



10 year workforce plan- Thought Leadership



Wicked Workforce Problems and Innovative Solutions

The workforce is experiencing seismic shifts driven by changes in demography and technology. The NHS workforce is no exception.

There is no silver bullet to address the challenges facing the NHS workforce. However, there are several key actions to improve capacity and capability, as well as culture that, implemented as a package, will reshape the workforce to deliver on the ambitions of the 10 Year NHS Plan.



Improving Capacity and Capability:

- Reform of speciality medical training posts to meet future population needs and rebalance medical workforce distribution away from London and the Southeast to the areas of greatest need.
- Exploring the creation of a new entry-level health and care role that feeds a new nursing role for Neighbourhood Health spanning community, primary and social care.
- Piloting a place-based employment contract to break down siloes between sectors and care settings.
- Creating routes for young people to progress into further education and NHS careers in a locality, widening participation.
- Improving digital literacy, including upskilling every staff member on the fundamentals of AI and upskilling senior decision-makers on the application and implementation of AI given regulatory and ethical considerations.

Improving Culture:

- Developing more leaders with the vision and skills to work with ambiguity and change, while caring for patients and staff.
- Empowering staff aligned with that vision, creating a new modern employment relationship, with learning and flexibility at its heart.

Critical Enablers:

- A refreshed employee value proposition, focusing on pensions and pay to cater for those at all life stages, meeting changing employee expectations.
- A cutting-edge workforce planning tool with AI-enabled functionality and advanced analytics to support improved operational and strategic workforce planning.
- Transformation of middle and back-office functions creating meaningful roles and releasing savings to re-invest in a leading national recruitment and onboarding tool.

Success requires this blend of actions that build capacity and capability, within the best culture, at pace.

Building capacity and capability

Problem statement:

Medical education and training have become increasingly specialised over the last 30 years. It takes too long to educate and train doctors who are concentrated in acute trusts, and there is chronic undersupply in many of the areas of greatest need. For instance, the East of England has approximately 2.5 doctors per 1,000 people, well below the OECD EU average of 3.9⁽¹⁾. These challenges are well documented but require time and a willingness to disrupt the status quo to address.

Solution:



Undertake analysis of both the skills and specialties required to meet future population health needs and use this to determine speciality training numbers. Commission a review to fundamentally re-think medical education and training to understand how the application of AI negates the need to recall extensive facts and figures and instead presents challenges requiring critical thinking.

Stand up the pilots of medical degree apprenticeships and focus recruitment in deprived areas to widen participation – using BMet Professional services academy as a model⁽²⁾. Continue the move to 4-year medical degrees as the norm.

Increase national speciality training numbers in line with the skills and specialty analysis and aligned with the expansion of medical school places. Shift national speciality training numbers to the areas of greatest deprivation and need, starting with setting an ambition for a 20% shift happening before the end of this parliament.

Pilot and evaluate living grants for priority clinical roles experiencing staff shortages, with a return-of-service requirement. Ensure roles are networked to larger healthcare facilities and research institutes to reduce isolation and provide opportunities for continued learning. These are key features of Australia and Canadian efforts to address workforce gaps in remote and rural areas.

Problem statement:

Complex co-morbidities are now a significant feature of the population across all age groups, reducing quality of life, and increasing demand for both the NHS and social care. Current nursing roles and associate/support roles do not enable integrated and holistic care for the growing trend of people expected to be living with multiple morbidities in the next decade. There are also shortages of both community and practice nurses, which face a retirement cliff edge. The number of community nurses working in the NHS in England fell by 43% between 2009 and 2024⁽³⁾, and approximately 33% of practice nurses are aged 55 or older, with a significant portion nearing retirement⁽⁴⁾. Gaps in the social care workforce have been well documented and are often exacerbated by the NHS, which is seen as offering better pay and career opportunities⁽⁵⁾.

Solution:



Develop a new training pathway for an entry-level healthcare support role that spans primary, community and social care, with a focus on both physical and mental health. Use micro-credentialling to continue to upskill trainees to enable them to take on more advanced practice or nursing roles.

Explore the creation of a new neighbourhood-based nursing role that spans primary, community and social care. Draw on models like Buurtzorg in the Netherlands, where nurses are empowered to provide holistic and cost-effective care⁽⁶⁾.



- 1 BMA Medical staffing in the NHS, 2025 ([Link](#)).
- 2 BMet Professional Services Academy, 2025 ([Link](#)).
- 3 Nursing in Practice: District nurse numbers down 43% since 2009, suggests think tank, 2025 ([Link](#)).

- 4 Nursing in Practice: 'Growing imbalance' in age profile of GPN workforce, 2024 ([Link](#)).
- 5 Community Care: Social worker morale has fallen since 2020, finds study for regulator, 2024 ([Link](#)).

Building capacity and capability (Cont.)

Problem statement:

For over 20 years NHS policy has advocated providing more services in the community, yet the number of staff working in the community has reduced as a proportion of the overall workforce. The Darzi report shows that from 2009 to 2023, the number of nurses working in the community fell by 5%, while hospital nurses increased by 35%⁽⁷⁾. Although the 10 Year Plan acknowledges that the Long-Term Workforce Plan perpetuated acute-centric workforce expansion, there are currently no policies to address the balance.

Problem statement:

Limited awareness of and exposure to the range of jobs across the NHS in a local area is hampering recruitment efforts. The NHS needs to make a more concerted effort to bring young people into careers, in particular given recent evidence that it is in the top two career choices for young people⁽⁸⁾. The process to apply for jobs in the NHS is onerous and relies on outdated technology systems that deters potential new hires from applying. The onboarding process is equally cumbersome, with average time to hire between 10-14 weeks⁽⁹⁾.

Solution:



Pilot and evaluate system employment contract that makes one NHS employer the lead employer on behalf of a 'place'. Provide Organisation Development (OD) support to build a population and place-based employment culture, moving away from the current organisational-based model and helping to erode professional and sector siloes.

Introduce a requirement for all new consultants in specific specialties to provide a minimum of one Programmed Activity (PA) per week as part of neighbourhood health teams, starting with specialties such as respiratory medicine, care of the elderly, paediatrics and psychiatry. Extend e-rostering to cover neighbourhood health teams, ensuring seamless deployment of the right skills.

Consider the options available to address discrepancies in remuneration and benefits for staff not on Agenda for Change, such as a new multi-professional contract or bespoke employee value proposition for neighbourhood health. Provide workforce planning support to help shape local workforce models and embed talent management and succession planning approaches.

Solution:



Implement a place-based route to accessing health and care careers by establishing a network of NHS Health and Care Academies. Linked to practical work experience and beginning at secondary school age. Focusing on increasing access for minority groups, and those from lower socioeconomic backgrounds, providing a local talent pipeline. Draw on the Leeds Health and Care Academy that supported 1,507 people into employment via its talent hub, and recorded 3,502 registered learners in 2024/25⁽¹⁰⁾.

Effective implementation across multiple systems will rely on:

- Effective local collaboration in a system with Further Education (FE) and Higher Education Institutes (HEIs) to facilitate better alignment between workforce supply and demand for specific professions.
- Using a nationally agreed set of core skills relevant to health and social care careers, as a foundation. This may mean providing upskilling before the core programme in maths and English, as well as providing all students with a base level of technological capability.
- Engaging across and with communities to recruit for both roles and courses, providing role models, mentors and clear pathways to substantive positions.
- Ensuring consistent delivery across healthcare systems, with local hubs as needed.

⁶ Buurtzorg – Home, 2025 ([Link](#)).

⁷ The King's Fund – NHS workforce in a nutshell, 2024 ([Link](#)).

⁸ The Career & Enterprise Company – Teenagers want NHS Jobs, 2025 ([Link](#)).

⁹ ERP – KPMG and ServiceNow shine light on the stark NHS recruitment gap, 2022 ([Link](#)).

¹⁰ Leeds Health and Care Academy – Annual Report 24/25 ([Link](#)).

Building capacity and capability (Cont.)

Problem statement:

Digital literacy is low across the NHS – as many as 63% of staff don't have the 20 digital skills deemed essential for work by the UK government ⁽¹¹⁾. Although a national digital academy exists, multiple frameworks and the lack of standardised core competencies create duplication and increase costs. Most NHS executives and board members have little understanding of AI or of legal, ethical, and regulatory issues related to its use. Technology investments such as EPRs often fail to deliver expected benefits, highlighting the need for better strategic oversight. Upskilling the NHS senior leadership is important for navigating these developments.

Pay for Digital Data and Technology (DDAT) professions in the NHS is much lower than in the private sector and the roles are not attractive, producing a reliance on external support for digital transformation. Staff therefore have varied knowledge and skill levels, increasing dependency on outside expertise and resulting in minimal experience of process innovation.

Solution:



Develop a mandatory digital and AI learning path for all NHS staff tailored to each role, covering use, implementation, future applications, and ethical and regulatory considerations. Staff who do not have 'essential' digital skills will be provided with training to develop these with achievement being a requirement for pay progression.

All NHS Directors and Non-Executives should complete mandatory training on AI to equip them to lead their organisations in a world where AI is pervasive.

The NHS should introduce market-linked pay scales for scarce digital and analytical skills and explore formal industry job rotations for senior staff.



¹¹ HTN Panel discussion: supporting the NHS workforce with digital skills and digital careers, 2024 ([Link](#)).

Improving Culture

Problem statement:

Leadership behaviours demonstrated do not consistently create a culture that empowers and values staff. In 2024, 62% of NHS staff said they feel safe to speak up about anything that concerns them in their organisation and only 57% feel confident that their concern would be addressed⁽¹²⁾. Many leaders and managers lack formal training. Patient dissatisfaction and increased instances of aggression towards frontline staff are also reported. Ethical dilemmas due to resource constraints contribute to stress and moral injury lead to stress and burnout. EDI targets are not central to organisational strategy, despite evidence that inclusive workplaces support better patient outcomes.

Solution:



Refresh and expand access to existing national leadership and management programmes, offering places regionally, especially to those waiting. Scaling up delivery to give all managers and leaders access to high quality development. Management training should be mandatory for new NHS managers and those who have not had formal development in the past 5 years. Link this to regulation and continuous professional development as an annual requirement for all managers and leaders. Develop specific board and executive level learning to support achievement of EDI targets, linked to improving population health.

Critical enablers

Problem statement:

The NHS Employee Value Proposition (EVP) has not evolved and is not valued. NHS staff aged 21-30 are enjoying their work less now than ten years ago, with 15% reporting not looking forward to their jobs in 2023, compared to 12% in 2013⁽¹³⁾. Monthly NHS staff sickness absence rates peaked at 6.7% in January 2022 and despite declining slightly since, remain higher than pre-pandemic levels⁽¹⁴⁾. Many NHS staff do not understand the value of their current benefits, nor how they compare to an equivalent private sector role.

Solution:



Staff engagement can be strengthened through a refreshed EVP that supports flexibility, autonomy, trust, and effective line management.

Flexibility:

Making part-time, job-share and other flexible working options, even in front line and senior roles easy to access, with the onus being on line managers to auto-approve. Supporting trials and experiments to allow staff more choice over how and when they work. Using technology to support rosters and rotas, allowing easier swapping and planning to give staff greater control.

Pensions:

Introduce greater flexibility and optionality for members across key elements of the benefit basis in the NHS Pension Scheme (the Teachers' Pension Scheme is a useful precedent). This could involve:

- Allowing members to choose and vary their pension build up rate (accrual rate) from a range of defined option, allowing either slower or faster accrual than the standard 54th accrual rate, with members paying less or more respectively.
- Allowing individuals to define the amount of their pay that is pensionable vs non pensionable, again with members paying the appropriate amount of contributions based on their decision.

¹² Patient Safety Learning – The Hub: NHS Staff Survey National Results, 2024 ([Link](#)).

¹³ Nuffield Trust: New study shows widening gulf in job satisfaction between the NHS's youngest and oldest staff, 2025 ([Link](#)).

¹⁴ NHS Long Term Workforce Plan – Section 3. Retain, 2023 ([Link](#)).

Critical enablers (Cont.)

This optionality provides employees with the autonomy to align their benefits more closely with their financial needs and circumstances and we would expect employees to select an option on a yearly basis, for example aligned to any flex benefit offering or salary sacrifice selections.

A strategic communication approach is essential to effectively explain the benefits of any optionality to employees and minimise risks of employee misunderstanding or future mis selling claims. Various safeguards could be incorporated into the design e.g. allowing flexibility over a defined period of time only and using the NHS PS standard scheme design as the default in the event of a non-election.

Explicitly linking pension optionality to the ways in which members can retire flexibly from the NHS Pension Scheme could help employees to make informed decisions in the later stages of careers, leading to valuable workforce retention. Finally, choice could also be provided more broadly across wider benefits. An example of this is life assurance in active service, allowing employees to increase above the standard multiple of two times pensionable pay at a cost to them on a yearly basis.

Undertake a full review of available benefits to ensure they are fit for the workforce of the future. There may also be appetite to review the scape rate of the NHS pension scheme, making savings for employers if the rating reduced their contributions. The NHS scheme is one of the highest rates in the public sector.

Sickness:

A review of sickness policy and other provisions, prioritising return to work and enabling short- and longer-term adjustments for individuals. This should be linked to priority access to NHS services for specific work-related conditions, such as backpain or stress, with an guaranteed appointment for frontline clinical staff within 14 days.

Lifelong learning:

linking funding for courses and programmes to career development and transitioning into new roles and professions. Using development opportunities like reciprocal mentoring, where longer-serving staff who may be 'winding down' can share their experience and learn from those at the start of their careers. This kind of intergenerational exchange creates mutual value through shared stories, skills, and insights.

Performance management:

Aligned with strategic regulation and the 10-year plan, focusing on team collaboration and linking salary increments to performance. A clearer expectation for staff on levels of performance AND line manager capability, tackling issues of behaviour early.

The new EVP will need a comprehensive education and communication plan, at national and local level.



Critical enablers (Cont.)

Problem statement:

"We now face the greatest workforce crisis in history in the NHS and in social care with still no idea of the number of additional doctors, nurses and other professionals we actually need." Rt Hon Jeremy Hunt MP, former Secretary of State, Chancellor of the Exchequer and former Chair of the Health Select Committee.⁽¹⁵⁾

The NHS finds it difficult to plan its workforce. The triangulation of demand, workforce and finance proves challenging for the NHS at all levels. In fact, the 10 Year Health Plan acknowledges that numbers in the long-term workforce plan were simply a projection of current numbers and perpetuated the current acute model of care⁽¹⁶⁾. There is an urgent need to produce a bottom-up workforce plan to understand the shortages in current workforce, as well as better project future needs. This should be accompanied by upskilling of regional and local teams on workforce planning and transformation.

Solution:

DHSC should develop a workforce planning tool on the Federated Data Platform. This tool should have AI-driven workforce forecasting capability and use advanced analytics to predict workforce needs for every role, profession and grade based on local health trends, the age of the current workforce, service demand and planned investments and changes in the model of care. The tool could automatically direct training places, recruitment drives, and even upskilling programmes to meet future demand, significantly enhancing traditional planning exercises.

Problem statement:

Corporate services costs in the NHS have increased by 54% over five years while in other sectors they have reduced, driven by technology⁽¹⁷⁾. The NHS is a huge outlier compared to other sectors in the way corporate services such as procurement, finance, technology, and HR are provided.

Solution:

Extend the current NHSE work to transform people services to all corporate services to deliver recurrent savings of over c.£1bn by 2032. At the same time, harnessing the potential of workflow technology and agentic AI in middle and back office/ corporate services alongside scaling these where appropriate. This will reshape roles releasing time for higher value activities, as well as release funding to reinvest in frontline services. The current timing for this is ideal as the centre, regions and systems re-think operating models and running costs.

Potential applications of agentic AI in corporate services could release funding for frontline service investment. Equally, savings could be re-invested in more centralised learning platforms and/ or a fit for purpose national recruitment and onboarding solution that improve staff experience and generate further efficiencies.



¹⁵ BMA: MPs highlight 'greatest workforce crisis in history' of NHS, 2022 ([Link](#)).

¹⁶ NHS 10 Year Health Plan – Chapter 7: an NHS workforce fit for the future, 2025 ([Link](#)).

¹⁷ HCSA: Mackey: Working together in 2025/26 to lay the foundations for reform, 2025 ([Link](#)).

Annex A: Illustrative case study – NHS St Elsewhere



Current state:

NHS St Elsewhere is a coastal and rural healthcare system in the East of England with a population of just under 100,000. It is a relatively deprived community, and life expectancy is lower than the regional and national average. The population is mainly white but there is also a population of asylum seekers. St Elsewhere has an aging population, with 24% of residents over 65. The local industry is focused on offshore energy, commercial boat building, agriculture and seasonal tourism. The population has fewer people with degree-level qualifications than the national average; and earnings are below the regional and national averages. The local DGH, Primary and Social Care have traditionally experienced workforce challenges, including an aging workforce, poor retention of newly qualified staff who leave for larger cities, and over-reliance on temporary staffing.

Future state:

The local Health and Care Academy, a partnership between health and social care employers and local FE and HEIs, visits all local schools to raise awareness of careers in the NHS and the routes into them. School leavers have access to a range of NVQ and BTEC courses, as well as help to improve English and maths skills, providing a route into healthcare and employment via the local FE college. Mature students have similar access and can return to work through specially designed academy programmes. Recruitment and onboarding are via a new NHS-wide platform that makes the process quick, easy and completed within one week.

Vacancies across all parts of the NHS and Social Care have significantly decreased due to the pipeline of local talent. The new neighbourhood nursing role has ensured a supply of staff skilled to look after the multiple co-morbidities of the local population and is particularly effective for frail older patients.

The new entry-level health and care support role acts as a pipeline for this nursing role. Retention, particularly in social care, has improved due to the variety provided by these roles, while OD support across the St Elsewhere system has ensured they have been fully integrated into the neighbourhood MDT.

The nearest medical school supplies doctors who now undertake a 4-year undergraduate degree and complete their training rotating through different settings across NHS St Elsewhere. The increase in National Training Numbers for Speciality Training and redistribution of these away from London to the areas of greatest deprivation has benefited St Elsewhere, which has seen marked improvements in the quality and continuity of care, alongside an 80% reduction in locum expenditure. These changes have also driven an increase in GPs locally, which has contributed to a 20% reduction in A&E attendances for chronic medical conditions.

NHS staff are all employed by NHS St Elsewhere, regardless of whether they primarily work in a hospital or neighbourhood health centres. This has made moving between organisations and roles easier, as well as leading to a seamless and consistent NHS employment experience. Staff work in multi-disciplinary teams (MDTs) of different sizes – all consultants deliver a minimum number of sessions (remotely or in person) as part of neighbourhood health centre MDTs.

Staff regularly move between settings, enabled by an app that details their education, training and professional registrations, as well as their key clinical and non-clinical skills and training. All pre-employment checks (e.g. DBS and occupational health assessments) are also on the app, along with their unique NHS staff number.

This staff app also has all their employment information and annual leave balance, pension, payslips, and wider benefits. The app is connected to the system's e-rostering platform that means that staff can see which setting they will be working in, with shift information available 12 weeks in advance. Flexibility to change and swap shifts is facilitated by the app, as is the ability to book annual leave. All staff are rostered in MDTs – AI functionality accounts for safe staffing levels and skill mix according to acuity.

The digital literacy of staff across St Elsewhere is unrecognisable from four years ago due to the personalised training made available to staff to upskill. Staff across the system are using AI encouraged by the Board, who are all advocates but also understand the regulatory issues surrounding its use. The adoption of AI tools that enable predictive analysis, diagnosis and personalised treatment plans, as well as automate end to end workflows, has improved access to services, made diagnosis faster and reduced administration.

The cost of corporate services has reduced by 40% over the last four years since St Elsewhere joined the Transforming Corporate Services Programme and started to benefit from regional and system wide services. Staff satisfaction with Corporate Services has significantly improved, while these savings have been reinvested in frontline care.

The St Elsewhere system has benefitted from the introduction of a new national DDAT pay scale, which has enabled them to recruit a small team with the specialist skills to support the roll out of their new system electronic patient record.

The same team has provided support to integrate ambient AI into all GP practices and neighbourhood health centres.

Operational and strategic workforce planning in St Elsewhere are enabled by a workforce planning tool that provides a consistent, real-time and automated view of the local NHS workforce and identifies gaps based on future population health needs. This feeds into the local health and care workforce forum that brings HEIs, employers and other representatives together to determine the future skill and role requirements, from training to retirement.

Leadership development is a mix of national, regional and local development. Each defined level of leadership and management has a clear training path – both on the job experiences enabled by digital learning via an intelligent platform that both tracks learning and suggests learning based on individual need. Utilising blended learning as roles become more senior and leadership tasks more complex. Competencies attained and standards link into regulation, and are also tracked and available via the app. There is an expectation of continuous professional development in management and leadership with each staff member refreshing their skills once a year at least. This management and leadership development has resulted in lower levels of absence and higher levels of engagement and retention across St Elsewhere.

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