



Prifysgol Cymru
Y Drindod Dewi Sant
University of Wales
Trinity Saint David

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Assessment 2: Group Presentation — NHS England

Focus area: Training & Development — rebuilding the learning culture of Europe's largest employer

Group member	Student ID	Group member	Student ID
Shivans Bhimbha	2514071	Sejal	2538991
Niraj Odedara	2541726	Mayur Sundavadra	2538588
Rekhaben Odedara	2534406	Dhrumilkumar Makrubiya	2536596

Lecturer: Eno Maycock (Birmingham)

Contents & presenter allocation

#	Section	What it covers
1	Introduction & current policies and practices	NHS context; the T&D architecture; policy direction of travel
2	Current opportunities	AI and digital learning at scale, new career pathway, apprenticeships
3	Current challenges	2025 Staff Survey evidence; the appraisal paradox; AI adoption tensions
4	Root-cause analysis	Why the gaps persist: structure, funding, culture, leadership, technology
5	Evidence-based recommendations	Five prioritised, theory-grounded interventions and a delivery roadmap
6	Future-of-work implications & synthesis	How AI reshapes NHS learning by 2031–36; leader's summary of findings
—	Group conclusion	Overall HRM strategy for NHS England

NHS England at a glance: why training is mission-critical

~1.5m

staff invited to the 2025 NHS Staff Survey — Europe's largest employer (NHS Staff Survey, 2026)

£192bn

annual budget across c.600 million patient contacts a year (Open Access Government, 2026)

350+

distinct careers spanning clinical, scientific, digital and support roles (NHS England, 2023)

206

NHS trusts covered by the national Staff Survey results (NHS Staff Survey, 2026)



Training is a patient-safety issue, not a perk. In a service where skills directly determine clinical outcomes, human capital theory (Becker, 1964) treats every hour of staff development as productive investment rather than cost — yet, as we will show, the NHS currently under-invests in exactly this asset.



Who “owns” learning? Since Health Education England merged into NHS England in April 2023, one national body now plans, funds and quality-assures education for the whole workforce — a structural change that shapes both the opportunities and the challenges in this presentation.

What the NHS currently does: the T&D architecture



Statutory & mandatory training

A national Core Skills Training Framework (fire safety, safeguarding, infection control) delivered annually to all staff — high compliance, but widely criticised as a tick-box exercise; the 10 Year Health Plan commits to reform it by April 2026 (DHSC, 2025).



eLearning for healthcare (elfh)

A free national digital platform hosting 400+ programmes, including the Patient Safety Syllabus (Levels 1–2 open to all staff) — the backbone of scalable, standardised learning (NHS England, 2025).



Apprenticeships & the levy

As a levy-paying employer, the NHS runs one of the UK's largest apprenticeship programmes — from healthcare support workers to registered nurse degree apprenticeships — widening access to clinical careers (NHS England, 2023).



Leadership & management development

The NHS Leadership Academy suite (e.g. Edward Jenner, Mary Seacole) plus a new Management and Leadership Framework introduced in autumn 2025 (Mills & Reeve, 2025).



Clinical education & supervision

Preceptorship for newly-qualified staff, protected clinical supervision, and placement quality monitored through the National Education and Training Survey (NETS) (NHS England, 2026).



Appraisal & personal development

Annual appraisals with personal development plans — completion is at a record 86.4%, though we will question their developmental value later (NHS Staff Survey, 2026).

Policy direction: from the Long Term Workforce Plan to the 10 Year Health Plan

NHS Long Term Workforce Plan (2023)

“Train, retain, reform”

- Double medical school places to 15,000 a year by 2031/32
- 6,300+ clinicians starting advanced practice pathways annually by 2031/32
- Nursing associate training places up to 10,500 by 2031/32
- GP training places up 50% to 6,000 by 2031/32
- Expert group on AI adoption, building on the Topol Review (2019)

Fit for the Future: 10 Year Health Plan (2025)

“The most AI-enabled health workforce in the world”

- Complete reform of mandatory training by April 2026
- “Skills escalators” giving every role a visible progression route
- Personalised career coaching and development plans for all staff
- Education and training curricula overhauled within 3 years to embed AI and digital competencies
- A successor 10 Year Workforce Plan (in development at the time of writing)

The theoretical lens we apply throughout



Human capital theory *Becker (1964)*

Skills are productive assets; development spend is investment with measurable returns in quality, safety and retention.

Justifies treating the CPD squeeze as value destruction, not saving.



Strategic HRD *Garavan (2007)*

Learning must be vertically aligned to strategy and horizontally integrated with other HR practices.

Tests whether NHS T&D actually connects to the 10 Year Health Plan's goals.



AMO framework *Appelbaum et al. (2000)*

Performance = Ability × Motivation × Opportunity.

Explains why courses fail when staff lack time (Opportunity) even where Ability provision exists.



Psychological contract *Rousseau (1995)*

Unwritten mutual expectations between employer and employee; breach damages engagement and retention.

Frames falling development scores as perceived broken promises.



Training evaluation *Kirkpatrick & Kirkpatrick (2016)*

Four levels: reaction, learning, behaviour, results.

The standard we apply to our own recommendations in Section 5.

Current opportunities: four levers for a step-change



AI-enabled learning at scale

Copilot for 505,000 staff by Oct 2026; AI embedded in curricula; national elfh platform ready to personalise.



Visible career pathways

Skills escalators, advanced practice (6,300 starters/yr by 2031/32) and personalised coaching promised for all.



Apprenticeships & widening access

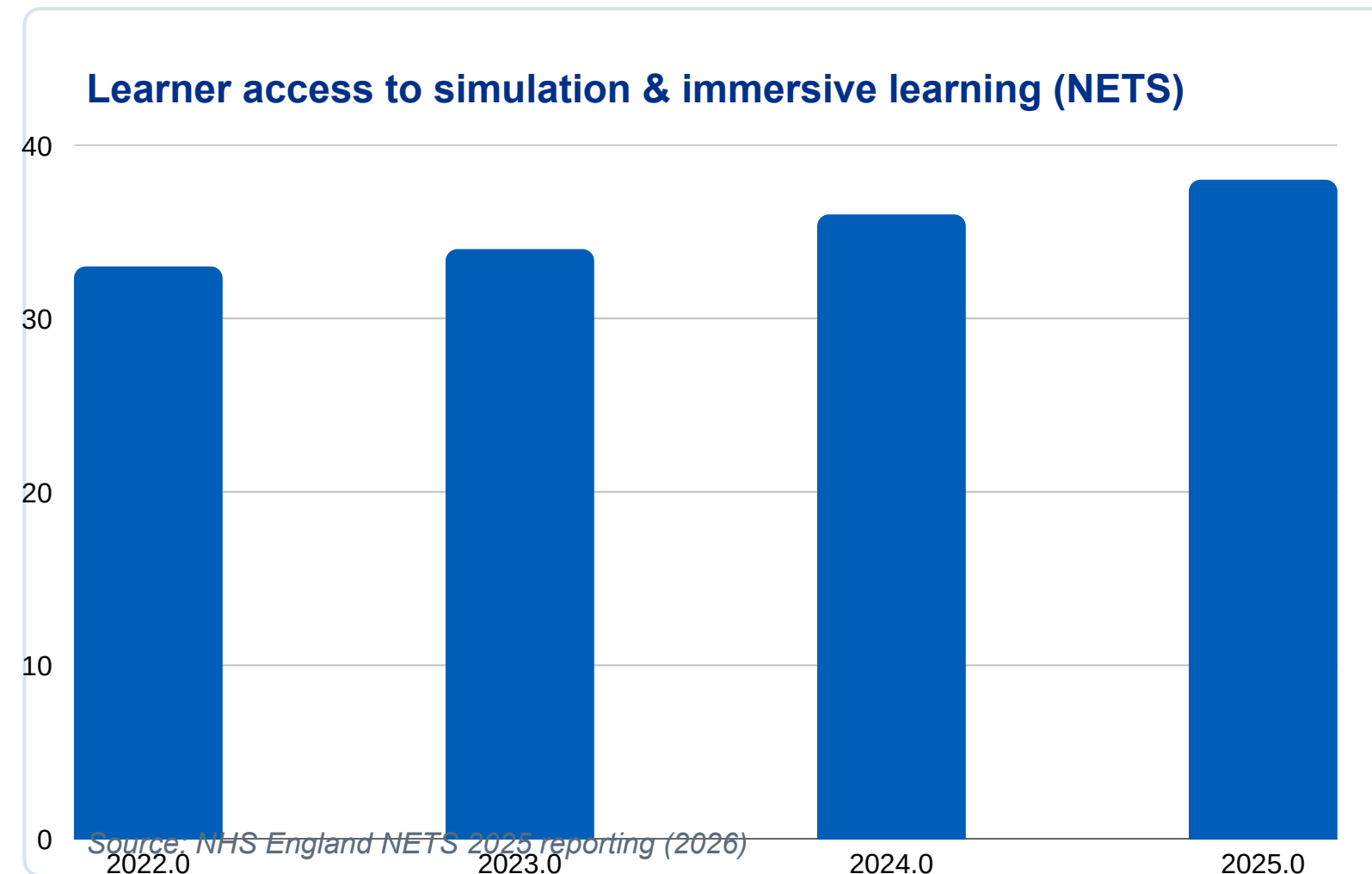
Levy-funded routes from support worker to registered professional — grow-your-own supply in shortage areas.



Simulation & immersive learning

Learner access to simulation up from 33% (2022) to 38% (2025) — momentum to build on (NETS, 2026).

Opportunity in depth: AI and digital learning



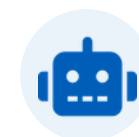
Copilot at national scale. 505,000 clinicians and support staff gain Microsoft 365 Copilot by October 2026 — potentially the world's largest workplace AI upskilling exercise (ICHP, 2026).



Curricula built for the digital future. The 10 Year Health Plan commits to embedding AI competencies in all education and training within 3 years — delivering, at last, the Topol Review's (2019) vision.

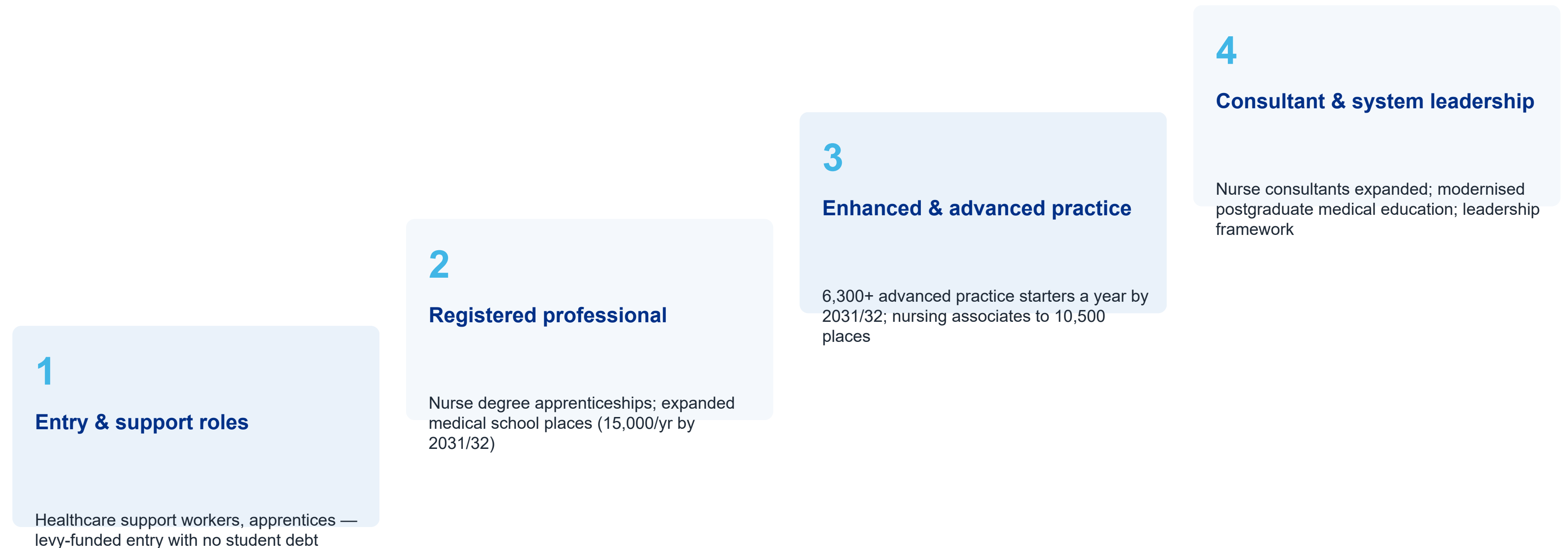


Personalisation of learning. AI can analyse workforce data to spot skill gaps and recommend individual pathways — shifting from one-size-fits-all courses to precision development (Oleeeo, 2025).



A growing clinical AI talent pipeline. The NHS Fellowship in Clinical AI (Cohort 5, 2026–27) builds in-house expert capacity to deploy AI safely.

Opportunity in depth: careers as an escalator, not a ladder



Why it matters: 51% of staff currently see no career development opportunity in their organisation — the lowest score ever recorded (NHS Staff Survey, 2026). Visible escalators attack the single biggest driver of avoidable turnover, and expectancy logic (Vroom, 1964) predicts effort rises when the path from development to progression is believable.

A critical evaluation: opportunity ≠ outcome



Ability

Provision is strong on paper

elfh platform, apprenticeships, simulation, Copilot licences — the NHS is not short of learning 'supply'.



Motivation

Fragile and falling

Only 55% of staff feel supported to develop their potential; appraisals rarely feel valuable — motivation cannot be assumed (NHS Staff Survey, 2026).



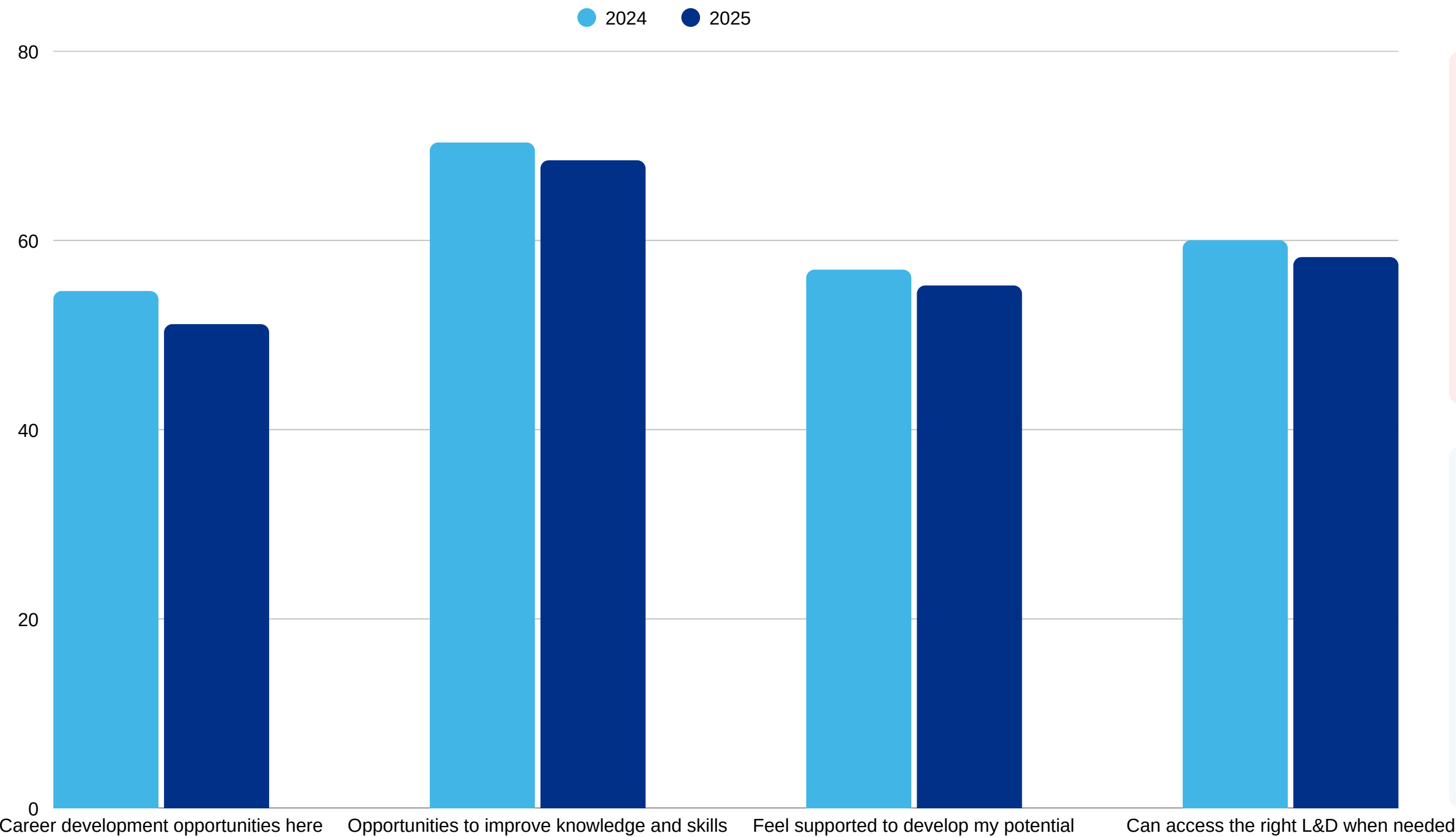
Opportunity

The binding constraint

Without protected time, backfill and manager support, provision goes unused — 58% can access the right L&D when needed, a three-year low.

Judgement: performance requires all three multiplied together — so the highest-value interventions are those that unlock Opportunity and Motivation, not more content. This directly shapes our recommendations in Section 5.

The challenge in the workforce's own words



51.15%

see career development opportunities in their organisation — the lowest level ever recorded in the survey's history.

Why this matters: development perception is a proven predictor of retention and care quality — both metrics the 10 Year Workforce Plan is expected to target (NHS Confederation, 2026).

The appraisal paradox: maximum compliance, minimum value

86.4%

of staff had an appraisal in the last 12 months — the highest completion rate ever

26.0%

say it helped them improve how they do their job

32.9%

left feeling their work is valued by the organisation

Source: NHS Staff Survey national results 2025 (2026)



The release-time problem. With vacancies and elective backlogs, wards cannot backfill staff to attend training — the AMO 'Opportunity' constraint in action. Ambulance trusts score worst on nearly every learning measure (e.g. 46% able to access clinical supervision) (NHS Staff Survey, 2026).



Interpretation through goal-setting theory (Locke & Latham, 2002): appraisals only motivate when they produce specific, challenging, accepted goals — just 35% of NHS staff say theirs produced clear objectives, so the process is compliance without the psychological mechanism that makes it work.

The AI double-edge: adoption is outpacing capability



Inconsistent national guidance

GPs report wide variation — some Integrated Care Boards prohibit AI use while others encourage piloting, leaving clinicians without shared standards (Nuffield Trust, cited in Skills for Health, 2026).



AI redistributes work rather than removing it

New duties of checking, validation and oversight are landing on staff without matching training or role redesign (Imperial College Health Partners, 2026).



Uneven digital confidence

A workforce of 1.5m spans digital natives and staff with limited basic IT skills; a Copilot licence is not capability — training must close the gap or it will widen inequity.



Professional scepticism

The BMA (2026) calls reliance on AI to fix workforce gaps a “massive, dangerous gamble” — credible adoption requires bringing staff with the change, not imposing it.

Challenge synthesis: five performance gaps

Performance gap	Headline evidence	Business & patient impact
Collapsing development perception	Career development at 51.15% — lowest ever; all L&D metrics fell in 2025	Higher turnover intention; weaker employer brand in a competitive labour market
Appraisals without development value	86% completion but only 26% found them useful for their job	Wasted management hours; disengagement; goal-setting mechanism broken
No time or backfill to learn	Access to right L&D at a 3-year low (58%); ambulance trusts worst	Provision unused; mandatory training crowds out developmental learning
AI capability gap	Copilot for 505k staff by Oct 2026, but guidance inconsistent and validation burden unaddressed	Safety and governance risk; benefits of £10bn tech investment unrealised
Inequity of access	Progression and access vary by profession, ethnicity and trust type	Legal/reputational risk; loss of diverse talent pipelines

Root-cause analysis: our approach

Policy design

Churn between national plans; mandatory training bloat

Structure

HEE merger; 42 ICBs with varying maturity

Resources

CPD funding erosion; no backfill economics

**Falling L&D
performance &
perception**

Culture & leadership

Compliance mindset; manager capability gaps

Technology

Legacy IT; AI governance vacuum

External pressures

Industrial disputes; fiscal constraint; demand growth

Root causes 1–2: structure and resources



Structural: education lost its champion

- HEE's 2023 merger into NHS England absorbed the dedicated education body into an organisation simultaneously cutting its own running costs by ~50%.
- Devolution to 42 ICBs created variation: L&D investment now depends on local maturity and finances — the inconsistent AI guidance is one visible symptom.
- Policy churn (2023 plan → openly criticised → 2025 replacement) resets priorities before delivery beds in.



Resource: the CPD squeeze

- Operational pressure is the binding constraint: with 54,300 patients waiting 12+ hours for emergency admission in Oct 2025, releasing staff to learn feels unaffordable day-to-day.
- Backfill economics: every study day requires cover the roster cannot supply — so development is the first thing cancelled (the AMO 'Opportunity' failure).
- Human capital logic inverted: treating training as discretionary spend saves pennies now and pays pounds later in turnover, agency costs and error (Becker, 1964).

Root causes 3–4: culture and leadership



A compliance culture. Years of regulator-driven mandatory training taught the system to equate 'learning' with box-ticking. The 86%-completion / 26%-value appraisal paradox is the same pattern: activity measured, development not. Culture, as Schein (2017) argues, is what gets rewarded — and the NHS rewards completion, not growth.



Line managers as the squeezed middle. Survey scores for immediate managers remain positive — staff don't blame their manager, they blame the system. But managers hold the development conversation without the time, coaching skill or budget to honour it; investment in manager capability has lagged the rhetoric.



Psychological contract breach (Rousseau, 1995). The NHS People Promise explicitly pledges “we are always learning”. When 49% of staff see no career development, the promise reads as broken — and breach theory predicts exactly what the survey shows: falling engagement, rising leaving intention, and cynicism about the next initiative.

Causal chain: compliance culture → development treated as paperwork → staff experience broken promises → disengagement → turnover → more pressure → even less time to develop. A self-reinforcing loop that explains why the metrics keep falling.

Root causes 5–6: technology and external pressures



Technology outpacing governance

- Legacy estates: some trusts “still struggle with decades-old technology” (BMA, 2026) — an unstable base for an AI-first learning strategy.
- No settled national AI standards yet, so training content and permissions vary by ICB.
- The Topol Review set the digital-skills agenda in 2019; six years on, implementation is only now being mandated — a lost half-decade of capability building.



External shocks and constraints

- Ongoing national industrial disputes corrode goodwill — the discretionary energy learning depends on.
- Fiscal constraint: a 2% annual productivity target (≈£17bn over 3 years) pressures anything not visibly 'frontline'.
- Demand growth and demographic change keep raising the skills bar (multimorbidity, frailty, mental health) faster than curricula adapt.

Root-cause verdict: the deepest drivers are systemic — time, structure and culture — not a lack of content or technology. Any recommendation that only adds more courses will fail. Over to Presenter 5.

Five recommendations, prioritised by impact and feasibility

#	Recommendation	Root cause addressed	Theory base	Impact	Feasibility
R1	Protected, rostered learning time with funded backfill	Resources / time	AMO (Opportunity)	High	Medium
R2	Replace annual appraisal with quarterly development conversations	Culture / compliance ritual	Goal-setting (Locke & Latham)	High	High
R3	AI-personalised learning pathways on the national elfh platform	One-size-fits-all provision	Self-determination (Deci & Ryan)	High	Medium
R4	Role-based AI capability framework riding the Copilot rollout	AI capability & governance gap	Topol (2019); 70:20:10	High	High
R5	Line-manager coaching academy with ring-fenced time	Manager capability	Social learning (Bandura)	Medium	High

Selection logic: every recommendation attacks a root cause identified in Section 4 rather than a symptom — and none of them is 'buy more courses'. R2 and R4 are quick wins; R1 is the hardest but highest-leverage change.

R1 & R2: give time back, make conversations count

R1 · Protected learning time

- What: a rostered minimum (e.g. 4 hours/month) of protected development time for all clinical staff, with backfill funded from the bank-staff transition savings (est. £1bn over 5 years from ending agency use, DHSC 2025).
- Why it works: precedent — protected characteristics of GP training and consultant SPA time show rostered development survives operational pressure where goodwill does not.
- Measure: 'access to right L&D' survey score back above 65% within two survey cycles.

R2 · Development conversations, not appraisals

- What: replace the annual form with quarterly 30-minute forward-looking conversations producing 2–3 specific, challenging goals — aligned with the 10 Year Health Plan's own appraisal-reform commitment.
- Why it works: goal-setting theory's strongest finding — specific + challenging + accepted goals raise performance; frequency builds the feedback loop the annual cycle cannot (Locke & Latham, 2002).
- Measure: 'appraisal helped me improve' from 26% to 40%+; adoption tracked via ESR.

R3–R5: make AI the engine of personalised development



R3 · AI-personalised pathways

Use workforce data (ESR + elfh) to recommend individual learning journeys — the 'skills escalator' made real for each person. Autonomy-supportive design sustains intrinsic motivation (Deci & Ryan, 2000). Pilot in 2 ICBs before national scale.



R4 · Role-based AI capability framework

Define what safe AI use means per role (admin, clinical, leadership); wrap mandatory-training reform around it; use the 505k-seat Copilot rollout as the live practice environment — 70:20:10 in action.



R5 · Manager coaching academy

Equip 1st-line managers to hold development conversations (R2) through observation, practice and feedback — social learning theory (Bandura, 1977) — with completion linked to the new Management & Leadership Framework.

Delivery roadmap and how we would know it worked

Phase 1 · 0–6 months

Launch development conversations (R2) · publish AI capability framework (R4) · baseline metrics

Phase 2 · 6–18 months

Protected time pilots in 6 trusts (R1) · manager academy cohort 1 (R5) · AI pathway pilot in 2 ICBs (R3)

Phase 3 · 18–36 months

National scale-up · integrate with 10 Year Workforce Plan delivery · independent evaluation & iterate

Kirkpatrick level	Evaluation measure for this programme	Target
1 · Reaction	Pulse surveys after development conversations and AI training modules	≥75% positive
2 · Learning	AI capability assessments passed, by role and by trust	90% of Copilot users certified
3 · Behaviour	Staff Survey: 'supported to develop potential' and 'access to right L&D'	Both ≥65% by 2028 survey
4 · Results	Turnover, agency spend, appraisal-value score, CQC well-led ratings	Turnover –2pp; value score 40%+

The next 5–10 years: how AI reshapes NHS learning



By 2028

Copilot embedded in daily work for 505k staff; single patient record; reformed mandatory training and AI-inclusive curricula fully live



By 2031

Ambient voice technology routine in documentation; skills escalators and personalised coaching at scale; 15,000 medical school places reached (2031/32)



By 2036

“The most AI-enabled health system in the world” ambition tested: AI as “every nurse's and doctor's trusted assistant”; workforce mix shifts toward enhanced and advanced roles (to ~5% of staff)

The contested question: government frames AI as the answer to workforce shortfall; the BMA calls that “a massive, dangerous gamble”. Our judgement sits between the two — AI will transform tasks faster than it replaces roles, which makes **continuous reskilling the core HR capability of the decade** (ICHP, 2026; BMA, 2026).

What this means for learning & development practice

From (today)	To (2031–36)	New capability required
Annual mandatory e-learning modules	Continuous, in-workflow micro-learning surfaced by AI at the point of need	Learning engineering; content curation over creation
Classroom + placement as the default	Simulation, VR and digital twins as standard rehearsal spaces	Educator workforce skilled in immersive pedagogy
Uniform curricula by profession	Personalised pathways built on live skills data	Workforce analytics; skills taxonomies; data ethics
Clinical skills as the core syllabus	Clinical + AI oversight skills: validating outputs, knowing when to overrule the machine	Human-in-the-loop judgement; safety-case literacy
L&D as a support function	L&D as strategic workforce transformation partner	Strategic HRD alignment (Garavan, 2007)

What NHS England must prepare for now



Governance before scale

National standards for AI use in practice and in training, ending the current ICB-by-ICB lottery — clinician confidence follows clarity, not enthusiasm.



An educator workforce plan

Simulation, immersive and AI-era pedagogy need trained educators; the forthcoming 10 Year Workforce Plan must fund them explicitly (NHS Confederation, 2026).



Equity by design

Digital capability gaps track age, role and background; without deliberate inclusion, AI-era learning will widen the very disparities the WRES agenda targets.



Reskilling as infrastructure

Treat continuous reskilling like estates or IT: permanently funded, centrally standardised, locally delivered — not a per-initiative afterthought.

Synthesis: the argument in one page

1 · Policies

A comprehensive T&D architecture exists, and national policy (2023 & 2025 plans) points the right way.

2 · Opportunities

AI at scale, career escalators, apprenticeships and simulation — execution, not invention, is the gap.

3 · Challenges

Every 2025 Staff Survey learning metric fell; career development perception is the lowest ever recorded.

4 · Root causes

Systemic: no protected time, structural churn, compliance culture, psychological contract breach, AI governance vacuum.

5 · Recommendations

Five theory-grounded moves — protected time, development conversations, AI-personalised pathways, AI capability framework, manager academy.

6 · Future of work

AI transforms tasks faster than roles; continuous reskilling becomes the NHS's defining HR capability.

One sentence: the NHS does not have a learning-content problem — it has a learning-conditions problem, and fixing the conditions is now urgent, affordable and policy-aligned.

Group conclusion: our overall HRM strategy for NHS England

“Rebuild the conditions for learning — and let AI personalise it.”

Time

Protected, funded learning hours as a non-negotiable operating standard — restoring the Opportunity in AMO.

Trust

Quarterly development conversations and honoured People Promise commitments — repairing the psychological contract.

Technology

AI-personalised pathways and a role-based AI capability framework — converting the £10bn digital investment into human capability.

Talent architecture

Skills escalators from apprentice to consultant — making growth visible so people stay to build careers, not just hold jobs.

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Appendix: glossary and data notes

Term	Meaning
AMO	Ability–Motivation–Opportunity model of performance (Appelbaum et al., 2000)
CPD	Continuing professional development
elfh	eLearning for healthcare — NHS England's national digital learning platform
ESR	Electronic Staff Record — the NHS national HR and payroll system
HEE	Health Education England (merged into NHS England, April 2023)
ICB / ICS	Integrated Care Board / System — 42 regional planning bodies in England
NETS	National Education and Training Survey (annual, all healthcare learners)
WRES	Workforce Race Equality Standard