NHS 10 year plan consultation

About us

This is a joint response to the NHS 10 Year Plan Consultation from Universities UK (UUK) and GuildHE. UUK is the collective voice of UK's universities, representing the Vice-Chancellors of over 140 member institutions. GuildHE is the voice of vocational, technical and specialist higher education across the UK representing just over 65 institutions. The Higher Education sector, across its diverse offerings and capabilities, is keen to be a key delivery partner for the 10-Year Health Plan.

Q1: What does your organisation want to see included in the 10-Year Health Plan and why?

Workforce training and development should be an essential component of the new 10-Year Health Plan. Access to high-quality healthcare is a prerequisite both for individual well-being and for boosting productivity and reducing economic inactivity. Higher education institutions (HEIs) are key to delivering the workforce pipeline that the future of the NHS and the success of its strategic transformation depend upon.

The Health Foundation estimates that, in order for the NHS workforce to grow in line with the country's needs, the proportion of first-year higher education students in England training to be NHS clinical professionals would need to increase by 50 per cent, from one in nine of the total first-year student intake in 2022–23 (76,300 students) to one in six (125,700 students) in 2031–32.

Such a systemic shift requires a long-term strategic ambition that sets out the direction of travel and offers confidence to HE institutions as they consider expansion to support the NHS. While the Long-Term Workforce Plan (LTWP) can be improved both operationally and strategically, there is significant value in defining clear growth milestones to collectively aim for. The 10-Year Health Plan should preserve a workforce growth plan that addresses the key challenges that universities and the NHS face in this area, including placement capacity, student interest in healthcare careers and burdensome regulatory processes. The NHS should collaborate with Skills England to deliver its growth milestones, as it will be well-positioned to map local and national skills gaps in the healthcare workforce and to act as a docking point for cross-departmental cooperation.

A significant challenge is student interest in healthcare courses – applications for subjects such as nursing and midwifery have fallen since 2021: nursing applications went down by 27% between 2021 and 2024, while midwifery went down by 34% over the same period. The 10-Year Health Plan should lay out a framework for concerted action by government, the health service and the HE sector to boost demand for courses leading to these careers (including in allied health professions). This could take the form of robust information, advice and guidance for both school leavers and adults and a public campaign to attract people into the profession. Equally important here is for the 10-Year Health Plan to recognise the importance of growth in all high-level study given the variety of skills needed to support the success of the NHS (e.g. construction skills for building new hospitals, AI & digital, management). The 10-Year Health Plan should also highlight the importance of higher-level apprenticeships, including at Level 7 for advanced and specialist roles funded via the Growth and Skills Levy, for expanding the recruitment pipeline and opening healthcare careers to applicants from non-traditional backgrounds.

Additionally, regional and local collaboration, including between universities and integrated care boards (ICBs), will be necessary to ensure that the education and training costing structure and placement capacity can support growth in the healthcare workforce pipeline. NHS England should encourage tri-partite partnerships between systems (ICBs), providers (hospital trusts) and the HE sector, fostering healthy collaboration dynamics. This cooperation should balance the expansion of clinical placement capacity and university provision planning to help address local needs, while also ensuring that health and social care become better integrated. Given the key role that universities play in delivering R&D activity, NHS England should also empower ICBs with the necessary support to carry out their R&D functions (e.g. considering research when exercising commissioning functions, having a dedicated research office and articulating local research needs) and strengthen their partnerships with HE. A stronger join-up between universities and ICBs on research would help support non-hospital clinical academic careers and is key for ensuring that new technologies and clinical research are embedded at pace within the NHS.

Thirdly, the 10-Year Health Plan should recognise the value of HEIs as anchor institutions with multiple docking points to both the NHS and local communities. This should underline the importance of HE-led innovation in the realisation of the three strategic shifts (analogue to digital, hospitals to communities and sickness to prevention). Universities and other HEIs are at the forefront of driving the innovation that delivers productivity gains, including via commercialised research and by

developing and implementing innovative teaching practices that respond organically to local and national health needs. These solutions include the use of simulators or virtual wards, leveraging AI for diagnosis and the opening of community-oriented clinical hubs or drop-in facilities where nursing students provide preventative care advice to members of the public. NHS England can support the strategic evolution of healthcare teaching and training by providing regions and local ICBs with adequate funding levers to foster grassroots innovation.

Key for the delivery of a long-term workforce strategy is a Whole Systems Approach to healthcare that brings together all stakeholders that have a role to play in education and training, including HEIs, the NHS, local government, DfE and DHSC. The government should facilitate and streamline cooperation between this wide range of stakeholders, as well as greater cross-Whitehall cooperation, and assess the impact of any new policies on the whole range of complex organisations affected. An example would be the need for DfE to consider NHS implications when assessing which qualifications and standards will be eligible for the new Growth and Skills Levy. A Whole Systems Approach should focus on accelerating healthcare education reforms, for instance DHSC and DfE cooperation on supporting clinical academic careers and strengthening apprenticeships routes. Given the centrality of healthcare to growth and productivity, the government should consider employing the capabilities of Skills England to map medium-term skills gaps within the healthcare sector.

Mental health should also be a key priority in the 10-Year Health Plan. The number of young people with poor mental health is rising: in 2020, one in six (16.0%) of children aged 5–16 years were identified as having a probable mental disorder, an increase from one in nine in 2017, and the likelihood of a mental health disorder increases as young people reach the age range of 17–22 years. The number of accepted English applicants via UCAS declaring a mental health condition increased by 126.4% between 2019 and 2023, though this figure partially reflects changes to data collection.

It is increasingly difficult for HEIs to support students with mental health conditions at this scale, especially given the complexity of cases and financial pressures that the higher education sector faces. As mental health services are expanded, the government should ensure the NHS can respond to increased student mental health needs. In particular, as current pressures on services are alleviated, the NHS should consider establishing a dedicated student pathway and ensuring that Child and Adolescent Mental Health Services (CAMHS) are available for students.

Q2: What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

Enablers

• Universities and other HE institutions have a key role in enabling the shift of care from hospitals to communities by training the needed workforce and providing community-focused healthcare via hubs, surgeries and clinics. They provide training programmes such as, but not limited to, nursing and midwifery, social care, occupational therapy, paramedic science, psychotherapy and counselling, early years health, special educational needs care, healthcare leadership, chiropractic care, physiotherapy, osteopathy, radiography, imaging and sport and physical rehabilitation. These students and apprentices are integral to the workforce of the NHS, and especially in community settings. These institutions are already great enablers of community health and social care across all of these areas. This includes both people, skills and training development, but also physical community hubs with the viable facilities in urban, rural, coastal and suburban areas of the UK.

• These institutions often have partnerships with local NHS trusts and local authorities to run community clinical practices for the public at reduced cost with student, graduate and staff clinicians - this model has great potential to better utilise our universities to bring healthcare, mental health support and illness prevention closer to people's homes at scale.

• Bringing the expertise and facilities of higher education institutions that are located in rural, coastal and other 'left-behind' areas into partnership with the NHS has the potential to support those young people with professional experience and increase trust in, and ambition to pursue, careers in the NHS.

• Universities and other HE institutions also have a key role to play in dual training, with many of those trained for careers in nursing and the allied health professions likely to be employed in social care settings as part of this NHS shift. The government should support universities and other HE institutions to expand dual training through funding and regulatory levers in order to achieve a better integration between health and social care. There is also a need to facilitate access to placements in community settings and to ensure education programmes build on the experience of those working in

social care settings (following the recommendations of the Social Care Workforce Strategy) in order to encourage more staff into high-need areas.

Challenges

• The current patchiness in the availability of NHS resources in various parts of the country poses a risk to an equitable transition of care to community settings. The NHS should consider the specific needs of rural and coastal communities and the important role that higher education institutions have in addressing these gaps.

• There is a need for some clinical placements to shift from hospitals to community settings to reflect the new approach to patient care. The fragmentation of community settings poses challenges to organising such placements and a strengthened join-up between the NHS, the HE sector and local government will be needed to ensure that students feel welcome and have a positive placement experience that encourages them to remain in the NHS.

• Government's recent proposal to remove funding, via the Growth and Skills Levy, for apprenticeships at Level 7 represents a significant risk to the workforce pipeline in professions that are essential to the shift to community care, such as dentists, nurses, midwives, healthcare leaders and managers and professionals in construction and surveying that support the building and development of hospitals and other NHS services.

Student health

• Student mental health poses challenges as well. As is well understood, poor mental health is rising for young people. Students' mental health difficulties are also becoming increasingly complex. For all students enrolled at higher education institutions, especially when they have relocated from their home domestically, or they are international students, the university is often the first port of call for mental health concern, with a need to fill in gaps in NHS mental health support for students with limited resources.

• The NHS should consider a student pathway that is built on strong partnership between universities and local NHS services, to improve information sharing and prevention activities as well as to establish more

effective responses to mental health crises. Some institutions work closely with their local CAMHS to provide help with clinical governance of its services, inform service delivery to students and review student cases where an urgent care pathway is required, in partnership with a named university liaison contact. However, partnerships such as these are not systematic or adopted across the country.

• More effective partnerships with clusters of universities, such as the Greater Manchester Universities Mental Health Services, could be a helpful model. This could support the aim to move initial tests and ongoing treatments and therapies closer to the patient. Shared services could also open opportunities for a more efficient use of shared resources, in a time of financial constraint for universities and the NHS.

• Creative Higher Education institutions create products, services and innovative solutions to support community healthcare including ways to effectively communicate with specific groups, (e.g. redesigning health buses to increase engagement with minority communities)

Q3: What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

University-delivered R&D enables the identification, development and deployment of the most effective technologies to deliver quality healthcare to patients. Academics from UK universities are developing new technologies to improve practices in many key areas, including healing without scarring, early cancer detection and enhanced prosthetics. For this technology to be employed effectively, there is a need to address key barriers such as outdated legacy systems and inadequate data interoperability within the NHS, which creates digital silos and impedes efficient data sharing. Digital qualifications, such as the Level 7 apprenticeship 'Digital technology solutions specialist', are essential for the effective deployment of new technologies in the NHS. The NHS should collaborate with Skills England to ensure that its needs for digital upskilling are reflected in national skills priorities.

There is also a need for the NHS to support universities and other HE institutions as they embed innovative teaching and training practices in healthcare education. Higher education institutions are at the forefront of leveraging computed-aided

simulations or AI to train the next generation of healthcare practitioners, but innovation-targeted funding streams and a more agile regulatory frameworks are needed to support this grassroots effort.

Specialist and creative institutions also have a key role to play here. They have deep expertise in advanced manufacturing, engineering and digital technologies and are producing research and innovation outputs that can support the NHS to modernise systems. Partnerships with institutions that are doing creative technology and design are also a huge enabler for the NHS to roll out new technology that can be intuitively adopted by the public. Creative institutions, working in creative technology, design, games design and special FX have untapped potential to contribute to the design of NHS products and services.

Q4: What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

University research is hugely important to tackling the causes of ill health, with UK universities delivering £3bn in clinical medicine R&D in 2022-23. The NHS should leverage this HE capability, as it is a key enabler to understanding risk factors and the development of diseases. Research can also be employed to guide lifestyle changes that can mitigate modifiable risk factors. The Medical Schools Council has highlighted the example of osteoporosis, where earlier detection, enabled by new technologies and research, would enable risk detection 20 years earlier. Universities can make major contributions to disease prevention and detection research if they are properly funded: to ensure the financial sustainability of research, the government should set an ambitious GDP-based R&D intensity target, covering both public and private investment, to match that of the most competitive and innovative countries in the world and should provide a sustained real-terms increase in quality-related funding.

The NHS should also work with universities to ensure that curricula evolves to reflect an increased focus on prevention and social determinants of health. An increased emphasis on building trust with communities who are less inclined to engage with healthcare providers will also help in preventing sickness.

To robustly provide community healthcare and relieve the UK's reliance on hospitals, we also need to better recognise and reward allied health practice. This includes occupational therapists, counsellors, early years nurses, physiotherapists,

chiropractors, osteopaths, mental health professionals, speech and language therapists and sports therapists. In the education system, there is little reward for institutions that deliver this training and provision through funding, fee waivers or regulatory support. Example institutions that are delivering these programmes in rural and suburban regions where preventative care is vital due to levels of health or ageing populations are Bishop Grosseteste University in Lincoln or Bath Spa University in Chippenham.

Alongside a clear commitment to train allied health practitioners (including in any long-term workforce strategy), the government should support university-powered community clinics, e.g. that provide physiotherapy, chiropractic care, osteopathy, as well as mental health support and counselling to the public. These clinics provide an opportunity to utilise the expertise of students, graduates and staff at high-quality institutions, for public benefit at no or low cost to the user. Projects like these are not currently at scale, standard or consistent due to eligible funding pots for them, coming from Research England in the form of the Higher Education Innovation Fund (HEIF). Prioritising projects like these in the NHS 10 Year Plan and funding them as a crucial part of the local NHS services offer, could scale up already effective practice in community healthcare. This would involve including these clinics as NHS partnerships rather than assessing them as HE research impacts.

Q5: Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:

- Quick to do, that is in the next year or so
- In the middle, that is in the next 2 to 5 years
- Long term change, that will take more than 5 years

Quick to do policy ideas

- The government should offer a clear commitment to a long-term workforce strategy that recognises universities and other HE institutions as a key delivery partner. There is scope for implementing key recommendations from the NAO

report on the Long-Term Workforce Plan, including embedding education stakeholders in the modelling underpinning the projections for the future workforce. In setting out its strategic workforce growth objectives, the NHS should also offer clarity on the future of pathways such as Physician Associates and Medical Doctor Degree Apprenticeships.

• To strengthen and widen the NHS recruitment pool, the government should ensure there is sustainable funding for higher-level apprenticeships, including at Level 7. Any reforms to Growth and Skills Levy must ensure that it continues to deliver across all ages and levels, while recognising the health service's particularly strong need for high level skills.

• NHS England should enhance the guidance clarifying the responsibilities for workforce planning across ICBs and higher education institutions. It should also encourage an enhanced strategic join-up between systems (ICBs), providers (hospital trusts) and universities in order to coordinate capacity expansion and enable the sharing of best practice.

•The government can support the higher education sector to deliver the healthcare workforce by laying out the funding and capacity milestones necessary for expanding training capacity. A strategic, long-term plan offers confidence to higher education institutions and articulates shared objectives. The government should also consider empowering NHS regions and local ICBs with the funding levers needed to support innovation in teaching and training.

• The government should consider setting up regional task forces to coordinate the delivery of a long-term health workforce strategy that addresses local needs. These should bring together Regional Workforce Directors, local ICBs, HE and FE institutions, and local government (LAs or MCAs).

• The NHS should consider establishing a dedicated student pathway and ensure that Child and Adolescent Mental Health Services (CAMHS) are available for students.

Medium-term policy ideas

• The government should work with universities and other HE institutions to capitalise on young people's interest in careers in healthcare. Our survey results show that 73% of young people are considering a career in healthcare, often because it offers the chance to improve other people's lives. However, many are put off these careers and related university courses (particularly in nursing, midwifery and allied health professions) due to perceptions of low pay, poor work / life balance and job stress. The government should address these perceptions and promote these professional pathways, both through a public campaign and by leveraging universities' marketing capacity.

• Given funding pressures, the government should also explore alternative levers for improving outcomes in workforce development. Particularly impactful would be a focus on the heavy burden of regulation over health care education, as the plurality of regulators involved in this space have rendered provision overtly complex. An example would be reconsidering and flexing the number of minimum practice hours required for nursing students in order to unlock additional placement capacity.

Long-term policy ideas

• The government should lay out a long-term commitment to investing in the digital and physical infrastructure needed to expand training capacity, including for dentistry