellows to exit training with a broad scope of practice (CPD and outcome monitoring by colleges). Rebalance supply & distribution (Priority 2). • Increase trainees in undersupplied specialties; reduce in oversupplied ones; improve incentives for rural/remote training; reduce reliance on locums/IMGs via better planning and aligned migration/distribution levers; create a nationally-structured service registrar model. Collaborative planning, data & governance (Priority 1). • Establish a joint national planning & advisory body, a workforce planning framework and a National Medical Workforce Data Strategy, including improved tracking of students/trainees through education and careers. Flexible, digital-ready workforce (Priority 5). • Embed telehealth/digital health in selection, education, training and supervision; adopt computerised decision support; enable lateral movement and flexible careers, learning from COVID-era changes.
C	New Zealand Health Workforce Plan 2024 - Health New Zealand | Te Whatu Ora Published December 2024 Accessed September 2025	A 3-year, annually refreshed plan (2024–27) to add to and better use New Zealand's clinical workforce, companion to the New Zealand Health Plan. It sets five priorities: (1) get workforce basics right; (2) work differently for productivity and better care; (3) keep people well, closer to home via primary care; (4) address workforce gaps to hit national health targets; (5) build a workforce that reflects community need. Right-sizing education supply & placement capacity (Priority 1). Secure extra HEI places in shortage programmes (e.g., sonography, radiation therapy, oral health therapy, podiatry), expand Health NZ placement capacity (allied and specialist nursing; medical), review training volumes to 2035 demand, and streamline tertiary pathways (flexible routes; RPL). Launch a *national, inter-professional simulation training service*. Reduce attrition via better placement systems and a final-year hardship fund; improve workforce planning models. Productivity-oriented training and culture (Priority 2). Re-design specialist service models (e.g., dermatology, radiology) and support innovation with added senior medical capacity and growth in specialist nursing. Improve experience of work (digital rostering, flexible

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		patterns, wellbeing and security programmes), and invest in clinical/service leadership and national culture programmes grounded in the NZ Health Charter — all of which should feed educator development and CPD. Primary & community capability (Priority 3). Grow "foundation" pipelines (kaiāwhina/HCSW → enrolled nursing/allied), establish assistant roles (incl. associate psychologists), expand New Entry to Practice roles for AHPs, and run national attraction campaigns. Strengthen GP/community medical pathways (house officer runs in community; public employment pathways for public health medicine and rural hospital registrars; sustain 300 GP trainees annually), modernise midwifery education (urban satellite model; midwifery assistant), and extend advanced nursing scope (nurse practitioner). Education and placements should track these new models of care. Targeted growth to hit access & flow targets (Priority 4). Focus recruitment/training where it unblocks pathways: radiology (radiologists, MITs/MRI, sonographers, nuclear medicine), peri-operative teams (anaesthetic technicians), general medicine and oncology, plus mental health and addiction (clinical psychology interns; psychiatry training to 50 roles; NESP expansion). Stand up advanced practice pathways (physiotherapy, radiation therapy), enable training in private providers delivering public care, and create NZREX and return-to-NZ bridges. Tie UG/PG/CPD commissioning to these pressure points. Equity, cultural safety & rural training (Priority 5). Adopt common cultural-safety expectations across education/regulation; review recruitment for inclusivity; invest in Māori and Pacific workforce pipelines; create inclusive pathways for disabled people. Establish *rural training hubs*, supported entry to rural practice, and grow rural hospital specialist training — all implying distributed placement networks and rural educator support. Seven long-term levers for educators & systems. Regulation (faster overseas registration; cross-profession movement), training (earn-as-you-learn; part-time; better match of supply to need), recruitment, retention, ways of working (MDT models; community shift), investment (sustainable funding for providers to train), and enablement (telehealth, simulation, AI, infrastructure). Education strategy should be built to move these in concert.

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		State of play & modelling (for context). Workforce grew markedly since 2020 (e.g., nursing +10.9% FTE in year to Mar 2024), yet productivity lags; without change, by 2033 the system would need +3,450 FTE doctors, +4,100 FTE nurses, +4,450 FTE allied — strengthening the case for model-of-care-driven education and targeted supply.
C	U.S. HHS / HRSA - Health Workforce Strategic Plan Published December 2024 Accessed September 2025	A department-wide plan with four goals to strengthen the U.S. health workforce: expand supply; improve distribution; enhance quality through professional development and collaboration; and develop & apply data and evidence. Required by the CARES Act, it aligns with COVID-19 recovery funding (e.g., American Rescue Plan) and commits HHS to report progress to Congress. Expand supply with funded education & retention levers (Goal 1). Use scholarships, stipends, loan-repayment and grants to expand education/training capacity; increase diversity and inclusion; and apply evidence-based retention approaches for the current workforce. Target distribution where needs are greatest (Goal 2). Focus incentives on shortage areas (Health Professional Shortage Areas / Critical Shortage Facilities) and in high-demand professions (e.g., behavioural health, oral health). Programmes include the National Health Service Corps and Nurse Corps loan-repayment streams, plus State Loan Repayment schemes. Education pipelines and placements are steered to underserved and rural communities. Professional development, integrated care & future skills (Goal 3). Fund residencies/fellowships and inter-professional training in community settings; strengthen skills for the future of care (team-based, integrated physical/behavioural health, evidence-informed practice); and back wellbeing/burnout prevention initiatives for students, trainees and staff. Data, evidence & accountability (Goal 4). Build a national data strategy to monitor/forecast workforce need and evaluate programmes; standardise performance measures and publish progress via reports to Congress. Pandemic-era enablement (context). American Rescue Plan funding expands scholarships, loan-repayment, public health workforce roles and provider wellbeing measures — all tied to accelerating workforce education and capacity.

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
C	CARING FOR CANADIANS: CANADA'S FUTURE HEALTH WORKFORCE Published December 2024 Accessed September 2025	Commissioned by Federal/Provincial/Territorial (FPT) Health Ministers to assess domestic training capacity, distribution and future supply–demand for key professions, and to set directions for coordinated action (full report on request). Build the planning "spine": data, modelling, and a joint council. The study calls for a foundational data set on learners and workers, integrated national modelling, and creation of a health professions education & workforce planning collaborative council spanning health and education ministries, Indigenous partners, educators, regulators, accreditors, employers and professional bodies. Scope: five primary-care professions; big nursing data gaps. Professions analysed: nursing (LPN, RPN, RN, NP), occupational therapy, physiotherapy, pharmacy, and physicians (focus on family medicine). Data for nursing programme capacity were not available nationally — a critical weakness for education planning — underscoring the need for standardised, timely reporting. Education capacity must increase now. Entry and graduation volumes grew only slowly 2018/19–2022/23 (except NPs at c.+13% p.a.); withdrawals in OT/PT programmes were notable (8–9%), often due to switches into medicine — a planning consideration for HEI intakes and placements. Future gaps without action; scenario levers matter. Base-case projections show gaps widening for RNs, pharmacists and family physicians to 2034; NPs and physiotherapists may have capacity by period end. Scenario work shows how demand rises with population need, how NP expansion can shift gaps between NPs and family physicians, and how early retirement widens shortages. Rural/remote training and equity. Needs are higher, supply lower and gaps larger in rural and remote communities; program location data exist but richer learner/place-of-work data are lacking. The report urges collaborative rural networks and stronger Indigenous workforce pipelines aligned with TRC Calls to Action and UNDRIP. Education system enablers. Accreditation and regulation should adapt quickly to societal needs; accelerate inter-professional education aligned to primary care; and employers should strengthen transition-to-practice and mentoring for new graduates.

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
C	NIVEL - Health workforce planning in the Netherlands Published October 2016 Accessed September 2025	NIVEL (Netherlands Institute for Health Services Research) / Tilburg University – Published a detailed account of how the Netherlands plans its medical and dental workforces using a national simulation model and an independent advisory body (Capaciteitsorgaan). The thesis shows how model outputs are used to set training inflow—illustrated for general practitioners and oral health—and evaluates accuracy, policy cycles and governance. Independent "Capacity Body" sets the planning spine. The *Capaciteitsorgaan* (formerly ACMMP) is an independent, ministry-funded body that issues 3–4-year Capacity Plans advising government on education/training inflow by profession; its statutes were broadened in 2015 to cover a wider set of professions beyond doctors/dentists. Governance brings together ministries, universities, professional bodies and insurers. Education commissioning is explicitly tied to these plans. Simulation model → training places. The Dutch model projects required vs available FTE over 10–20 years, then calculates the annual inflow to training needed in the next 5–15 years to close gaps. It uses stock-and-flow dynamics (graduates, immigration, retirement, part-time patterns), and its outputs are debated with stakeholders before inflow decisions are taken. Measured accuracy & iterative improvement. Evaluations of GP planning show how successive cycles improved parameter estimates (e.g., retirement, participation rates) and narrowed forecast error—supporting confidence in using model outputs to set medical school/GP training numbers. Role-mix and substitution scenarios. Dutch projections routinely test skill-mix (e.g., Nurse Specialists, Physician Associates) alongside physician supply to reflect changing models of care—an approach recommended for broader professions as planning matures. Primary-care focus and oral health. The thesis gives worked examples for GP and oral health workforces, showing how needs, participation and service-use trends translate into education inflow decisions (useful templates for GP/dental planning elsewhere).

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		Data infrastructure as an enabler. NIVEL's Healthcare Professionals Registries and linked administrative sources underpin the model with up-to-date headcount/FTE, age-sex structure and working-hours patterns—critical for education planning that reflects real capacity, not just numbers on the register. Regular national Capacity Plans. The most recent pre-pandemic cycle illustrates how Capacity Plans (e.g., 2021–2024) translate modelling into recommended training inflow across specialties and settings—anchoring discussions with ministries and universities. Operating model & governance context How it fits together. Ministries commission and fund the Capaciteitsorgaan; NIVEL and partners provide data/modelling; stakeholder platforms (colleges, universities, payers) debate assumptions; government then sets training numbers (including medical school and specialty training). This has been in routine use since the early 2000s and is widely cited internationally.
C	Masterplan Medizinstudium 2020 (Germany) Federal / State Health & Education Ministries (Germany) Published March 2017 Accessed September 2025	A cross-government reform setting competency-based, practice-oriented undergraduate medical education, stronger general practice, and fairer admissions; it links curriculum, assessment and supervision to patient-centred care and distributed training. Competency-based education anchored to national outcomes (NKLM). Make NKLM a binding element of regulation; reduce content overload, emphasise cross-disciplinary learning, scientific literacy and communication skills. General practice elevated in curriculum & exams. Require assessment in general practice at state exam and expand teaching practices to expose all students to community care; restructure the Practical Year (PJ) to enable broader experience (quarter-based). Admissions beyond grades. Universities must use at least two additional selection criteria (e.g., tests/interviews/experience) alongside school-leaving grades to better predict professional suitability. Inter-professional education & community orientation. Promote learning with and from other professions and increase practice in ambulatory care, reflecting service shift.

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		Implementation/governance. Joint federal–state commission to refine NKLM, update exam catalogues (via IMPP), and monitor capacity/QA as curricula change; public communications confirm the 31 March 2017 adoption.
C	EUR/RC73/8: Framework for action on the health and care workforce in the WHO European Region 2023–2030 Published September 2023 Accessed October 2025	Published by the World Health Organization (WHO) Regional Office for Europe. A regional "Framework for Action on the Health and Care Workforce 2023–2030" providing governments across the WHO European Region with a shared roadmap to stabilise, transform and invest in their workforces. It translates the Global Health and Care Workforce Compact into regional priorities and targets, emphasising resilience after COVID-19, equitable distribution, digital transformation and cross-border collaboration. Four strategic objectives. 1. Protect and support the existing workforce (safe staffing, wellbeing, fair pay, decent working conditions). 2. Invest in workforce education, skills and lifelong learning to match evolving models of care. 3. Plan and build capacity through data-driven governance, mobility management and international collaboration. 4. Transform work and service models using digital, inter-professional and community-based approaches. Education and lifelong learning. • All member states should ensure transformative, competency-based education aligned to service models and public-health needs. • Promote inter-professional education (IPE), digital-skills frameworks and new career pathways (advanced practice, hybrid roles). • Embed reskilling/upskilling mechanisms to support task-shifting and workforce flexibility. • Expand clinical educator capacity and quality assurance for training sites. Equity and distribution. • Address geographical maldistribution through regional education pipelines, incentives and digital learning access. • Integrate gender equality and fair career progression into workforce policy. Digital transformation.

Ref	Strategy Document	Key Reference points and areas of focus for education strategy
		• Prepare the workforce for digital health, AI and data use; adopt "digital-ready" curricula across all professions. • Support telehealth competencies and digitally enabled supervision networks to sustain rural/remote services. Data and intelligence. • Develop comparable datasets on workforce stock, flows, education and employment. • Use these to drive evidence-based planning and cross-border cooperation across the European Region. Sustainability and green health-care systems. • Build workforce literacy in planetary health, sustainability and climate resilience, recognising the workforce as a key actor in sustainable health systems. Implementation & monitoring. • Member states should create or update national health-workforce strategies consistent with this Framework by 2025. • The Regional Office will monitor progress via biennial reporting up to 2030. Anchored in WHO European Programme of Work 2020-2025 – "United Action for Better Health" and endorsed by all 53 Member States. Provides a shared results framework: six headline indicators (education capacity, density, retention, mobility, equity, digital readiness). Aligns with UN SDGs (3 & 8), the Global Strategy on Human Resources for Health 2030, and WHO Europe's digital-health and primary-care programmes.