Essex Partnership University
NHS Foundation Trust

COUNCIL OF GOVERNORS PART 1

Meeting to be held 19 November 2025, 13:45

Via MICROSOFT TEAMS

AGENDA

Vision: To be the leading health and wellbeing service in the provision of mental health and community care

CEO Briefing – 13:00

1	Apologies for Absence	HLD	Verbal	Noting	13:45
2	Declarations of Interest	HLD	Verbal	Noting	13:47
Presentation: Here For You Service Dr Helen Sinclair, Head of Clinical Care Psychology and Here For You					13:50
3	Minutes of previous meeting, held on 9 October 2025	HLD	Attached	Approval	14:20
4	Action Log and Matters Arising	HLD	Attached	Noting	14:23
5.	**STANDING REPORTS**				
(a)	Report from the Chair	HLD	Attached	Noting	14:25
(b)	Chief Executive Officer (CEO) Report	PS	Attached	Noting	14:30
6.	**ITEMS FOR DISCUSSION**				
(a)	Freedom to Speak-Up	BR	Verbal	Discussion	14:35
(b)	Community First	AS	Presentation	Discussion	14:45
(c)	External Audit	EL / TS	Attached	Discussion	15:00
7.	**ITEMS FOR DECISION**				
(a)	Standing Orders for the Council of Governors	CJ	Attached	Approval	15:10
8.	**ITEMS FOR INFORMATION**				
(a)	Lead Governor Report	SS	Attached	Noting	15:12
					15:15

9.	**ANY OTHER BUSINESS**				
9.1	Fit for the Future: 10-year Health Plan for England – Future of Governors	HLD	Attached	Noting	
10.	**QUESTIONS AND ANSWERS SESSION FROM MEMBERS OF THE PUBLIC**				
11.	**DATE AND TIME OF FUTURE MEETINGS** 11 March 2026 20 May 2026 9 September 2026 18 November 2026 17 March 2027 (All start at 1pm)				15:30

Hattie Llewelyn-Davies
Chair

Essex Partnership University
NHS Foundation Trust

MINUTES OF THE COUNCIL OF GOVERNORS PART 1

Held on 9 October 2025
Via MS Teams

MEMBERS PRESENT:

Hattie Llewelyn-Davies	HLD	Chair
Simon Cross	SC	Public Governor, Essex Mid & South
Gwyn Davies	GD	Public Governor, Essex Mid & South
Spencer Dinnage	SD	Staff Governor, Clinical
Nat Ehigie-Obano	NE	Public Governor, West Essex and Hertfordshire
David Finn	DF	Public Governor, Essex Mid & South
Richard Gregory	RG	Public Governor, Essex Mid & South
Ashley John	AJ	Public Governor, North East Essex & Suffolk
James McCarthy	JM	Public Governor, North East Essex & Suffolk
Oladipo Ogedengbe	OO	Staff Governor, Clinical
Cllr Elizabeth Rigby	ER	Appointed Governor, Thurrock Council
Cllr Maxine Sadza	MS	Appointed Governor, Southend-on-Sea City Council
Stuart Scrivener	SS	Public Governor, Essex Mid & South
Helen Semoh	HS	Staff Governor, Non-Clinical
Edwin Ugoh	EU	Staff Governor, Clinical
Cort Williamson	CW	Public Governor, North East Essex & Suffolk

IN ATTENDANCE:

Ellen Auty	EA	
Doug Field	DF	Associate Non-Executive Director
Alex Green	AG	Executive Chief Operating Officer
Denver Greenhalgh	DG	Executive Director of Governance
Chris Jennings	CJ	Assistant Trust Secretary
Dr Ruth Jackson	RJ	Non-Executive Director
Dr Mateen Jiwani	MJ	Non-Executive Director
Diane Leacock	DL	Non-Executive Director
Loy Lobo	LL	Non-Executive Director
Claire Mellons	CM	EY
Elena Lokteva	EL	Non-Executive Director
Nicky Reeves	NR	
Naomi Sams	NS	
Paul Scott	PS	Chief Executive Officer
Ann Sheridan	AS	Executive Nurse
Trevor Smith	TS	Executive Chief Finance Officer
Richard Spencer	RS	Non-Executive Director
Sarah Teather	ST	Non-Executive Director

There was one member of the public present.

40/25 WELCOME AND APOLOGIES FOR ABSENCE

HLD welcomed everyone to the meeting and welcomed new Governors to their first meeting of the Council of Governors.

Apologies were received from:
Jason Gunn, Public Governor, West Essex, Hertfordshire and Rest of England

41/25 DECLARATIONS OF INTEREST

There were no new declarations of interest.

42/25 MINUTES OF THE PREVIOUS MEETING HELD ON 21 MAY 2025

The Council reviewed the minutes of the meeting held on the 21 May 2025 and agreed these as an accurate record.

43/25 ACTION LOG / MATTERS ARISING

The Council of Governors reviewed the action log from the meeting held on 21 May 2025 and noted two actions had been completed and one action remained open.

The open action related to further updates being provided in relation to the hydro pool in West Essex. TS advised this had continued to be taken forward, highlighting the complexities relating to the commissioning of its use and the property and it's landlords who are NHS Property Services. Partner organisations had been contacted to potentially utilise the pool.

44/25 PRESENTATION: TOGETHER WITH BABY

EA and NS delivered a presentation providing details of the Together with Baby service. The presentation highlighted the following:

- The background and context of perinatal services provided in Essex, including the purpose and the strength of the services relating to perinatal mental health.
- There are a number of different mental health conditions which could be experienced by new mothers. Paternal perinatal mental health still needed significant investment.
- The services operate with the concept of the "baby is always in the room", which ensures the baby is at the centre of any care from the different stages of pregnancy until and after the birth.
- Infant mental health recognises the importance of brain development at an early age, with social experience and relationships helping with the development.
- Experiences, such as neglect and abuse, can cause issues later in life and persistent stress can change the brain architecture.
- The Together with Baby service was developed in 2018 and brings together different family relationships that are important to the baby as part of early brain development.
- The service is Essex-wide and takes place in various different settings. The service also includes indirect interventions, such as consultations and teaching and helps build relationships with other services.

<u>Questions and Discussions</u>

- SC commented positively on the service and asked if any work had been undertaken to look at neurodivergent developmental needs, to avoid these becoming mental health issues in the future. EA agreed it was important to identify any neurodivergent needs early in development, and also noted the importance of understanding neurodivergence in parents. NS advised any neurodivergence identified is discussed early with the parents to help support them in meeting the baby's needs at an early stage.
- MS commented on the importance of the service in ensuring children are supported during their infancy and arrive in school prepared. MS asked how mothers were referred to the service and if anyone outside can refer the individual. NS advised referrals were usually from perinatal services and health visitors, but can also come from other professionals such as midwives. Individuals can also self-refer, and any phone call or message will always be returned to find the best pathway for the individual. EA highlighted family centres in Thurrock, which include a parent / infant therapist. EA hoped the model could be rolled out more widely.
- SD commented on the importance of the service and the understanding that early development can affect people in older age. SD asked what the next steps for the service were. EA advised new 0-5 national guidance would soon be published, and this could be used to influence commissioners to help expand the service. NS commented that it was important to raise the profile of the service to gain wider support.
- DF asked whether the issues identified around maternity services in Essex were having an impact on the service. EA agreed this was having an impact and could cause issues with barriers between organisations. However, she also noted the indirect work undertaken by the service to support colleagues and services. NS advised that the service worked with colleagues to help them retain compassionate and trauma informed approaches in difficult circumstances.

HLD thanked EA and NS for the presentation.

EA and NS left the meeting at this point.

45/25 AUDITORS ANNUAL REPORT

CM presented a report providing the Council of Governors with the Auditor's Annual Report for the year ending 31 March 2025. CM highlighted the following:

- The audit had provided an unqualified opinion on the financial statement, noting these as a true and fair representation of the financial position of the Trust as at 31 March 2025 and of its expenditure and income for the year then ended.
- The parts of the remuneration report and staff report subject to audit identified no matters to report.
- The financial information in the Annual Report and published with the financial statement was consistent with the audited accounts.
- There were no matters to report in relation to the Trust's Value for Money (VFM) arrangements.
- The Annual Governance Statement was consistent with the Auditors understanding of the Trust.
- The Auditors did not identify any reasons to enact any of its other powers as part of the audit.
- The Auditors had reported to the National Audit Office (NAO) as part of its group instructions. The audit could not be fully concluded and an audit certificate issued until the NAO, as group auditor, had confirmed that no further

assurances were required from EY. CM confirmed that no further work was required by EY in auditing the Trust.

HLD thanked CM for the reporting, noting the complex audit process which had led to a good outcome report.

The Council of Governors received and noted the report.

CM left the meeting at this point.

46/25 REPORT FROM THE CHAIR

HLD presented a report providing an update to support Governors and provide an understanding of the work of the Non-Executive Directors. HLD highlighted the following:

- Welcome to Doug Field who had joined the Trust as an Associate Non-Executive Director.
- Congratulations to SS in his appointment as Lead Governor.

HLD asked for any comments on the content of the report to ensure it is useful in supporting Governors.

The Council of Governors received and noted the report.

47/25 CHIEF EXECUTIVE OFFICER (CEO) REPORT

PS presented a report providing a summary of key activities and information to be shared with Governors. PS highlighted the strategic direction of the Trust and commissioning arrangements going forward.

The Council of Governors received and noted the report.

48/25 RISE PROGRAMME

NR delivered a presentation regarding the RISE programme, noting this was a request from a previous Council meeting for further information and outcomes to be provided to the Council. NR highlighted the following:

- The presentation provided context in relation to the Organisational Development team and its role within the organisation.
- The RISE programme underpinned the Workforce Race Equality Standards (WRES) and provided a blended learning programme for staff from a global majority background.
- The programme was established in 2022. Recent developments include opening the programme to health and care system colleagues
- The next cohort of the programme will have 75 places across the system and will provide the programme within three categories, based on individuals' banding.
- The presentation provided positive testimonials from individuals who had completed the programme.
- The presentation provided learner data, including individuals who had been promoted since completion of the programme. The data would be developed going forward to provide more detail on the impact of the programme.

<u>Questions and Discussions</u>

- SC asked what impact the programme had on the retention of staff. NR advised this would need further work to analyse data to provide this information. NR agreed to share further data with the Council once this had been analysed.

- SC asked whether the programme could be offered to individuals as part of other protected characteristics. NR advised this was something other organisations had undertaken and agreed this would be considered.
- LL commented he had attended the RISE programme graduation and encouraged Governors to attend.
- MS commented positively in the programme and looked forward to receiving further figures regarding the impact.

The Council of Governors received and noted the report.

Action:

1. **Provide further details of the impact of the RISE Programme once the detailed data analysis has been completed. (NR)**

49/25 REMUNERATION AND NOMINATIONS COMMITTEE TERMS OF REFERENCE

CJ presented a report providing a proposal to merge the Council of Governors Remuneration and Nomination Committee and a proposed Terms of Reference for approval. CJ outlined the remit of the Committees and the work being undertaken with the Chair and Lead Governor in reviewing Council processes to ensure good use of Governor time. The links between the remit of the Committees provided a case for the merging of the Committees, with the proviso that there would be clear delineation between the roles of each part of the Committee.

CJ advised that the Council of Governors Remuneration Committee and Nominations Committee had met together on 28 August 2025 and had agreed to recommend the merger of the Committees to the Council for approval.

The Council of Governors received, noted the report and:

- **Approved the merging of the Council of Governors Remuneration and Nominations Committee.**
- **Approved the Terms of Reference for the Council of Governors Remuneration and Nominations Committee.**

50/25 NED OBJECTIVES 2025/26

HLD presented a report providing the objectives for Non-Executive Directors for 2025/26. HLD advised that this concluded the appraisal process for 2024/25.

The Council of Governors received and noted the assurance provided in respect of the NED appraisal process and outcome.

51/25 LEAD GOVERNOR UPDATE

CJ provided a verbal update, noting the appointment of SS as the EPUT Lead Governor for a period of six months. This was recommended by the Council of Governors Governance Committee to allow SS time in the role, before an election process takes place. CJ congratulated SS on his appointment.

The Council of Governors received, noted the verbal update and congratulated SS on his appointment as Lead Governor.

52/25 MEMBERSHIP UPDATE

CJ presented a report providing the membership metrics as at September 2025 and details of the ongoing work to implement the Membership Strategy.

CJ provided details of the attendance at Chelmsford College and Anglia Ruskin University freshers week, to promote membership and EPUT. This was part of the

Membership Strategy in encouraging younger people to join and to build a good level of representation across the membership.

The Council of Governors received and noted the report.

53/25 CHANGES TO THE COUNCIL OF GOVERNORS COMPOSITION AND MEMBERSHIP OF ITS COMMITTEES

CJ presented a report providing details of changes to composition, current sub-committee membership and attendance at the Council of Governors. CJ advised that, as part of the review into papers being presented to the Council, it had been proposed to discontinue this report and highlight any changes in composition through the Chair's report.

Questions and Discussions

- SC agreed with the proposal to discontinue the report, highlighting the importance of providing necessary information by exception.

The Council of Governors received and noted the report.

54/25 LEAD GOVERNOR REPORT

SS presented a report providing a summary of the key activities undertaken by the Lead Governor and sharing information and learning identified.

The Council of Governors received and noted the report.

55/25 ANY OTHER BUSINESS

None

56/25 QUESTIONS AND ANSWERS SESSION FROM MEMBERS OF THE PUBLIC

Length of Stay

Pippa Ecclestone (PE), Member of the Public, noted reference in the CEO report to the recently published league tables. PE noted one area of underperformance was length of stay on acute wards and that this had been a challenge for EPUT for some time. There was also data in the Quality and Performance Scorecard for the Board on the rates of patient clinically ready for discharge and delayed transfers of care. PE asked whether EPUT had liaised with other Trusts to see how they are managing the issue and whether anything could be done to improve the situation.

PS thanked PE for the important point and highlighted the work undertaken to implement Time to Care, which is designed to reduce length of stay and out of area placements. There is a trajectory in the annual plan, which is currently being met, but could be a rapidly changing situation. PS highlighted work underway to review community health teams and implement the Community First project to support discharge and prevent patients from needing an inpatient bed. The delayed transfers of care were often due to system pressures and the league tables could help bring more focus to system delays. The new Greater Essex ICB should allow a more coordinated approach and if providers such as EPUT could have commissioning responsibility it would allow it to use resources more efficiently.

PS advised there were different approaches used by other Trusts, such as restricting beds, but EPUT was not in a position to do this.

EU commented that there was now a mechanism in place to review and reduce length of stay. EU advised he was a clinical director and was part of the ongoing

process to reduce length of stay in West Essex and that other clinical directors were working hard on the issue.

AS highlighted the Community First project and provided contact details for Governors who would like to be involved in the project.

LL advised that the average length of stay was regularly scrutinised at Board standing committee level.

Mental Health Act
PE commented that there was lack of knowledge of the Mental Health Act, the processes and the impact it has on services. HLD suggested having a future presentation or learning session on the impact of the Mental Health Act on services.

Future Plans
SC highlighted the number of changes that were likely to take place over the next 18 months and asked that any detail could be communicated to Governors to allow them to keep members informed. PS agreed to build this into future CEO reports.

Action:

1. **Provide a presentation or learning session to Governors for the process and impact of the Mental Health Act on services. (CJ)**

57/25 DATE AND TIME OF THE NEXT MEETING

19 November 2025 (13:45)

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Council of Governors Meeting
Action Log (following Part 1 meeting held on 9 October 2025)

Lead	Initials	Lead	Initials	Lead	Initials
Hattie Llewelyn-Davies	HLD	Nicky Reeves	NR		
Chris Jennings	CJ				

Requires immediate attention /overdue for action	
Action in progress within agreed timescale	
Action Completed	
Future Actions	

Minutes Ref	Action	Owner	Dead - line	Outcome	Status Comp/ Open	RAG rating
October 48/25	Provide further details of the impact of the RISE Programme once the detailed data analysis has been completed.	NR	Mar 2026		Open	
October 56/25	Provide a presentation or learning session to Governors for the process and impact of the Mental Health Act on services.	CJ	Mar 2026	This has been added to the Governor Learning Plan	Open	
December 66/24	Provide further updates regarding the Hydro Pool in West Essex for future Council meetings.	HLD	~~May 2025~~ ~~Sep 2025~~ Mar 2026	The Trust is currently commissioned to utilise the pool for 2.5 days per week and is not able to fund a further use of the pool beyond this. **19 March 2025:** Council of Governors agreed to extend the action until September 2025 to allow for any progress to be made. **9 October:** TS advised this had continued to be taken forward, highlighting the complexities relating to the commissioning of its use and the property and it's	Open	

Minutes Ref	Action	Owner	Dead - line	Outcome	Status Comp/ Open	RAG rating
				landlords who are NHS Property Services. Partner organisations had been contacted to potentially utilise the pool. **5 November:** Meeting held with Governors and further update provided, including further details of plans and challenges currently faced. The Governors agreed to reconvene in 3-months to consider the further action taken.		

SUMMARY REPORT	COUNCIL OF GOVERNORS PART 1	19 November 2025

Report Title:	**Report from the Chair**					
Executive/ Non-Executive Lead:	Professor Hattie Llewelyn-Davies, Chair					
Report Author(s):	Angela Laverick, PA to Chair, CEO and NEDs					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
This report provides the Council of Governors an update report from the Chair of the Trust in support of Governors holding the Non-Executive Directors to account both individually and collectively for the performance of the Board.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Council of Governors is asked to:

1 Note the contents of the report

Summary of Key Issues

The report provides an overview of the Chair's and Board related activities since the last report to the Council of Governors.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	
Data quality issues	
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	
Service impact/health improvement gains	
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**	
Governance implications	
Impact on patient safety/quality	
Impact on equality and diversity	

Equality Impact Assessment (EIA) Completed	~~YES~~/NO	If YES, EIA Score	

Impact on Statutory Duties and Responsibilities of Council of Governors	
Holding the NEDs to account for the performance of the Trust	✓
Representing the interests of Members and of the public	
Appointing and, if appropriate, removing the Chair	
Appointing and, if appropriate, removing the other NEDs	
Deciding the remuneration and allowances and other terms of conditions of office of the Chair and the other NEDs	
Approving (or not) any new appointment of a CEO	
Appointing and, if appropriate, removing the Trust's auditor	
Receiving Trust's annual accounts, any report of the auditor on them, and annual report	
Approving "significant transactions"	
Approving applications by the Trust to enter into a merger, acquisition, separation, dissolution	
Deciding whether the Trust's non-NHS work would significantly interfere with its principal purpose or performing its other functions	
Approving amendments to the Trust's Constitution	
Another non-statutory responsibility of the Council of Governors (please detail):	

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Report from the Chair

Lead

Hattie Llewelyn-Davies.

Hattie Llewelyn-Davies
Chair

REPORT FROM THE CHAIR

1.0 PURPOSE OF REPORT

This report provides the Council of Governors an update report from the Chair of the Trust in support of Governors holding the Non-Executive Directors to account both individually and collectively for the performance of the Board.

2.0 A NEW STYLE

Following on from the lead provided by Stuart in his Lead Governors Report to the last meeting, I am trialling a new approach to my report to you and would be grateful for feedback and observations.

The aim is to maintain the accountability to you for what the NEDs are doing, but to make it more interesting and to cover the issues that we and the Board more generally are involved with at the moment.

This time the report is just being written by me, but I hope that in future my fellow NEDs will write bits to add into the report, as they have items they want to share with you.

3.0 WHAT HAVE I BEEN DOING SINCE I BECAME THE TRUST CHAIR?

3.1 Locally

I have been visiting our venues all over Essex to get an idea of the services we provide and to meet our EPUT colleagues. I have really enjoyed meeting my new colleagues, they have been really open with me about their pride, fears and frustrations. I have seen the impact of the Lampard Inquiry on our colleagues.

Some of our venues look great and have benefitted from the investment that has been made in them over the last few years. Sometimes they look like old buildings, no longer really adequate for the provision of a modern service, despite everyone's efforts to keep them looking as nice as they can do. Sometimes they desperately need more investment or a complete redesign.

I have also been meeting our Essex partner organisations, learning and understanding the services they provide and the challenges they face. It is a period of massive change both in the NHS but also in local government, which makes the services we provide even more essential, despite the environment being tough. The pattern of provision both for mental health services and our community services is incredibly complex and hard to understand, both for us as the service providers but most important for our service users. Hopefully, the decision to move to one Integrated Care Board (ICB) across the whole of Essex will help us to simplify this pattern of services over time.

3.2 The Lampard Inquiry

The Inquiry has just completed its hearings for October. On each day, that the Inquiry was sitting we had at least one NED and Denver Greenhalgh (or sometimes someone from her team) present to hear the evidence from the families about their loved ones. Stuart Scrivenor also attended on one of the days, so he had a greater understanding of how it all works.

Each session has been moving to hear, and I know makes all of us determined to learn lessons and provide better safer, more effective services. Each day is conducted in a very calm and respectful manner, which allows everyone to learn lessons.

We are continuing to provide significant amounts of written evidence to the Inquiry as it progresses, which is time consuming and puts significant strain on the organisation, and I want to acknowledge the tremendous amount of work which is going on in the background.

So far, Paul Scott, Dr Milind Karale and Zephan Trent have all given evidence to the Inquiry in person. At present, we do not know who else will be called to given evidence in future sets of hearings.

We have stepped up our support for all staff and volunteers who are affected by the Inquiry.

The Inquiry records on video each day's evidence and they are available for anyone to watch via the Inquiry Website.

3.3 The Board's Work

Alongside all the normal governance, accountability and strategic management the Board does, we have also been updating the Corporate Plan, which will be published shortly.

The audited accounts and annual report have been published, and we are ready for our Annual General Meeting which will be held at 5:30pm, 26 November 2025 at Anglia Ruskin University. It would be great to see as many people as possible attend.

We have welcomed Richard Spencer, Sarah Teather and Doug Field to the Board and have at our last meeting welcomed Dr Kallur Suresh as our Interim Medical Director, following Dr Milind Karale's standing down from the Board of Directors.

We have also been working to develop a new community Mental Health strategy as some of the Governors were able to learn about at the joint session on 5 November.

I was proud to be able to be present at two wider events:

The Joint Conference with Anglia Ruskin University and EPUT called **Celebrating Partnership,** demonstrating the key relationship with have the university and the joint work we do with them.

The Co-Production Conference, again, showing our commitment to working in partnership, but this time with our service users, our experts by experience and Lived ambassadors.

4.0 CONCLUSION

I would value feedback on whether this approach is helpful in keeping the governors up to date with what the NEDs have been doing and more widely the issues that are at the top of the agenda for the Trust at the moment.

5.0 RECOMMENDATIONS AND ACTION REQUIRED

The Council of Governors is asked to:

1. Note the content of this report.

Report prepared by
Angela Laverick
PA to Chair, Chief Executive and NEDs

On behalf of
Hattie Llewelyn-Davies
Chair

SUMMARY REPORT	COUNCIL OF GOVERNORS PART 1	19 November 2025

Report Title:	**Chief Executive Officer (CEO) Report**					
Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Angela Laverick, PA to the Chair, Chief Executive & Non-Executive Directors					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
This report provides a summary of key activities and information to be shared with the Council of Governors.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Council of Governors is asked to:

1. Note the contents of the report

Summary of Key Points

The report attached provides information on behalf of the CEO and Executive Team in respect of performance, strategic developments and operational initiatives.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	
Data quality issues	
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	
Service impact/health improvement gains	
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**	
Governance implications	

Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**~~YES~~/NO**	**If YES, EIA Score**	

Impact on Statutory Duties and Responsibilities of Council of Governors	
Holding the NEDs to account for the performance of the Trust	✓
Representing the interests of Members and of the public	
Appointing and, if appropriate, removing the Chair	
Appointing and, if appropriate, removing the other NEDs	
Deciding the remuneration and allowances and other terms of conditions of office of the Chair and the other NEDs	
Approving (or not) any new appointment of a CEO	
Appointing and, if appropriate, removing the Trust's auditor	
Receiving Trust's annual accounts, any report of the auditor on them, and annual report	
Approving "significant transactions"	
Approving applications by the Trust to enter into a merger, acquisition, separation, dissolution	
Deciding whether the Trust's non-NHS work would significantly interfere with its principal purpose or performing its other functions	
Approving amendments to the Trust's Constitution	
Another non-statutory responsibility of the Council of Governors (please detail):	

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices
Chief Executive Officer (CEO) Report

Non-Executive Lead:

Paul Scott,
Chief Executive Officer

Council of Governors Part 1
November 2025

CHIEF EXECUTIVE OFFICER REPORT

1. UPDATES

1.1 Interim Chief Medical Officer Appointment

Following the announcement of Dr Milind Karale's decision to step down from his role as Medical Director at Essex Partnership University NHS Foundation Trust (EPUT) in December 2025, the Trust has initiated a formal recruitment process to appoint a substantive successor. In the interim, Dr Kallur Suresh has been appointed as Interim Chief Medical Officer, effective from 1 December 2025, following a robust internal selection process. We extend our gratitude to Dr Karale for his dedicated service and welcome Dr Suresh to his new role.

1.2 National Staff Survey

The National Staff Survey remains open until 28 November 2025. The Executive Team recognises the critical importance of listening to staff and ensuring their voices shape the future of our organisation. As of this report, over 40% of colleagues have completed the survey. To further encourage participation and engagement, members of the senior leadership team are undertaking more than 30 site visits across the Trust. These visits provide opportunities to discuss the survey, answer questions, and reinforce our commitment to continuous improvement informed by staff feedback.

1.3 Sophia Platform for Policies and SOPS

The Trust has transitioned to SOPHIA as the sole platform for accessing clinical and operational documents, including policies, guidelines, and standard operating procedures (SOPs). This move supports the delivery of safe, effective, and consistent care by ensuring all staff have access to the most up-to-date information in a single, centralised location. Virtual demonstrations and training sessions have been organised to support staff in navigating the platform and addressing any queries. This initiative marks a significant step forward in enhancing document governance and patient safety.

1.4 Lampard Inquiry

The October 2025 public hearings of the Lampard Inquiry concluded on 28 October, having heard further testimony from bereaved families regarding the care, treatment, and deaths of their loved ones. Key themes emerging from the hearings included the integration of physical and mental health care, the management of substance misuse, the care of older patients, and the use of patient monitoring systems.

The Inquiry has announced additional hearings scheduled for October 2026, which will focus on illustrative cases aligned with these themes. Support continues to be available for staff through the Here For You Team and the EPUT Inquiry Project Team. All colleagues are encouraged to engage with the Inquiry, particularly if they believe they hold relevant information, and to respond directly if contacted.

SUMMARY REPORT	COUNCIL OF GOVERNORS PART 1	19 November 2025

Report Title:	**External Audit Contract**					
Executive Lead:	Elena Lokteva, Chair of the Audit Committee Trevor Smith, Executive Chief Finance Officer					
Report Author(s):	Clare Barley, Head of Financial Accounts Megan Booth, Interim Head of Procurement					
Report discussed previously at:	Audit Committee (07/11/2025)					
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	

Purpose of the Report

Following discussions at the November Audit Committee, this paper updates the Council of Governors on the launch of a procurement exercise for the provision of external audit services for 2025/26 audit onwards. As responsibility for appointment of external audit services lies with the Council of Governors the paper requests input into both the procurement and award process.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Council of Governors is asked to:

1. Note the contents of the report
2. Note the request for inclusion of two Governors in the evaluation process
3. Confirm interest in being part of Evaluation Panel to the Trust Secretary's Office by 26 November 2025, noting the time commitments detailed in appendix 1.
4. Support the exercise by convening an extraordinary Governor meeting on 15 January 2026.

Summary of Key Points

The 2024/25 audit undertaken by Ernst and Young represented the third year of a three-year contract (with option to extend by two 12-month periods). Following discussions and a review of all audit service provisions (including Internal Audit and Counter Fraud), coupled with a natural contractual break in the external audit contract, it is timely to explore the market to ensure best value for money and quality of service is being achieved by the Trust.

At the November Audit Committee, a detailed paper on all aspects of the procurement exercise was discussed. The Committee approved the launch of a procurement process for external audit services via the East of England procurement hub. The Committee recognised risks associated with the exercise, in particular nationally there continues to be low response rates to such tenders and locally it was recognised that the process could involve mobilisation of a new supplier ahead of the 2025/26 audit. The Trust has endeavoured to minimise this risk by allowing suppliers a window of four weeks to return bids, and a proposed weighting of 30% price and 70% technical / quality. It is proposed that the contract be for an initial two-year period, with option to extend by two 12-month periods.

The timetable includes a launch date of 14th November and a tender return date of 11th December 2026. An Evaluation Panel will be established consisting of Audit Committee members (including the Chair of the Committee), the Executive Chief Finance Officer and / or Director of Finance, Executive Director of Governance, Head of Financial Accounts and two Governors. Governors are asked to express their interest in participating in the process to the Trust Secretary's Office by 26th November noting the time commitments detailed within the timetable (appendix 1). The Evaluation Panel and process will be supported by the Head of Procurement.

The technical / quality evaluation will be based on written responses, and a short presentation to the Evaluation Panel. Proposed questions are attached at appendix 2. Following the presentation from suppliers, the Evaluation Panel will identify the preferred supplier, with the Audit Committee making a recommendation to an extraordinary meeting of the Council of Governors on 15 January. Due to the short turnaround between the Audit Committee and Council of Governors meetings, the recommendation paper to Council of Governors will be circulated on 13 January ahead of meeting on the 15 January. Subject to

Council of Governor approval, financial approval will then be sought from the Executive Operational Committee and / or Finance and Performance Committee subject to contract value.

Subject to the above, it is anticipated that the implementation phase of the new contract could commence from mid-February 2026. In the event that nil returns are received, the Trust options could be a direct award to a supplier under an Accredited Framework or extend the current contract with Ernst and Young albeit noting both options may be influenced by responses to the procurement exercise. NHS England have been advised of this process noting that in cases where no external auditors are in place NHS England do assist in assignment.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	
SO2: We will enable each other to be the best that we can	
SO3: We will work together with our partners to make our services better	
SO4: We will help our communities to thrive	

Which of the Trust Values are Being Delivered	
1: We care	
2: We learn	
3: We empower	

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			✓
Governance implications			✓
Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**YES/NO**	**If YES, EIA Score**	

Impact on Statutory Duties and Responsibilities of Council of Governors	
Holding the NEDs to account for the performance of the Trust	
Representing the interests of Members and of the public	
Appointing and, if appropriate, removing the Chair	
Appointing and, if appropriate, removing the other NEDs	
Deciding the remuneration and allowances and other terms of conditions of office of the Chair and the other NEDs	
Approving (or not) any new appointment of a CEO	
Appointing and, if appropriate, removing the Trust's auditor	✓
Receiving Trust's annual accounts, any report of the auditor on them, and annual report	
Approving "significant transactions"	
Approving applications by the Trust to enter into a merger, acquisition, separation, dissolution	
Deciding whether the Trust's non-NHS work would significantly interfere with its principal purpose or performing its other functions	
Approving amendments to the Trust's Constitution	
Another non-statutory responsibility of the Council of Governors (please detail):	

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices

Appendix 1 – Timetable
Appendix 2 – Evaluation Criteria and Weighting

Non-Executive Lead:

Elena Lokteva
Chair of Audit Committee / Non-Executive Director

Trevor Smith
Executive Chief Finance Officer

Appendix 1

TIMETABLE

	Deadline
Audit Committee considered and approved procurement process for external audit services, including agreeing evaluation criteria and weightings	7 November 2025
EoE Procurement Hub issue documentation to the framework suppliers	14 November 2025
Update paper to be presented to the Council of Governors meeting	**19 November 2025**
Trust Secretary's Office to confirm which two Governors will join the Evaluation Panel	**26 November 2025**
Seek delegated authority from Board to allow Finance and Performance Committee to approve awarding of contract to successful bidder in event that contract value exceeds £1m (and contract is therefore not able to be approved by delegated authority of CEO and ECFO)	3 December 2025
Suppliers to return documentation to Procurement Hub	11 December 2025
Evaluation Panel members individually review, evaluate and score quality aspects of the documentation and return scores to Megan Booth, Interim Head of Procurement.	**6 January 2026 – by 9am**
Evaluation Panel to meet to agree combined score for written responses.	**7 January 2026 at 12pm till 2pm**
Commercial evaluation to be undertaken	8 January 2026
Suppliers to make presentation to members of the Evaluation Panel	**9 January 2026 (all day)**
Extraordinary meeting of the Audit Committee to agree preferred supplier to be recommended for approval to the Council of Governors	12 January 2026 at 2pm
Recommendation paper to be presented to extraordinary meeting of Council of Governors for approval by Chair of Audit Committee / Executive Chief Finance Officer	**15 January 2026 at 1pm**
Paper to be presented to EOC for approval if contract value is less than £1m or noting of contract value and recommending to Finance and Performance Committee for approval	20 January 2026
Paper to be presented to Finance & Performance Committee for information and approval of contract value (subject to approval limits and / or delegated authority from Board of Directors)	22 January 2026
Advise bidders of outcome and 10 day standstill period to commence	22 January 2026
Implementation Phase (subject to no delays with above)	10 February 2026

Appendix 2

QUALITY CRITERIA AND WEIGHTING

		Weighting	Via
SERVICE DELIVERY			
1	Please detail your audit strategy and planning process in respect of the Trust's financial audit, demonstrating your understanding of the system and environment the Trust is working within, and any identified risks you envisage the Trust may face. This should include an understanding of audit approach to the Lampard Inquiry including associated accounting policies and standards. Please also detail your approach to undertaking an independent examination of the Trust's charity accounts. *(Time: 15 minutes)*	10%	Presentation
2	Please provide a brief biography of the personnel who will deliver the services, including their experience of working with NHS Foundation Trusts. Please outline how you can assure the Trust that you can provide continuity of services and staff over the contract period. *(Maximum word count: 750)*	10%	Written response
3	Please describe your experience of managing and resolving major issues arising on an audit in order to ensure a fully completed audit report is received by the Trust's Audit Committee against both the Trusts and national timetable. *(Maximum word count: 750)*	10%	Written response
4	Please explain how you would work with an outgoing or incoming auditor to ensure there is a robust transfer of knowledge during any handover period. In addition, please explain how you would work with the Trust in order to ensure a robust interim audit / knowledge sharing is in place ahead of audit commencement date. *(Maximum word count: 750)*	10%	Written response
5	Please provide details of any training programme you could offer to members of the Audit Committee and any areas of innovation where you could add value to the Trust. Please indicate if included in the audit fee or an additional charge. *(Maximum word count: 500)*	5%	Written response
6	<u>Tackling climate change – your organisational position, actions, achievements and way forward</u> Please provide details of the steps your organisation has taken to reduce its climate change impact. These might include the following sequential activities:	5%	Written response

	• Calculation of current direct and indirect carbon emissions (baseline). • Carbon reduction targets and timeline. • Methodology/process for monitoring and reporting success. • Actions completed to date and carbon savings achieved. • Forward plan to realise targets and timeline. Responses will be scored against: understanding/calculation of baselines, ambition of targets, actions to date, demonstrable achievement and forward planning *(Maximum word count: 500)*		
6b	<u>Reducing Carbon and Waste footprints: Improvement</u> Please commit to working collaboratively with EPUT on the steps that should and will be taken to reduce the carbon and waste footprints of the specified service throughout the contract period. Please provide details/proposals of how this will be achieved. Responses will be scored against: the extent of commitment expressed, and the details provided as to how this will be realised. *(Maximum word count: 500)*	5%	Written response
CONFLICTS			
7	Please confirm the lack of, or potential for, any Conflict of Interest; specifically relationships with the Directors and / or staff of the Trust. Where conflicts do or may exist, please provide details of the arrangements you have or will have in place to deal with the Conflict of the Interest. *(Maximum word count: 500)*	5%	Written response
QUALITY ASSURANCE AND REPORTING			
8	Please provide details of quality assurance for this external audit service, and how lessons learned can be acted on in order to negate further occurrences. *(Maximum word count: 500)*	5%	Written response
LIAISON WITH OTHER BODIES			
10	Please demonstrate how you intend to work with other auditors and external bodies and how the Trust will be kept up to date and informed. Please include how you will work to maximise the total resources available and avoid any unnecessary duplication of work, for example taking into account internal audit outputs in order to reduce duplication of effort which in turn will have a positive impact on the costs associated with delivering external audit services. *(Maximum word count: 500)*	5%	Written response
		70%	

SUMMARY REPORT	COUNCIL OF GOVERNORS PART 1	19 November 2025

Report Title:	**Standing Orders for the Council of Governors**					
Report Lead:	Chris Jennings, Assistant Trust Secretary					
Report Author(s):	Chris Jennings, Assistant Trust Secretary					
Report discussed previously at:	CoG Governance Committee					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
This report provides the Standing Orders For The Council Of Governors for the required annual review.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Council of Governors is asked to:

1 Note the contents of this report.

2 Approve the reviewed Standing Orders For The Council Of Governors for onwards approval by the Board of Directors.

Summary of Key Issues

The Standing Orders (SOs) For The Council Of Governors are required to be reviewed annually. The Council of Governors is required to approve these SOs.

The review of the Standing Orders was completed by the Assistant Trust Secretary. The review identified minor amendments to references caused by the transfer of the document into a new template.

The reviewed Standing Orders were circulated to the Council of Governors Governance Committee for consultation.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	
SO4: We will help our communities to thrive	

Which of the Trust Values are Being Delivered	
1: We care	
2: We learn	
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	
Data quality issues	
Involvement of Service Users/Health watch	
Communication and consultation with stakeholders required	
Service impact/health improvement gains	
Financial implications: **Capital £** **Revenue £**	

		Non Recurrent £	
Governance implications			✓
Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**YES/NO**	**If YES, EIA Score**	

Impact on Statutory Duties and Responsibilities of Council of Governors	
Holding the NEDs to account for the performance of the Trust	
Representing the interests of Members and of the public	
Appointing and, if appropriate, removing the Chair	
Appointing and, if appropriate, removing the other NEDs	
Deciding the remuneration and allowances and other terms of conditions of office of the Chair and the other NEDs	
Approving (or not) any new appointment of a CEO	
Appointing and, if appropriate, removing the Trust's auditor	
Receiving Trust's annual accounts, any report of the auditor on them, and annual report	
Approving "significant transactions"	
Approving applications by the Trust to enter into a merger, acquisition, separation, dissolution	
Deciding whether the Trust's non-NHS work would significantly interfere with its principal purpose or performing its other functions	
Approving amendments to the Trust's Constitution	
Another non-statutory responsibility of the Council of Governors (please detail): • Standing Orders for the Council of Governors	✓

Acronyms/Terms Used in the Report			
CoG	Council of Governors		

Supporting Documents and/or Further Reading
Standing Orders For The Council Of Governors

Lead
Chris Jennings **Assistant Trust Secretary**

Essex Partnership University NHS Foundation Trust

Document title:	**STANDING ORDERS FOR THE PRACTICE AND PROCEDURES OF THE COUNCIL OF GOVERNORS**		
Document reference number:	TB02	**Version number:**	sV 3.0
Document type: (Policy/ Guideline/ SOP)	Policy	**To be followed by:** (Target Staff)	All Staff
Author:	Chris Jennings, Assistant Trust Secretary		
Approval group/ committee(s):	Board of Directors Council of Governors CoG Governance Committee		
Professionally approved by: (Director)	Denver Greenhalgh, Senior Director of Corporate Governance		
Executive Director:	Denver Greenhalgh, Senior Director of Corporate Governance		
Ratification group(s):	Council of Governors Board of Directors		03 December 2025
CQC Quality Statement	Well – Led Governance		
Key word(s) to search for document on Intranet / TAGs:	Standing Orders	**Distribution method:**	☒Intranet

Initial issue date:	03 April 2017	**Last Review date:**	03 December 2025	**Next Review date:**	31 December 2026	**Expiry Date:**	01 January 2027

What we do together matters

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Related Trust documents (to be read in conjunction with)
Trust Constitution

Document review history:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/ record documents superseded by:**	**Issue date:**
001	Trust Secretary	Minor – Reflects New Constitution	01 April 2017
003	Trust Secretary	Recommendations by Legal Advisor following review of Trust Constitution	01 September 2019
004	Trust Secretary	Updated to include references to digital working and virtual meetings. Updated sections relating to Conflict of Interest to reflect national guidance.	23 September 2020
5.0	Trust Secretary	Section 3.5.3: Amended to provide Governors to consider contacting the Lead Governor prior to contacting Monitor (NHSE/I) directly. Section 3.7.3: Amended to provide action to be taken if a Governor vacancy cannot be filled. Section 14.7.3: Amended to clarify the formal location of a meeting when held completely virtually.	01 September 2021
5.1	Trust Secretary	Section 3.5.3: Amended to provide Governors to consider contacting the Lead Governor prior to contacting Monitor (NHSE/I) directly. Section 3.7.3: Amended to provide action to be taken if a Governor vacancy cannot be filled. Section 14.7.3: Amended to clarify the formal location of a meeting when held completely virtually.	01 September 2021
6.0	Trust Secretary's Office	Minor Amendments	27 September 2023
6.1	Trust Secretary's Office	Extension for review granted until January 2025	01 March 2024
7.0	Trust Secretary's Office	Transferred to New Template Minor Amendments	02 October 2024
sV 1.0	Policy Team	Uploaded to SOPHIA document library	21 March 2025
sV 2.0	Policy Team	Extension PORG approved until end of December	08 October 2025
SV3.0	Trust Secretary's Office	Amendments to references to reflect layout changes caused by the transfer of the document into a new template.	03 December 2025

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Contents

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

1 Introduction

1.1 Essex Partnership University NHS Foundation Trust (the Trust) is a public benefit corporation. It was established on 1st April 2017, following the grant of an application pursuant to Section 56 of the National Health Service Act 2006 (the 2006 Act), by Monitor (now part of NHS England).

The functions of the Trust are conferred by this legislation and the Trust will exercise its functions in accordance with the terms of its provider licence (no: 120163) and all relevant legislation and guidance.

These standing orders add clarity and detail where appropriate. Nothing in these standing orders shall override the Trust's constitution, the National Health Service Act 2006, the Health & Social Care Act 2012 and the Health and Care Act 2022.

The Trust's standing orders and wider governance arrangements are further supported by various policies and procedures.

The principal place of business of the Trust is The Lodge, Lodge Approach, Wickford, Essex SS11 7XX.

2 Interpretation

2.1 Unless otherwise permitted by law, at any meeting of the Council of Governors the Chair of the Trust shall be the final authority on the interpretation of these standing orders (on which they should be advised by the Trust Secretary).

2.2 Any expression to which a meaning is given in the National Health Service Act 2006 or regulations made under it shall have the same meaning in these standing orders and in addition:

2.2.1 **2006 Act** means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

2.2.2 **2012 Act** means the Health & Social Care Act 2012.

2.2.3 **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

2.2.4 **Board of Directors** or **Board** or **Board Member** or **Member of the Board** means the Chair, Executive and Non-Executive Directors of the Trust collectively as a body in accordance with the constitution. This term is used interchangeably with the term **Director**.

2.2.5 **Chair of the Board** or **Chair of the Trust** means the person appointed under paragraph 28 of the constitution by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the

Vice-Chair of the Trust if the Chair is absent from a meeting or is otherwise unavailable or such other Non Executive Director as may be appointed as acting Chair in accordance with these SO.

2.2.6 **Chief Executive** is the person appointed as the Chief Executive Officer (the Accounting Officer) of the Trust under paragraph 31 of the constitution.

2.2.7 **Committee** means a committee appointed by the Council of Governors.

2.2.8 **Committee members** means persons formally appointed by the Council of Governors to sit on or to chair specific committees.

2.2.9 **Constitution** means the Trust's constitution which has effect in accordance with Section 56(11) of the 2006 Act.

2.2.10 **Council of Governors** or **Council** means the Council of Governors of the Trust as described in paragraphs 14 and 18 of the constitution.

2.2.11 **Directors** means the Executive and Non-Executive members of the Board of Directors.

2.2.12 **Executive Director** means a member of the Board of Directors, including the Chief Executive, appointed under paragraph 31 of the constitution.

2.2.13 **Lead Governor** is the person appointed by the Council of Governors in accordance with the *Code of Governance for NHS Provicers (May 2022).*

2.2.14 **Licence** means the Trust's provider licence (no: 120163) issued by NHS England (Monitor) on 1st April 2017.

2.2.15 **Motion** means a formal proposition to be discussed and voted on during the course of a meeting.

2.2.16 **Non-Executive Director** means a member of the Board of Directors, including the Chair, appointed by the Council of Governors under paragraph 28 of the constitution.

2.2.17 **SOs** mean these Standing Orders (for the Council of Governors).

2.2.18 **Trust** means Essex Partnership University NHS Foundation Trust.

2.2.19 **Trust Secretary** means a person appointed by the Chair and Chief Executive as the Trust Secretary.

2.2.20 **Vice-Chair** means the Non-Executive Director appointed under paragraph 30 of the constitution.

2.2.21 **Working days** a day that is not a Saturday or Sunday, Christmas Day, Good Friday or any day that is a bank holiday.

2.3 Words importing the plural shall import the singular and vice-versa.

2.4 Any reference to an Act shall, where appropriate, include any Act amending or consolidating that Act and any regulation or order made under any such Act.

3 Council of Governors Roles and Responsibilities

3.1 The purpose of these SOs is to ensure that the highest standards of corporate governance and conduct are applied to all Council meetings and associated deliberations.

3.2 The roles and responsibilities of the Council which are to be carried out in accordance with the Trust's constitution, license and the Code of Conduct for NHS Provider Trusts (February 2023) (and any subsequent versions) are:

3.3 **General Duties**

3.3.1 To hold the Non-Executive Directors individually and collectively to account for the performance of the Board, including ensuring that the Board acts so that the Trust does not breach the terms of its licence. "Holding the Non-Executive Directors to account" includes scrutinising how well the Board is working, challenging the Board in respect of its effectiveness, and asking the Board to demonstrate that it has sufficient quality assurance in respect of the overall performance of the Trust, questioning Non-Executive Directors about the performance of the Board and of the Trust and making sure to represent the interests of the Trust's members and of the public in doing so.

3.3.2 To represent the interests of the members of the Trust and the interests of the public.

3.4 **Chair and Non-Executive Directors**

3.4.1 To approve the policies and procedures for the appointment and removal of the Chair and/or Non-Executive Directors in accordance with any guidance issued by NHS England and on the recommendation of the Council's Nominations Committee.

3.4.2 To appoint and remove the Chair and other Non-Executive Directors. The Council should only exercise its power to remove the Chair or any other Non-Executive Directors after exhausting all means of engagement with the Board.

3.4.3 To approve the policies and procedures for the appraisal of the Chair and Non-Executive Directors on the recommendation of the Council's Remuneration Committee. The performance of Non-Executive Directors should be subject to regular appraisal and review. All Non-Executive Directors should be submitted for re-appointment at regular intervals. The Council should ensure planned and progressive refreshing of the Non-Executive Directors.

3.4.4 To decide the remuneration, allowances and other terms of office for the Chair and Non-Executive Directors having regard to the recommendations of the Council's Remuneration Committee. Professional advisers should be consulted to market test the remuneration levels of the Chair and other Non-Executives Directors at least once

every three years and when there is a material change to the remuneration of the Chair or another Non-Executive Director.

3.5 **Chief Executive**

3.5.1 To approve the appointment of the Chief Executive of the Trust.

3.6 **Auditors**

3.6.1 To approve the criteria for the appointment, removal and re-appointment of the auditor.

3.6.2 To appoint, remove and reappoint the auditor having regard to the recommendation of the Trust's Audit Committee.

3.7 **Strategy Planning**

3.7.1 To provide feedback to the Board on the development of the strategic direction of the Trust, as appropriate.

3.7.2 To collaborate with the Board in the development of the Trust's forward plan.

3.7.3 Where the forward plan contains a proposal that the Trust will carry out activities other than the provision of goods and services for the purpose of the NHS in England, to determine whether it is satisfied that the carrying out of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and notify its determination to the Board.

3.7.4 Where the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purpose of the NHS in England, approve such a proposal.

3.7.5 To approve entering into any significant transactions (as defined under paragraph 49 and Annex 9 of the constitution) in accordance with the 2006 Act and the constitution.

3.7.6 When appropriate, to make recommendations for the revision of the constitution and approve any amendments to the constitution in accordance with the 2006 Act and the constitution.

3.7.7 To receive the Trust's annual accounts, any report of the auditor on them, and the annual report at a general meeting of the Council.

3.8 **Representing Members and the Public**

3.8.1 To prepare and from time to time review the Trust's membership engagement strategy and policy.

3.8.2 To notify NHS England, via the Lead Governor, if the Council is concerned that the Trust is at risk of breaching the terms of its licence, and if these concerns cannot be resolved at local level.

3.8.3 To report to the members annually on the performance of the Council.

3.8.4 To promote membership of the Trust and contribute to opportunities to recruit and engage members in accordance with the membership strategy.

3.8.5 To seek the views of stakeholders and feedback to the Board.

3.8.6 All business shall be conducted in the name of the Trust.

4 The Council of Governors

4.1 Composition of the Council

The composition of the Council shall be in accordance with paragraph 14 of the constitution.

4.2 Appointment of the Chair

The Chair is appointed by the Council as set out in paragraph 28 of the constitution.

4.3 Terms of Office of the Chair

The provisions governing the period of tenure of office of the Chair are set out in Board of Directors SO 2.8.

4.4 Role of the Chair

4.4.1 The Chair is not a member of the Council. However, under the regulatory framework, they preside at meetings of the Council and holds a second or casting vote.

4.4.2 Where the Chair has died or has ceased to hold office, or where they are unable to perform their duties as Chair owing to illness or any other cause, and there will be an absence of a Chair for less than 3 months the Vice-Chair of the Board shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these SOs shall, so long as there is no Chair able to perform their duties, be taken to include references to the Vice-Chair.

4.4.3 Where an absence of the Chair has or will exceed a period of 3 months the Council at a general meeting shall appoint one of the Non-Executive Directors as the acting Chair. Before a resolution for such an appointment is passed, the Board shall be entitled to advise the Council of the Non-Executive Director (who may be the Vice-Chair) who is recommended by the Board of Directors for that appointment. This recommendation will not, however, be binding upon the Council of Governors; it will be presented to the Council of Governors at its meeting before it comes to its decision. The Vice Chair shall act as Chair until an appointment of an acting Chair is made by the Council.

4.5 Role of the Lead Governor

4.5.1 The Lead Governor shall be appointed by the Council.

4.5.2 The Lead Governor will facilitate communication between NHS England and the Council where Governors have concerns about the leadership provided to the Trust

by the Board or in circumstances where it would be inappropriate for the Chair to contact NHS England, or vice versa (for example, regarding concerns about the appointment or removal of the Chair).

4.5.3 Having a Lead Governor does not prevent any other Governor from making contact with NHS England directly if they feel this is necessary. However, any Governor should consider contacting the Lead Governor prior to contact with NHS England. For the avoidance of doubt, a person holding the role of Lead Governor shall not assume greater power or responsibility than other Governors. Where the Trust chooses to broaden the Lead Governor's role, the Chair and the Council should agree what powers should be included.

4.6 Termination of Office and Removal of Governors

4.7 Paragraphs 16, 17 and Annex 6 paragraph 5 of the constitution sets out the period of tenure of office of Governors and provisions relating to the termination or suspension of office of Governors.

4.8 Vacancies amongst Governors

4.8.1 Where a vacancy arises amongst the appointed Governors, the Trust Secretary shall request that the appointing organisation appoints a replacement.

4.8.2 Where a vacancy arises amongst the elected Governors within the first 24-months of their term of office, the Trust Secretary shall offer the next highest polling candidate in the election for that post the opportunity to assume the vacant office for the unexpired balance of the retiring member's term of office. If that candidate does not wish to fill the vacancy, it will then be offered to the next highest polling candidate and so on until the vacancy is filled.

4.8.3 Where the vacancy cannot be filled, consideration will be given for holding a by-election, based on cost of the election and the proximity of any by-election to other elections to the Council of Governors.

4.9 Appointment and Powers of Vice-Chair

4.9.1 The Council at a general meeting shall appoint one of the Non-Executive Directors as a Vice-Chair in accordance with paragraph 30.1 of the constitution and, in similar manner, shall remove any person so appointed from that position and appoint another Non-Executive Director in their place.

4.9.2 In line with paragraph 30.2 of the constitution, before a resolution for any such appointment is passed, the Board may decide which of the Non-Executive Directors it recommends for that appointment; the Chair shall advise the Council of the recommendation from the Board which will not be binding upon the Council but will be presented to the Council at its meeting before it comes to a decision.

4.9.3 Subject to SO 3.4.2 and SO 3.4.4 in the absence of the Chair, the Vice-Chair shall be the acting Chair of the Trust.

4.9.4 Any Non-Executive Director so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Council may then appoint another Vice-Chair in accordance with paragraph 30.1 of the constitution and SO 3.8.

5 Meetings of the Council

5.1 Subject to SOs 4.2.1 and 4.2.2 below and any other provisions of these SOs, the Council may only exercise any powers and make decisions when in formal session. The Council may be advised by committees appointed by the Council but may not devolve any decision making powers to these committees, which, for the avoidance of doubt, shall operate as working groups of the Council.

5.2 Admission of the Public and the Press

5.2.1 The meetings of the Council shall be open to members of the public and the press.

5.2.2 Members of the public and the press may be excluded from a meeting for special reasons. Special reasons include for reasons of commercial confidentiality. The Council will resolve that:

"In accordance with paragraph 34.1 of the constitution and paragraph 13(2) of Schedule 7 of the 2006 Act, the Council of Governors resolves that there are special reasons to exclude members of the public from Part 2 of this meeting having regard to commercial sensitivity and/or confidentiality and/or personal information and/or legal professional privilege in relation to the business to be discussed."

5.2.3 The Chair may exclude any person from a meeting of the Council if that person is interfering with or preventing the proper conduct of the meeting.

5.2.4 Nothing in these SOs shall require the Council to allow members of the public to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Council.

5.2.5 Matters discussed at a meeting following the exclusion of the public and representatives of the media shall be confidential to the Council and shall not be disclosed by any person attending the meeting without the consent of the Chair of the meeting.

5.2.6 All decisions taken in good faith at a meeting of the Council or of any committee shall be valid even if there is any vacancy in its membership or it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Governors attending the meeting.

5.3 Calling Meetings

5.3.1 Ordinary meetings of the Council shall be held at such times and places or via digital platforms as the Council may determine.

5.3.2 There shall be not less than four meetings in any year except in exceptional circumstances.

5.3.3 Meetings of the Council may be called by the Trust Secretary, or by the Chair. Not less than one-third of the Governors in office can requisition the Trust Secretary to call a meeting at any time by giving written notice to the Trust Secretary stating the business to be considered at the meeting.

5.4 Notice of Ordinary Meetings

5.4.1 The Trust Secretary shall give to all Governors at least 10 (ten) working days written notice of the date and place of every ordinary meeting of the Council.

5.4.2 Agendas will be sent to Governors not later than three (3) working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, save in the case of the need to conduct urgent business under a meeting called under paragraph 5.5.

5.4.3 A notice or other document(s) to be served upon a Governor under these SOs shall be delivered by hand or sent by post to the Governor at the place of residence which he shall have last notified to the Trust, or where sent by email, to the address which he shall have last notified to the Trust as the address to which a notice or other document may be sent by electronic means.

5.4.4 A notice or other document(s) where delivered by hand or sent by post shall be presumed to have been served on the next working day following the day it was sent and where it was sent by email at the time at which the email is sent.

5.4.5 Failure to serve notice and supporting papers on any Governor shall not affect the validity of an ordinary meeting.

5.4.6 Save in the case of urgent meetings, for each meeting of the Council a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's office and on the Trust's internet site for general access at least three working days before the meeting.

5.5 Notice of Urgent/Extraordinary Meetings

5.5.1 At the request of the Chair or not less than one-third of Governors, the Trust Secretary shall send written notice of a meeting to all Governors as soon as possible after receipt of such a request. The Trust Secretary shall give Governors as much notice of the meeting as is practicable in light of the urgency of the request.

5.5.2 If the Trust Secretary does not call a meeting of the Council of Governors within ten (10) working days of receiving a requisition from Governors pursuant to SO 5.5.1, the Governors who made the requisition may convene the meeting themselves by giving written notice to all Governors; this notice must be signed by all of the Governors who signed the requisition. A meeting called under this SO may only consider the business set out in the requisition.

5.5.3 In the case of a meeting called under SO 5.5.2, the notice shall be signed by the Chair or by at least one-third of Governors in office.

5.5.4 No business at a meeting called under SO 5.5.2 shall be transacted at that meeting other than that specified in the notice. Agendas will be sent to Council members three (3) working days before the meeting and supporting papers, shall accompany the agenda, save in the case of urgent meetings.

5.5.5 In the case of a meeting called under SOs 5.5.2 failure to serve such a notice on more than three (3) Governors will invalidate the meeting.

5.6 Setting the Agenda

5.6.1 The Council may determine that certain matters shall appear on every agenda for an ordinary meeting and shall be addressed prior to any other business being conducted.

5.6.2 A Governor desiring a matter to be included on an agenda shall make their request in writing to the Chair at least seven (7) working days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 (ten) working days before a meeting may be included on the agenda at the discretion of the Chair.

5.7 Motions

5.7.1 Notices of motion: A Governor desiring to move or amend a motion shall send a written notice thereof at least seven (7) working days before the meeting to the Chair who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This SO shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda.

5.7.2 Withdrawal of motion or amendment: A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

5.7.3 Motion to Rescind a Resolution: Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Governor who gives it and also the signature of four other Governors. Such notice shall be sent to the Chair at least 10 (ten) working days before the meeting, who shall insert it in the agenda for the meeting. When any such motion has been disposed of by the Council, no Governor may propose a motion to the same effect within six months. However, the Chair may do so if they consider it appropriate.

5.7.4 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

5.7.5 When a motion is under discussion or immediately prior to discussion, it shall be open to a Governor to move one of the following motions:

(a) an amendment to the motion
(b) the adjournment of the discussion or the meeting
(c) that the meeting proceed to the next business*
(d) the appointment of an ad hoc committee to deal with a specific item of business; or
(e) that the motion be now put*

Provided that in the case of sub-paragraphs denoted by * above and to ensure objectivity, motions may only be put by a Governor who has not previously taken part in the debate.

5.7.6 No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

5.8 **Petitions**

Where a petition has been received by the Trust not less than 10 (ten) working days before a meeting of the Council, the Chair of the Council shall include the petition as an item for the agenda of the next meeting of the Council.

5.9 **Chair of Meeting**

5.9.1 At any meeting of the Council the Chair, if present, shall preside. If the Chair is absent from the meeting, the Vice-Chair or another Non-Executive Director, if there is one present, shall preside.

5.9.2 If the Chair, Vice-Chair and all Non-Executive Directors are absent, the Lead Governor, if present, shall preside. If the Lead Governor is not present, such Governor to be appointed from amongst the Council present shall preside.

5.10 **Chair's Ruling**

Statements of Governors made at meetings of the Council shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

5.11 **Record of Attendance**

5.11.1 The names of the Chair and Governors present at a meeting shall be recorded in the minutes. Board Directors who attend a meeting will be recorded in the minutes as 'in attendance'.

5.11.2 Governors who are unable to attend a Council meeting should advise the Trust Secretary in advance of the meeting so that their apologies may be submitted.

5.11.3 A meeting of the Council refers to officers being physically present or officers being present via the use of technology, as defined in SO 5.17.

5.12 **Quorum**

5.12.1 The quorum for every meeting of the Council shall be one-third of the total number of Governors in office on the date of the meeting, a majority of whom must be Public Governors.

5.12.2 If at the time of the meeting no quorum is present:

(a) The Chair shall announce a 30 minute delay
(b) If after the delay a quorum is present, the meeting shall proceed
(c) If a quorum is not present after the delay, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such a time and place as the Chair shall determine and a notice of the adjourned meeting shall be circulated to Council members. When the meeting reconvenes, if a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of Governors present during the meeting is to be a quorum

5.12.3 Where during a meeting of Council a quorum is no longer present:

(a) The Chair shall announce a five (5) minute delay
(b) If after the delay there remains no quorum, the Council meeting shall be adjourned

5.12.4 Where the Council is adjourned under SO 5.12.3(b), the Trust Secretary shall list the uncompleted business from the meeting as the first items for consideration at the next following meeting of Council.

5.12.5 If a Governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest, they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

5.12.6 Governors may participate (and vote) in its meetings by telephone, teleconference, video or computer link in accordance with SO 5.17 below. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

5.13 **Voting and Decisions**

5.13.1 At the end of a discussion on business not subject to a decision, the Chair may summarise the view of the Council for recording in the minutes.

5.13.2 On any matter requiring a decision, Council shall determine its position by voting.

5.13.3 Subject to statutory or constitutional requirements, a decision of the Council is reached by a majority of Governors present and voting. Votes in abstention shall not be counted in determining a majority. In the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting

vote. No resolution can be passed if it is opposed by all of the Public Governors present and voting.

5.13.4 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

5.13.5 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands.

5.13.6 On the request of the one-third of the Governors present, a recorded vote shall be taken:

(a) The Trust Secretary will call the names of all Governors
(b) Each Governor shall declare their vote as 'In Favour', 'Against' or 'Abstain'
(c) The vote of each Governor shall be recorded in the minutes accordingly

5.13.7 On the request of the majority of Governors present at the meeting, a vote may be taken by secret ballot:

(a) Each Governor shall be issued with a ballot paper allowing a vote of 'In Favour', 'Against' or 'Abstain'
(b) Each Governor shall have the opportunity to vote in secret
(c) The Trust Secretary shall count the ballots, and record the number of votes cast for each option on the minutes
(d) Governors may not record their vote in the minutes if a secret ballot is taken.

5.14 **Voting by Paper Ballot**

5.14.1 If the Chair of the Trust calls an extraordinary meeting of the Council under Sos 5.3 – 5.5 they may, subject to SO 5.14.2 below, determine that any Governor may cast their vote on the matter(s) to be dealt with at the meeting by paper ballot in accordance with the process set out at SOs 5.14.3 - 5.14.5 (inclusive) below.

5.14.2 The Chair may only determine that Governors may cast their vote by paper ballot on any matter where this is compatible with the 2006 Act.

5.14.3 Where the Chair makes a determination pursuant to SO 5.14.1 in respect of any extraordinary meeting of the Council, the Trust Secretary shall circulate a ballot paper to all of the Governors together with the papers for the meeting.

5.14.4 Any Governor may cast their vote at the meeting or by:

(a) marking the ballot paper, in accordance with the instructions on the ballot paper, to show how he wishes to vote
(b) subject to SO 5.14.6, signing the ballot paper
(c) returning the ballot paper to the Trust Secretary so that it arrives before the date and time stipulated on the ballot paper.

5.14.5 Governors must return the ballot paper by hand, by email or by post. Any ballot paper received on or after the date and time stipulated shall be rejected.

5.14.6 If a Governor returns a ballot paper to the Trust Secretary by email, the ballot paper does not have to be signed by the relevant Governor provided that it is returned from an email address that the Governor has previously notified to the Trust Secretary.

5.14.7 Any votes duly cast by paper ballot shall be added to the votes cast by Governors voting in person at the meeting. Unless otherwise provided by the Trust's constitution or by law, every matter shall be determined by a majority of votes cast and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote. No resolution can be passed if it is opposed by all of the Public Governors voting, whether at the meeting or by paper ballot.

5.14.8 The Trust Secretary shall ensure that the Trust keeps a record, in writing, of all ballot papers for at least twelve (12) months from the date of the meeting in respect of which the votes were cast. The votes (whether in person or by ballot) shall recorded in the minutes in accordance with SO 5.13.

5.15 **Prevention of Disorder at a Meeting**

If there is disorder in the public gallery (including members of the public attending in a virtual capacity) at a meeting of the Council:

5.15.1 The Chair may direct those causing the disorder to leave the meeting, and they shall thereupon leave and not return to the meeting.

5.15.2 The Chair may suspend the meeting to a stated time (not longer than 30 minutes from the time of the suspension) to allow order to be restored

5.15.3 If those causing disorder refuse to comply with the Chair's direction, the Chair may move that the public gallery be cleared to allow the Council to proceed in proper order.

5.15.4 A motion under SO 5.15.3 shall be voted on immediately and without debate.

5.15.5 If Council agrees to a motion under SO 5.15.3, the Chair shall suspend proceedings until the public gallery is cleared; the gallery shall remain cleared for the remainder of the meeting, unless the Council shall otherwise decide.

5.16 **Written Resolution Process**

5.16.1 Subject to SO 5.16.2, the Council may use the process for adopting a written resolution set out in this SO 5.16 to enable it to transact business between meetings of the Council. The process for adopting a written resolution shall not be used to replace meetings of the Council.

5.16.2 The Council may only use a written resolution for transacting business where this is compatible with the 2006 Act.

Proposing written resolutions

5.16.3 At the Chair's request, the Trust Secretary shall propose a written resolution to the Governors**.**

5.16.4 A written resolution is proposed by giving notice of the proposed resolution to the Governors. Such notice shall stipulate:

(a) the proposed resolution; and
(b) the long-stop date by which the written resolution is to be adopted, which shall be not less than ten (10) days from the date the written resolution is dispatched by the Trust Secretary
(c) Notice of a proposed written resolution must be given in writing to each Governor. Notice by email or post is permitted.

Adopting written resolutions

5.16.5 Unless otherwise provided by the Trust's constitution or by law and subject to SO 4.16.7 below, a proposed written resolution shall be adopted when it has been signed and returned to the Trust Secretary by hand, by email or by post by a majority of the Governors.

5.16.6 If a Governor returns a written resolution to the Trust Secretary by email, the written resolution does not have to be signed by the relevant Governor provided that it is returned from an email address that the Governor has previously notified to the Trust Secretary.

5.16.7 For the avoidance of doubt, the proposed written resolution shall lapse if it has not been returned by the requisite number of Governors pursuant to SO 5.16.6 above, by the longstop date.

5.16.8 Once a written resolution has been adopted, it shall be treated as if it had been a decision taken at a Council of Governors' meeting in accordance with these SOs.

5.16.9 The Trust Secretary shall ensure that the Trust keeps a record, in writing, of all written resolutions for at least six (6) years from the date of their adoption.

5.17 **Meetings: Electronic Communication**

5.17.1 In this SO, 'communication' and 'electronic communication' shall have the meanings as set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof.

5.17.2 A Governor in electronic communication with the Chair and all other parties to a meeting of the Council or of a committee of the Council shall be regarded for all purposes as being present and personally attending such a meeting provided that, and only for so long as, at such a meeting they have the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

5.17.3 A meeting at which one or more of the Governors attends by way of electronic communication shall be deemed to be held at such place at which the Chair is physically present. If the meeting takes places by way of electronic communication entirely, the meeting shall deemed to have been held via the electronic communication platform and will be recorded in the minutes as such.

5.17.4 Meetings held in accordance with this SO are subject to SO 5.12. For such a meeting to be valid, a quorum must be present and maintained throughout the meeting.

5.17.5 The minutes of a meeting held in this way must state that it was held (whether wholly or partly) by electronic communication and that the Governors were all able to hear each other and were present throughout the meeting.

5.18 **Minutes**

5.18.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next meeting where they will be signed by the person presiding at it, including electronically.

5.18.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

5.18.3 Minutes shall be retained in the Trust Secretary's office.

5.18.4 Minutes shall be circulated in accordance with Governors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

5.19 **Additional Powers**

5.19.1 The Council may require one or more of the Directors to attend a Council meeting to obtain information about the Trust's performance of its functions or the directors' performance of their duties, and to help the Council to decide whether to propose a vote on the Trust's or Directors' performance.

5.19.2 The Trust may choose to involve Governors in hospital/service visits or volunteering. However, Governors acknowledge that they do not have a right to inspect Trust property or services and they are not under a duty to meet patients and conduct quality reviews.

5.19.3 Governors may refer a question concerning whether the Trust has failed, or is failing, to act in accordance with its constitution, or Chapter 5 of the 2006 Act to the Panel for Advising Governors appointed by NHS England under the 2006 Act.

5.20 **Variation and Amendment of Standing Orders**

5.20.1 Any variation of these SOs shall not constitute a variation of the constitution. These SOs shall be amended only if:

(a) unless proposed by the Chair, a notice of motion under SO 4.7 has been given; and
(b) not fewer than half of the Trust's Governors vote in favour of amendment; and
(c) at least half of the Governors are present at the meeting at which the amendment is considered; and
(d) the variation proposed does not contravene a statutory provision or requirement, condition or notice issued by NHS England; and
(e) the amendment is approved by the Council.

6 Arrangements for the Exercise of Council Functions

6.1 The Council may not delegate its functions to any committee of the Council. Subject to the constitution and any requirements of NHS England, the Council may appoint committees to assist the Council in the proper performance of its functions under the constitution and the regulatory framework, consisting wholly of the Chair and members of the Council.

6.2 A committee appointed under this SO 6 may, subject to such requirements, conditions or notices as may be given by NHS England or such directions as may be issued by the Council, appoint sub-committees consisting wholly of members of the committee.

6.3 The SOs of the Council, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council. In which case the term "Chair" is to be read as a reference to the chair of the committee as the context permits, and the terms "member of the Council" or "Governor" is to be read as a reference to a member of the committee also as the context permits.

6.4 There is no requirement to hold meetings of committees established by the Council in public.

6.5 Each such committee shall have such terms of reference and be subject to such conditions (as to reporting back to the Council), as the Council shall decide and shall be in accordance with the regulatory framework and any requirement, condition, notice or guidance issued by NHS England. Such terms of reference shall have effect as if incorporated into the SOs.

6.6 The Council shall approve the terms of reference and appointments to each of the committees which it has formally constituted.

6.7 The committees established by the Council shall be such committees as are required to assist the Council in discharging its responsibilities.

6.8 A Governor and/or a member of a committee of the Council and/ or any non-Governor shall not disclose a matter dealt with by, or brought before, the Council or a committee of the Council without the permission of the Council or such committee (as applicable)

until such matter shall have been concluded or in the case of such committee, until the committee shall have reported to the Council.

6.9 A Governor or a non-Governor in attendance at a committee or of a meeting of the Council shall not disclose any matter dealt with by the committee or the Council, notwithstanding that the matter has been reported or concluded, if the Council or committee resolves that it is confidential.

6.10 The Trust Secretary or their deputy or assistant will attend all meetings of the committees in support of them.

6.11 Notwithstanding anything in these SOs, the Chair and Governors may meet informally or as a committee of the Council at any time and from time to time, and shall not be required to admit any member of the public or any representative of the media to any such meeting or to send a copy of the agenda for that meeting or any draft minutes of that meeting to any other person or organisation. For the avoidance of doubt, no business shall be conducted at such meetings.

7 Prevention of Conflicts of Interest

7.1 Declaration of Interests

7.1.1 The Trust recognises that, as volunteers, Governors may have private interests that could conflict with those of the Trust. It is the responsibility of Governors to ensure that any potential conflicts of interest are registered and declared at meetings in accordance with this SO and paragraph 22 of the constitution.

7.1.2 The Trust policy for Conflicts of Interest, Gifts and Hospitality (CP80) defines a conflict of interest as “A set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold”.

7.1.3 A conflict of interest may be

- **Actual:** There is a material conflict between one or more interests.
- **Potential:** There is the possibility of a material conflict between one or more interests in the future.

7.1.4 Governors may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see if different and perceived conflicts of interests can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

7.1.5 Interests fall into the following categories:

(a) Financial interests: Where an individual may get direct financial benefit from the consequences of a decision they are involved in making.

(b) Non-financial professional interests: Where an individual may obtain a non-financial professional benefit from the consequences of a decision

they are involved in making, such as increasing their professional reputation or promoting their professional career.

(c) Non-financial personal interests: Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

(d) Indirect interests: Where an individual has a close associationwith another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

7.1.6 Governors must declare interests which are relevant and material to the Council. All existing Governors should declare such interests. Any Governors appointed subsequently should do so on appointment

7.1.7 At the time Governor's interests are declared they should be recorded in the Council register of interests and in the minutes of the relevant meeting at which the declaration is made. Any changes in interests should be declared at the next meeting following the change occurring.

7.1.8 Governors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.9 During the course of a meeting of the Council, if a conflict of interest is established, the Governor concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

7.1.10 There are a number of common situations which can give rise to risk of conflicts of interest, as follows:

- Gifts
- Hospitality
- Outside employment
- Shareholdings and other ownership issues
- Patents
- Loyalty interests
- Donations
- Sponsored events
- Sponsored research
- Sponsored posts
- Clinical private practice

7.1.11 The interests of Governors' spouses or partners if living together, in contracts are to be declared. If Governors have any doubt about the relevance of an interest, this should be discussed with the Chairman. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an

interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.2 Register of Interests

7.2.1 The Trust Secretary will ensure that a register of interests is established to record formally declarations of interests of Governors. In particular the register will include details of all directorships and other actual and potential interests which have been declared by Governors, as defined in paragraphs 22 of the constitution and SO 7.1

7.2.2 The Trust Secretary shall keep these details up to date by means of an annual review of the register, for which Governors will be required to complete a further declaration via an Annual Declaration of Interest Form. It is the responsibility of each Governor to provide an update to the Trust Secretary of their register entry if their interests change. The form will also require Governors to provide consent to process and publish this information as per GDPR or equivalent requirements.

7.2.3 The register will be available to the public and the Trust Secretary will take reasonable steps to bring the existence of the register to the attention of the local population and to publicise arrangements for viewing it.

7.2.4 In establishing, maintaining, updating and publicising the register, the Trust shall comply with all guidance issued from time to time by the NHSE/I.

7.3 Interests of Relatives, Spouses and Partners

7.3.1 A Governor is required to declare, as if it was their own interest, interests owned or otherwise held by:

- Their spouse or civil partner
- Any person with whom they have a long-term relationship as a couple on a domestic basis
- Their children, step-children or other minors living in the same household as them
- Any parent, grandparent, uncle or aunt living in the same household as them

7.3.2 Where a declaration is made under SO 6.3, the Governor shall declare and the Trust Secretary shall note on the Register:

- The name of the individual having the interest
- Their relationship to the Governor making the declaration.

7.4 Interest of Governors in Contracts

7.4.1 If it comes to the knowledge of a Governor that a contract in which they have any pecuniary interest not being a contract to which they are themselves a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Trust Secretary of the fact that he is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

7.4.2 A Governor should also declare to the Trust Secretary any other employment or business or other relationship of theirs, or of a cohabiting spouse, civil partner or person living together with them as partner, that conflicts or might reasonably be predicted could conflict with the interests of the Trust. Interests, employment or relationships declared, are to be entered in a register of Governor's interests.

7.4.3 Further details are included in the Conflict of Interest, Gifts and Hospitality policy & procedure.

8 Standards of Business Conduct

8.1 Standards of Conduct

8.1.1 The Council shall agree, from time to time, codes of conduct for the proper execution of the office of Governor.

8.1.2 Governors must comply with the Council's Code of Conduct, the requirements of the regulatory framework, the constitution and any guidance, requirement condition or notice issued by NHS England.

8.2 Canvassing of, and Recommendations by, Members of the Council of Governors in Relation to Appointments

8.2.1 Except in relation to the appointment of a person as a member of the Trust, a Governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment, but this SO shall not preclude a Governor from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

8.2.2 This SO does not prevent a Governor from contributing to the appointment of a Non-Executive Director to the Trust or the Chief Executive in accordance with the statutory requirements.

8.2.3 Informal discussions outside appointment panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

9 Miscellaneous

9.1 Standing Orders to be given to all Governors

9.2 It is the duty of the Trust Secretary to ensure that existing Governors and all new appointees are notified of and understand their responsibilities within these SOs.

9.3 Review of Standing Orders

9.4 The SOs shall be reviewed annually by the Council. The requirement for review extends to all documents having the effect as if incorporated in the SO.

9.5 Potential Inconsistency

9.6 In the event of any conflict or inconsistency between these SOs and any of the legislation and guidance listed in these SOs, the legislation shall prevail. In the event of any conflict or inconsistency between these SOs and the licence and/or the constitution, the licence and/or the constitution shall prevail.

10 Dispute Resolution

10.1 Where there is a dispute between the Council of Governors and the Board of Directors, Governors shall follow the procedure set out in the current Council of Governors Policy for Engagement with the Board of Directors where there is disagreement and/or concerns regarding performance.

10.2 Where a dispute arises out of or in connection with the constitution, including the interpretation of these SOs and the procedure to be followed at meetings of the Board, the Trust and the parties to that dispute shall use all reasonable endeavours to resolve the dispute as quickly as possible.

10.3 Where a dispute arises that involves the Chair, the dispute shall be referred to the Senior Independent Director who will use all reasonable efforts to mediate a settlement to the dispute.

10.4 For the avoidance of doubt, the Trust Secretary shall deal with any membership queries and other similar questions in the first place including any voting or legislation issues and shall otherwise follow a process for resolving such matters in accordance with any procedures agreed by the Board.

11 Relationship Between the Board of Directors and the Council of Governors

11.1 Governors should discuss and agree with the Board how they will undertake their statutory roles and responsibilities, and any other additional roles, giving due consideration to the circumstances of the Trust and the needs of the local community and emerging good practice.

11.2 Governors should work closely with the Board and must be presented with, for consideration, the annual report and accounts (including any report of the auditor on them) and the annual plan at a general meeting. The Governors must be consulted on the development of forward plans for the Trust and any significant changes to the delivery of the Trust's business plan.

11.3 The annual report should state how performance evaluation of the Board, its committees, and its Directors, including the Chairman is conducted and the reason why the Trust adopted a particular method of performance evaluation.

11.4 The annual report should identify the members of the Council, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the appointed Lead Governor. A record should be kept of the number of

meetings of the Council and the attendance of individual Governors and Directors and it should be made available to members on request.

11.5 The Council should take the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors. The Council will need to ensure they have the skills and knowledge to choose the right external auditor and monitor their performance. However, they should be supported in this task by the Trust's Audit Committee, which provides information to the Governors on the external auditor's performance as well as overseeing the Trust's internal financial reporting and internal auditing.

11.6 If the Council does not accept the Audit Committee's recommendations, the Board should include in the annual report a statement from the Audit Committee explaining the recommendation and should set out reasons why the Council has taken a different position.

11.7 The annual report should describe the process followed by the Council in relation to appointments of the Chair and Non-Executive Directors

SUMMARY REPORT	COUNCIL OF GOVERNORS PART 1	19 November 2025

Report Title:	**Lead Governor Report**					
Executive Lead:	Stuart Scrivener, Lead Governor					
Report Author(s):	Stuart Scrivener, Lead Governor					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
This report provides a summary of the key activities undertaken by the Lead Governor and sharing any information and learning identified.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Council of Governors is asked to:

1. Note the contents of the report

Summary of Key Points

This report provides a summary of the activities of the Lead Governor over the last few months, including:

- Service Visits
- Co-Production Conference
- Lampard Inquiry
- Governor Training (Team Building)
- Joint Board / Council Seminar Session
- Future Plans

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	
2: We learn	✓
3: We empower	✓

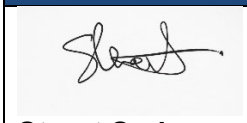
Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	
Data quality issues	
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	
Service impact/health improvement gains	
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**	
Governance implications	

Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**~~YES~~/NO**	**If YES, EIA Score**	

Impact on Statutory Duties and Responsibilities of Council of Governors	
Holding the NEDs to account for the performance of the Trust	✓
Representing the interests of Members and of the public	
Appointing and, if appropriate, removing the Chair	
Appointing and, if appropriate, removing the other NEDs	
Deciding the remuneration and allowances and other terms of conditions of office of the Chair and the other NEDs	
Approving (or not) any new appointment of a CEO	
Appointing and, if appropriate, removing the Trust's auditor	
Receiving Trust's annual accounts, any report of the auditor on them, and annual report	
Approving "significant transactions"	
Approving applications by the Trust to enter into a merger, acquisition, separation, dissolution	
Deciding whether the Trust's non-NHS work would significantly interfere with its principal purpose or performing its other functions	
Approving amendments to the Trust's Constitution	
Another non-statutory responsibility of the Council of Governors (please detail):	

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices
Lead Governor Report

Non-Executive Lead:

Stuart Scrivener **Lead Governor** **Public Governor, Essex Mid & South**

LEAD GOVERNOR REPORT

1.0 INTRODUCTION

This is my second report as your Lead Governor, and I would like to begin by thanking everyone for their continued commitment and engagement. It was a real pleasure to chair our recent Governor Informal meeting. I hope you found the new format more welcoming and that it provided a better opportunity to share your thoughts, raise concerns, and get to know your fellow Governors.

The next informal meeting is scheduled for next year, but if there is interest in holding another session before Christmas, I would be very happy to arrange one - please do let me know if you think this would be helpful.

I have continued to explore ways to make the best use of Governors' time, ensuring that everyone has a voice and that we work effectively together as a team. Where individuals have raised concerns or questions about their roles, I have liaised with the appropriate people to ensure feedback is shared and any necessary action is taken.

2.0 LEAD GOVERNOR ACTIVITY

2.1 Service Visits

On Sunday, 5th October, I visited five wards at the Linden Centre Site alongside Matt Sisto, Director of Patient Experience and Barbers from "Essex Boys Barbers," who generously provided free haircuts to anyone. This initiative highlighted the strong partnership developed between EPUT and external organisations, who visit the centre every 2–3 months to offer this valued service. I feel the therapeutic benefits are significant and the experience contributes positively to the patient's overall wellbeing.

2.2 Co-Production Conference (10 October 2025)

I attended the annual EPUT Co-Production Conference on the 10 October 2025 at Colchester Rugby Club. The event began with a thoughtful remembrance of Mark Dale, which was well received and provided a fitting reflection on his many contributions. The conference featured several speakers who brought valuable insights on their subjects. The presentations focused on specific elements of care and services, touching on where co-production had been incorporated. I provided some feedback following the conference for consideration to ensure co-production remains at the heart of the conference going forward.

I was pleased to be accompanied by three of our NEDs, Sarah, Richard, and Loy.

2.3 Lampard Inquiry (20 October 2025)

I attended the Lampard Inquiry on the 20 October 2025, along with Hattie and Denver. It was an incredibly emotional and humbling day, hearing the families speak about their loved ones, their lives, and the devastating circumstances that led to their deaths was deeply moving and profoundly sad. Listening to their stories and the evidence presented was a stark reminder of the immense responsibility that comes with providing care and support to those who are most vulnerable.

During the event, I had the opportunity to speak with a few colleagues about how the inquiry had affected them personally, not just in their professional roles, but also in their lives outside of work and their families. It was clear from those conversations that there is a significant impact. Many current and former staff members, as well as members of the Board, have been affected by what has happened and by revisiting these events through the inquiry process.

I know that support is available for staff, and I hope colleagues feel able to reach out and use those resources when needed. However, I also think it's important for us all to remain mindful of the emotional weight this inquiry carries for those within our organisation who are reflecting on their own experiences.

As we continue to ask questions and hold discussions at Board and Council of Governors meetings, I would encourage us to do so with empathy, understanding, and respect for the emotional toll this process takes on everyone involved. Compassion and care must underpin not only the work we do for others, but also the way we treat and support one another

2.4 Governor Induction (Team Focus Session – 31 October 2025)

I attended this session alongside six other governors. The morning session was delivered by the Organisational Development team. This included team activities and taking the Keirsey temperament sorter. I felt this session enabled us to get to know each other better and how we can work together as a team in the future and understand how we are all individuals who work in different ways with differing opinions.

During the morning session we discussed some proposed ground rules for meetings to help them to run effectively, ensure everyone has a voice and things are kept respectful.

1. **Respect the Chair**
   Support the chair in keeping the meeting structured, fair, and focused.

2. **Equal Voice for All**
   Everyone has an equal opportunity to speak and be heard - regardless of age, title, or background.

3. **Healthy Debate, Shared Decisions**
   Differences of opinion are welcome, but we work towards consensus and collective ownership of decisions.

4. **Use the "Raise Hand" Function**
   Indicate when you wish to speak rather than speaking over others.

5. **Be Mindful of Speaking Time**
   Keep contributions focused and concise, allowing space for others to share their perspectives.

6. **No Wrong or Silly Questions**
   Every question deserves respect and a considered answer — curiosity strengthens understanding.

7. **Follow Up on Unanswered Questions**
   If something can't be answered during the meeting, we'll ensure a response is provided afterward.

8. **Empower and Include**
   Encourage and support others to contribute. Create an environment where all voices feel valued.

9. **Respect Different Communication Styles**
   We all learn and express ourselves differently - listen actively and adapt as needed.

10. **Provide Constructive Feedback**
    When sharing updates or feedback, do so respectfully and helpfully, especially for those unable to attend.

11. **Encourage Constructive Challenge**
    It's healthy to question ideas - do so fairly, respectfully, and with the aim of improvement.

12. **It's Okay Not to Agree**
    Consensus doesn't mean uniformity. Disagreement is acceptable when expressed respectfully.

13. **When Directing questions to individuals or asking for their thoughts**
    Give others time to think and respond. If clarification is needed, rephrase questions or return to the topic later.

I will be bringing these to our next Governor Informal meeting for further discussion, but please let me know if you have any initial thoughts.

The afternoon session, Membership Engagement / Holding the Non-Executive Directors to Account, was jointly developed by Chris Jennings and myself, with Chris leading the delivery. The session explored a range of approaches for contacting and engaging with members. We highlighted the existing meetings and events organised by the Trust, while also recognising the opportunities for individual engagement outside of these formal Trust activities.
Feedback indicated the session was well received and improved understanding of the governor role and better team working.

2.5 Joint Board Seminar (5 November 2025)

I attended the seminar which covered two topics, the first session was about the “Community First Project”. The second session was a culture review delivered by BRAP – a Charity whose mission is “To help people, communities, and the organisations that serve them turn equality into reality”.

Community First - The presentation provided a good level of detail, and the discussion addressed key questions clearly. It did a great job of highlighting the challenges and pressures the services are facing. I have asked Ann and her team, when presenting at our Council of Governors meeting, to consider including additional detail on the plan and strategy outlining how Community First intends to address these challenges and enhance services and outcomes for service users.

BRAP – The team provided an update on the work undertaken so far to understand the current culture within the Trust. They have visited several sites and gathered feedback from a wide range of staff to gain a fuller picture of the organisational climate. Early insights suggest that the Inquiry is having a significant impact on colleagues, with the Inquiry featuring in a large number of the conversations held by BRAP. Once their research is complete, BRAP will present their findings to the Board and Council of Governors, along with a series of recommendations aimed at supporting positive cultural development - rather than imposing another set of “must-do” actions.

3.0 FUTURE PLANS

- Continue to work with the Trust Secretary’s Office to look at papers coming to the Council of Governors. The idea is to try to make more room for patient stories and discussions and allow more time for Q&A sessions.
- Looking at different processes to see if we can streamline and make better use of Governors time
- Strengthen links with The National Lead Governors association to share ideas and concerns with other lead governors.
- I am developing a new approach to delivering the governors’ message at the Annual Members’ Meeting. Together with some fellow governors, I have been working on creating a short, pre-recorded video presentation to be shown at the meeting. We believe this format will be a more engaging and effective way to communicate our key messages, highlight the work governors are doing, and share our future plans with members in a clear way.

4.0 CONCLUSION

It has been encouraging to see the continued commitment, compassion, and collaboration among our Governors and colleagues across the Trust. Each of the activities and events I have attended has reinforced the important role that Governors play in ensuring transparency, accountability, and genuine engagement with our patients, staff, and wider community.

By continuing to create open, inclusive spaces for discussion, and by refining our processes to make best use of everyone's time and expertise, we can ensure that our collective voice makes a real difference.

I look forward to continuing our work together to champion improvement, uphold our values, and ensure that the Trust continues to provide compassionate, high-quality care for those we serve.

I would like to thank all Governors for your ongoing dedication and contributions.

Stuart Scrivener
Lead Governor
Public Governor for Essex Mid and South

SUMMARY REPORT	COUNCIL OF GOVERNORS PART 1	19 November 2025

Report Title:	**Fit for the Future: 10-year Health Plan for England – Future of Governors**					
Executive Lead:	Hattie Llewelyn-Davis, Chair					
Report Author(s):	Hattie Llewelyn-Davis, Chair					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
The report provides the government ten-year plan for healthcare in England, which includes details of the proposed future of the Council of Governors.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Council of Governors is asked to:

1. Note the contents of the report

Summary of Key Points

The government published its ten-year plan for healthcare in England in July 2025. Page 81 of the document provides a short sentence regarding the plan to remove the requirements for Foundation Trust's to have governors. Further information has been provided in different sources, such as the Advanced Foundation Trust Programme – Guide for Applicants and a verbal update will be provided at the meeting by the Chair.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	
2: We learn	✓
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	
Data quality issues	
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	
Service impact/health improvement gains	
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**	

Governance implications			
Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**~~YES~~/NO**	**If YES, EIA Score**	

Impact on Statutory Duties and Responsibilities of Council of Governors	
Holding the NEDs to account for the performance of the Trust	
Representing the interests of Members and of the public	
Appointing and, if appropriate, removing the Chair	
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Deciding whether the Trust's non-NHS work would significantly interfere with its principal purpose or performing its other functions	
Approving amendments to the Trust's Constitution	
Another non-statutory responsibility of the Council of Governors (please detail):	✓

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices
Fit for the Future: 10-year Health Plan for England (July 2025)

Non-Executive Lead:
Hattie Llewelyn-Davies. **Hattie Llewelyn-Davies** **Chair**

UK Government

NHS

FIT FOR THE FUTURE

10 Year Health Plan for England

CP 1350

July 2025

Fit for the Future: The 10 Year Health Plan for England

Presented to Parliament by the Secretary of State for Health and Social Care by Command of His Majesty

July 2025

CP 1350

This publication is available at www.gov.uk/official-documents.

Any enquiries regarding this publication should be sent to us 10yearplan@dhsc.gov.uk

ISBN 978-1-5286-5807-2

E03381504 07/25

Printed on paper containing 40% recycled fibre content minimum

Printed in the UK by HH Associates Ltd. on behalf of the Controller of His Majesty's Stationery Office

CORRECTION SLIP

Title: Fit for the Future: The 10 Year Health Plan for England

Session: 2024-2025

Number: CP 1350

ISBN: 978-1-5286-5807-2

Date of laying: 3 July 2025

Correction:

Page 12, first bullet point

Current text

launch a moonshot to end the obesity epidemic. We will restrict junk food advertising targeted at children, ban the sale of high-caffeine energy drinks to under 16-year-olds, reform the soft drinks industry levy to drive reformulation; and - in a world first - introduce mandatory health food sales reporting for all large companies in the food sector. We will use that reporting to set new mandatory targets on the average healthiness of sales

Replacement text

launch a moonshot to end the obesity epidemic. We will restrict junk food advertising targeted at children, ban the sale of high-caffeine energy drinks to under 16-year-olds, consider reforms to the soft drinks industry levy to drive reformulation; and - in a world first - introduce mandatory healthy food sales reporting for all large companies in the food sector. We will use that reporting to set new mandatory targets on the average healthiness of sales

Page 63, last bullet point

Current text

current food and advertising and promotion restrictions use the 2004 nutrient profile model to categorise which foods are more or less healthy. This is plainly out of date, and we will update these standards. We estimate this simple modernisation of existing regulation could reduce adult obesity cases by nearly 170,000.

Replacement text:

current food and advertising and promotion restrictions use the 2004 nutrient profile model to categorise which foods are more or less healthy. This is plainly out of date, and we will update these standards. We estimate this simple modernisation of existing regulation could reduce childhood obesity cases by nearly 170,000.

Page 124, last paragraph

Current text:

Last year, the government struck a deal with Eli Lilly to widen access to tirzepatide with a world-first trial evaluating the utility of weight loss medication to tackle economic inactivity in Greater Manchester.

Replacement text:

Last year, the government announced a strategic collaboration with Eli Lilly. One part of which was to establish a world-first ‘real world evidence’ study evaluating the effectiveness of weight loss medication, including gathering data on health-related quality of life and changes in

participants' employment status.

Page 123, right column 3rd paragraph

Current text:

In collaboration with partners across the public, private, and charitable sectors, we will support development and roll out of high impact medicines through the Healthcare Goals Programmes, including in cancer, obesity and dementia. Through the Dementia Goals Programme we intend to set up public-private partnership to accelerate development and implementation of new dementia therapies. We will also be more proactive in preparing the system to implement medicines in areas like asthma, where new care models have can shift care into the community.

Replacement text:

In collaboration with partners across the public, private, and charitable sectors, we will support development and roll out of high impact medicines through the Healthcare Goals Programme, including in cancer, obesity, mental health and dementia. Through the Dame Barbara Windsor Dementia Goals programme we intend to set up a public-private partnership to accelerate development and implementation of new dementia therapies. We will also be more proactive in preparing the system to implement medicines in areas like asthma, where new care models can shift care into the community.

Page 125, infographic, left side, second text box down

Current text:

Better access to identified data through HDRS

Replacement text:

Better access to deidentified data through HDRS

Page 155, updated reference, ref 147

Current text:

147Movendi International. 'Age Verification Failure in Alcohol Online Sales and On-Demand Delivery' 2022. https://movendi.ngo/policy-updates/age-verification-failure-in-alcohol-onlinesales-and-on-demand-delivery/ (viewed on 26 June 2025)

Replacement text:

147 Movendi International. 'Alcohol Warning Labelling, How it works and why it's needed' 2022 https://movendi.ngo/policy-updates/special-feature-alcohol-warning-labelling-how-it-works-and-why-its-needed (viewed on 26 June 2025)

Page 159, updated reference, ref 213

Current text:

213 Based on internal unpublished analysis.

Replacement text:

213 Underlying data available at: https://digital.nhs.uk/supplementary-information/2025/supplementary-data-underpinning-selected-10-year-health-plan-statistics (viewed on 3 July 2025)

Date of correction: 15 July 2025

Contents

Foreword by the Prime Minister

It is no exaggeration to say that we inherited an NHS facing the worst crisis in its history. Across the country, people are stuck on waiting lists for years on end. Our fabulous NHS staff let down by endless bureaucracy. And a society that is slowly getting sicker.

That has an effect across the whole of society. It causes huge pain and suffering to families. It prevents people from working, putting them in a precarious position. It boosts inequality. And it puts more strain on other services.

This government was elected to deliver change. To get the NHS back on its feet and fit for the future.

We have started immediately. In our first year in government, we promised to deliver an extra two million appointments. We've delivered more than four million. We've recruited more than 1,500 newly qualified GPs, cut waiting lists, and invested in desperately needed upgrades to hospitals and GP surgeries.

But there is much more for us to do. This government will seize the huge opportunities that lie in front of us in technology, innovation and healthcare. On my visits to hospitals around the country, I've seen the potential of new equipment that transforms how we treat and manage conditions from cancer to diabetes.

So we will build a truly modern NHS that delivers the best and fastest treatment for

patients and offers taxpayers better value for money.

This government is determined to put power back in the hands of people and professionals to make the best choices about their own lives, treatment and care.

That is what our 10 Year Health Plan to get the NHS back on its feet and fit for the future will achieve. Three fundamental shifts in how the NHS works.

First, from hospital to community. More care will be available on your doorstep and from the comfort of your own home. It will be easier to see a GP and Neighbourhood Health Centres will be available in every community.

Second, from analogue to digital. New technology will liberate staff from time-wasting admin and make booking appointments and managing your care as easy as online banking or shopping.

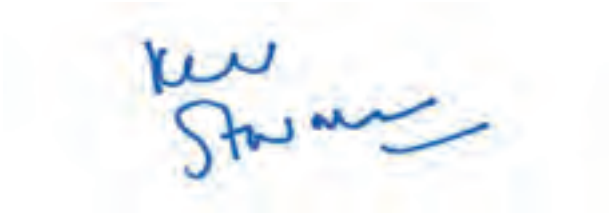
Finally, from sickness to prevention. We will reach patients earlier, to catch illness before it spreads and prevent it in the first place, by making the healthy choice the easy choice.

At the same time, we will slash unnecessary bureaucracy, giving more power and resources to the frontline. An extra £29 billion in investment will fund the reforms, service improvements and new technology required.

This is personal for me. The NHS was my mum's livelihood for years, until she became too sick to work. Then it became her lifeline. I know how hard our NHS staff work, and I know how incredibly important their work is when people need their care.

This is at the heart of who we are as a country – the idea that every single person, no matter who they are or where they come from, deserves the same quality treatment, free at the point of use, from the cradle to the grave.

This is a time for radical change – major surgery, not sticking plasters. The measures in this Plan are radical and urgent. It won't be easy, but the prize will be worth it. This is a Plan that will take the NHS from the worst crisis in its history, and renew it so it serves generations to come.



The Rt Hon Sir Keir Starmer KCB KC MP

Prime Minister

Executive Summary

The National Health Service (NHS) is at a historic crossroads. Lord Darzi's Investigation revealed the sheer extent of its current failings, concluding the NHS was in 'critical condition'. He set out in stark terms that this government's inheritance is an NHS where:

- many cannot get a GP or dental appointment
- waiting lists for hospital and community care[1] have ballooned
- staff are demoralised and demotivated[2]
- outcomes on major killers like cancer lag behind other countries[3].

That is why the NHS now stands at an existential brink. Demographic change and population ageing[4] are set to heap yet more demand on an already stretched health service. Without change, this will threaten yet worse access and outcomes - and even more will opt out to go private if they can afford to. People will increasingly wonder why they pay so much tax for a service they do not use, eroding the principle of solidarity that has sustained the NHS. We will be condemned to a poor service for poor people.

The choice for the NHS is stark: reform or die. We can continue down our current path, making tweaks to an increasingly unsustainable model, or we can take a new course and reimagine the NHS through transformational change that will guarantee its sustainability for generations to come. This Plan chooses the latter. It represents a break with the past.

That choice has been informed by the biggest conversation about the NHS in its history. Over the past 8 months, we have spoken to thousands of staff and members of the public and considered the 250,000 contributions to the Change.NHS website. The conclusion was clear: no one defends the status quo. Staff and patients are crying out for change.

This is a Plan to create a new model of care, fit for the future. It will be central to how we deliver on our health mission. We will take the NHS' founding principles - universal care, free at the point of delivery, based on need and funded through general taxation - and from those foundations, entirely reimagine how the NHS does care so patients have real choice and control over their health and care.

Science and technology will be key to that reinvention. Today the NHS is behind the technological curve. This Plan propels it to the front. The NHS of the future will be a service that offers instant access to help and appointments. One that predicts and prevents ill health rather than simply diagnosing and treating it. A patient-controlled system, in place of today's centralised state bureaucracy, and one where frontline staff are empowered to reshape services. A service with the core principles and values of the NHS but with the know-how of a wider network of technology, life sciences, local government, civil society and third sector organisations, working in partnership to improve the nation's health.

It will be a service equipped to narrow health inequalities. Evidence[5] shows that people in working class jobs, who are from ethnic minority backgrounds, who live in rural or coastal areas or deindustrialised inner cities, who have experienced domestic violence, or who are homeless, are more likely to experience worse NHS access, worse outcomes and to die younger. This is an intolerable injustice. Our reimagined NHS will be designed to tackle inequalities in both access and outcomes, as well as to give everyone, no matter who they are or where they come from, the means to engage with the NHS on their own terms.

Despite the scale of the challenge we face, there are more reasons for optimism than pessimism. The NHS is the best-placed system in the world to harness the advances we are seeing in artificial intelligence (AI) and genomic science. This Plan describes how we will use these advantages to propel the NHS into a position of global leadership. When coupled with our country's excellence in science, innovation and academia, the UK can lead the world in developing the treatments and technologies of the future[6].

This Plan will put the NHS at the front of the global genomics revolution and make the NHS the most artificial-intelligence -enabled care system in the world. We will get upstream of ill-health and make a reality of precision medicine. We will put the NHS on a sustainable footing by adopting a new value-based approach, that aligns resources to achieve better health outcomes. In turn, we will unlock broader economic benefits for the UK, helping to get people back into work and providing a bedrock for the industries of the future. This Plan will transform the NHS into an engine for economic growth rather than simply a beneficiary of it.

We will reinvent the NHS through 3 radical shifts - hospital to community, analogue to digital and sickness to prevention. These will be the core components of our new care model. To support the scale of change we need, we will ensure the whole NHS is ready to deliver these 3 shifts at pace: through a new operating model, by ushering in a new era of transparency; by creating a new workforce model with staff genuinely aligned with the future direction of reform, through a reshaped innovation strategy; by taking a different approach to NHS finances.

From hospital to community: the neighbourhood health service, designed around you

If the NHS does not feel like a single, coordinated, patient-orientated service, that is for a simple reason: it is not one. It is hospital-centric, detached from communities and organises its care into multiple, fragmented siloes. We need to shift to provide continuous, accessible and integrated care.

The neighbourhood health service is our alternative. It will bring care into local communities, convene professionals into patient-centred teams and end fragmentation. In doing so, it will revitalise access to general practice and enable hospitals to focus on providing world class specialist care to those who need it. Over time, it will combine with our new genomics population health service to provide predictive and preventative care that anticipates need, rather than just reacting to it.

At its core, the neighbourhood health service will embody our new preventative principle that care should happen as locally as it can: digitally by default, in a patient's home if possible, in a neighbourhood health centre when needed, in a hospital if necessary. To make this possible we will:

- shift the pattern of health spending. Over the course of this Plan, the share of expenditure on hospital care will fall, with proportionally greater investment in out-of-hospital care.
- This is not just a long-term ambition. We will also deliver this shift in investment over the next 3 to 4 years as local areas build and expand their neighbourhood health services

- end the 8am scramble by training thousands more GPs and building online advice into the NHS App. People who need one will be able to get a same-day GP appointment
- introduce 2 new contracts, with roll-out beginning next year, to encourage and allow GPs to work over larger geographies and lead new neighbourhood providers
- support people to be active participants in their own care by ensuring people with complex needs have an agreed care plan by 2027
- at least double the number of people offered a Personal Health Budget by 2028 to 2029, offer 1 million people a Personal Health Budget by 2030, and ensure it is a universal offer for all who would benefit by 2035
- through the NHS App, allow patients to book appointments, communicate with professionals, receive advice, draft or view their care plan, and self-refer to local tests and services
- establish a neighbourhood health centre in every community, beginning with places where healthy life expectancy is lowest - a 'one stop shop' for patient care and the place from which multidisciplinary teams operate
- neighbourhood health centres will be open at least 12 hours a day and 6 days a week
- increase the role of community pharmacy in the management of long-term conditions and link them to the single patient record
- improve access to NHS dentistry, improve children's oral health and increase the number of NHS dentists working in the system by making the dental contract more attractive, and introducing tie-ins for those trained in the NHS
- deliver more urgent care in the community, in people's homes or through neighbourhood health centres to end hospital outpatients as we know it by 2035
- end the disgraceful spectacle of corridor care and restore the NHS constitutional standard of 92% of patients beginning elective treatment within 18 weeks
- expand same day emergency care services and co-located urgent treatment centres. We will support patients to book into the most appropriate urgent care service for them, via 111 or the app, before attending, by 2028
- invest up to £120 million to develop more dedicated mental health emergency departments, to ensure patients get fast, same-day access to specialist support in an appropriate setting
- free up hospitals to prioritise safe deployment of AI and harness new technology to bring the very best of cutting-edge care to all patients. All hospitals will be fully AI-enabled within the lifetime of this Plan.

From analogue to digital: power in your hands

Modern technology has given us more power over our everyday lives. But that same scale of change has yet to come to the NHS. This Plan will take the NHS from the 20th century technological laggard it is today, to the 21st century leader it has the potential to be.

To do this, we will use the unique advantages of the NHS' healthcare model - world-leading data, its power in procurement and its means to deliver equal access - to create the most digitally accessible health system in the world. Patients will have a 'doctor in their pocket' in the form of the NHS App, while staff will be liberated from a burden of bureaucracy and administration.

By harnessing the digital revolution, we will be able to:

- ensure rapid access for those in generally good health

- free up physical access for those with the most complex needs
- help ensure the NHS' financial sustainability for future generations.

To make the move 'from bricks to clicks' we will:

- for the first time ever in the NHS, give patients real control over a single, secure and authoritative account of their data with a single patient record to enable more co-ordinated, personalised and predictive care
- transform the NHS App into a world leading tool for patient access, empowerment and care planning.

By 2028, the app will be a full front door to the entire NHS. Through the app, patients will be able to:

– get instant advice for non-urgent care and help finding the most appropriate service first time, through My NHS GP

– choose their preferred provider, whether it delivers the best outcomes, has the best feedback or is simply closer to home, through My Choices

– book directly into tests where clinically appropriate through My Specialist, and hold consultations through the app with My Consult

– manage their medicines through My Medicines and book vaccines through My Vaccines

– manage a long-term condition through My Care, access and upload health data through My Health or get extra care support through My Companion

- manage their children's healthcare through My Children, or co-ordinate the care of a loved one or relative through My Carer
- allow patients to leave feedback on the care they have received - compiled and communicated back to providers, clinical teams and professionals in easy-to-action formats
- use continuous monitoring to help make proactive management of patients the new normal, allowing clinicians to reach out at the first signs of deterioration to prevent an emergency admission to hospital
- build 'HealthStore' to enable patients to access approved digital tools to manage or treat their conditions, enabling innovative businesses to work more collaboratively with the NHS and regulators
- introduce single sign on for staff and scale the use of technology like AI scribes to liberate staff from their current burden of bureaucracy and administration – freeing up time to care and to focus on the patient.

From sickness to prevention: power to make the healthy choice

People are living too long in ill health, the gap in healthy life expectancy between rich and poor is growing[7] and nearly 1 in 5 children leave primary school with obesity[8]. Our overall goal is to halve the gap in healthy life expectancy between the richest and poorest regions, while increasing it for everyone, and to raise the healthiest generation of children ever. This will boost our health, but also ensure the future sustainability of the NHS and support economic growth.

We will achieve our goals by harnessing a huge cross-societal energy on prevention. We will work with businesses, employers, investors, local authorities and mayors to create a healthier country together. Specifically, we will:

- deliver on our world-leading Tobacco and Vapes Bill, which will mean that children turning 16 this year (or younger) can never legally be sold tobacco. The number of 11 to 15 year olds who regularly vape has doubled[9] in the last 5 years, and to crack down on this unacceptable trend, we will also halt the advertising and sponsorship

of vapes and other nicotine products

- launch a moonshot to end the obesity epidemic. We will restrict junk food advertising targeted at children, ban the sale of high-caffeine energy drinks to under 16-year-olds, consider reforms to the soft drinks industry levy to drive reformulation; and - in a world first - introduce mandatory healthy food sales reporting for all large companies in the food sector. We will use that reporting to set new mandatory targets on the average healthiness of sales
- restore the value of Healthy Start from financial year 2026 to 2027, expand free school meals so that all children with a parent in receipt of Universal Credit are eligible, and update school food standards to ensure all schools provide healthy, nutritious food.
- harness recent breakthroughs in weight loss medication and expand access through the NHS. We will negotiate new partnerships with industry to provide access to new treatments on a 'pay for impact on health outcomes' basis
- encourage citizens to play their part, including through a new health reward scheme to incentivise healthier choices. We will also work with the Great Run Company to set up a campaign to motivate millions to move more on a regular basis
- tackle harmful alcohol consumption by introducing new standards for alcohol labelling. We will support further growth in the no- and low- alcohol market
- join up support from across work, health and skills systems to help people find and stay in work. We will work with all ICBs to establish Health and Growth Accelerators models
- expand mental health support teams in schools and colleges – and provide additional support for children and young people's mental health through Young Futures Hubs
- increase uptake of human papillomavirus (HPV) vaccinations among young people who have left school, to support our ultimate aim to eliminate cervical cancer by 2040. We will fully roll out lung cancer screening for those with a history of smoking
- create a new genomics population health service, accessible to all, by the end of the decade. We will implement universal newborn genomic testing and population-based polygenic risk scoring alongside other emerging diagnostic tools, enabling early identification and intervention for individuals at high risk of developing common diseases.

A devolved and diverse NHS: a new operating model

To realise the ambition of this Plan, we will create a new NHS operating model, to deliver a more diverse and devolved health service. Today, power is concentrated in Whitehall, rather than distributed among local providers, staff and citizens.

Our reforms will push power out to places, providers and patients - underpinned by an explicit goal to make the NHS the best possible partner and the world's most collaborative public healthcare provider. To achieve this, we will:

- combine the headquarters of the NHS and the Department of Health and Social Care, reducing central headcount by 50%
- make ICBs the strategic commissioners of local healthcare services. We will build ICB capability, and close commissioning support units
- introduce a system of earned autonomy and, where local services consistently underperform, step in with a new failure regime. Our priority will be to address underperformance in areas with the worst health outcomes. Our ambition over a 10-year period is for high autonomy to be the

norm across every part of the country

- reinvent the NHS foundation trust (FT) model for a modern age. By 2035, our ambition is that every NHS provider should be an FT with freedoms including the ability to retain surpluses and reinvest them, and borrowing for capital investment. FTs will use these freedoms and flexibilities to improve population health, not just increase activity
- create a new opportunity for the very best FTs to hold the whole health budget for a defined local population as an integrated health organisation (IHO). Our intention is to designate a small number of these IHOs in 2026, with a view to them becoming operational in 2027. Over time they will become the norm
- set higher standards for leaders, with pay tied to performance, and good work rewarded
- continue to make use of private sector capacity to treat NHS patients where it is available and we will enter discussions with private providers to expand NHS provision in the most disadvantaged areas
- work in closer partnership with local government and other local public services. We will streamline how local government and the NHS work together and make ICBs coterminous with strategic authorities by the end of the Plan wherever feasibly possible
- introduce a new patient choice charter, starting in the areas of highest health need. This will ensure the NHS is receptive and reactive to patient preference, voice and choice
- trial new 'patient power payments', which are an innovative new funding flow in which patients are contacted after care and given a say on whether the full payment for the costs of their care should be released to the provider.

A new transparency and quality of care

The NHS' history is blighted by examples of systematic and avoidable harm. The commonality in these tragedies has been a fundamental lack of transparency. We will make the NHS the most transparent healthcare system in the world.

From this foundation, we will reintroduce a new, rigorous focus on high-quality care for all. Specifically, we will:

- publish easy-to-understand league tables, starting this summer, that rank providers against key quality indicators
- allow patients to search and choose providers based on quality data on the NHS App, including length of wait, patient ratings and clinical outcomes. The App will also show data on clinical teams and clinicians
- use patient reported outcome measures and patient reported experience measures to help patients when choosing their provider on the NHS App
- set up a national independent investigation into maternity and neonatal services. We will also establish a national maternity and neonatal taskforce, chaired by the Secretary of State for Health and Social Care, to inform a new national maternity and neonatal action plan, co-produced with bereaved families
- reform the complaints process and improve response times to patient safety incidents and complaints
- change the time limit for the Care Quality Commission (CQC) to bring legal action against a provider and review how to improve patients' experience of clinical negligence claims
- reform the National Quality Board (NQB) with all other bodies, including Royal Colleges, feeding into it. We will task it with developing a new quality strategy as well as the development of modern

service frameworks. Early priorities will include cardiovascular disease, mental health, frailty and dementia.

- give all providers new flexibilities to make additional financial payments to clinical teams that have consistently high clinical outcomes and excellent patient feedback or are significantly improving care
- reform CQC towards a more data-led regulatory model. When concerns are identified, CQC will rapidly assemble inspection teams of highly qualified staff to assess service quality in greater detail
- make sure persistent poor-quality care results in the decommissioning or contract termination of services or providers, no matter the setting, no matter whether the provider is in the NHS or independent sector, and no matter whether they are a GP practice or an individual NHS trust.

An NHS workforce, fit for the future

It will be through the workforce that our 3 shifts are delivered. Because healthcare work will look very different in 10 years' time, we will need a very different kind of workforce strategy.

While, by 2035, there will be fewer staff than projected in the 2023 Long-Term Workforce Plan, those staff will be better treated, more motivated, have better training and more scope to develop their careers. The NHS will be not only the country's biggest employer but its best. To achieve this, we will:

- ensure every single member of NHS staff has their own personalised career coaching and development plan, to help them acquire new skills and practice at the top of their professional capability
- make AI every nurse's and doctor's trusted assistant - saving them time and supporting them in decision making. Over the next 3 years we will overhaul education and training curricula with the aim of future-proofing the NHS workforce
- work with the Social Partnership Forum to develop a new set of staff standards, which will outline minimum standards for modern employment. We will introduce these standards in April 2026 and publish data on them at the employer level every quarter
- continue to work with trade unions and employers to maintain, update and reform employment contracts and start a big conversation on significant contractual changes that provide modern incentives and rewards for high quality and productive care
- reduce the NHS' sickness rates from its current rate of 5.1%[10] - far higher than the average in the private sector[11] - to the lowest recorded level in the NHS
- give leaders and managers new freedoms, including the power to undertake meaningful performance appraisals, to reward high performing staff, and to act decisively where they identify underperformance
- develop advanced practice models for nurses and other professionals, and work across government to prioritise UK medical graduates for foundation and specialty training
- increase the number of nurse consultants, particularly in neighbourhood settings
- over the next 3 years, create 1,000 new specialty training posts with a focus on specialties where there is greatest need
- accelerate delivery of the recommendations in General Sir Gordon Messenger's review of health and care leadership[12] and establish a new College of Executive and Clinical Leadership to define and drive excellence
- introduce new arrangements for senior managers' pay to reward high performance and to withhold pay increases from executive leadership teams who do not meet public, taxpayer and

patient expectations on timeliness of care or effective financial management

- reorientate the focus of NHS recruitment away from its dependency on international recruitment, and towards its own communities - to ensure sustainability in an era of global healthcare workforce shortages. It is our ambition to reduce international recruitment to less than 10% by 2035
- create 2,000 more nursing apprenticeships over the next 3 years - prioritising areas with the greatest need. Expansion of medical school places will be focused on widening access to talented students from underprivileged backgrounds.

Powering transformation: innovation to drive healthcare reform

Our aim is to be in the driving seat of the biggest industrial revolution since the 19th century as we harness technology to create a new model of care in the NHS. We will use the UK's competitive edge - NHS data, life sciences prowess, world leading universities - to lead the world on the innovation that will most accelerate reform.

We have identified 5 transformative technologies - data, AI, genomics, wearables and robotics - that will personalise care, improve outcomes, increase productivity and boost economic growth. We will:

- create a new Health Data Research Service in partnership with the Wellcome Trust and backed by up to £600 million of joint investment
- make the NHS the most AI-enabled health system in the world with AI seamlessly integrated into clinical pathways
- support the Generation Study as it sequences the genomes of 100,000 newborn babies. This study will inform our longer-term ambition to make genomic sequencing at birth universal
- launch a new large-scale study to sequence the genomes of 150,000 adults this year - and assess how genomics can be used in routine preventive care. A new globally unique set of studies will explore personalised prevention of obesity, applying genomic and other insights to identify people who are at the highest risk of developing obesity
- make wearables standard in preventative, chronic and post-acute NHS treatment by 2035. All NHS patients will have access to these technologies, which will be part of routine care. We will provide devices for free in areas where health need and deprivation are highest
- beginning next year, expand surgical robot adoption in line with National Institute for Health and Care Excellence (NICE) guidelines
- establish new global institutes with the ambition to help the UK lead the world on science and innovation
- speed up clinical trial recruitment. By March 2026, clinical trials setup time will fall to 150 days
- expand NICE's technology appraisal process to cover devices, diagnostics and digital products. NICE will also be given a new role to identify which outdated technologies and therapies can be removed from the NHS to free up resources for investment in more effective ones
- introduce multi-year budgets and require NHS organisations to reserve at least 3% of annual spend for one-time investments in service transformation, to help translate innovations into practice more rapidly
- expand the role life sciences and technology companies can play in service delivery. We will streamline procurement of technology, and we will move to a single national formulary for medicines within the next 2 years.

Productivity and a new financial foundation

Today the NHS accounts for 38% of day-to-day government spending - a figure projected to rise to nearly 40% by the end of the Parliament[13]. While the NHS will need investment in the future, it is now self-evident that more money alone has not always led to better care.

The era of the NHS' answer always being 'more money, never reform' is over. It will be replaced with a new value-based approach focused on getting better outcomes for the money we spend. Our new financial flows will incentivise innovation to support the flow of money from hospital into community and reward best practice across the NHS.

Our three shifts each help secure financial sustainability. More care in the community is cheaper and more effective than care in hospitals. Digitalisation, as in other industries, will deliver far more productively for far lower cost. Prevention bends the demand curve. We will:

- urgently resolve the NHS' productivity crisis. For the next 3 years we have set the NHS a target to deliver a 2% year on year productivity gain
- restore financial discipline by ending the practice of providing additional funding to cover deficits. Over time, our aim is for the NHS to move into surplus, with the majority of providers achieving that by 2030
- break the old, short-term cycle of financial planning, by asking all organisations to prepare robust and realistic five-year plans, demonstrating how financial sustainability will be secured over the medium term
- deconstruct block contracts - paid irrespective of how many patients are seen or how good care is - with the intention of realigning the activity delivered and funding being provided by an ICB. Payment for poor-quality care will be withheld and high-quality care will attract a bonus. In addition, we will introduce new incentives for the best NHS leaders, clinicians and teams
- move from national tariffs based on average costs to tariffs based on best clinical practice that maximises productivity and outcomes. We will also test the development of 'year of care' payments starting in financial year 2026 to 2027. This will drive the shift of activity and resource from hospital to community
- distribute NHS funding more equally locally, so it is better aligned with health need. In the meantime, we will target extra funding to areas with disproportionate economic and health challenges.
- ensure all trusts have the authority to retain 100% of receipts from the disposal of land assets they own, and are able to use the proceeds from disposals across multiple financial years
- develop a business case for the use of Public Private Partnership (PPP) for Neighbourhood Health Centres, ahead of a final decision at the autumn budget
- explore a new mechanism for the NHS to access low risk pension capital
- in the longer-term, move to a new NHS financial model, where money will increasingly follow patients through their lifetime. Providers will be rewarded based on how well they improve outcomes for each individual, as well as how well they involve people in the design of their care, not solely on whether they provide episodic instances of care on demand.

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It’s change or bust

We choose change

The National Health Service stands at a historic crossroads. As Lord Darzi's independent investigation[14] into the National Health Service in England found, the NHS is in a 'critical condition'. Public satisfaction is the lowest it has ever been, millions are waiting for treatment and the health of the nation is deteriorating, dragging down the health of our economy with it.

The choice is stark: continue like this, making tweaks to an increasingly unsustainable model, or take a new course and reinvent the NHS through transformational change that will guarantee its sustainability for generations to come. This Plan chooses the latter: it represents a break with the past.

It sets out how we will reinvent our healthcare model. We need to move on from today's hospital-centric system, where patients are largely treated as passive recipients of disconnected episodes of care. Outdated ways of working, organising and thinking are being challenged by new developments in demography and technology just as much as they are by changes in disease patterns and social attitudes. This Plan has at its core - powered by exponential advances in human knowledge - the ambition to create a new model where patients are empowered to control their care.

That does not mean undoing the founding principles of the NHS: universal care, free at the point of use, based on need not ability to pay, funded from general taxation. Far from it. We will take these principles and then transform how care is delivered by harnessing the power of advances in technology and science. Today the NHS is behind the technological curve.

The scientific and technological revolution is reshaping the world. This Plan will put the NHS at the forefront of that revolution. It will be a service that offers instant access to advice and appointments. One which predicts and prevents ill health rather than simply diagnosing and treating it. A patient-controlled system, in place of today's centralised state bureaucracy and one where frontline staff are empowered to reshape services. A health service with the core principles and values of the NHS but with the know-how of a wider network of technology, life sciences, local government and third sector organisations, working in partnership to improve the nation's health. This plan aims to catalyse a new national effort to revolutionise the delivery of care.

Why change is needed

Both the public and staff recognise our current model of care is no longer fit for purpose. Over the past eight months, we have led the biggest national conversation about the future of the NHS in its history, with events involving over 4,000 staff and members of the public and 1.9 million visits to our Change NHS website, where 250,000 experiences and ideas for change were shared.

Voluntary organisations, community groups, MPs and healthcare organisations ran 650 events with 17,000 members of the public to reach the people we could not. We have consulted expert working groups made up of NHS and care staff, Royal Colleges, trade unions, think tanks, patient representatives, frontline NHS and care leaders, charities, economists, scientists, and tech entrepreneurs.

No one defends the status quo. Staff and patients are crying out for change.

There has never been such a consensus across all parts of the health service that it needs radical reform.

> **"There is a need, a real dire need to make it better now. And it is very clear that if something radical doesn't change, then the NHS as we know it will not be able to continue to exist"**
>
> ***Jess, public deliberative event participant in Leicester, November 2024***

This government agrees that the status quo is no longer an option. Today's NHS is broken. Patients are seen too late when they should be diagnosed earlier. Prevention and care in the community plays second fiddle to treatment in hospital. Children are sicker today than a decade ago and adults are falling into ill health earlier in life. Patients have little say and even less choice.

Worse, the NHS is leaving behind those that need it the most, with working class communities most impacted by this failure. This is an intolerable injustice. In the current system, areas that have the highest need for the NHS have the fewest GPs, the worst performing services, and the longest waits. The most deprived people spend more of their lives in ill health, life expectancy among women with the lowest incomes is falling[15], while infant mortality is twice as high among Black people than White people[16].

Over recent years, those who can afford to opt out have been voting with their feet. More people are paying for private medical insurance[17] and out-of-pocket expenditure on healthcare is growing faster here than in any other G7 country[18]. Nearly half of younger people now say they would consider paying for private treatment[19]. The public is increasingly anxious about the future of the NHS. A poll on the 75th anniversary of its founding revealed that 7 in 10 people believe more charges will be introduced over the next 10 years[20]. Some may argue this is a good thing if it reduces demand on an overstretched health service, but this government sees it as a sign of failure.

The NHS was never intended to be just a safety net only for those who cannot afford to pay. Such a healthcare system would be doomed to provide a low-quality service, widen inequalities and to lose public support, as better-off taxpayers question why they are asked to pay for a service they do not use. Yet, as more people with the means to do so choose to go private or take out private medical insurance, that is the path we are on. The very real risk is that the NHS becomes a poor service for poor people.

For the first time in a generation some politicians are openly calling for the NHS' founding principles to be abandoned and the taxpayer-funded, free at the point of need health service to be scrapped. This would be a devastating mistake. We choose to reform the NHS, not give up on it.

It is time to move beyond a "one more heave" iterative approach to change and instead take a decisive leap to propel the NHS into the modern age. That is needed because it is more than just a decade-long organisational upheaval and 'stop:go' funding that has brought the NHS to its knees. The problems go far deeper than either. In the 21st Century, 4 big factors are shaping healthcare of the future. Each presents a challenge but also an opportunity.

First, an ageing population living with multiple health conditions. That will require more seamless services. The challenge is that as today's generations grow old, they are far more likely to want to live out the end of their lives cared for in their own homes with more choice and control over how their care is delivered. The opportunity is to refashion

care so that it is aligned with that more independent mindset.

Second, changes in illness. More than a quarter of the population have a long-term health condition[21], and they now account for 65% of NHS spending[22]. The NHS today is no longer just a safety net to help people in crisis - it must provide a continuous service for those who have a chronic illness. The challenge is to shift from a model of care that is episodic and disempowering, to one that is continuous and empowering. The opportunity is to enable patients to exercise greater control over both their health and care.

Third, higher public expectations. How the NHS provides services is stuck in the past. We order goods, socialise, and do our banking at the touch of a button. Yet booking an NHS appointment means queueing on the telephone, or even outside a GP's surgery, and waiting for letters that never arrive. It is not that the public want surgeries or hospitals to behave like supermarkets or salesrooms. The relationship people desire is personal, not transactional. The challenge is to find new ways of treating each patient as an individual rather than as just another number. The opportunity is to harness that appetite for knowledge and control to give patients greater voice and far more choice.

Fourth, increases in cost. In 2010, we spent below the OECD average on healthcare and achieved above average outcomes[23]. Today we spend the average and achieve worse outcomes. More resources have failed to deliver corresponding improvements in productivity or performance. The NHS today accounts for 38% of day-to-day government spending – a figure projected to rise 40% by the end of the decade[24] - crowding out investment which could tackle the wider social determinants of ill health. That is unsustainable. This Plan ends the era of more money being the answer to every problem. We have to get more out for what is being put in. That is a challenge, but it is also an opportunity to adopt a new value-based approach, obtain better value for taxpayers' money and secure the sustainability of all public services.

Why change is possible

Despite the challenges, there are more reasons for optimism than pessimism. The NHS has unique advantages in seizing the opportunities that lie ahead[25]. We stand at the cusp of an era where data and AI will fundamentally transform healthcare; where a digital healthcare revolution promises to unlock a new era of access and choice; where new discoveries in preventative medications offer to transform population health; and where genomics and predictive analytics will deliver an increasingly sophisticated understanding of individual health risk, powering a totally new approach to prevention.

The NHS is the best-placed system in the world to harness these advances. We have examined how other countries fund and provide healthcare and have concluded that the new age we are entering of being able to predict and prevent ill health make the NHS' principles the best ones from which to build into the future:

- It has unparalleled data: The NHS has the best population health data in the world. It has extensive population coverage; it covers people cradle-to-grave; and it is not skewed by people's ability to pay for healthcare. The NHS number is a powerful tool for data linkage across different settings. As healthcare becomes more data-driven, the NHS has a huge advantage
- It is more efficient by design: As a single-payer, it has marked advantages in securing the best price for innovative treatments – making it far more able to deliver a new era of personalised or preventative medicines. And it does not need to run complicated co-payment schemes, making it one of the cheapest

health systems to administer in the world[26]

- It will thrive with predictive technology: Fields like genomics are making it easier to understand each individual's health status and health risk. As need becomes more predictable, insurance models begin to break down – as insurers compete to avoid covering high-risk individuals. On the other hand, the NHS covers each individual 'from cradle to grave' and has a natural incentive to take advantage of this new science, which will in turn create huge health and economic benefits.

This Plan describes how we will use these advantages to propel the NHS into a position of global leadership. When coupled with our country's excellence in science, innovation and academia[27], the UK can lead the world in developing the treatments and technologies of the future.

It is the collision of huge advances in genomics and analytics that will allow our whole model of health care to be transformed. Inexpensive gene sequencing will allow doctors to routinely diagnose and treat patients based on information about their individual genomes. It is possible in the future that gene editing will allow us to cure rather than just treat diseases[28]. Vaccines for a wide range of chronic illnesses are already in clinical development.

In the next decade science will reveal the nature of a baby's personal genome, giving parents and clinicians the ability to unlock the secrets of a child's future health. This Plan will put the NHS at the forefront of the global genomics revolution. Advances in AI technology will assist patients and clinicians, accelerate drug discovery and extend the predictive nature of genomics. This AI will also be an early warning system, detecting subtle signs of health changes by analysing data from wearables, lifestyle and medical records to trigger timely interventions at an individual and a population level. Pre-disease states, before a person displays symptoms, will be identified and targeted. This Plan will make the NHS the most AI-enabled care system in the world.

Getting upstream of ill health and making a reality of precision medicine will not only improve outcomes, but also contain costs. As this Plan sets out, we will put the NHS on a sustainable footing by adopting a new value-based approach, that aligns resources to achieving better health outcomes. In turn, we will unlock broader economic benefits for the UK, helping to get people back into work and providing a bedrock for the industries of the future. This Plan will transform the NHS into an engine for economic growth rather than simply being a beneficiary of it.

Improving NHS productivity is a key focus of this Plan. Our approach is not to ask for more, but to stop doing things that are not productive, or do things differently. Home based hospital models, supported by community teams, can cost as little as one fifth of inpatient care[29]. Two-thirds of outpatient appointments - which currently cost in total £14 billion a year[30] - will be replaced by automated information, digital advice, direct input from specialists and patient-initiated follow ups as we introduce a new digital front door to the NHS via the NHS App. Patients simply being able to book an appointment digitally will generate significant savings in comparison to today's convoluted process[31]. AI-backed ambient voice technology will automate clinicians' note-taking, delivering a significant productivity gain while also allowing them to better engage with patients. Shifting the focus from sickness to prevention will reduce the burden of disease and improve health and life expectancy.

How change will happen

We will reimagine the NHS through 3 radical shifts. The shift from hospital to community will reverse decades of services becoming ever more distant from local communities through a historic expansion of provision in people's neighbourhoods. By bringing more

integrated services into local communities, patients will have more power to tailor care to their individual needs and more convenient access. The shift from analogue to digital will transform the NHS from being a bricks and mortar service to a digitally led one, where patients can access care online and offline 24 hours a day, 365 days a year. By embracing the digital revolution, we will give patients the ability to control their appointments, choose their providers and access the help they need to manage their health and their care. By working with partners to make the healthy choice the easy choice, we will transition the NHS from a sickness service to a prevention service, powered by the new engine of genomic science.

There are 3 shifts, but only one core purpose: to put power in patients' hands. By equipping patients with more choice and voice in the system, the most disadvantaged communities will have the agency and opportunities that better-off citizens take for granted. We will end the class divide in healthcare by giving power to people who have always been denied it. This Plan is unashamedly a means of redistributing power in our society.

The prize is enormous, but realising this opportunity will require a programme of profound change. Today's NHS is not set up to harness the technology advances we are seeing. We will need new types of skills in the workforce. We will need new infrastructure in the community. We will need new reforms to how the system is organised and how money flows around it. We will need to embrace technology and build new partnerships with innovators. We will need new ways to actively empower patients. This Plan describes what those changes will be and how they will happen.

First a new operating model to drive devolution. Improvements in care will be driven less by top-down regulation and more by bottom-up transparency, with performance more open to public scrutiny and patient input than ever before. There will be greater plurality of provision, and the best NHS providers will be in charge of improving the health of whole local populations. A new choice charter will not only give patients more power, but will create new incentives for improved service performance. This will be underpinned by changing how NHS money is allocated and creating sharper incentives and a new pay-for-performance culture that will drive better value and outcomes.

Second, that same philosophy will create a new workforce model which aims to harness the ingenuity of staff working at the frontline of healthcare and which gives them the freedom to innovate. The NHS will remain stuck in the past unless its staff are freed up to shape the future. This profound change in culture will mean embracing reforms to skill mix and training to allow more clinical tasks to be performed by nurses and allied health professionals - backed by AI - liberating doctors to work to the top of their license.

Third, embracing partnership. Instead of going it alone, the Plan sets out how the NHS will create new collaborations with commercial partners, universities, councils and mayors, and make five big technological bets. This will accelerate transformation and, in the process, make our country a global leader in health innovation. Doing this entails a shift in mindset to think of healthcare less as a single institution and more a wide network, with more NHS resources being spent on the new technologies that can improve population health and deliver better care.

This transformation will take time, so this is unashamedly a 10 Year Health Plan. The scale of transformation over 10 years will require us to test, learn and grow as we implement, in line with the Government's public service reform principles. The pace of delivering the commitments over the full 10 years of the Plan will be subject to future decisions outside the scope of this Plan, for example through planning guidance rounds, future government Spending Reviews or wider changes in economic and fiscal circumstances.

The process of change has to begin at once. The pace of change in healthcare and science is electric and will only quicken in the years ahead. So, we have to actively prepare now to harness the benefits of the healthcare revolution that is already underway and set the NHS up not just to embrace the future but to lead it.

By the end of this Parliament the NHS will be back on its feet and we will have laid the foundations of longer term transformation. Within 10 years the NHS will look very different from today.

Its model of care will have been transformed into a world-class service where citizens know their risks from birth, where clinical staff and AI work together to provide instant access to help, where patients have a 'doctor in their pocket', where neighbourhood health has replaced outpatient care, and where diseases are increasingly prevented before they happen.

Securing the NHS' founding promise in the 21st century

We are living in an era of profound economic, social and political change. But one thing remains constant: an NHS that is based on the enduring core principle that care is publicly funded, universal, free at the point of use.

That principle is more relevant than ever in today's world, and this Plan upholds it.

It is the practices of the NHS that need to change to make it relevant to this and future generations of patients.

When the NHS was created in 1948 it was a revolution. For the first time, it made universal healthcare accessible to the public. But its creator, Nye Bevan, never intended for it to be preserved in aspic. Instead, he compelled future generations to embrace modernisation, decreeing that the NHS "must always be changing, improving."[32]

The scale of change today, however, has to be greater than ever before. The need is greater because the NHS risks becoming obsolete without it. And the potential for change is greater because the NHS is better placed than any other system in the world to harness the healthcare revolution that has begun. That is why this Plan is a reimagining - one to make the NHS fit for the future.

We are already making significant progress in getting the NHS back on its feet

- Over 4.1 million extra elective appointments delivered since July 2024[33]
- Hospital waiting lists are falling, dropping over 200,000 since July 2024[34]
- Over 160 Community Diagnostic Centres are now open – allowing people to get diagnostic tests and scans closer to their home[35]
- 10 new or expanded surgical hubs opened over the last year, and another 7 will be open by August 2025[36]
- Rolled out the first of our updates to the NHS App to give patients more choice and control – with patients now able to track prescriptions through it[37]
- Invested an extra £889 million on top of the existing budget for general practice with £102 million for upgrades to 1,000 GP surgeries[38] [39]
- Agreed a deal with GPs for better services for the first time in four years[40]
- Recruited over 1,700 newly qualified GPs since October 2024[41]
- Frozen prescription charges to help with the cost of living, and invested in pharmacies so people can get more support on their doorstep, including mental health support and free emergency contraception[42]
- Above inflation pay rises for NHS staff for 2 years in a row[43]
- £120m funding for 85 dedicated mental health emergency departments[44]
- Over halfway towards our target of recruiting 8,500 extra mental health workers[45]
- Committed to a national roll out of mental health support teams in schools, with almost 1 million more young people set to benefit this year[46]
- Announced 40 same-day emergency care centres to be built this year[47]
- £750 million for 400 hospitals, mental health units and ambulance sites to fix their buildings[48] and new radiotherapy machines for 28 hospitals[49]
- Committed to a new health data research service so that scientists can develop the treatments of the future[50], such as the world-leading trial to speed up diagnosis of 12 of the most common and lethal cancers using a blood test.[51]

02

From hospital to community

The Neighbourhood Health Service designed around you

This is a Plan to put power in patients' hands. To do that, we need to create an NHS that delivers convenient care, at a time and place that fits around people's lives. Where it's easy to get health advice or book a GP appointment. Where people can personalise their care to their own individual needs, choices and preferences. The NHS must work for its patients, not demand they fit around the way it has chosen to organise care.

Our public engagement was clear: the NHS is far from that vision today. Too often, using the NHS means navigating a complex web of services; making many trips, at personal cost, to see different professionals on different days; or being forced to constantly repeat yourself to professionals who have not talked to each other, or had proper access to your medical records.

There are 2 reasons for this unsatisfactory status quo. First, more and more staff and resource have been concentrated in hospitals - while in parallel, hospitals have become further distanced from many local communities - embedding a model where 'you come to care', rather than one where 'care comes to you'. Second, that healthcare in this country is organised into multiple, fragmented siloes - across community care, primary care, mental healthcare, hospitals, social care providers, local government and the voluntary sector. If the NHS doesn't feel like a single, coordinated, patient-orientated service, that's for a simple reason: it isn't one.

> **"My mother has dementia, and it has been a frustrating journey navigating between the right parts of the NHS and more widely how the NHS community and hospital settings interact with other services such as the GP and the local council. There is no cohesion, no clarity of who should help, lots of signposting of services and people who can help but no-one taking responsibility for a solution.**
>
> ***Muhammed[52], public participant, via Change NHS website***

This doesn't work for anyone. But it works least well for those who already experience disadvantage. They are far more likely to have complex needs, making poorly joined up care particularly ineffective. And they are less able to take the time off work or secure the childcare cover they need to fit into the NHS' '9-5' appointment availability. This is the inverse care law in practice[53].

> **"It is a bit of a catch 22 for the NHS at the minute. Everything's 9 to 5 and it is also about encouraging people with health conditions and disabilities to get back into work. So, I work as much as I am able to, but those appointments drop in the letter box pretty much every week and sometimes I find myself with 3 appointments across 3 different days. Smack bang in the middle of a working day. I can either work or I can go to appointments."**
>
> ***Hannah, public deliberative event in Leicester, November 2024***

The neighbourhood health service is our alternative. It will bring care into local communities; convene professionals into patient-centred teams; end fragmentation and abolish the NHS default of 'one size fits all' care. It will transform access to general practice and prevent unnecessary hospital admissions. It will help reintegrate healthcare into the social fabric of places.

Most importantly, it will be a service where good outcomes no longer depend on a patient's ability to navigate complexity, advocate for themselves loudly or skip a shift at work. Its promise is simple: for those who have felt like the NHS is designed for almost anyone else, the neighbourhood health service will put them first.

As first steps to deliver the neighbourhood health service, we will restore GP access and ensure a far better experience of arranging care. People with complex needs will be offered a care plan and supported to personalise their care.

Securing the financial sustainability of the NHS

The neighbourhood health service will not only ensure our model of care is fit for the future. It will also put the NHS back on the path to long-term financial sustainability.

Our choice to do more in the community, and to bring more staff and resource into the places people live as a result, will achieve substantial value. For example, analysis commissioned by NHS Confederation found that systems that invested more in community care saw on average 15% lower non-elective admission rates and 10% lower ambulance conveyance rates, together with lower average activity for elective admissions and A&E attendances[84].

More specifically, the more integrated and coordinated care provided by the Neighbourhood Health Service will support NHS sustainability in a range of ways:

- More integrated working within the NHS – and between the NHS, local government and voluntary sector - can deliver large efficiencies. A recent systematic review showed a 6% reduction in costs and a 6% improvement in patient outcomes from integrated care[85]
- Where Integrated Neighbourhood Teams have been trialled in England, they have significantly reduced hospital use. In Derby[86] integrated teams led to 2,300 fewer Category 3 ambulance callouts and 1,400 fewer short hospital stays among the over 65 population within a year
- Evidence shows care plans and personal health budgets both improve outcomes and deliver value. One evaluation[87] in England found they delivered quality of life improvements worth between £1,520 and £2,690 per patient, per episode of care
- Different approaches to bringing hospital care to people's home reliably show value improvements. For example, one trial[88] found that Hospital at Home is less expensive than inpatient treatment, with average savings of £2,265 per patient, per care episode
- Our creation of digital-and-AI enabled modern hospitals draw on international evidence that they can deliver more productive and higher quality care. South Korea's smart hospital network[89] has shown promise in driving efficiencies, higher staff satisfaction and better patient outcomes

We will fully digitally enable the Neighbourhood Health Service, with the NHS App allowing patients to book appointments, communicate with professionals, see who is on their team, share their data, receive advice and self-refer or tests: a 'doctor in the pocket' of every patient. For those who need them, neighbourhood teams - organised around people with similar needs, rather than into NHS institutional siloes - will deliver truly seamless care, in the community. For the first time in the NHS' history, personalisation and convenience will become the default.

As we do more in the community - funded by a reduction in hospitals' share of total NHS expenditure - we will reduce demand on hospitals.

It will be by preventing demand and boosting operational productivity that we can restore constitutional waiting time standards and deliver increasingly innovative hospital care.

By 2035, the Neighbourhood Health Service will have further evolved to fully incorporate genomic data, digital tools and technology. The Single Patient Record (outlined in chapter 3), supplemented by advances in genomic data, will enable personalised predictive care. Instead of spotting a symptom and joining a long waiting list, neighbourhood care will increasingly happen before a disease happens, enabling a real and transformative shift to prevention.

A new era for general practice

The 2024 GP Patient Survey[54] found that over 25% of people did not have a good experience of making a GP appointment the last time they needed one. GP access has become so poor that A&E has become some people's de-facto primary care, particularly in more disadvantaged areas, where there are far fewer GPs per head.

That is no foundation from which to build the Neighbourhood Health Service. We will act to end the 8am scramble for GP appointments and bring back the family doctor.

> **"My local GP surgery, we call it 'the ghost', the ghost surgery. Because if you go down there, well, you can no longer actually make an appointment."**
>
> ***Douglas, public deliberative event in London, December 2024***

This means we will need more capacity in primary care. Our work has already begun. Between October 2024 and April 2025, we recruited 1,700 extra GPs[55]. We will train thousands more in the coming years, and through the course of this Plan we will increase the proportion of staff we train for community and primary care roles, as outlined in chapter 7.

We will also free up GP capacity. Across the country, GPs told us how the burden of bureaucracy steals joy from work and time from patient care. We have already cut down central targets and, as a next step, we will deliver the recommendations of the 'Red Tape Challenge' - a programme to identify and then cut needless bureaucracy.

In the next 2 years, we will support providers to roll out technology to cut unnecessary administrative and clerical work. Ambient voice technology ('AI scribes'), digital triage and the Single Patient Record will end the need for tasks like clinical note taking, letter drafting and manual data entry. We estimate that saving just 90 seconds on each appointment would generate over 2,000 full time equivalent worth of GP capacity[56], with local trials showing that ambient voice technology can achieve this on its own[57]. That will mean more appointments, at more convenient times, and better continuity of care for those with complex needs.

In parallel, we will end the 8am scramble - a feat some local GP practices have already achieved. To scale their success, we will build AI-powered online advice into the App (via the My NHS GP tool, chapter 3). We will also use digital telephony to ensure all phones are answered quickly.

Case study: 'Total Triage' – ending the '8am scramble' - Brondesbury Medical Centre in London

Brondesbury Medical Centre[90] has transformed access to care by introducing a total triage system, which has significantly improved patient access and reduced staff pressure. The practice, serving a diverse urban population, had previously struggled with high call volumes and long waits at peak times.

All patient requests, whether submitted online or by phone, now go through a streamlined online e-consultation digital triage process. Reception staff support patients without internet access by completing the online form on their behalf, ensuring equitable access.

Since adopting this approach, online requests have increased tenfold, while phone calls have dropped significantly. Routine appointment waits have fallen from 14 days to 3 days, with over 95% of patients seen within a week. The new system also makes it easier to match patients with the right clinician, improving continuity of care. As a result, patient satisfaction has risen from 66% to 85%, reflecting quicker access, better outcomes, and a more responsive service.

Case study: Primary care at scale

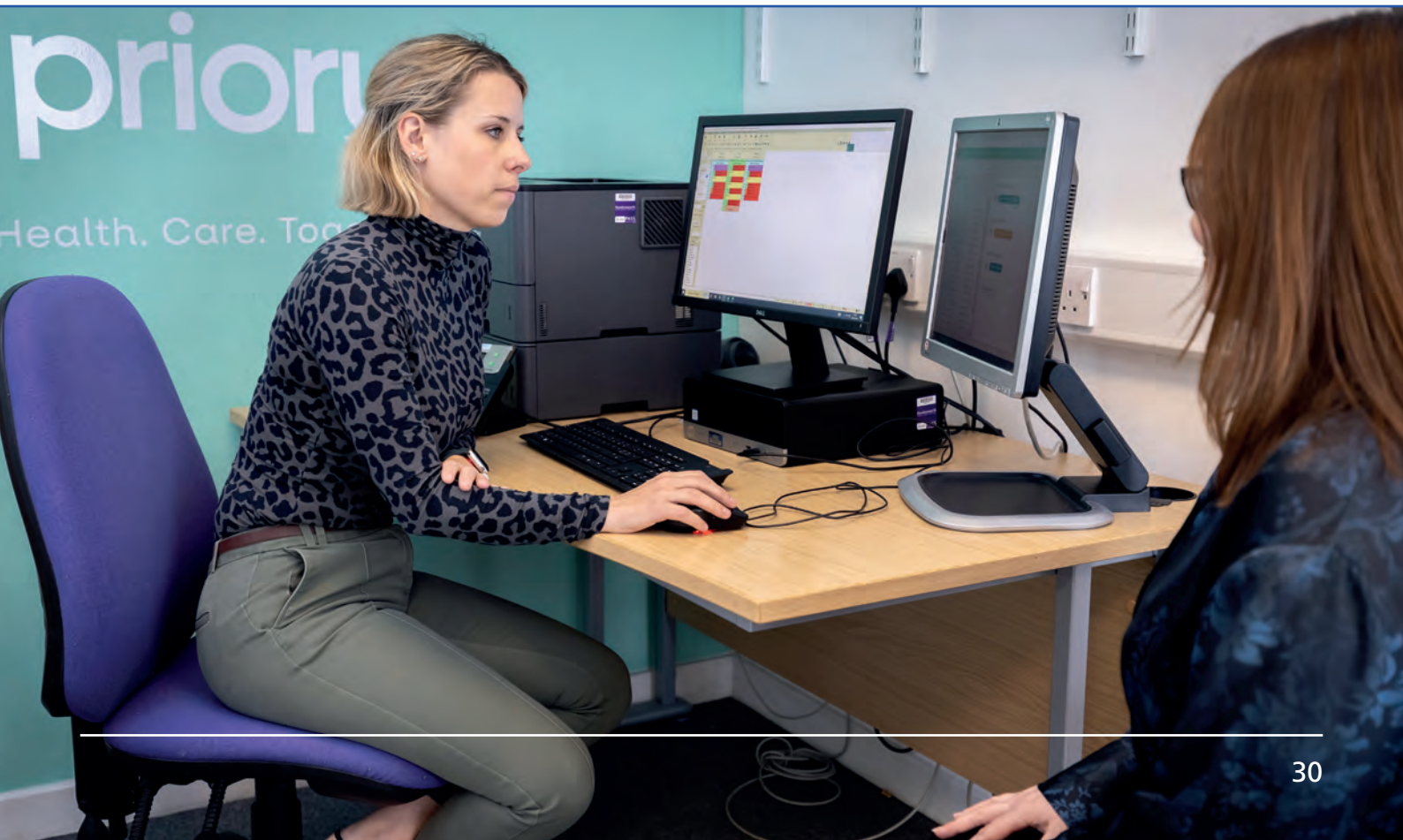
Primary Care Sheffield[91] is a social purpose organisation rooted in the values of the NHS, founded by the city's GPs. It delivers support to its membership – the 69 GP Partnerships and 16 primary care networks in the city – whilst also directly managing a further 9 GP surgeries. Through its 442 staff, many deployed at a neighbourhood level, it delivers a range of services to a population of 600,000, from diagnostics (24-hour electrocardiograms, tele-dermatology) to a home visiting service.

The scale of Primary Care Sheffield offers significant resilience to GP practices in the city, through the provision of shared back-office functions and flexing capacity across practices during busy winter and bank holiday periods. During the winter of 2023 to 2024, one of the highest periods of demand for the NHS on record, it provided over 12,000 additional respiratory illness appointments, and a further 15,000 additional appointments for children. It also supports the wider healthcare system, with evidence of lower hospital use, better uptake of contraceptive services and significant extra care capacity for patients with severe mental illness.

Those who need it, will get a digital or telephone consultation for the same day they request it. Enhanced access could have wide-ranging benefits, for example by reducing the need for parents to take children out of school for medical appointments.

However, truly revitalised general practice will depend on more fundamental reform. Having served us well for decades, the status quo of small, independent practices is struggling to deal with 21st century levels of population ageing and rising need. Without economies of scale, many dedicated GPs are finding it difficult to cope with rising workloads. Far too often, that means work is causing chronic stress and mental illness among hardworking professionals. Many GPs are voting with their feet: 74% of fully qualified GPs were partners in 2015, compared to just 55% today[58].

Where the traditional GP partnership model is working well it should continue, but we will also create an alternative for GPs. We will encourage GPs to work over larger geographies by leading new neighbourhood providers. These providers will convene teams of skilled professionals, to provide truly personalised care for groups of people with similar needs.



Fixing the Foundations in Dentistry

Satisfaction with NHS dentistry has fallen to a record low; from 85% in 2019 to 69% in 2024[92]. The British Dental Association estimates 13 million adults - over 1 in 4 - are struggling to find NHS dental care[93].

Worse, evidence[94] shows that even amongst those who do get appointments, it is patients with the greatest clinical need who miss out. Today, more people are paying for private treatment, while those who cannot afford the cost go without- leaving them unable to eat properly, work, or, in some instances, forced to resort to DIY dentistry. We will continue our urgent action to improve NHS dentistry in the short term and lay the foundations to make it fit for the future.

By 2035, the NHS dental system will be transformed, so it provides high quality care at the right time, and nobody goes without because they cannot afford it. We will build a service which is attractive to, and values dental care professionals. With a new dental contract at its heart, NHS dentistry will be more transparent for patients. It will provide more readily accessible, good quality care - including better prevention - to those most in need.

Our first step is to stabilise NHS dentistry and make sure the budget we have is spent on those who need care most. Initially, we will prioritise urgent care. We have already made progress this year, creating capacity for 700,000 additional urgent appointments.

Training a dentist costs the taxpayer up to £200,000[95]. Having consulted on the principle of requiring all dentists to work in the NHS for a minimum period, we will now make it a requirement for newly qualified dentists to practice in the NHS for a minimum period. We intend this minimum period to be at least 3 years. That will mean more NHS dentists, more NHS appointments and better oral health.

In parallel, we will deliver a step change in prevention. Children will be our urgent priority. Tooth extraction is the leading cause of hospital admission among children aged 5 to 9 years old, yet it is almost entirely preventable[96]. We will improve access to dental care for children, making better use of the wider dental workforce, especially dental therapists, including through a new approach to upskill professionals to work at the top of their clinical potential beginning in 2026 to 2027. This will build on our supervised toothbrushing programme and expand the use of fluoride varnish and fissure sealants — proven interventions that significantly reduce decay.

We will expand community water fluoridation in the north east of England from 2028 so that it reaches 1.6 million more people by April 2030. We will assess further rollout in areas where oral health outcomes are worst. And we will refurbish older, existing water fluoridation schemes in the north east, west midlands and east of England, benefitting a further 6 million people by 2030.

In the short-term, we will work with dentists to improve the dental contract. From financial year 2026 to 2027, payments will better reflect the cost of treating patients with higher needs, and we will reduce low-value activity — including check-up frequency exceeding that stipulated in the National Institute for Health and Care Excellence (NICE) guidance, through changes to financial incentives and improved system oversight. These changes will improve access to care and ensure dentists are rewarded fairly.

We are clear that even greater change is needed. This year, we will begin the process of more fundamental contract reform. We want a contract that matches resources to need, improves access, promotes prevention and rewards dentists fairly, while enabling the whole dental team to work to the top of their capability.

Our Neighbourhood Health Service will

provide opportunities for dental care professionals, including dental therapists and dental nurses, to work as part neighbourhood teams to provide integrated and proactive care in a way that meets individual needs while also maximising the capacity and capability of the workforce. Dental therapists could undertake check-ups, treatment, and referrals, while dental nurses would lead individual and community oral health education efforts. The work therapists cannot do would be safely directed to dentists.

Similar approaches are already being adopted in some areas. For example, a Paediatric Dentistry Advice Clinic model has transformed the Whittington's Community Dental Service's ability to enable every child in their catchment of north west and north central London to get timely access to specialist-led dental care. A consultant dentist in London provides virtual support to a community dental team, enabling them to treat children within their service and preventing onwards referral to secondary care.

We will introduce 2 new contracts, with roll-out beginning next year. The first will create 'single neighbourhood providers' that deliver enhanced services for groups with similar needs over a single neighbourhood (c.50,000 people). In many areas, the existing primary care network (PCN) footprint is well set up as a springboard for this type of working. The second will create 'multi-neighbourhood providers' (250,000+ people). These larger providers will deliver care that requires working across several different neighbourhoods (e.g. end of life care).

Multi-neighbourhood providers will also be responsible for unlocking the advantages and efficiencies possible from greater scale, working across all GP practices and smaller neighbourhood providers in their footprint. They will support sustainability and professional autonomy by delivering a shared back-office function, overseeing digital transformation and estate strategy, and by providing data analytics and a quality improvement function. They will be large enough to create new commercial partnerships, including clinical trials, so that the Neighbourhood Health Service becomes a hotbed for innovation. And they will actively support and coach individual practices who struggle with either performance or finances - including by stepping in and taking over when needed. In some places this role is

already being played by GP federations, with excellent results. We will also give integrated care boards (ICBs) freedom to contract with other providers for neighbourhood health services, including NHS Trusts.

Convening neighbourhood teams

Too often, the NHS has tried to get around its fragmentation by creating ever more complicated schemes to support collaboration, without ever actually breaking down its own institutional siloes. Neighbourhood providers will enable an altogether simpler approach.

They will convene a diverse mix of professionals into new neighbourhood teams. They will draw on the full talents of the NHS, across primary, community and acute settings - but they will also have the flexibility to include staff from other sectors where they are involved in a patient's care. For example, professionals working in hospice outreach services will be part of teams delivering high quality end of life care.

Social care professionals will be part of teams and we will deepen their involvement in rehabilitation, recovery and frailty prevention. We will work with social care organisations to enable care professionals to carry out more healthcare activities, such as blood pressure checks, to help people receive more proactive and timely care. We will also improve pay, terms and conditions for social care staff through Fair Pay Agreements. In the longer-term, our creation of a National Care Service, informed by Baroness Louise Casey's independent commission into adult social care, will support better integration of health and care services.

We will expand the talents of neighbourhood teams by scaling new roles. As we developed this Plan, we saw successful models such as community health workers - who lead community outreach door-to-door, street-to-street. We also saw the impact of peer support workers – people who are experts by experience and help others to better manage their care. We welcome these innovations, and local areas will have the ability both to trial new roles and to adopt existing, proven models. We also know volunteers can play an important role in supporting neighbourhood services and we will help neighbourhood teams draw on this through a new central platform for NHS volunteers, launching later this year.

This approach has demonstrated impressive results when trialled locally. For example, the Birmingham & Solihull Community Care Collaborative is pioneering the shift from hospital to community, deploying multidisciplinary teams and implementing a new data-led care model. Washwood Heath, a new hub in East Birmingham, has seen A&E attendances fall by over 30% in the last 12 months among targeted patients, and length of hospital stay fall 14%. Focused on prevention and early intervention, this approach is now being rolled out across Birmingham and Solihull.

Case study: Community health and wellbeing workers ("Chewies")

Inspired by Brazil's successful family health strategy, community health workers visit residents in their homes on a monthly basis. They build personal relationships, rather than delivering transactional care – allowing the service to identify health and social needs early and personalise support.

Their impact has been significant. For example, a one-year evaluation of Westminster's CHWW programme[97] - one of the country's most established - showed a 47% increase in immunisation uptake and an 82% increase in cancer screening and NHS Health Check uptake in visited households (compared to unvisited households), while hospital admissions fell by 10% and emergency department visits by 7% among people living in postcodes covered by the service.

Personalised, patient-centred care

Patients will not just be passive recipients of care: in the Neighbourhood Health Service, they will be active partners in its delivery. We will support this in several ways.

First, through care plans. These are a vital enabler of seamless care. Evidence shows high-quality care plans can improve care experience, while also achieving a return on investment of £3 to the £1 spent on those who use healthcare most often[59]. However, recent data also shows only about 20% of people with a long-term condition have one[60]. We will set a new standard that, by 2027, 95% of people with complex needs will have an agreed care plan. We will expect all care plans to be co-created with patients and cover their holistic needs, not just their treatment. They will align with national standards for high-quality care but, within that, give patients significant choice and freedom.

Unpaid carers will also be actively involved in care planning. We will mirror the inclusive practices of family group conferencing, which are meetings where family, friends and carers agree decisions about care together. We will capture information about unpaid carers systematically, to ensure their responsibilities are recognised and supported.

Second, as we outline in chapter 3, we will support patients to manage and direct their care digitally through the NHS App. By 2028, patients will be able to see who is involved in their care, communicate with professionals directly, draft and view their care plans, book and hold appointments and leave feedback. For many people, this will mean they can access all they need from their neighbourhood team. This will include both booking and holding appointments with health professionals through their phone.

Third, we will expand uptake of Personal Health Budgets (PHBs). PHBs help patients manage how their health and care needs are met. In their simplest form, a patient is told how much money is available for their assessed needs and they then work with their care team to decide how to spend it. That might be on physiotherapy, mobility aids, a choice of wheelchair, or on activities to support them to get involved in their community.

Evidence shows that this approach not only improves patient experience and quality of life, but helps patients become active partners in their care. 180,000 people benefit from PHBs today[61] and we will at least double the number offered a PHB by financial year 2028 to 2029, increasing this to 1 million by 2030. We will make PHBs a universal offer for all who would benefit from them by 2035. For example, this will help make end of life care from hospices or the voluntary sector, more easily accessible for people at the end of their life (where appropriate), and their families, helping people die in the place of their choosing.

Fourth, we will support patients to be more active in the delivery of their own care, recognising that people are the authority in managing their own health conditions. Good self-care depends on having the right knowledge, skills and support. However, evidence shows large inequalities in access to these resources, including by class and ethnicity. We will partner with a range of charities to deliver new, formal support that helps people with a new diagnosis manage their condition and live their lives.

These will be the foundations through which we abolish ‘one size fits all’ care.

In the next 3 years we will roll out this new approach to the groups most failed by the current system - to maximise our ability to improve lives, ease pressure on hospitals and adult social care, and support the health service’s financial sustainability.

- People with long-term conditions will benefit from teams that include hospital specialists, GPs and other care professionals, meaning better health outcomes, fewer complications and

fewer unplanned hospital visits. They will have access to advice, guidance, self-care support and appointment management via the NHS App (see chapter 3).

- People living in care homes or who have frailty are particularly likely to experience poor outcomes when their care is poorly coordinated. They often end up in hospital unnecessarily and can lose their independence while there.
  Care will come to them, including hospital care - supported by wearables and other monitoring technology. 'Call before convey' will avoid unnecessary transfers to hospital, and teams spanning health and social care professionals will help integrate care.
- People nearing the end of their lives often do not have the support they need for a good death, in the place of their choosing - which for most people is their home. Community-based advice and support will help more people die in their home, while community teams will work closely with care homes and paramedics to share care plans to avoid people being taken to A&E by default. Teams will include hospice outreach staff and palliative care professionals. Rapid response teams will help symptom management, including pain.
- People with severe and enduring mental illness face being bounced from one service to another, with little to no continuity. For many, care only comes during a crisis, with emergency departments acting as the default care provider. Even then, waits are unacceptably long - with recent Royal College of Nursing research[62] finding that some people with mental health crises faced waits of up to 3 days in emergency departments before admission. We will transform mental health services into 24/7 neighbourhood care models. We will improve assertive outreach care and treatment to ensure 100% national coverage in the next decade, with a focus on narrowing mental health inequalities.
- Disabled people often do not get the

A care model for every neighbourhood

Neighbourhood services will be designed in a way that reflects the specific needs of local populations. While we will be clear on the outcomes we expect, we will give significant licence to tailor the approach to local need. While the focus on personalised, coordinated care will be consistent, that will mean the service offer will look different in rural communities, coastal towns or deprived inner cities.

There are already innovative models demonstrating what a neighbourhood approach can look like in rural and coastal areas - demonstrating the wide applicability of its principles. Whitstable Medical Practice is a single GP practice primary care network with 300 staff, including 32 GPs, 27 allied health professionals and a range of community multi-disciplinary teams.

The practice works across 3 sites, serving nearly 45,000 patients.

It delivers a wide range of services, including many traditionally found in hospitals, such as day surgery, integrated urgent treatment centres, pharmacy, physiotherapy, specialist clinics and outreach services. It also offers evening and weekend GP appointments and consultant led outpatient clinics. It is accredited for research, has pioneered local data-sharing agreements to create single patient records, and provides enhanced online services. 97% of its patients reported they had confidence and trust in the last GP they saw and 91% would recommend it to someone who had moved to the local area, and it is rated outstanding by the Care Quality Commission (CQC)[98].

health support they need and face stark health inequalities, including poorer life expectancy. Individuals with learning disabilities die about 20 years earlier on average[63]. Care from a neighbourhood team will improve their life outcomes through more holistic, on-going support.

- Children and their parents: face new life events and major transitions. In the early years, it is vital to get prevention right, as well as addressing any potential developmental concerns, particularly in the critical 1,001 days[64]. We will introduce new models where health visitors can administer vaccines to babies and children in underserved groups, to increase uptake. Moreover, we will ensure that health visitors fully support children's broader development as part of this government's plan to give children the Best Start in Life - including in supporting higher uptake of and better quality early childhood developmental checks.

This work will begin this year with the launch of the National Neighbourhood Health Implementation Programme.

We will bring the NHS closer to patients

We need an estate that provides neighbourhood teams with the equipment, working space and technology they need to make our new care model a reality. Our aim is to establish a Neighbourhood Health Centre (NHC) in every community.

We will begin establishing NHCs in the places where healthy life expectancy is lowest. Once open, NHCs will be a 'one stop shop' for patient care and the place from which multi-disciplinary teams operate.

Wherever possible, we will maximise value for money by repurposing poorly used, existing NHS and public sector estate. NHCs will be open at least 12 hours a day and 6 days a week providing access to coordinated services locally, removing the need to go to hospital for urgent care

Case Study: Tower Hamlets Women's Hub

The co-location of services into a Neighbourhood Health Centre will be transformative for people who have faced systematic challenges around the coordination of their care. For example, we know that women have faced particular difficulty with NHS fragmentation in the past[99] and we are committed to women's health never again being ignored.

In Tower Hamlets[100], women's health hubs have proven effective by providing women referred by their GP with a single point of access, triage and direction to the right care, in the right place. The benefits have included:

- a reduction in the number of gynaecology referrals that needed to be seen in secondary care. In its first 12 months, only 25% of referrals needed hospital care, representing a 60% reduction
- a decrease in the average wait for a gynaecology appointment from 27 weeks to 11 weeks with waiting lists falling by 30% in a matter of months
- 95% of patients receiving an initial response from their referral within 48 hours and 100% doing so within 5 days

NHCs will need to consider how they build on this evidence and provide coherent, coordinated experiences of care for those who have otherwise not had one.

NHCs will co-locate NHS, local authority and voluntary sector services, to help create an offer that meets population need holistically. That will mean NHCs will not only bring historically hospital-based services such as diagnostics, post-operative care and rehabilitation into the community, but they will also offer services like debt advice, employment support and smoking cessation or weight management services. NHCs could host a variety of services, such as fracture liaison services, supporting the government's

commitment to national roll out by 2030. Co-location will not only help ensure convenient access to services, particularly for those with complex needs, but will support more integrated working by professionals.

Ensuring every child has the best start in life is essential to future health and education outcomes. Building on the legacy of Sure Start, Family Hubs and Start for Life programmes have started to bring together children's services, NHS, and public health with a focus on the critical 1,001 days. We will bring this support to all our communities by matching Start for Life to Family Hubs expansion to ensure seamless provision of services for families with young children. Through local commissioning, we will ensure that Neighbourhood Health Services work in partnership with family hubs, schools, nurseries and colleges to offer timely support to children, young people and their families including those with Special Educational Needs and Disabilities (SEND). Start for Life services will be extended to the whole conception to age 5 range, enabling additional health visitor and speech and language support for children and their families.

Pharmacy will have a vital role in the Neighbourhood Health Service – bringing health to the heart of the high street. This has been the direction of reform in other countries and there is much we can learn. For example, Canada's 'Pharmacy Care Clinics'[65] provide services including support with minor ailments through to chronic disease management. As well as improving patient choice and convenience, there is now strong evidence that a bigger role for pharmacy can deliver efficiencies and support financial sustainability.

Over the next 5 years, we will transition community pharmacy from being focused largely on dispensing medicines to becoming integral to the Neighbourhood Health Service, offering more clinical services. As community pharmacists increasingly become able to independently prescribe, we will increase their role in the management of long-term conditions, complex medication regimes, and treatment of obesity, high blood pressure and high cholesterol. We will also give community pharmacy a bigger role in prevention by expanding their role in vaccine delivery and in screening for risk of cardiovascular disease and diabetes. Over time, community pharmacy will be securely joined up to the Single Patient Record, to help them provide a seamless service - and to give GPs sight of patient management.

Pharmacists will play a critical role in our ambition to improve access to fast and convenient healthcare for women. We have already announced plans to make emergency hormonal contraception freely available from community pharmacists by the end of this year. From 2026, to help hit our target to eliminate cervical cancer, women and young people who missed out on the human papillomavirus (HPV) vaccination at school will be able to have the vaccine administered at their local pharmacy.

We now get many of life's essentials delivered straight to our home. Medicines should not be an exception. Over the first half of this Plan, we will modernise our approach to dispensing of medicines and make better use of the technology available, including dispensing robots and hub and spoke models. We will engage with the sector and the public on proposals to modernise our approach to medicine dispensing, so that it is fit for the 21st century.

The Neighbourhood Health Service will lead on prevention

In chapter 4, we outline how we'll create a new genomic population health service. This will take advantage of a new era of prevention promised by combined advances in genomic technologies, diagnostics and the power of predictive analytics - to create a far more sophisticated understanding of both people's existing needs and future risk of

poor health. By default, it will be delivered in neighbourhoods, not hospitals.

Realising its promise relies on the Neighbourhood Health Service doing more to make information from predictive analytics meaningful. It does little to know about an individual's risk of disease if that knowledge does not lead to behaviour change, or different approaches to care.

We will look to clinicians to use genomic insights to inform care delivery. Nurses and other clinical staff working in the community will lead these services. We will expect neighbourhood teams to adjust their skill mix based on individual or population insights, while ICBs and neighbourhood providers will consider genomic insights in how they define 'groups with similar needs' - and commission and provide care accordingly. Patients will be supported to change behaviour or lifestyle through genomic counselling, and access to data on their individual risk.

To begin embedding this approach into neighbourhood care, we will:

- make a complete account of a patient's risk accessible to them, through the Single Patient Record and NHS App (chapter 3)
- actively support innovation in genomics and similar fields, as part of our innovation strategy (see chapter 8)
- support neighbourhood teams to work with the NHS Genomic Medicine Service to understand and act on insights from genomics, as part of our approach to ensuring staff have the skills (including genomic counselling skills) they need to meet the future (see chapter 7). This will include skills in supporting patients to make behaviour change on the basis of their future risk of developing a condition
- train genomics champions in the neighbourhood in conjunction with the NHS Genomic Medicine Service. These will be local health professionals with the requisite knowledge and ability to increase uptake of local genomic testing in their community, equitably

As we outline in chapter 4, genomic testing will be a choice and our approach will be anchored in patient consent. We will utilise the ethics advisory committees and structures of the NHS Genomic Medicine Service, Genomics England and Our Future Health to ensure strong safeguards, where needed.

The future of hospital care

Our shift from hospital to community is not just about what we do in neighbourhoods, it is also about the future of hospitals. As outlined in our Plan for Change, restoring the NHS' constitutional standard of 92% of patients beginning treatment within 18 weeks of referral is a first-order priority for this government. Over the lifetime of this Plan we will reduce waiting times further still and as digital access becomes the norm many patients will get instant access to a clinician, removing the need to wait for advice or care.

However, our strategy is not 'fix the roof, and then begin reform': it is only through reform that we can restore standards. We will adopt a relentless focus on preventing demand, improving operational efficiency and boosting productivity.

To achieve this, we will replace the status quo of 'hospital by default' with a new preventative principle that care should happen as locally as it can: digital-by-default, in a patient's home where possible, in a neighbourhood health centre when needed, in a hospital if necessary. To deliver, we will increase the share of NHS resources spent in the community and decrease the share spent in hospital over the course of this plan.

Small amounts of community expenditure can unlock disproportionate amounts of hospital capacity. For example, a 2023 study by NHS Confederation[66] found that £100 spent on community care could achieve, on average, £131 in acute sector savings.

As we take demand pressures off hospitals, they will do less firefighting. They will have greater means to boost productivity through

technology and AI; they will be able to make science and innovation a core purpose, not just a nice to have; and they will have more means to contribute to economic and social development in their capacity as anchor institutions.

Redesigning outpatient services

The elective waiting list[67] stands at 7.4 million, up from 2.3 million in 2010. Just 60% of people are seen within 18-weeks[68]. While elective care is non-urgent, it is still important. Long waits can be anxious, leave people needlessly in pain or otherwise interrupt their lives.

There are many ways we can reduce the number of low-complexity elective hospital appointments - to benefit patients, free up clinical capacity and boost productivity. For example, as outlined in our elective reform plan, patient-initiated follow-up is a way to give patients greater control over when they need an appointment, such as when their symptoms change. Evidence[69] shows that not booking in patients by default can safely reduce the number of follow-up appointments which, in turn, gives hospitals more capacity for those who most need them.

We will make patient-initiated follow-up a standard approach for all clinically appropriate pathways by 2026. Over the course of the plan, we will use the NHS App to further expand this approach. First, by allowing patients to sign up for patient-initiated follow-up directly through the App. Second by enabling patients to update their clinicians directly on their condition, to help them make faster, more accurate decisions on next steps.

Specialists are increasingly able to provide advice without the patient needing to travel to an appointment. For example, 'advice and guidance' - where a GP requests advice from a consultant through the NHS e-referral service - helped divert 1.3 million referrals from hospitals in 2024 to 2025[70]. Such approaches have proven particularly effective in high-volume specialties. Technology will enable us to embed it in many more specialties through the next 10 years.

Advances in technology continue to change the way hospital care is delivered. In specialties like dermatology, AI-enabled digital tools are already transforming diagnoses. For example, teledermatology hubs[71] allow GPs to refer patients with suspected skin cancer to community-based 'photo clinics'. Trained healthcare assistants use a smartphone with a dermoscopic lens attachment to capture high-quality images of suspicious skin lesions. These are analysed by AI to support triage. Benign cases are discharged without any need for a hospital appointment. Suspicious cases receive specialist care. Subject to NICE approval, this will be standard practice in dermatology by 2028 to 2029.

We will take an active role in expanding similar approaches to other specialties (where clinically appropriate). In the next few years, we will prioritise ophthalmology, cardiology, respiratory medicine and mental health. In the case of mental health, that could mean virtual therapists providing 24/7 support for mild or moderate need. For people with more severe illness, remote monitoring will help support a proactive response in crisis.

To help support more patients to receive specialist care at home, we will ensure the NHS can provide GP and consultant-led elective services virtually through the NHS app - available to everyone, regardless of where they live - where safe to do so and always subject to patient choice. We will not allow privately provided digital healthcare to be the only option and we will increase the availability of virtual services for NHS patients.

> **"Being treated at home could be better especially for those with long term conditions and allow them to see friends and family easier. Much more comfortable environment to help with recovery time."**
>
> ***Aisha, community-led engagement with children and young people***

For those who need an operation or more complex test, there is also much we can do to deliver their care in the community. For example, in the past few decades, surgery has moved from fully invasive (e.g. open surgery) to increasingly non-invasive (e.g. keyhole surgery). Combined with improvements in anaesthetics and post operative care, 80% of surgeries can now be carried out as day cases[72]. New advances in robotics are reducing the need for hospital-based diagnostics like endoscopy or colonoscopy, while countries like Denmark are pioneering in day case knee operations[73] supported by wrap around physiotherapy (with trials in the NHS also underway). We will adopt these models as we continue to move away from a default of surgery requiring multiple day hospital stays. This will be supported by the new surgical hubs announced in our elective reform plan.

Combined, these changes will contribute to our goal to end outpatient care as we know it. By 2035, most outpatient care will happen outside of hospitals. Digital tools will help people manage their care from the convenience of their home, with support from clinicians when needed. Personalised support, informed by advances in individual data, will help people get ready for planned treatment, and receive effective rehabilitation in the community afterwards.

Case study: Nimbuscare - Improved triage and navigation in York

The York Community Frailty Hub[101] was established in November 2023 to tackle fragmented care for older frail people in the community. It brings together general practice, the acute trust, adult social care,, the ambulance service, and the voluntary sectors into one coordinated system.

The service is made up of 3 key parts: a frailty prevention team, a discharge support team, and a frailty crisis response team. The crisis response team helps reduce avoidable hospital admissions through a dedicated advice and guidance line and rapid multi-disciplinary community response. In 84% of cases, the York Community Frailty Hub has helped paramedics avoid hospital transfers by providing advice after an ambulance is dispatched, enabling patients to be safely supported in the community rather than in hospital.

The Hub also serves as an alternative to calling 999, offering early advice to frail residents, families, carers and health professionals, and working collaboratively to determine the best course of action to keep people safely at home.

Redesigning urgent and emergency care

The most important social contract between the public and the NHS is that it will be there for us in a time of crisis. But all too often today, ambulances do not arrive in good time, waits in emergency departments are unacceptably long, while the disgraceful spectacle of corridor care has become business usual - normalised with benign nomenclature like 'temporary escalation spaces'.

The constitutional standard that 95% of patients are admitted, referred or discharged within 4 hours has not been met since 2015.

In the long-term our ambition is for digital technology, community care, predictive

analytics and greater operational efficiency to mean long waits are no longer the assumed default.

Often, overwhelmed emergency care is the result of poorly managed hospital flow. Some hospitals are seeing nearly twice as many overnight admissions as others (from 45 to 81 people per 1,000 weighted population)[74]. This indicates much improvement can be achieved by spreading good practice from the best of the NHS to the rest of the NHS - for example, supporting low performers to improve prevention, or discharge processes.

As we outline in our urgent and emergency care (UEC) plan 2025 to 2026, all systems will be expected to set out how they intend to expand access to urgent and emergency care services at home and in the community, so patients do not attend hospital unnecessarily. That will mean systems need to better understand their virtual ward capacity, and plan with the ambulance service and 111 how to use this capacity most effectively. It will also mean doing more with population health data to identify frequent emergency department attenders, and to offer proactive, targeted support. We will help reduce demand by increasing uptake of vaccines (see chapter 4), and by introducing new national standards for care technology that helps prevent falls. The use of predictive tools is already being used to good effect to prevent falls by some care providers[75] and by 2035, it will be commonplace.

We will continue the transformation of UEC services in hospitals through the expansion of same day emergency care services and co-located urgent treatment centres, going further to split urgent and emergency care into separate streams, and investing in digital tools to support better triage, patient flow and discharge through coordination centres.

Research has estimated around 1 in 5 people who attend an emergency department do not need urgent or emergency care. Unnecessary attendances at A&E often happen because people simply do not know where else to go, or because other appointments weren't easily available[76] (e.g. in general practice). Evidence from 2017 suggested an increasing number of callers to 111 were being sent to A&E[77]. By 2028, My NHS GP, a new AI-enabled tool in the NHS App, will help patients better navigate the health service. While this will not be a replacement for 999 in an emergency, it will help people who do not have an urgent or emergency care need, but who are struggling to find an alternative to A&E, to access more suitable care (e.g. via a GP or pharmacist).

There is no reason why so many patients should have to wait hours, or sometimes days, in an A&E department. Learning from the most effective UEC models from around the world, by 2028 we will support more patients to book into an appropriate urgent care service for them, via 111 or the App, before attending. This will be an optional way for people with urgent needs to identify the fastest route to care without a long wait in the emergency department. It will also enable clinical professionals to triage patients in advance and redirect them if appropriate. Countries that have implemented booking, such as the Netherlands and Denmark, have realised significant benefits from the approach[78].

The ambulance service will play a key role in supporting neighbourhood health. Advanced analytics and AI tools will allow far more people to be assessed remotely, and ambulances to only be sent when necessary. Paramedics will have secure access to Single Patient Records, as well as remote support from a specialist team - either a neighbourhood team, or hospital-based specialist. They will be able to view diagnostics, see the patient on a video screen and give expert advice to help the paramedic decide how best to proceed: whether to treat them there and then, take them to a neighbourhood health centre for further tests, or convey them to hospital if required.

When people's immediate UEC needs are met, rehabilitation often takes too long to organise and is insufficiently integrated into wider local services, particularly adult social care. These services - often referred to as intermediate care - will be fully integrated with neighbourhood health services. We will expand overall capacity through a transition to more intensive, but shorter, periods of rehabilitation and recovery.

Many people experiencing a mental health crisis go to A&E because it is the most visible or accessible option[79]. However, emergency departments are not always the best environment for mental health needs, and historically mental health services have not been sufficiently integrated into urgent care pathways. We will increase capacity for urgent mental health care by developing dedicated mental health emergency departments (MHEDs), ensuring patients get fast, same-day access to specialist support in an appropriate setting.

Over the course of the first half of this Plan, we will invest up to £120 million to bring the number of MHEDs to around 85, meaning there will be one co-located (or very close to) 50% of existing type 1 A&E units[80]. These units will provide walk-in access, receive patients conveyed by ambulance, or referred by the police or 111 and undertake rapid assessment typically within 4 hours, alongside short-term support and safe discharge or onward referral. MHEDs will work closely with physical health A&E teams to make sure any physical health needs are met. They will also support first response services, which can help meet need in the community.

The hospital of the future

As we reduce demand on hospitals by doing more in the community, we will free them from perpetual firefighting. That means, by 2035, hospitals will spend a smaller proportion of the NHS' total budget and employ a smaller proportion of its total staff. But it will also mean that they are liberated to focus on providing the best, most cutting-edge and most productive care for those who most need it.

Today, the very best care is still the preserve of a small number of hospitals - often, large teaching hospitals. We want every patient to have access to the high-quality hospital care, across the whole country. That will mean spreading new approaches like:

- advanced robotics already in use at Guy's and St Thomas'[81] in specialties including urology, gynaecology and transparent surgery are resulting in better patient outcomes and shorter hospital stays
- advanced use of personalised medicine - utilising genomics, AI and data - in Leeds

Case study: South Korea's National Smart Hospital Programme

Seoul National University Bundang Hospital[102] has adopted a fully digital medical record system and uses autonomous mobile robots to transport supplies, reducing staff workload and infection risks. Its Healthcare Innovation Park supports collaboration across disciplines, accelerating the development of advanced medical technologies.

Samsung Medical Centre has implemented AI-driven predictive analytics to better manage resources, helping to address overcrowding and reduce patient wait times. By forecasting patient flow and adjusting staffing accordingly, the hospital has improved both care quality and operational efficiency.

At a national level, the Korea Health Industry Development Institute has promoted the rollout of smart hospital models across the country. Initiatives include AI-powered infection control, smart outpatient services, and remote monitoring tools. These innovations have helped lower staff stress, boost patient satisfaction, and improve healthcare delivery overall.

Teaching Hospitals NHS Trust[82], a national trial site for personalised cancer vaccines

- world-leading gamma knife technology in Sheffield[83] which delivers non-invasive radiation therapy with computer-guided precision, to treat brain and upper spine conditions more effectively

We recognise not every hospital will need every new technology - but our aspiration is far more scale and spread, so that hospitals can offer all patients world class care.

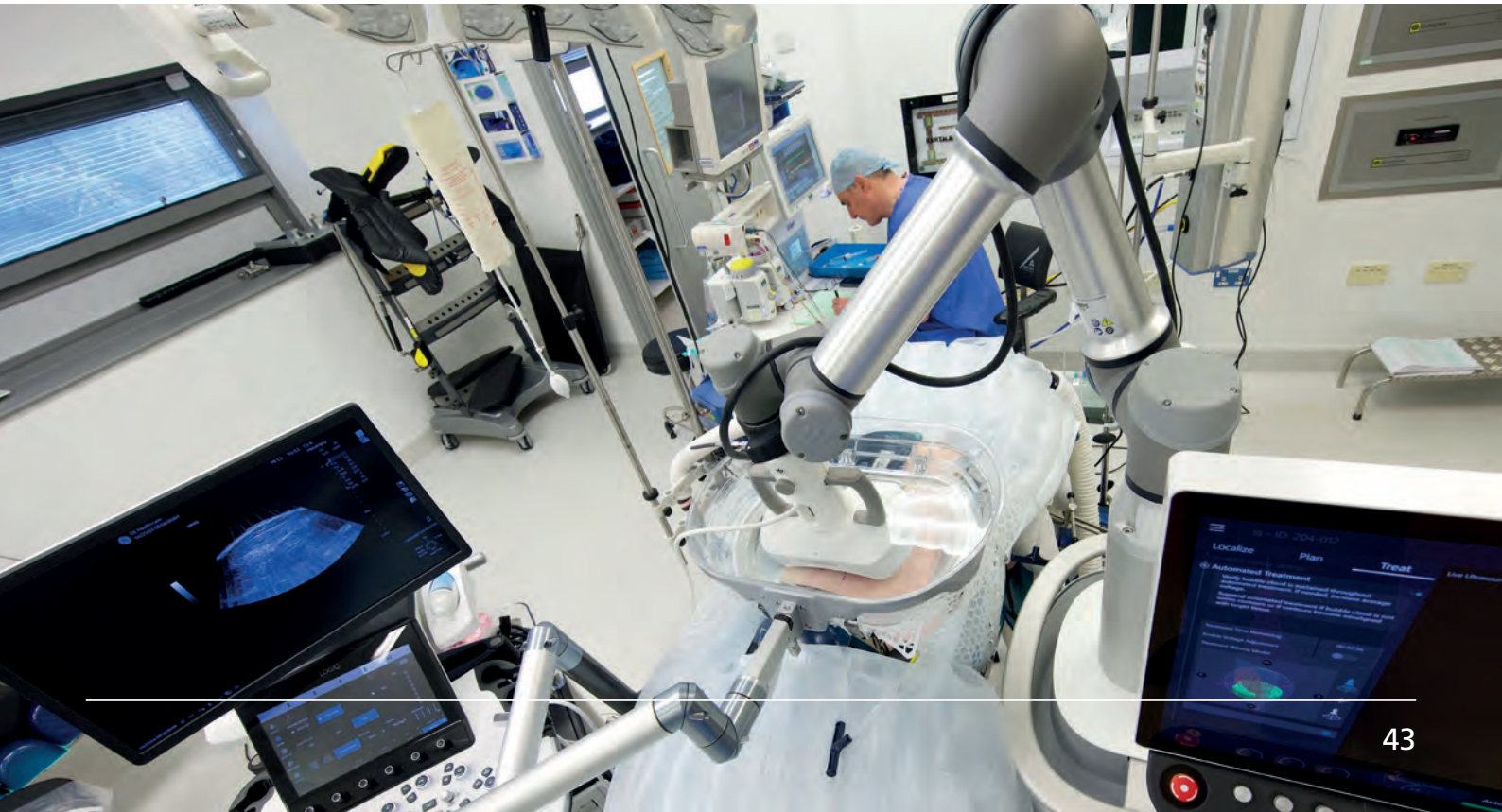
In countries like South Korea, a new fleet of AI-enabled hospitals has begun to transform both care and efficiency. In England, we will deploy similar principles to ensure hospitals harness automation in staff rostering and procurement; AI to support reporting in radiology and pathology; remote monitoring to support virtual care of patients at home; and predictive models to predict need and manage hospital flow.

In clinical services, we will deploy technology in all aspects of care - from using ambient AI to support note taking in appointments and for discharge summaries to managing the flow of patients through a hospital (see chapter 3). This will free up and support NHS staff to do what they know best and focus on the patient. We will expect the NHS to partner more effectively with the health tech industry in this endeavour. All hospitals will be fully AI enabled within the lifetime of this Plan.

Many hospitals already make a strong contribution to research and life sciences. Moreover, those that do so deliver better patient care as a result. We will increasingly expect hospitals to make this a business-as-usual activity, not a 'nice to have'. We outline how we will increase skills and time for clinical research in chapter 7, and how we will make the NHS a hotbed for innovation in chapter 8.

We will also expect hospitals to do more as anchor institutions to support wider societal and economic goals. Through their procurement, supply chains and role as an employer, they have significant influence over social and economic development in their communities. We outline our plan for NHS employment to become a force for economic prosperity and social mobility in chapter 7.

In a similar vein, we will prioritise the NHS' existing commitments set out in Delivering a Net Zero Health Service - including achieving net zero by 2040 for the emissions the NHS controls and by 2045 for the emissions it can influence. It will continue to partner with Great British Energy on solar energy for public sector buildings. All NHS bodies



will be expected to decarbonise, reduce environmental impact and increase resilience to climate risks in line with the climate change duties set out in the Health and Care Act 2022.

Conclusion

The creation of a Neighbourhood Health Service marks a break from the past and a sharp choice: to put a higher share of NHS expenditure into community settings, and less in hospitals over the next 10 years.

We make this decision because it will mean we can genuinely transform our model of care and bring the NHS into the 21st century. Instead of fragmentation and one-size-fits-all - patients will have real choice over the care they receive, real power to steer their care team (including through the NHS App and a care plan), and care will be more personalised.

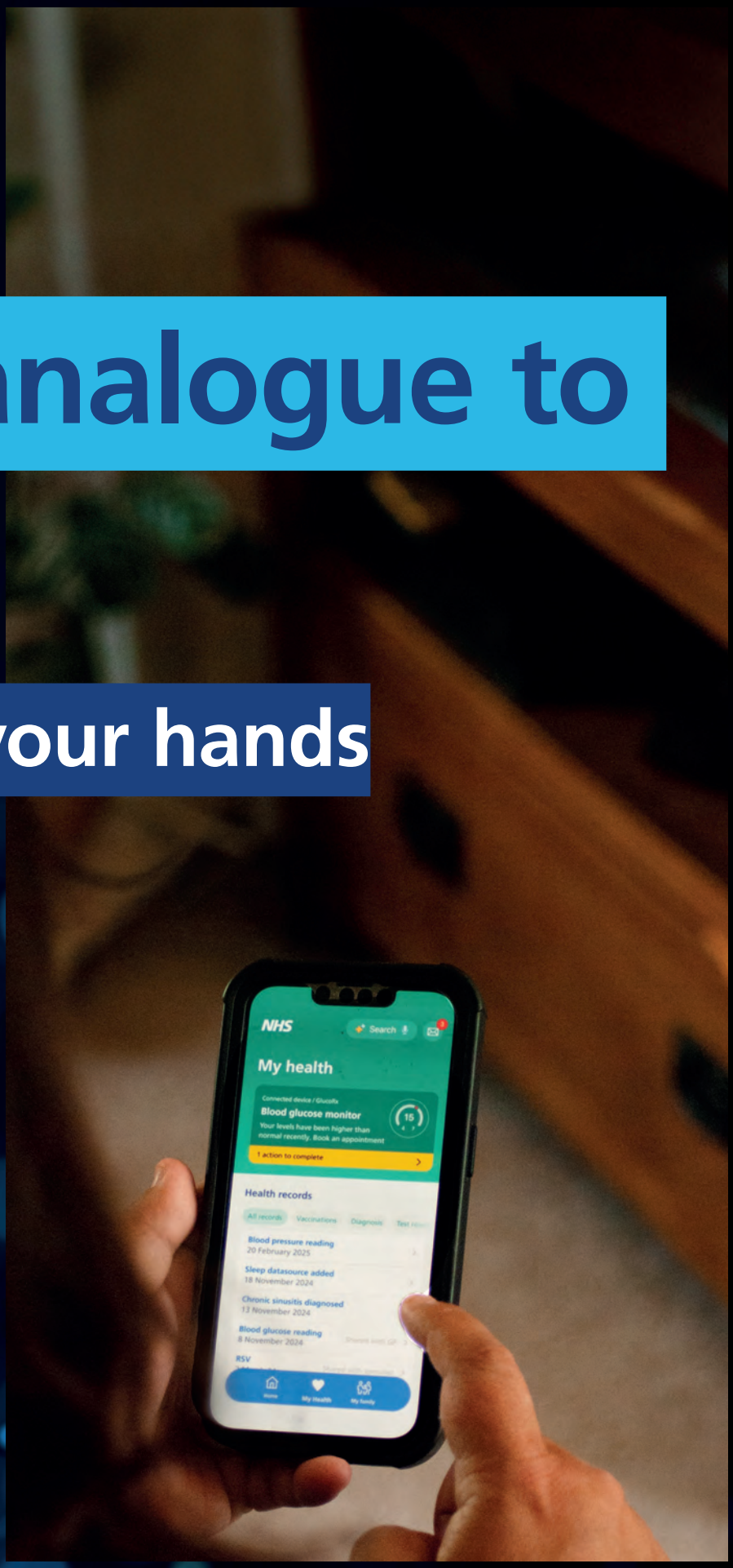
This will mean we need less acute space, fewer emergency staff based in hospitals and fewer outpatient departments in future. As services transition into community this will be a sign of success. Lower demand, and higher productivity will enable hospital transformation, enabling hospitals to lower waiting times for good.

The Neighbourhood Health Service is not just the right care model for today - it is fit for the future. A hospital-led, episodic care model - that waits for and reacts to need - is unlikely to realise the full preventative potential of genomics, data and predictive analytics. Neighbourhood care can. As a model of care that comes to people proactively, it will be able to harness scientific advance to become truly predictive and pre-emptive.

03

From analogue to digital

Power in your hands



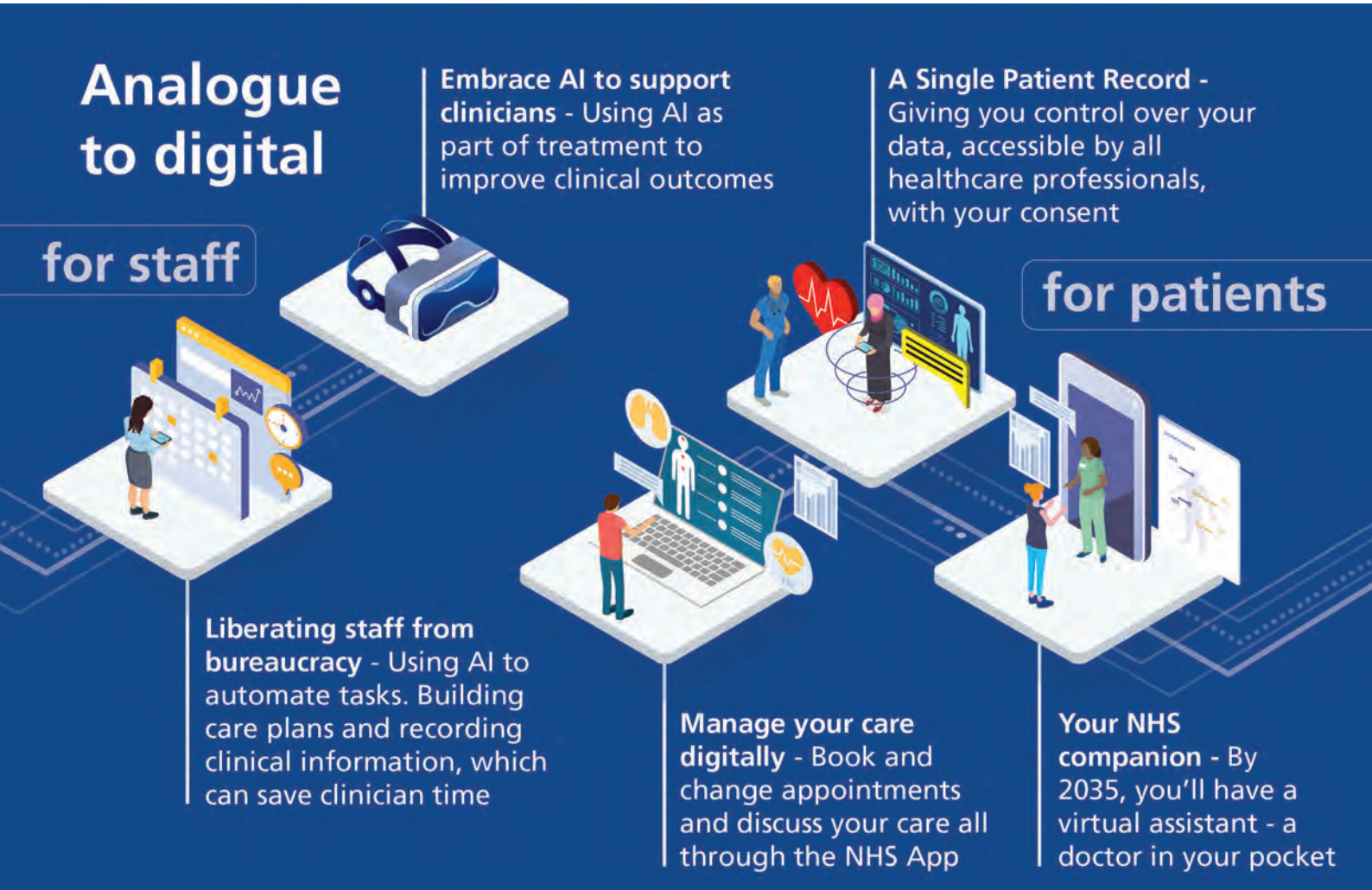
Modern technology has given us more power over our everyday lives. Most of us do our banking online when we want, not when banks choose to be open. We control our financial data, where it was previously opaque. We stream TV on our laptops and phones without being bound to 'what's on the telly'. Across the economy, technology has shifted power from producer to consumer, giving us the ability to choose.

That change is yet to come to the NHS. Despite the wider technological revolution in healthcare happening globally, the NHS remains a distinctly analogue service. We have not got the basics right: staff are still forced to put up with obsolete computer systems and paper records.

Nor have we done enough to create the digital tools that will give patients real control over their healthcare in the future.

In the next decade, the NHS must not only catch-up: it must lead. We will harness the NHS' unique advantages - world-leading data, procurement power and the means to deliver equal access - as we create the most digitally accessible health system in the world.

This Plan will give everyone a virtual assistant, a 'doctor in their pocket' to provide 24/7 advice and guidance. The NHS App will be the front door to the NHS: patients will be able to book, move and cancel their appointments, and communicate with their health team, with ease.



Just like the NHS provides access to the best, most cost-effective medicines, it will provide universal access to the best digital tools and health apps, free at the point of need. This will all be underpinned by a Single Patient Record, a secure and authoritative account of each patient's health data that allows for care, whether digital or physical, to be personalised and seamless.

Through the course of this Plan, the NHS will become a fully digitally enabled service, operating 24/7 both online and offline. Many will access care digitally by default, and everyone's care will be digitally enhanced. We make this move 'from bricks to clicks' on an evidence-based conviction that it will transform access and convenience for those in generally good health; free up physical NHS services for those with the most complex needs; and help secure NHS financial sustainability for future generations.

A Single Patient Record

Giving patients real control over a single, secure and authoritative account of their data is crucial to each of the 3 shifts. It will facilitate a more coordinated, personalised and predictive care model of the Neighbourhood Health Service. It will be how the NHS App becomes a truly personal digital assistant for every patient. As genomics and predictive data analytics advance, it will help unlock the potential of predictive prevention.

More fundamentally, we believe fast, transparent and secure access to our own health data is a right, not a privilege.

Securing the financial sustainability of the NHS

The shift to digital is among our clearest routes to secure the productivity gains that will ensure the NHS' financial sustainability. In other industries, digital technology has fundamentally disrupted the status quo. Listening to music no longer requires the manufacture of a physical CD, its distribution to shops, or the costs of physical retail space. Higher convenience, at a far lower unit cost.

We will secure this combination of better experience and higher value for the NHS. The developments to the NHS App outlined in this plan promise to substantially reduce a range of on-going NHS costs, as does our commitment to liberate staff from duplication and admin.

- The process of booking appointments currently involves multiple staff. This will soon be automatic, which will generate significant savings.
- Our reforms will also reduce the need for patients to physically attend appointments – for example, by facilitating 'straight to test' pathways, or through digital preassessment forms. This will free up appointments for those who need them and reduce costs.
- Duplicative efforts to collect information about a patient's condition accounts for a third of clinical time. One London-wide trial found ambient voice technology reduced time spent on paperwork by 51.7%, saving 6 minutes per patient.
- The NHS spends over £200 million communicating with patients through SMS and letters alone each year[109]. Much of this should be saved via the direct messaging functionality in the NHS App.
- Expenditure on services like 111 will reduce - as more people choose more effective App based advice. While the choice to use 111 will remain, we expect its cost to the NHS to decrease.
- Digital pre-assessment will cut down staff clerical work whilst reducing the scope for human error. AI diagnostic processing can increase speed markedly - with a recent study[110] showing accuracy improvements of 90% or more.

That is why, for the first time ever in the NHS, we will introduce a new Single Patient Record (SPR).

The SPR will bring together all a patient's medical records into one place. Clinicians will be able to securely access it in order to deliver higher quality care - and patients will be able to add their own data from clinically validated wearables. The SPR will operate as a patient passport, making sure patients get seamless care no matter where they are in the NHS.

It will end many of the frustrations patients told us about in our public engagement. No more repeated stories. No more appointments where the clinician does not know what happened at the previous one.

> **"I have to repeat [my son's] story. I want to say, "You've got the information." It's so bad. A nurse said he's reliving all the surgeries every single time. I have got it all written down on a piece of paper and I give it to the doctor, so [my son] doesn't have to repeat it."**
>
> ***Emily, public deliberative event in Middlesbrough, November 2024***

We will make this possible through new legislation that places a duty on every health and care provider to make the information they record about a patient, available to that patient. We will also legislate to give patients access to their SPR by default. Subject to parliamentary time, our ambition is that from 2028, patients will be able to view it, securely, on the NHS App. Over time, that data will include not only medical records, but also a personalised account of health risk, drawing from lifestyle, demographic and genomic data - to help personalise the NHS' service offer and to support individual behaviour change.

Shared digital records in Estonia puts data in the patient's hands

In Estonia, the national Health Information System[111] links healthcare providers' systems together and securely store patient data in a central platform. This includes appointments, visits, referrals, procedures, and results. Only authorised medical professionals can access patient data, and patients are able to set access restrictions and see who has viewed their records.

This system means that patients can use a single platform to review past appointments, prescriptions, receive health advice, and book appointments with any healthcare provider. Digital prescriptions mean that the health service can use algorithms to detect potential drug interactions when new prescriptions are made, while reducing the administrative workload for clinicians and pharmacists. In emergencies, paramedics can access time-critical information such as blood type, pregnancy status, and existing prescriptions and treatments.

We have spoken to the public around the country about how they want their data to be used. We heard their desire for a rigorous approach to privacy and security, which will inform our redesign of the opt-out system. We also heard their surprise at the barriers we put up to using NHS data that does not contain any identifying information (e.g. anonymised aggregate hospital information). We will reform the legal framework to allow for health data to be used to improve the NHS and for research that benefits its patients - including, through the Health Data Research Service announced by the Prime Minister in April 2025.

Once the necessary legislation is in place, we will roll out the SPR in maternity care first. We know from both evidence and our engagement that experiences of maternity care are not good enough, and that mothers' preferences are frequently ignored.
The SPR will ensure maternity teams have all

the information they need about previous consultations, medical history and stated preferences, helping them provide genuinely high-quality, personalised care.

Making the NHS App a world-leading tool for patient choice

The NHS App will be how we create a truly empowering, digitally enabled NHS, that shifts power from 'producer' to patient. By 2028, the App will be a full front door to the entire NHS. It will be where patients go to manage their medicines, view their data, book and hold their appointments, communicate with their health team and draft their care plan. We will add functionality to the App in every subsequent year of this plan, as we build a fully digitally enabled NHS over the next 10 years.

As new functionality comes online, we will bring it together in the App in a way that makes sense to patients. We will create new tools that redefine how patients engage with the health service. Our aims will be:

- fast advice, so no patient faces uncertainty about what care they need, or a needlessly anxious wait
- more choice, between different services and different providers
- direct access, so patients can book appointments or self-refer to tests wherever clinically appropriate
- more convenience, including the ability for patients to manage their care in one place
- accessible knowledge, so patients can find the information they need to get the most out of their healthcare - or to manage their caring responsibilities for others.

Fast advice, more choice

Today's NHS is far too comfortable with people waiting anxiously for advice, or struggling to work out which service is right for them. That can leave patients being bounced between services, as they try to get the care they need. Digital technology gives us the means to change this.

The My NHS GP tool will provide a single, trusted source of instant advice for patients who need non-urgent care, available 24/7. It will use AI-algorithms to take a patient's descriptions of their worries or symptoms, ask the right follow-up questions and provide personalised guidance.

It will direct people to the care they need, in the setting best equipped to meet their needs first time. In some cases, it will advise on self-care - and help direct patients to well-evidenced consumer healthcare products. In others, it might direct to a community pharmacy, to general practice, a neighbourhood health centre or to emergency care. It will help patients book a remote consultation if they need one, or a face-to-face appointment if they prefer.

My NHS GP will use evidence-based techniques. Safety will be paramount, and it will be designed with clinicians. Technology is to enhance care, not replace its human quality.

When patients access care, they should have at least as much choice over who provides it as in any other part of their lives. In the past 20 years, the trend has been towards far more consumer choice, but the NHS has clung onto 'one size fits all'. My Choices will give every patient the ability to make a meaningful choice.

It will help patients find everything from the nearest pharmacy to the best outcome scores for heart surgery from providers across the country. By providing a range of data on those providers, whether that is the shortest wait, the best outcomes, the best patient satisfaction scores or is the closest to home, patients will be able to pick based on their preferences. In turn, this will inspire providers to respond to patient choice, raise their game, and design services based on what patients truly value.

My Choices will be transformative for equity. We know, including from our engagement, that 'one size fits all' misses the distinct needs of women, people from ethnic minority backgrounds or people who live in more rural communities, among many others. Meaningful choice will be how we strengthen their voice, and the NHS' ability to truly deliver care based on need.

Direct access, more convenience

The My Specialist tool will be where patients can make self-referrals to specialist care where clinically appropriate. From the outset, patients will be able to self-refer to mental health talking therapies, MSK services, podiatry and audiology. This will help us transform the working lives of GPs - letting them focus on care where they provide the highest value-add. It will also be how we make sure everyone can self-refer, not just the most confident and health literate. In other cases, the tool will allow patients to leave a question for a specialist to answer without making an appointment.

My Consult will allow patients to connect with a clinician for a remote consultation and will give patients the information about what each appointment is for.

For those who need more intensive support, such as people with long-term conditions or other complex needs, managing healthcare can feel more like a full-time job than a service. My Care will be each patient's one-stop shop for managing their care. It will be where patients can find and review their care plan. It will be where they can book and manage appointments, enrol in a clinical trial and access their Single Patient Record. Over time, My Care will increasingly link to services outside the NHS - in the voluntary sector, from social enterprises, social care, community groups or local government. It will be a digital social prescriber.

Accessible knowledge for all

The digital era is democratising knowledge. People have long turned to their phone as a first port of call for health advice. Advances like AI will only increase patients' ability to directly access health information. We will use the NHS App to give everyone the knowledge they need to get the most out of their healthcare, and to ensure there are always 2 experts in every consulting room.

For those who need more support, My Companion will help them articulate their health needs and preferences confidently, and will provide all the information a patient needs about a health condition if they have one, or a procedure if they need one. It will support translation, so that everyone can engage with their healthcare in their first language. It will support patients to ask questions, including any they may have forgotten about or felt too embarrassed to raise at an in-person appointment.

Medicines should be much easier to organise and manage than they are today. The My Medicines tool will make it simple to manage repeat prescriptions for delivery or collection. Medicine regimes can be complex and hard to remember, so this tool will remind patients what they need to take and when. In the longer-term, My Medicines will be able to guide patients on drug interactions - using scientific advances like pharmacogenomics (the study of how genetic variations impact how drugs work for different people) - and help avoid adverse drug reactions. Currently, adverse reactions are estimated to cost the NHS up to £2.2 billion per year[103].

My Vaccines will mean patients can see whether their vaccines are up-to-date and book appointments to get them organised if they are not. It will have easy booking options, alongside information about travel vaccines and where to find them.

The My Health tool will bring all health data into one place, such as blood pressure, heart rate and blood sugar measurements.

It will include real-time data from wearables, biometric sensors, or smart devices and will connect to the results of recent tests and investigations. Patients will have control over whether this data is shared in real-time with their care team, so they can proactively monitor their health and step in if needed.

My Children will help parents collect their children's health information in one convenient place - a 21st century alternative to the 'red book'. It will provide advice and support throughout childhood, on weaning, maintaining healthy habits, or where to find support for concerns about mental health. Over time, we will add more information and create more functionality to support parents to record feeding times, monitor sleep, or use AI analytics to understand the best way to care for their child if, for example, they have developed a new rash.

My Carer will allow people to securely prove they are providing care, often for an older family member, and gain access to the App on their behalf. It will help unpaid carers book appointments and communicate with their loved one's care team. For carers, this will streamline their care responsibilities significantly, while giving them a means to seek advice or reassurance directly from a range of professionals when they need it.

Combined, these tools will transform how patients engage with the NHS. Better, they will make the delivery of healthcare substantially more efficient. We estimate that 1 million administrative staff requests could be automated through AI-support for patient navigation alone and that improving services for public and patients through digital means could deliver a return of more than £6 on every £1 invested[104].

Delivering a more personal and rewarding experience

The NHS does not take patient feedback seriously enough. We can only improve if we know what is working well and what is working less well. Though many providers already have their own feedback systems, comments or complaints often receive a formulaic response from someone who is far removed from the frontline. This feedback is too rarely aggregated and translated into quality improvement actions.

The NHS App will give patients the chance to leave their feedback on a service, clinical team or healthcare provider. Patients will be able to provide scores in as much or as little detail as they like, and to offer thoughts about what worked well and what could be improved.

To ensure the NHS can and does act on feedback, we will store it and deploy AI to help translate it into actions for managers and clinicians. As we outline in chapters 4 and 5, patient feedback will be part of how we judge and reward excellence, define good leadership and a consideration for regulators. We will also use ratings to support patient choice, by displaying them alongside other quality indicators during the booking process.

We recognise the NHS does not have a monopoly on good digital technology, and that many exciting developments are happening beyond the NHS. We want to work in partnership with those creating exciting new technologies, and to make sure patients have access to the products that deliver better outcomes, more empowerment and better value for the NHS.

We will build a new HealthStore - which will enable patients to access approved health

apps to manage or treat their condition. Its purpose will be to get new digital tools directly into the hands of those who need them. No-one questions that the NHS should work with pharmaceutical companies and get their medical innovations to patients: that is one of the NHS' core functions. We will treat digital tools in a similar way.

The first technologies to be surfaced through the HealthStore will be those that already have the best evidence of effectiveness following evaluations by NICE. These will be procured once by the NHS to secure a good price, with the costs borne from central budgets. New apps will become available regularly, across different condition areas. Some apps made available through the HealthStore will be made available to everyone and some will be made available to those who have a diagnosed condition, accompanied with a recommendation from a clinician to use the technology. Patients will be able to choose which tool best suits them, when there is more than one option.

Digital transformation to drive inclusion

A digital NHS will be a force for inclusion, by giving voice, control and choice to those otherwise denied it.

Inclusion will be designed into the NHS App by default. We will tailor health information so it meets the needs of people from different backgrounds, and we will proactively identify people who may have lower digital literacy so their support needs can be addressed. Deaf people will be supported through British Sign Language accessibility, while blind and visually impaired people will be supported through screen readers. Our commitment is that people who have not previously been able to access and use healthcare on their own terms will, through digital technology, be able to.

As the Patients Association[105] and other groups have long argued, one of the most important ways we can maximise the inclusive potential of digital technology is by co-creating it with patients, especially those previously excluded by other NHS services most of all. We will involve patient groups and patient organisations in the development and testing of new App functionality from the

outset, harnessing their expertise to ensure excellent, inclusive user experience.

We will also continue our current partnership with libraries and other community organisations to help set people up on the NHS App. We will continue recruiting App Ambassadors across the country to support uptake. The NHS will continue to contribute fully to the cross-government Digital Inclusion Action Plan, led by the Department for Science, Innovation and Technology, to improve access to and skills with technology among socially excluded groups.

Digital liberation: freeing the frontline from bureaucracy

Information technology in healthcare has often resulted in more work for clinicians rather than less[106]. Many of the most burdensome parts of the job are associated with entering, accessing and updating information.

As a first step, we will fix one of the biggest complaints we heard in our staff engagement: the need to sign-on countless times to different NHS software each day. We will introduce single sign-on for NHS software to remove this duplication and reduce the clinical time lost on repeated calls to IT helpdesks to reset passwords.

> **"There are too many systems which do not link up. Redundant log ins waste our time."**
>
> ***Ibrahim, health and care staff deliberative event in Sheffield, February 2025***

More fundamentally, developments in AI have the potential to transform the experience of staff for the better by automating administrative work. By liberating staff from bureaucracy, AI can help bring the joy back to work and give staff more control over their most precious resource: their time. We have identified 3 important areas of proven technology that are already in use in some areas of the NHS, that we expect to boost clinical productivity and can be scaled up quickly. We outline our strategy to make the

Case study: Interactive dashboard to enhance health pre-surgery

A clinically led collaboration in the north-east of England has developed the RAIDR platform[112], an innovative digital tool that integrates patient health information from surgical waiting lists with primary care records into an interactive dashboard accessible to anaesthetists and other clinicians. This platform enables preoperative assessment teams to visualise the health profiles of all patients awaiting surgery and identify opportunities to improve their health before the procedure. It also helps sort patients by risk level so that those with lower risk can follow simpler care plans.

Currently, targeted support is provided through the north east of england and north Cumbria Waiting Well programme, which includes initiatives such as opioid deprescribing, weight management, and intensive support for better diabetes management, alongside addressing wider determinants of health and well-being. These efforts significantly reduce the likelihood of surgery cancellations or postponements and improve the management of long-term health conditions. They also help ensure those with the most complex needs, including those who experience disadvantage - get more bespoke support, helping to ensure equity.

Since the Waiting Well programme started[113] 25,000 people have been contacted to offer targeted support, with nearly 20% accepting an offer of support.

UK a global leader on AI in more detail in chapter 8.

Improving the quality of patient interactions through more accessible information

Since clinicians do not currently have access to patient records from different care settings, they often see patients without knowing enough about their context. For example, they often do not know their patient's housing status, level of digital exclusion or caring responsibilities.

The introduction of the Single Patient Record will change that, by making information visible across different care settings. It will also enable clinicians to better understand contextual as well as clinical information. This will be strengthened with the introduction of tested and validated personalised social risk assessments, to more consistently capture non-clinical risk factors for ill health, so that care can be tailored and co-ordinated to improve patient outcomes and reduce health inequalities.

Time-strapped clinicians often attempt to read through notes as quickly as possible to understand their patients. Failing that, they ask patients to repeat their story. For those patients with long-term conditions, to whom this happens most often, this is particularly frustrating. We will further enhance the Single Patient Record so that it offers clinicians and patients a high-quality summary of the patient's clinical history and processes information to guide clinicians towards evidence-based care protocols and guidelines.

Embracing ambient AI to release time to care

In recent decades, many healthcare interactions have become dominated by interrogating and entering data. During consultations today, clinicians spend as much as 14% of their time entering information into the care record[107]. Inevitably, their focus is split between talking to the patient and entering data into the system. Patients, rightly, feel they have not been listened to, with research by the Institute for Public Policy Research (IPPR) showing that the UK went from having the best quality of communication to among the worst, as reported by patients, between 2010 and 2024[108].

Clinical systems often provide a poor and inefficient user experience requiring multiple clicks to set the next step in the care process. Many of the systems in use in the NHS today were originally designed for the US healthcare system to capture as many care delivery steps as possible to maximise the opportunity for private healthcare providers to bill private healthcare insurers. Their purpose was to maximise revenues rather than productivity or patient outcomes. It is unsurprising that most clinicians find the data entry squeezes out the joy from their work.

Ambient AI technology can listen to what is being said, identify the key points, and record them into the care record. It can also capture clinical and administrative information without requiring clinicians to enter it manually. This can help healthcare professionals get more done, focus more actively on their patient and listen to them more effectively.

We are already trialling this technology, with interim results showing a significant decrease in admin, freeing up time for patient care. For example, one London-wide study led by Great Ormond Street Hospital's Data Research, Innovation and Virtual Environments unit found that ambient voice technology reduced the time spent on paperwork by 51.7% and allowed each doctor to treat 13.4% more patients during a shift. Applying this across all emergency departments in England, this would create capacity to see 9,259 additional patients per day.

> **"The reality is that in the NHS, investing in better and faster software, with the inclusion of AI assistants to doctors doing their admin work, with support of specialist admin staff, would easily reduce the workload."**
>
> ***Joe, public participant, via the Change NHS website***

In some GP practices and hospitals, these technologies are already in use. The problem is not one of adoption but of scale. To accelerate this, and bring benefits to the frontline more quickly, in 2026 to 2027 we will undertake a framework procurement process that can be accessed by all NHS organisations and provide support to GPs and trusts, so they can adopt this technology safely.

A new platform for proactive, planned care

As we build the Neighbourhood Health Service, it will be essential to ensure community-based services have the digital tools and capabilities necessary to excel. We will undertake national procurement for a new platform that will be available to all NHS provider organisations. This will have a core set of functions that include:

- the ability to remotely monitor patients, with data flowing through to the NHS App and Single Patient Record – enabling proactive management of patients to become the new normal, reaching out at the first signs of deterioration to prevent an emergency admission to hospital
- the creation of care plans and management of evidence-based care processes – scheduling, tracking and managing against the plan. Generative AI could help create the first draft of care plans for review and discussion by the patient with their clinician, leveraging the patient's own data and the existing evidence base on interventions
- visualising and summarising the Single Patient Record to improve the quality of interaction – and ability to use ambient AI to capture data.
- support for managing multidisciplinary teams – including workflow management and escalation of cases where there are concerns about physical or mental health

Hundreds of thousands of NHS staff work in the community, visiting patients at home or elsewhere, without the benefit of digital technology. They should have access to important safety features such as GPS tracking, emergency help buttons, and live broadcast in emergency situations. We will take a national approach to sourcing technology that delivers these requirements and make it available to all provider organisations.

Conclusion

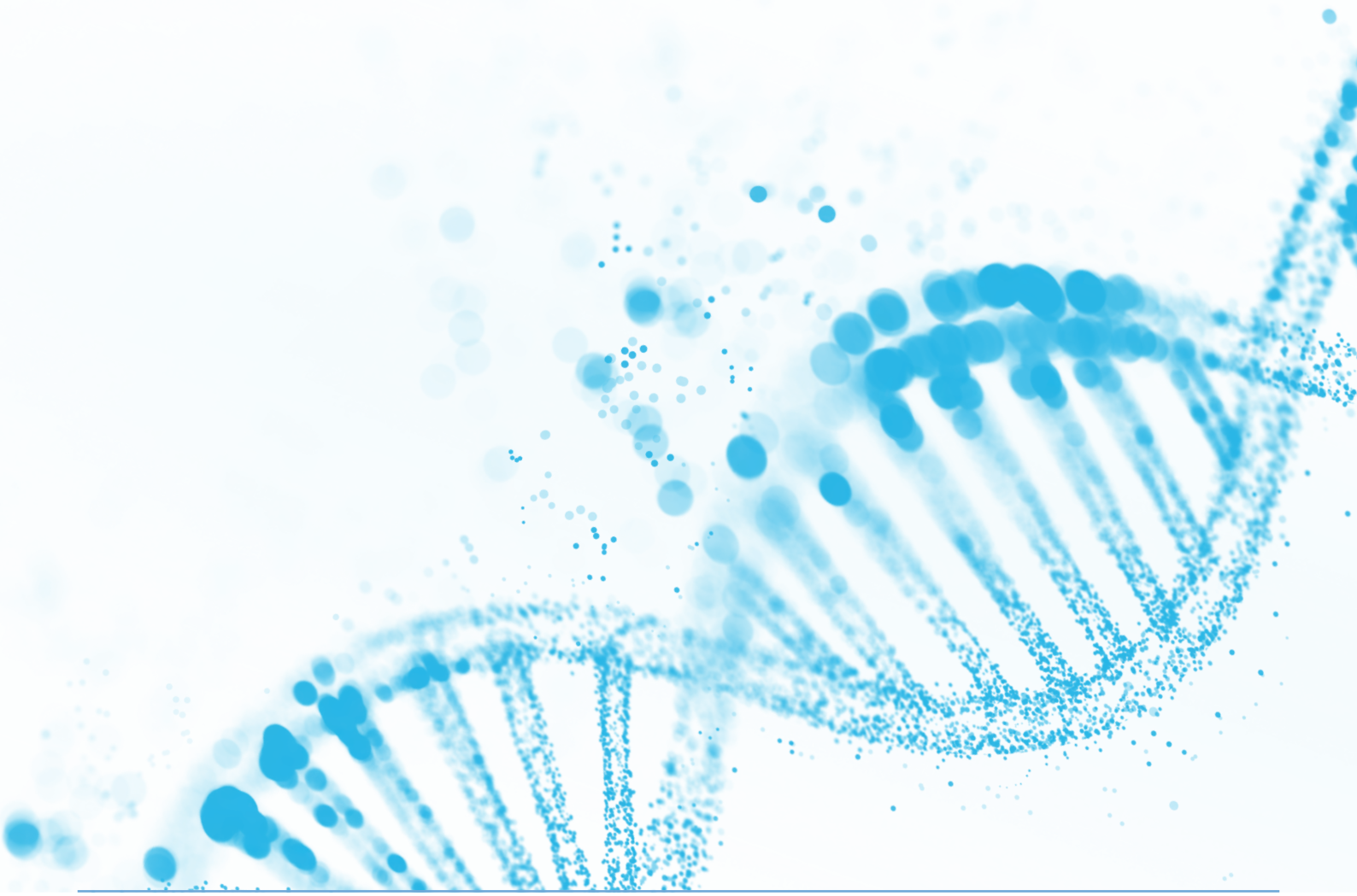
We will take the NHS from global laggard to global leader in technology. It will be through digital technology that we push out power from the centre of the NHS - to clinicians and to citizens.

This will be a fundamental break from the past. For patients, the change will feel like it has in other industries. Much as they now stream film, music and TV - and could not imagine returning to a world where they pop to a video rental store to choose a Friday night film - so the experience of accessing healthcare quickly and conveniently through digital means will quickly become second nature. For those who prefer or rely on in-person care, that choice will remain - indeed, we anticipate digital making their access far better.

Our choice will mean that the NHS becomes less dependent on buildings and beds in future, and as a result, patients will have far better access to the services they actually need.

Technology will supplement rather than replace the health service's human quality. We will use it to liberate the front-line from bureaucracy and admin, freeing up time to care. This will mean far better access, higher quality appointments and better continuity of care for those with the most complex needs.

The point of the NHS is getting patients to the care they need, quickly, easily, and ideally the first time. A fully digitally enabled NHS will transform our means to strengthen that principle through better navigation, clearer choice and faster access. That is the future we choose.



04

From sickness to prevention

Power to make the healthy choice

Our health is shaped by the places we live in. Whether because of the quality of the jobs available, the standard of the housing listed for rent, the price and availability of healthy food, or the extent of the mental health offer at the local school, good health can be easier or harder to maintain depending on factors as arbitrary as postcode.

As the work of Professor Sir Michael Marmot[114] among others has long shown, it is these social determinants that explain this country's wide and widening health inequalities. The injustice is that the social determinants of ill health cluster in more deprived parts of the country.

For example, Blackpool has the lowest healthy life expectancy in England[115]. Pay is also 16% lower than the national average, there is less work available and, where it is, it's more likely to be precarious[116]. It has the second highest rate of looked after children[117] and the number of alcohol-related hospital admissions and deaths is among the highest in the country. Nearly 36% of its children live in poverty[118].

Prevention will be how we restore the means to lead a healthy life in places – like Blackpool – where it has become most difficult. In turn, it will be our route to create a healthier, fairer, more prosperous country.

A turning point on prevention

We stand at the cusp of a historic transformation in our means to deliver on the promise of prevention. Until now, government strategy has been defined by a mix of government striking out alone on primary prevention, often without cohesion or real strategy – while the NHS has avoided taking its responsibility seriously on secondary prevention. Today, we have the technology, knowledge, science and cross-society energy to make transformational progress.

In part catalysed by the COVID-19 pandemic, which showed us all both how much we depend on health, and the vast societal, economic and individual harm poor health can cause, there has never been so much cross-societal energy on health. In developing this plan, we have heard from:

- businesses who want to partner on innovation
- employers who want to drive productivity by transforming employee wellbeing investors and pension funds who want to put health at the heart of how they build their portfolio
- mayors striving to make their Strategic Authority the healthiest and most prosperous in the country.

This coalition is not waiting for government. Danone[119] has committed to never introducing a high fat, salt or sugar product targeted at children. Sainsbury's run a 'Great fruit and veg challenge', where customers can win bonus Nectar points by shopping for fruit and vegetables, as well as offering £3 off fruit and vegetables as a weekly top-up for very low-income customers during key holiday periods[120]. Jaguar Land Rover[121] has established wellbeing centres for its staff, alongside an enhanced mental health offer. Apple is helping us track health information. Impact on Urban Health and Mission Ventures have crowded-in private finance to help healthier food start-ups reach the market[122]. It will be by working with these partners that we will make all our efforts more than the

Case Study: Live Well - Greater Manchester

Live Well[170] is Greater Manchester's movement focused on tackling health, social and economic inequalities by changing how partners work together across public services, voluntary organisations and communities. Its aim is to ensure people in every neighbourhood can access the right support, at the right time, in the right place. This includes integrated access to financial, employment, wellbeing, health and social support through Live Well centres, spaces and offers, backed by a connected and proactive workforce.

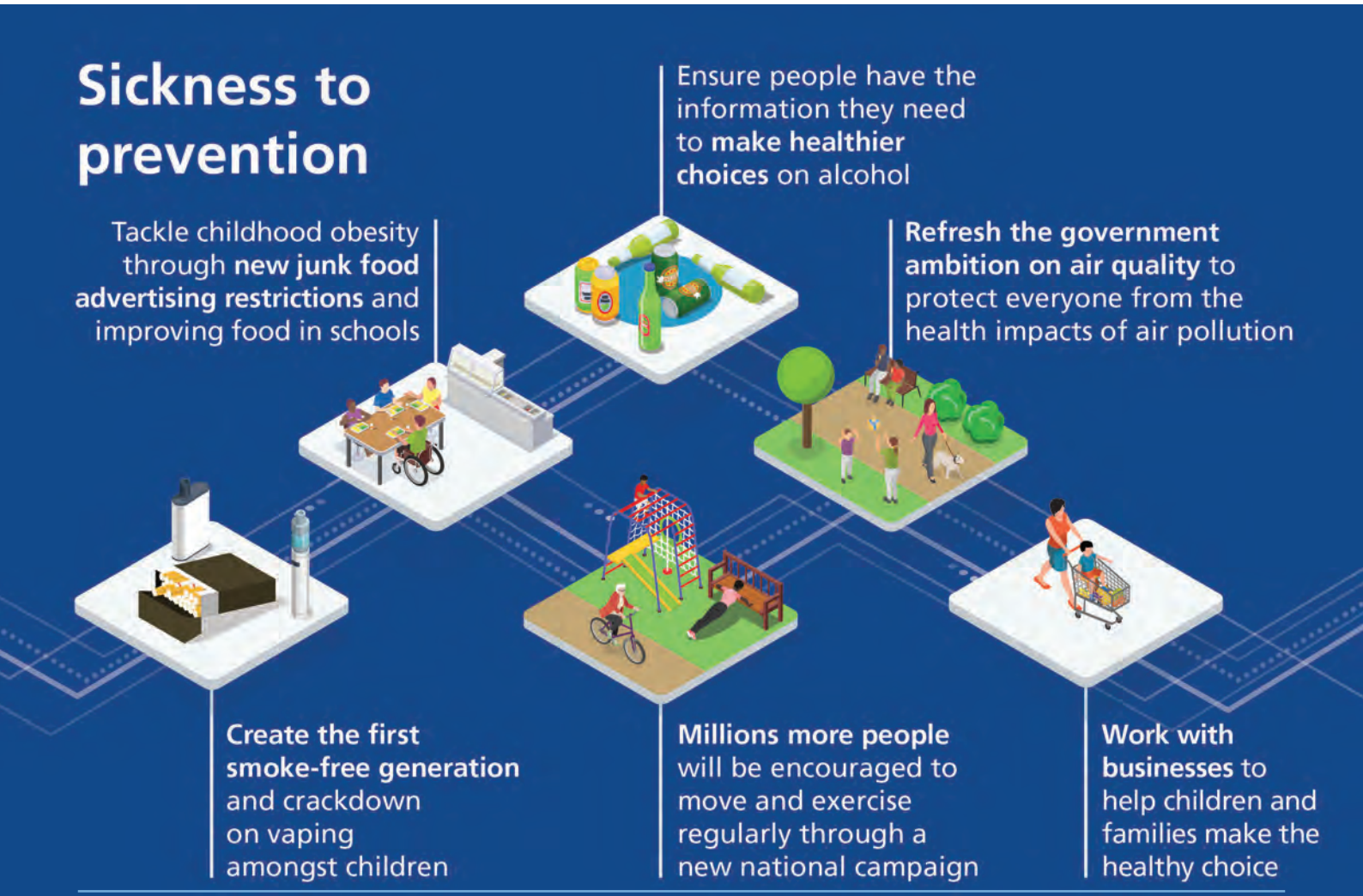
The approach follows what's already working across Greater Manchester's neighbourhoods and aims to grow consistent, community-led, preventative models of support—reducing reliance on public, especially crisis, services and improving lives for individuals and communities.

sum of their parts.

At the same time, citizens have never been more engaged, knowledgeable and active in their own health. This is reflected in an explosion in the consumer health market. It is valued at £4.1 billion in 2024, with sales up 8% on 2023[123] – and strong growth projections for the next 5 years. Elsewhere, Joe Wicks has got the nation into exercise and Dr Chris van Tulleken, among others, has opened a public debate about how our food is made. Over 3 million people in the UK have crossed the finish line at their local park run[124]. The groundswell of public interest and energy on health is huge.

New innovations are making a level of progress on prevention possible that was, until recently, unimaginable. One of the standout medical innovations in recent years has been GLP-1 receptor agonists, which are showing astounding promise in the treatment of type 2 diabetes and obesity[125].

Over the course of this plan, the combination



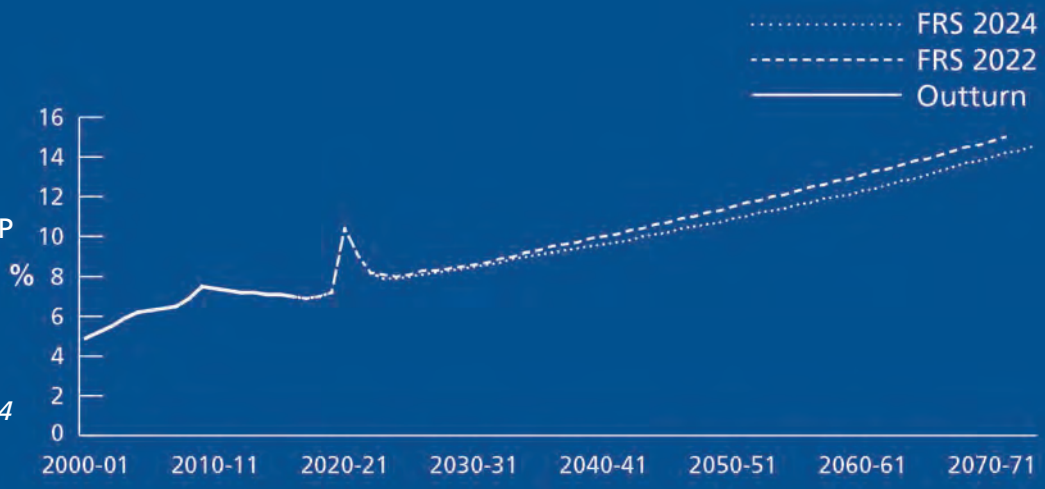
Securing the financial sustainability of the NHS

In England, more people are falling sick, earlier in life. Recent research by The Health Foundation[171] projected that the number of people living with a major condition will increase from under 1 in 6 (2019), to around 1 in 5 by 2040. This is not solely driven by an ageing population; increasing numbers of children and working age adults have long-term conditions.

If trends continue unimpeded over the next 50 years, the Office for Budget Responsibility[172] (OBR) project that government health spending will rise from around 8% of GDP (2024 to 2025) to 14.5% of GDP (2073 to 2074). This would mean health spending rising at twice the real growth rate of the economy.

The OBR suggests a rise in health spending from 7.8% (in 2023 to 2024) to 14.5% by 2074, using their baseline projection for public health spending as a per cent of GDP up to 2073 to 2074

Adapted from figure 3.14 in the OBR Fiscale risks and sustainability - September 2024



Poor health is already acting as a drag on the economic growth needed to support the NHS and invest in other, vital public services. Economic inactivity due to sickness has risen by half a million since just 2020[173].

Evidence from the Institute For Public Policy Research's Commission on Health and Prosperity[174] shows that health and worklessness are clustered around more disadvantaged parts of the country - and that people in working class occupations are both more likely to fall sick avoidably, and to leave work because of their illness.

This trend has been termed 'the double injustice'. Fiscally, the OBR estimate[175]:

- each person inactive due to health means around £5,000 less tax per person for the Exchequer
- that an individual moving into health-related inactivity costs the NHS between £900 - £1800 extra per year
- that over four-fifths of those inactive for health reasons are in receipt of incapacity benefits - contributing to the marked rise in health benefit spending in the last few years

Prevention is how we change this course, by pushing poor health into later life - and helping millions more get on with their lives, raising their children and progressing their careers unimpeded by avoidable sickness. The possibilities are huge: around 70% of cardiovascular disease, 40% of cancers and 40% of dementia are preventable[176].

In the long-term, primary prevention is critical to improve health, boost the labour market, narrow inequality and reduce NHS costs. That means bold action on obesity, tobacco and the social determinants of health. In the shorter-term it is secondary prevention that will have the most immediate health and economic impacts. We set out a radical new path, fit for the future, on both.

of genomics, predictive analytics and AI will usher in a new era for secondary prevention. They can provide a more informed view of each individual's risk, often from birth, and serve as an early warning signal for disease at both the individual and population level. This insight will give the NHS new means to pre-empt need, where it currently predominantly reacts to it. That is, we have the means to create a health service not just free at the point of use, based on need, but also based on risk.

We will harness this energy to take a new approach to prevention. Our overall ambition will be to halve the gap in healthy life expectancy between the richest and poorest regions, while increasing it for everyone, and raising the healthiest generation of children ever. Our means will be a moonshot to end the obesity epidemic, creating a truly smoke-free future, solutions to the mental health crisis engulfing our young people and harnessing the technology that will make the NHS a genuine health service – not just a sickness service.

To help us make sure we're on track on improving the nation's health – recognising there is often a lag between intervention and impact on healthy life expectancy – we will work with the Office for National Statistics and other experts to develop a new suite of delivery indicators, alongside a broader measure of the health of the nation.

Our first step: creating a smoke-free generation for a smoke-free UK

Tobacco is the only legal consumer product that kills up to half of its users when used as intended by the manufacturer[126]. Over 70% of lung cancers are caused by smoking, and it is a major risk factor for heart disease, stroke and dementia[127]. 230,000 households live in smoking-induced poverty, and the children of smokers are 4 times as likely to start, perpetuating a cycle of dependence and disadvantage[128].

The government will play its role in protecting citizens by creating the first smoke-free generation.

The world-leading Tobacco and Vapes Bill will mean that children turning 16 this year and those younger than them will never legally be sold tobacco, guaranteeing a long-term end to the sale of tobacco products across the country. The bill will also strengthen the existing ban on smoking in public places, to reduce the harms of passive smoking, particularly around children.

By bringing smoking prevalence to essentially zero during the expected lifetime of a child born today, this single piece of legislation will prove transformative for our health, the NHS' financial sustainability and the economy. We estimate that by 2100 the benefit of this policy will provide cumulative savings to the NHS of £6.6 billion and £64.2 billion in economic productivity gains[129].

While we accept that vapes can help some adults quit, the proportion of 11 to 15 year-olds who regularly vape has more than doubled in the past 5 years[130]. This is plainly unacceptable – and we know from our engagement that many parents and teachers feel powerless to prevent their use.

In June this year, we banned single-use disposable vapes but we will go further. The Tobacco and Vapes Bill will halt the advertising and sponsorship of vapes and other nicotine products. It will also provide government with powers to restrict point of sale displays, packaging and flavours, particularly those that appeal to children. We will consult on these regulations as soon as possible after the bill receives Royal Assent.

We will launch Health Coach later this year. This is a new programme to help people take greater control of their health, including smoking and vaping habits. Users will receive guidance and resources to support their quitting journey. In the longer term, we will launch a new AI powered digital tool to provide more personalised health advice to

millions of people, helping them to make healthier choices every day. We will offer effective third party stop smoking tools through HealthStore.
We will deliver our manifesto commitment to integrate opt-out smoking cessation interventions in all routine care within hospitals.

As set out in our elective reform plan, we will expect patients to engage with the support available to them, such as smoking cessation services. Evidence shows that stopping smoking 4 weeks before surgery means patients have a 25% lower risk of respiratory complications, compared to those who continue to smoke[131]. We have asked providers only to give patients a date for their routine (non-cancer) procedures once they have been confirmed clinically fit to proceed when pre-assessed

Our next big leap: ending the obesity epidemic

Obesity is one of the leading causes of poor health. In the past 30 years, obesity rates have doubled, and it is a leading cause of cancer, cardiovascular disease and type 2 diabetes[132]. Around 1 in 5 children leave primary school with obesity – rising to nearly 30% among those living in the most deprived parts of the country[133].

We stand at the cusp of a historic reversal. Today, we have the science, technology and public health knowledge to end the obesity epidemic. This is an ambitious moonshot: one that would make the UK a world leader in public health and one that would have huge returns in better health, reduced health inequality, a stronger labour market and lower NHS demand.

Food choices are partly an individual choice, but they are also influenced by our environment. This is particularly true for children, who have little choice in the food

they eat and are less able than adults to resist food advertising or product placement[134]. That is why this government will take decisive action:

- we will fulfil our manifesto commitments to restrict junk food advertising targeted at children, ban the sale of high-caffeine energy drinks to under-16-year-olds, and use our revised National Planning Policy Framework to give local councils stronger powers to block new fast-food outlets near schools. We estimate the energy drink ban alone could reduce childhood obesity rates by 0.4 percentage points, with health benefits worth £7.7 billion[135]
- alongside the Department for Education, we will update school food standards legislation, to ensure all schools provide healthy, nutritious food. As part of this, we will work closely with schools to explore what support they need to comply with higher standards. We estimate that if all schools do, childhood obesity could fall by 1.8 percentage points[136]
- to support the poorest families and tackle child poverty, we will restore the value of the Healthy Start scheme from 2026 to 2027. Pregnant women and children aged one or older but under 4 will each receive £4.65 per week (up from £4.25). Children under one year old will receive £9.30 every week (up from £8.50)
- for families with school age children, we are expanding free school meals so that all children with a parent in receipt of Universal Credit will be eligible for free school meals from September 2026. This step will put £500 back into families' pockets and lift 100,000 children across England out of poverty, to break down barriers to opportunity and tackle the scar of child poverty across our country
- we will continue to drive innovations in the soft drinks industry. The Soft Drinks Industry Levy (SDIL) has already driven innovation, with manufacturers reducing the sugar content of their products (reformulation). The total sugar sold in soft drinks decreased by 46% following SDIL's introduction[137]. However, it has not risen with inflation, so we will uplift the rate at which the levy is paid. The 'Strengthening the Soft Drinks Industry Levy' consultation sets out proposals to further drive reformulation, including ending the exemption for milk-based drinks and reducing the minimum sugar thresholds.
- current food and advertising and promotion restrictions use the 2004 nutrient profile model to categorise which foods are more or less healthy. This is plainly out of date, and we will update these standards. We estimate this simple modernisation of existing regulation could reduce childhood obesity cases by nearly 170,000.[138]

> **"In my job I speak to families who find it difficult to meet their basic needs. Families don't always have a choice to feed their children in a certain way […] young people are coping in whatever way they can and turn to quicker cheaper fast food. Mums can't always feed their children healthier food."**
>
> ***Sam, public deliberative event in Folkestone, December 2024***

Wherever possible, we will prioritise smart regulation and give business the best chance to innovate to support the nation's health. We know many need a level playing field to do so. To that end, retailers and manufacturers have expressed support for mandatory reporting, either publicly or privately. This is significant and aligns with the development of the government's food strategy.

In a world-first, by the end of the Parliament, we will introduce mandatory healthy food sales reporting for all large companies in the food sector. This will set a robust baseline upon which to base our future policies as well as improving transparency in the food industry. As well as supporting continued efforts on transparency, the data will support customers with their choices and support investors to invest in healthy companies. For example, an investor coalition led by Rathbone Greenbank Investments[139], which manages £6 trillion in global funds, has previously backed this policy, as has the Food and Drink Federation[140].

Using that reporting we will set new targets to increase the healthiness of sales in all communities and work with the Food Strategy Advisory Board on how to sequence the introduction of this policy. Targets will be mandatory but companies will have the freedom to work out how to achieve the target, whether through reformulation, by changing their layout, introducing new healthy products or through changes to customer incentive and loyalty schemes.

The previous government legislated to introduce restrictions on the volume price promotions retailers can offer, including a ban on buy-one-get-one-free deals on unhealthy food. These measures will come into force on 1 October 2025. By introducing smarter regulation, focused on outcomes, we expect to be able to repeal legislation restricting volume price promotions and aisle placement.

Government can only go so far on its own to end the obesity epidemic. To achieve such a significant ambition, we will need to harness scientific innovation, including recent breakthroughs in weight loss medication.

Today, it is estimated as many as 1.5 million people are taking GLP-1 medications such as semaglutide, liraglutide and tirzepatide through private prescriptions[141]. This indicates both their widespread appeal, and potential for transformational population health benefit. However, it also highlights a risk that these medications become the preserve of those who can afford them despite those without the financial means having higher need.

The NHS was created to universalise the best, so we believe it is important to expand access to weight loss services and treatments free at the point of need. To that end, we are establishing pioneering relationships with industry to test innovative models of delivering weight loss services and treatments to patients effectively and safely. This may include:

- digital only models, where everything is done and managed online
- delivery in local communities in a place that is genuinely convenient for citizens,

Case study: incentives in Singapore

Singapore's Healthy 365 app[177], developed by the Health Promotion Board, was launched to encourage healthier lifestyles and curb the rise of chronic diseases. Initially part of the National Steps Challenge in 2015, it rewarded users for daily step goals. The app has since expanded to include features like diet logging, sleep tracking, and team-based health challenges.

Users earn health points by engaging in activities such as walking, purchasing healthier food options, and participating in health screenings. These points can be redeemed for e-vouchers usable at places including supermarkets and restaurants.

The programme has achieved significant engagement, with over a million participants by 2022. A study[178] indicates that such initiatives have led to sustained increases in physical activity and health screenings among users, contributing to better health outcomes and supporting Singapore's shift towards preventive healthcare.

such as on the high street, or at any out-of-town shopping centre

- and models that can work in rural and other less urban geographies

We will seek further collaborations with medicines suppliers and digital weight management services building on successful approaches in the hepatitis C elimination programme – to offer fast and equitable access to weight management treatment through the NHS. This will include partnership with industry to provide access to new treatments on a pay for impact on health outcomes basis: whereby companies are not just paid if people lose weight, but if that also translates into outcomes that really matter for patients, such as fewer heart attacks, strokes or cancer diagnoses.

Successful treatment relies on good weight management services, including wraparound support. We will build on the success of the NHS Digital Weight Management Programme, expanding it to 125,000 more people per year and so doubling the number of people who can access it. This programme has strong evidence for delivering sustainable weight loss and delivers excellent value for money.

Being physically active is good for physical and mental health and has a measurable positive impact on relieving NHS pressures, worth an estimated £10.5 billion in savings a year. Despite that, inactivity levels remain stubbornly high for adults and children, with huge inequalities across the country.

Solving this challenge will require cross-system join-up. The evidence is clear, where investment in physical activity is designed with local people, inactivity rates are 2.5 percentage points lower than otherwise in the most deprived places[142]. Working with the Department for Culture, Media and Sport (DCMS), we will move to a place-based approach to physical activity across Government Departments: through £250 million of investment into 100 places by Sport England; at least £400 million of investment into local community sport facilities; new partnerships on school sport, and local health plans. DCMS will set out more detail on the strategy for physical activity in due course.

The Great Run Company has been at the leading edge of encouraging mass

participation in sport for many years with over 5 million finishers having taken part in their events[143]. Its president, Sir Brendan Foster, has agreed to advise and help assemble a group of expert partners to set up a campaign to motivate millions to walk – and where possible to run – on a regular basis.

The long-term aim is to have millions more people moving and exercising regularly as part of their lifestyle, as well as showcasing communities with the best initiatives.

We will partner with the Ministry of Housing, Communities and Local Government (MHCLG) and the Department for Digital, Culture, Media and Sport (DCMS) to run a new bidding process, modelled on the UK City of Culture, to name the UK's most physically active community each year. The scheme will showcase the exercise, sport and active transport initiatives in that community – to support public participation, spread best practice, and to crowd-in investment.

Citizens clearly have a role to play in managing their weight and diet. Incentives are embedded in many other parts of our lives, from supermarket shops, to buying a morning coffee, or choosing who to bank with. Evidence shows that incentives can also help people make healthier choices.

For example, a recent pilot of a health incentive scheme in Wolverhampton – which rewarded some people with points exchangeable for gift vouchers for making healthy choices – helped increase participants' physical activity and improved their diets. Building on this, we will create a new digital NHS points scheme where people are rewarded for taking positive actions to improve their health. We will shortly launch a market engagement process to start the conversation with business about what behaviours could be incentivised.

Tackling harmful alcohol consumption

The estimated total societal cost of alcohol harm in England was £27.4 billion per year in 2021 to 2022[144], equivalent to over 1.2% of GDP. While many people enjoy a drink in moderation, 4% of people drink as much as 30% of alcohol consumed each year[145].

An Organisation for Economic Co-operation and Development (OECD) study[146] estimates that the UK spends a greater proportion of its healthcare budget on diseases caused by excess alcohol consumption than the OECD average (3.0% compared to 2.4%).

To help tackle this, we will strengthen and expand on existing voluntary guidelines for alcohol labelling by introducing a mandatory requirement for alcoholic drinks to display consistent nutritional information and health warning messages. A mandatory requirement will bring alcohol labelling in line with existing health and nutritional labelling requirements for tobacco, food and alcohol-free drinks – all of which currently have more detailed nutritional and health information on their labels than alcoholic drinks. This will ensure greater public awareness of the health risks of alcohol consumption and help consumers make more informed, healthier choices. Mandatory health warning labels have proven effective in addressing alcohol harm in other countries, including South Korea[147].

As we tackle harmful levels of alcohol consumption, we want to support innovation in new product categories and support businesses that sell them to thrive. In the past 10 years, there has been significant growth in the no- and low- (NoLo) alcohol market[148]. To support further growth, we will consult on changing the upper strength threshold at which a drink may be described as alcohol free to 0.5% ABV, which will bring it into alignment with international standards. Alongside this we will explore options to restrict access to NoLo products so they are treated in the same ways as all alcohol products, including banning sales to under 18 year-olds. This work will be taken forward alongside the results of the licensing taskforce.

We will also support innovative community-level innovations where they have shown promise in reducing alcohol harm – including peer-led support groups, peer mentoring and coaching and mutual aid networks. We will work with local government to roll-out community led schemes with evidence of efficacy and value over the course of this Plan.

Cleaning up our air

Air pollution impacts all of us. It causes the equivalent of between 26,000 and 38,000 deaths per year in England alone[149], with working class communities most exposed to harm.

We are already making good progress in reducing air pollution from transport. This government is committed to delivering greener, safer and healthier transport, including by:

- decarbonising the transport system
- rolling out clean technologies across road, rail, aviation and maritime sectors
- support for active travel

We are creating more charging infrastructure to support our zero emission vehicle mandate. Both the Bus Services Bill and the Passenger Railway Services Act will support the delivery of more accessible and inclusive public transport for passengers across England. The government has invested nearly £300 million in local authorities in 2024 to 2025 and 2025 to 2026 for local authorities to deliver high-quality, accessible active travel schemes by 2026, and the Department for Transport is taking forward measures to increase the roll out of zero-emission buses.

Active travel is also an effective way to reduce emissions, while also supporting physical activity. In some parts of the country, there has been significant progress on active travel. In Cambridge, nearly 49% of journeys to work are made actively[150], while at Kesgrave High School near Ipswich, as many as 86% of students walk or cycle to school every day[151]. We will partner with Active Travel England, local authorities and other government departments to identify simple changes that can substantially boost active travel rates to help spread this best practice and reduce physical inactivity.

This government is also investing £616 million to build and maintain walking and cycling infrastructure from 2026 to 2027 to 2029 to 2030. This is in addition to funding to improve local authority capability to deliver active travel schemes, and to support other activities, such as Bikeability cycle training. The Spending Review also confirmed £15.6 billion to provide Transport for City Regions settlements for 9 eligible mayoral strategic authorities. This includes an objective to enable more people to walk, wheel, cycle or use public transport as part of everyday journeys.

However, good progress on transport emissions is not enough to deliver the air quality improvements we need to see to protect everyone's health. We will work with the Department for the Environment, Food and Rural Affairs (Defra) as they set out action on air pollution through the Environmental Improvement Plan review. This will set out policies and measures to reduce emissions, concentrations and population exposure to the most harmful pollutants, further steps to improve understanding of air pollution and activities to increase public engagement on air quality issues. We will explore ways to strengthen collaborations with the health community to improve awareness of and communications on the health impacts of air pollution.

Later this year, government will consult on how to reduce emissions from domestic burning – a major source of emissions of harmful particulate matter, especially in urban areas. In the medium term, the Defra will refresh the government's ambition on air quality through a review of the air quality strategy, renegotiate an international protocol

on emissions, and review our long term PM2.5[152] targets.

The government is also taking action to improve the standard of rented homes requiring social landlords to act promptly to fix housing hazards. This will initially focus on damp and mould, which can cause respiratory illness and other health problems. The Department for Energy Security and Net Zero (DESNZ) is also leading the development of an ambitious new Warm Homes plan and Fuel Poverty Strategy, backed by £13.2 billion of investment to help make homes warmer, more comfortable and energy-efficient. DESNZ will work with the Department of Health and Social Care to help ensure more health-vulnerable households get the help they need to improve their homes.

Employment and good work

Good work is good for health. It provides a sense of purpose, financial security and social connection. Yet poor health is increasingly a major barrier to people finding work. Health related economic inactivity has increased by 700,000 people since 2020[153]. This government will support people into good work, to support their health, and we will also ensure good population health, to support the labour market, deliver economic growth and prosperity.

Almost everyone will interact with the health service between a health diagnosis and leaving employment. We know early intervention to keep people in work is far more effective than late intervention after they have left it. Yet, keeping people in work is too rarely an explicit and intended outcome for the NHS.

Therefore, as announced in the Get Britain Working White Paper, we will join up support from across the work, health and skills systems to help address the multiple complex challenges that often stop people finding and staying in work. Our Health and Growth Accelerators are testing a novel approach where local NHS systems are supported to increase – and are held accountable for – the impact they have on people's work status. If those Accelerators are successful, we will expect all integrated care boards (ICBs) to establish specific and measurable outcome targets on their contribution to reducing economic inactivity and unemployment based on this model. In developing that approach, we will expect ICBs to seek the closest possible collaboration with local government partners – including mayors and strategic authorities in particular – so that citizens benefit from a seamless work, health and skills offer in their area.

Building on our WorkWell[154], Employment Advisers in Talking Therapies[155] and Connect to Work[156] programmes, we will ensure people with a health condition have access to the holistic support they need. In the government's Pathways to Work green paper[157], we further committed to developing a support guarantee, so that disabled people and those with a health condition affected by benefit changes also get the work, health and skills support they need to access and thrive in employment. We will further pilot the integration of employment advisers and work coaches into the neighbourhood health service, so that working age people with long-term health conditions have an integrated public service offer. A patient's employment goals will be part of care plans, to support more joined up service provision.

We will continue to expand provision of Individual Placement and Support schemes to help people with severe mental illness or drug and alcohol addiction find good work, provide employment support through primary care and offer employment advice to those accessing talking therapies. The changes we will make in the NHS App will allow many more people out of work due to stress and depression to access online support.

Across the country, including areas with the

least economic opportunity, the NHS is the largest employer. We will work with local job centres and others to ensure that people from all backgrounds can benefit from a career in the NHS. Some organisations are already innovating in this space, including the Leeds Anchor Network[158], which has developed a novel approach to community recruitment. We outline further actions we will take to make the NHS a force for social mobility and economic prosperity in chapter 7.

We will also engage and partner with employers. The independent Keep Britain Working Review led by Sir Charlie Mayfield[159] will consider the role of employers in tackling economic inactivity due to sickness and in creating healthy and inclusive workplaces. We will use the findings of that review to further explore how the systems around work and health can be improved.

In exchange for improved support, we think it is right that citizens also take responsibility for improving their health and employment prospects. In Pathways to Work, we proposed a shift to a fundamentally more active system for those out of work due to ill health, where a guarantee of work, health and skills support is matched by an expectation to engage with conversations about work and health. Alongside our commitment to legislate for the Right to Try, which will mean that trying work will never in and of itself trigger a benefits reassessment. We are committed to reforming the system so that no-one is abandoned or written off. As we progress these reforms, we will ensure that those with the most significant level of disability or most complex health needs, who will never be able to work, have their income protected and are not required to undergo reassessments for their benefits.

Thriving young lives

Prevention starts with children and young people. Effective preventative support can both provide a solid foundation for a thriving life and reduce lifetime NHS costs. This is why our Opportunity Mission starts with children's crucial early years.

Almost half of mental health conditions develop before the age of 18[160]. For children and young people with mental health needs,

fast access to early, high-quality support is critical. Yet NHS mental health services have never truly met the needs of the population in a comprehensive way, and there are significant gaps in support. Evidence shows that unaddressed mental illness early in life can result in worse school attendance and results[161], and may mean hundreds of thousands of pounds of lost earning potential over a lifetime[162].

We will work with schools, colleges and universities to better identify and meet children's mental health needs. We will continue to roll out mental health support teams in schools and colleges, to reach full national coverage by 2029 to 2030 – and we will include health practitioners in the child protection teams that we will legislate to create through the Children's Wellbeing and Schools Bill. We will also ensure embedded support for children and young people's mental health in new Young Futures Hubs, alongside a wellbeing offer, to ensure there is no 'wrong front door' for people seeking help.

Alongside better early support we will also address longstanding issues with access to specialist children and young people's mental health services. We will recruit 8,500 mental health staff focused on reducing long waits for both children and adults. We will work with local authorities to ensure that children with the most complex mental health needs in residential care get the treatment and support they need to avoid even more expensive hospital admissions and repeated emergency department visits.

These core principles of early intervention and support, without the need for diagnosis, particularly apply for children and young people with Special Educational Needs and Disabilities (SEND). In the autumn, we will bring forward a schools white paper, which will detail the government's approach to SEND reform, ensuring joined-up support for children and young people. Building on the successes of programmes such as Early Speech and Language for Every Child, that prioritise early intervention ensuring, where possible, needs do not escalate, we will ensure that education and healthcare providers work together with other local services to plan and deliver evidence-based early interventions for children. Reforms will focus on ensuring allied health professionals, such as speech and language or occupational therapists, who are vital for supporting children and young people with SEND, are more effectively deployed spending time supporting children not on bureaucracy and admin. Early evidence suggests these approaches have the potential to reduce pressure on referrals and make it easier to secure a sufficient supply of these key specialists.

Further, this summer, the Department for Culture, Media and Sport will publish a new National Youth Strategy, which will set out how this government will support young people in all aspects of their lives including, support for mental health, wellbeing and the ability to develop positive social connections.

Health services will also do more to play their part in child safeguarding. We will work in partnership with the Department for Education to implement a single unique identifier for every child, to enable proactive, preventative and joined-up care across different public services. Dependent on successful piloting, the NHS number will become the single unique identifier for children.

From a sickness service to a prevention service

The NHS has too often been fatalistic about its role in prevention. Typifying this, the share of the NHS budget spent on prevention has effectively been cut by 28% per person in real terms over the past decade[163], despite the significant rise in long-term and chronic illness making prevention even more important to both population health and NHS financial sustainability.

Today's NHS is more 'sickness service'

than 'health service'. Over the course of this plan, that will need to change. While primary prevention and action on the social determinants of health is how we will bend the NHS' cost curve in the long run, it will be secondary prevention that achieves NHS financial sustainability in the short term.

We will tilt the NHS towards prevention in 3 ways. First, we will do far better at taking the immediate opportunities available to deliver prevention: vaccination, screening and early diagnosis. Second, looking to the longer-term, we will create a new genomics population health service, to harness the potential for predictive analytics to support more predictive and precise prevention in the future. Third, as we outline in the next chapter, we will ensure the NHS is incentivised to move away from ever more hospital activity and towards population health outcomes.

Our first steps: getting the basics right

Vaccines prevent between an estimated 3.5 to 5 million deaths globally each year[164]. They remain one of our best means to protect people against disease.

Today, vaccines have given us a unique opportunity to consign cervical cancer to history for the next generation. We will increase uptake of human papillomavirus (HPV) vaccinations among young people who have left school, to support our aim to eliminate cervical cancer by 2040. We will continue to work with local government, civil society, voluntary organisations and community groups to support the public trust in vaccines needed to restore childhood immunisation rates more broadly. We will also work with families and schools to improve the consent process to help children get vaccines at school, and help parents book vaccinations and check they are up to date through the NHS App.

Looking towards the future, mRNA technologies – used in COVID-19 vaccines – are showing huge potential. There is particular promise in cancer immunotherapy, where personalised cancer vaccines can be designed to recognise and eliminate cancer cells[165]. To harness this, the NHS will work with key partners in universities and industry to ensure it is well placed to generate research evidence and plan the implementation of mRNA vaccines. We are committed to delivering 10,000 cancer vaccines to patients in clinical trials in the next 5 years, and we will scale this up further as new vaccines are shown to be clinically effective.

We anticipate that at least one breakthrough technology such as multi-cancer early detection tests will be proven effective in the next 5 years. The NHS will evaluate new pathways of care to support their development and then test implementation as quickly as possible. This will support our Plan for Change aspiration to reduce the number of lives lost to cancer through earlier diagnosis.

We will end new HIV transmissions in England by 2030. Later this year, we will publish a new HIV action plan to continue our progress

towards this ambition. This will include efforts to improve testing, tackle inequalities in access to HIV prevention interventions, and better identify the need for and initiation of HIV pre-exposure prophylaxis particularly among people from ethnic minority groups such as Black African and Black Caribbean communities.

Each year, over 15 million people are invited to screening programmes. These people have no symptoms, but an increased risk of developing a disease or condition. Around 10,000 lives are saved every year as a result, and many others are supported to make better decisions about their health.

Through our upcoming national cancer plan, we will increase access and uptake of screening services. Using the NHS App, we will make it easier for people to book appointments. We will fully roll out lung cancer screening for those with a history of smoking, which we expect will detect 9,000 cancers earlier each year[166]. We will also ensure women who have not taken up the offer of cervical screening are sent a self-sample kit, so they can test themselves in the privacy of their own home.

> **"As a result of routine bowel screening, I was called for further tests (colonoscopy) and found to have a cancer tumour in my rectum. Within 4 weeks I had MRI and CT scans, consultant meeting and operation to remove the growth which was found to be stage 1 cancer…"**
>
> ***Charlotte, public participant, via the Change NHS website***

Secondary prevention interventions are often excellent value, and well evidenced, but suffer from variable uptake across the country.

To address this, we will test new delivery models for secondary prevention through the Neighbourhood Health Service. These new 'Prevention Accelerators' will initially run in selected ICBs and will focus on community-led methods to tackle variation in uptake of high-impact cardiovascular disease and diabetes interventions. We estimate that increasing the proportion of people with hypertension who are well-managed from 70% to 80% in 3 years would lead to nearly 2.24 million fewer healthcare episodes[167] across primary care, outpatients and inpatients over a 10-year period, freeing up GPs and contributing to progress on elective waiting times.

We will pivot health research and development to focus on primary and secondary prevention, as well as multiple long-term conditions. Our goal will be to mobilise both public and private investment to improve health and prosperity. To do this, we will change our approach to research funding so more Medical Research Council and National Institute for Health and Care Research funding is invested in the prevention, detection and treatment of long-term conditions. We will expect this to have a crowding-in effect on private investment.

A new paradigm: the genomics population health service

Our longer-term plan is to break from business as usual and create an entirely new prevention paradigm within the NHS. Genomics and predictive analysis, supported by AI, can increasingly tell us the likelihood of a person developing a condition before it occurs, support early detection of disease (especially cancer), and enable personalised prevention and treatment.

The NHS is uniquely placed to take advantage of these developments. While the ability to predict disease might undermine insurance-based healthcare models, our universal single-payer system, which covers everyone, from cradle to grave, will be enhanced by it.

The NHS is already a global leader in genomic

medicine. The NHS Genomic Medicine Service, launched in 2018, made the NHS the world's first healthcare system to systematically embed comprehensive genomic testing across the country, including whole genome sequencing as part of routine clinical care. The service currently delivers over 850,000 genomic tests annually through a network of seven consolidated Genomic Laboratory Hubs, providing comprehensive coverage for prenatal, rare and inherited diseases, cancer and pharmacogenomics[168].

This provides a platform for a future where genomic information and insights are as fundamental to healthcare as basic vital signs, enabling precision medicine, predictive prevention and personalised treatment for the entire population of England. We will build on this, leaning from evidence and experience, by expanding the existing NHS Genomics Medicine Service to create a new genomics population health service, accessible to all by the end of the decade.

This new service will combine the power of genomics, new diagnostics and predictive analytics with AI. It will mean the NHS of the future will proactively maintain wellness, identifying and mitigating disease risks years – even decades – before symptoms arise. It will also equalise access to knowledge to help empower citizens to make healthy choices so that everyone, no matter their background, will have the opportunity to know their risk and be supported by the NHS to act on it early.

The genomics population health service will, informed by the Generation Study (discussed in more detail in chapter 8), implement universal newborn genomic testing and population-based polygenic risk scoring alongside other emerging diagnostic tools. This will enable early identification and intervention for individuals at high risk of developing common diseases. Our approach to implementation will be informed by learning from our existing programmes, the best clinical evidence and working with people and communities. Genomic testing at birth, with consent, will allow science to reveal the nature of a baby's genome, giving parents and clinicians the ability to unlock the secrets of a child's future health.

The new service will also eliminate the diagnostic odyssey experienced by some patients with rare diseases, reducing the time it takes to get a definitive diagnosis from 4 years to 3 months in some instances.

Cancer genomics will also be universally implemented, and every cancer patient will have the choice to receive a comprehensive genomic analysis and molecular profiling to guide precision treatment decisions, while liquid biopsy technology will enable early detection non-invasively through a blood test and monitoring of on-going treatment response.

Pharmacogenomics will be integrated into routine clinical practice. Pre-emptive testing and integration with the Single Patient Record will optimise medication effectiveness for individual patients and prevent adverse drug reactions that cause patients harm and cost the NHS up to £2.2 billion per year[169].

We will develop a unified genomic record integrating genomic data with relevant clinical and diagnostic data. This will be linked to the Single Patient Record. Patients will be able to view a complete account of their risk of major conditions and manage their personal health risks through the NHS App, with the Neighbourhood Health Service providing bespoke support to help individuals manage these risks. We will ensure patients have absolute confidence in how their genomic data is protected and used, giving them control over who has access.

The NHS App will use this information to deliver personalised health coaching, recommend healthier choices and provide reminders and alerts to participate in risk-stratified screening and other diagnostic tests. Those with a long-term condition will have the opportunity to use genomic information and insights to help shape their personal care plan. To support this, staff working in

the Neighbourhood Health Service will be equipped to provide genomic counselling, as outlined in chapter 2.

To seize this opportunity and take our first steps in developing the genomics population health service, from next year:

- the NHS Genomics Medicine Service will expand the population health testing it already provides and will shorten testing times further. We will expand the NHS' whole genome sequencing programme, with a focus on risks relating to common disease areas including cardiovascular, renal and diabetes
- we will work with clinical experts to integrate genomic testing for pharmacogenomic profiles into the NHS over-40s Health Check. Over time, we will make this a universal offer
- we will monitor uptake across different communities and build in robust evaluation from the start to demonstrate value. Using pharmacogenomic insights in mental health prescribing will also be a priority
- we will expand genomic testing for inherited causes of major diseases to allow earlier detection and intervention, including cancer (e.g. BRCA1/2 genes), and cardiovascular disease predisposition (e.g. familial hypocholesteraemia)
- we will begin integrating genomic insights into cardiovascular disease prevention and care through a trial with Our Future Health implementing Integrated Risk Scores (which bring together genomics and other non-biological risk factors) in neighbourhood health services, expanding to all 5 million participants in the Our Future Health programme. Subject to evaluation, we will begin wider roll out – including expansion to other conditions like diabetes, breast, bowel and prostate cancer, and dementia.

We recognise that there are important ethical considerations about the wider use of genomics and that some people would rather not know their risk of developing a life altering health condition. We will utilise the ethics advisory committees and structures of the NHS Genomic Medicine Service, Genomics England and Our Future Health to ensure that these services are developed in line with public opinion and with strong safeguards in place. Patient consent, choice and informed shared decision making will be paramount.

Conclusion

Social justice runs through this plan. We know everyday life poses greater health risks to the most disadvantaged in society, whether the price of healthy food, the level of pollution or the quality of jobs available. Prevention will be how we deliver healthier, more prosperous lives for all, but particularly for those suffering the consequences of widening levels of health inequality.

Our means to tackle inequality, improve health for everyone and deliver economic growth have been transformed by new science, knowledge and a growing, cross-society appetite for partnership.

The state will support the foundations of good health. Partners in the private and voluntary sectors will drive the innovation that supports healthier lives. In exchange, citizens will be empowered to take responsibility for their health.

We will harness technological advances in vaccines, screening and genomics to turn the NHS into a prevention service.

In 10 years time, we will have transformed the nation's health. We will have restarted progress on longevity, healthy life expectancy, made progress through prevention on the biggest killers. And we will have begun narrowing the wide and widening health inequalities that unjustly divide our country.

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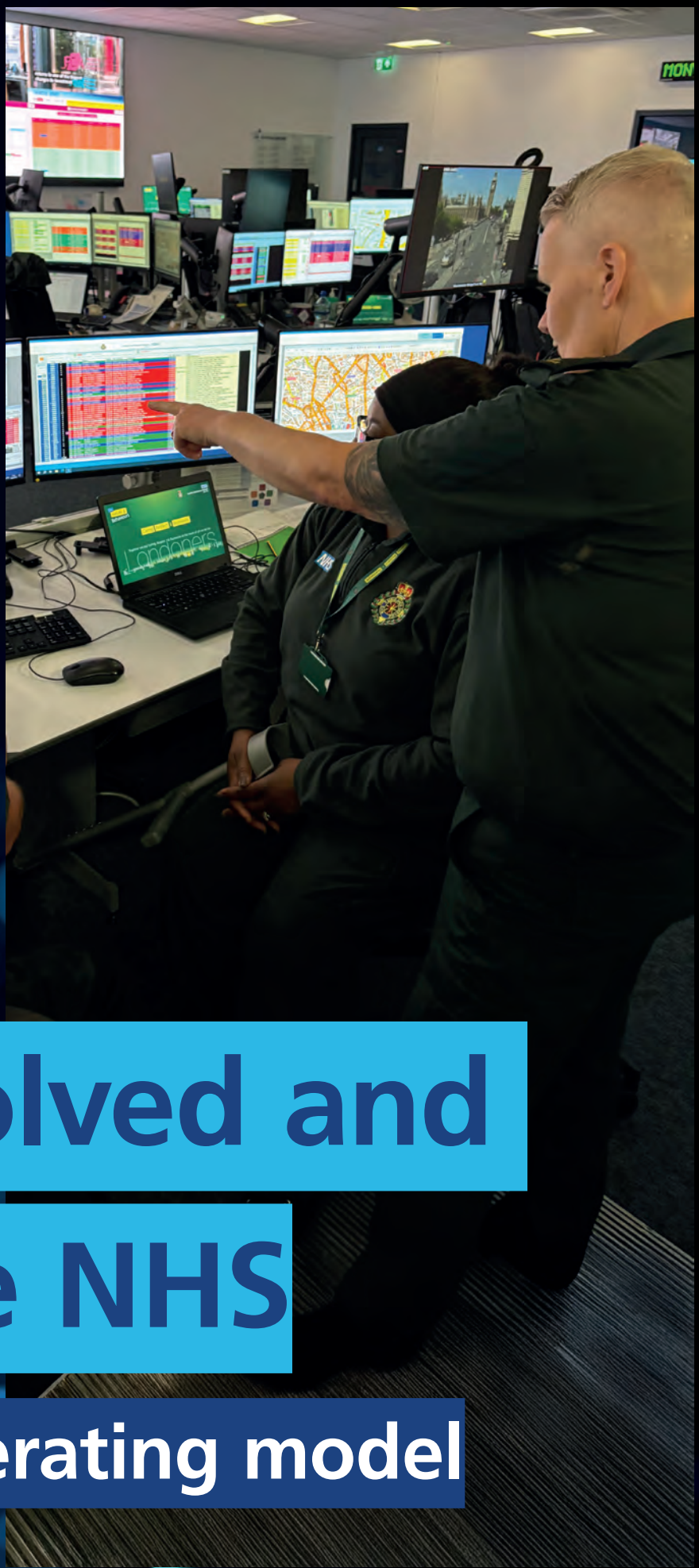


A devolved and diverse NHS

A new operating model

This government has an unwavering commitment to the NHS' founding principles: universal care, free at the point of delivery, based on need, publicly funded. However, it is less often remembered that these principles were predicated on a broader ambition of patient empowerment. In 1948, Minister of Health Nye Bevan told the Institute of Almoners how the new NHS would act as a 'public megaphone' to the mouths of patients[179]. His goal, like ours, was to distribute power to patients and the public.

That ambition has never truly been achieved. Today, the NHS operates as a centralised state bureaucracy, unable to harness the pace and scale of change of the healthcare revolution taking place globally. Power is concentrated in Whitehall, rather than with local providers, staff and individual citizens.

> **"Bureaucracy kills innovation and motivation for change."**
>
> ***Leo, health and care staff deliberative event in Taunton, March 2025***

To realise the ambition of this Plan, and to fulfil the ambitions of the NHS' founders in 1948, we will require a new operating model that supports rather than impedes the redistribution of power from the centre to the frontline. Devolution will not be achieved by simply moving from one set of centrally controlled institutions to another. Instead, patients need to be given genuine control.

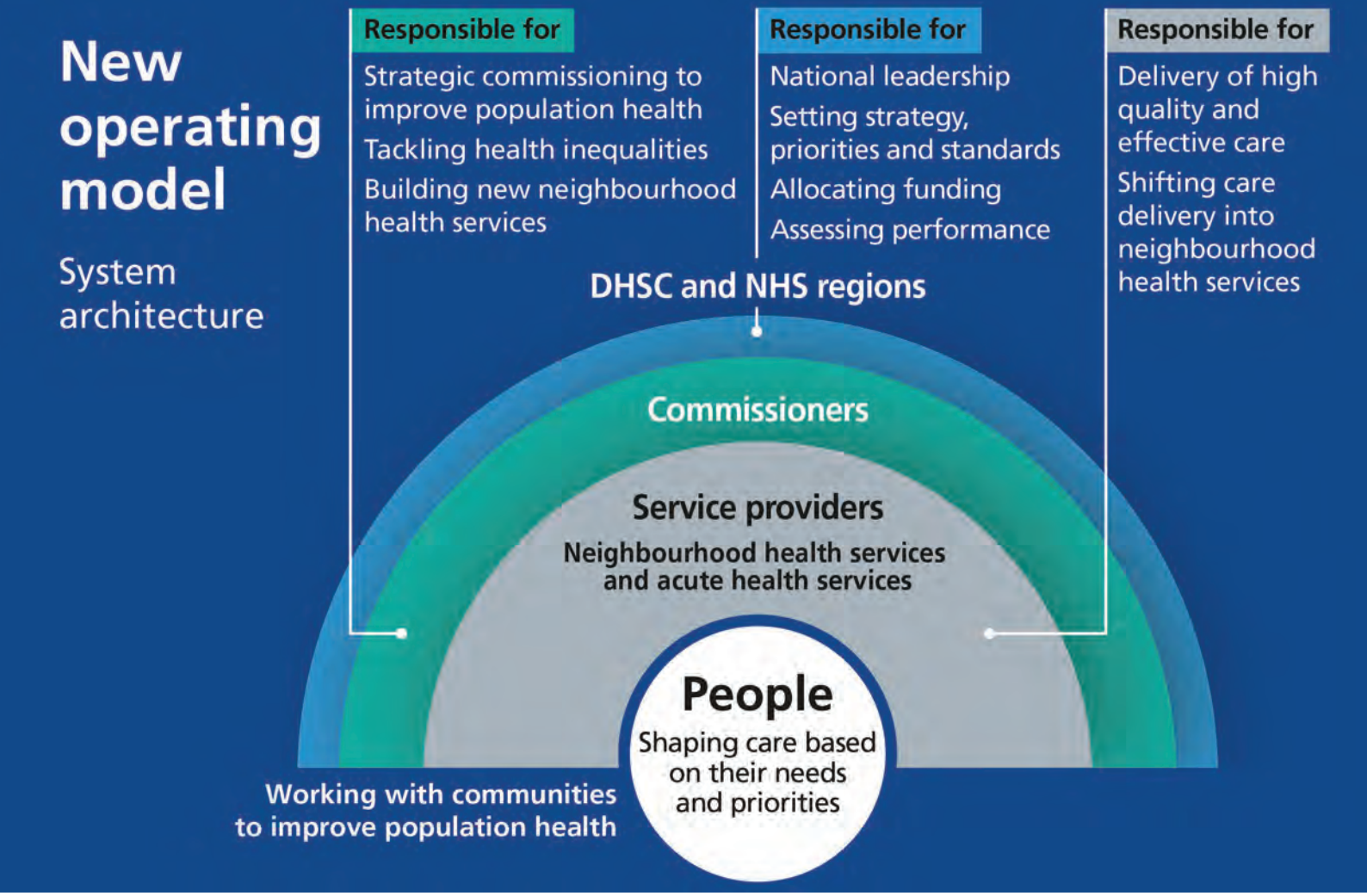
The Coalition government's 2012 reorganisation was framed as an attempt to achieve just that. The 2010 White Paper Equity and Excellence: Liberating the NHS[180] argued that "the headquarters of the NHS will not be in the Department of Health…but instead, power will be given to the frontline clinicians and patients. The headquarters will be in the consulting room and clinic".

In reality, it achieved the exact opposite of its stated goals. The devolution of power delivered by the previous Labour government in the 2000s was abandoned. Financial incentives to encourage local services to improve were jettisoned. Rules and frameworks disappeared, replaced with management discretion.

The succession of organisational workarounds introduced over the past decade to sidestep the worst impact of the 2012 reorganisation has resulted in roles and responsibilities that lack clarity. This has served to amplify the power of the chain of command. More and more decisions have become centralised and prescriptive. The system has become obsessed with, and dependent on, instruction from the centre.

The frontline, despite having the best sense of how to improve care, has become disempowered and demoralised. There are few rewards for the best organisations and leaders to truly lead, to be entrepreneurial, and to innovate. In this model, the NHS looks to the centre, and not to its patients and the public, for instruction and accountability. Compliance is the priority, and the patient is left on the periphery.

Ironically, despite the rhetoric of uniformity that justified a centralised command and control model of the NHS, it reinforces inequality of outcomes. The poorest communities often have the worst services, and a one-size-fits-all approach serves these areas least well. Our operating model, and the greater diversity of provision and personalisation of services it enables, will deliver more equal outcomes.



A new operating model

The loss of a clear governing philosophy - and with it, any kind of rules-based framework, clear accountability or effective incentives - has contributed to the marked fall in productivity, quality and innovation observed in the NHS in recent years. Patient outcomes have suffered as a result, while the public - left without a meaningful say in the direction of their health service, and lacking confidence in its future - are despondent at how the NHS is run. The 2024 British Social Attitudes survey[181] showed just 21% of people were satisfied with how the NHS is run today, compared to 70% in 2010.

The NHS has 1.5 million staff[182]. It delivers around 600 million patient interactions across all its services each year[183]. On a typical day, 835,000 people visit their GP, there are 94,000 emergency admissions to hospital and 36,000 planned hospital treatments[184]. A service of this scale and complexity cannot be run effectively from Whitehall.

We will create a new NHS operating model, to deliver a more diverse and devolved health service:

- the centre of the system in Whitehall will be smaller, more agile, and focused on developing strategic frameworks and building partnerships
- the lack of clarity in the system about roles and purpose will be fixed by establishing clear priorities, mandating fewer targets and equipping local leaders to improve population outcomes
- where providers are treated the same today, whether they deliver good or bad services, a new system of earned autonomy will mean they are treated differently. There will be a failure regime to bring poor performers up to standard.

We will reward the best performers and give them new freedoms to innovate

- we will set higher standards for leaders, with pay tied to performance and good work rewarded
- we will use multi-year budgets and financial incentives to enable investment in better outcomes, not just into inputs and activity. Resources will be tied to outcome-based targets, which all commissioners and providers will have a responsibility to help meet
- transparency and choice will drive performance. Providers and commissioners will be measured against clear metrics, ranked on performance and that information will be provided to patients. Patient reported outcomes, experience and feedback will be among the most important measures on which they are ranked as part of a new choice charter to empower patients.

Reinventing the Centre

We cannot devolve power without recasting the role of the centre. We will redesign the centre in both form and function.

Our first step will be to combine the headquarters of the NHS and the Department of Health and Social Care. Integration of teams will begin in the coming months and the process of abolishing NHS England will be complete within the next 2 years.

It was never a sensible proposition that an arm's length body would be responsible for resources amounting to nearly a tenth of the economy. Nor was it ever likely that having 2 central organisations would do anything other than concentrate more power in the centre. We will strip out duplication and bring many of NHS England's functions into the department.

> **"It is my opinion that the greatest barrier to improving NHS efficiency, value for money and service delivery, is the multiple layers of management and red tape that prevents those with good ideas from effecting change."**
>
> ***Ahmed, staff participant, Change NHS website***

The centre will be smaller in the future. By 2027, its headcount will fall by 50%, with savings redirected to local systems. The major benefit will be the reduction in the burden that central bodies place on systems and providers. We will replace the culture of bureaucracy that has disempowered local leaders, through endless micromanagement, with proportionate and streamlined regulation and oversight.

The function of the centre will change alongside its form. Alongside setting strategy, its purpose will be to form partnerships with investors, industry, local government, employers, small or medium-sized enterprises (SMEs), voluntary organisations and trade unions. There will be an explicit goal to make the NHS the best possible partner and the world's most collaborative public healthcare provider and it will do more to create the conditions for local entrepreneurship, both inside and beyond the NHS, to support grass-roots innovation.

The centre will continue to have seven NHS regions. They will be responsible, alongside the national headquarters, for performance management and oversight of providers. Working with integrated care board (ICBs), they will oversee transformation at scale; ensure services are configured appropriately to deliver; and that structures, functions and incentives are implemented effectively. Regions should support the national team in its assurance functions, but never duplicate them.

Integrated care boards will be strategic commissioners

ICBs will be strategic commissioners of local health services, responsible for all but the most specialised commissioning using multi-year budgets. This means ensuring that the money available to each local care system is put to the best possible use: to improve their population's health, reduce health inequalities and improve access to consistently high-quality services.

They will be expected to draw on a deep understanding of population need, and to make long-term decisions in the interests of improved outcomes and financial sustainability. They will need to shape commissioning plans through deep engagement with patients and the public; and to use competitive processes where helpful, alongside clear contracting and contract management to drive change and ensure delivery.

ICBs will need to evolve new capabilities to be successful in their role. Every ICB will need:

- Excellent analytical capability, to be guided by population health data
- A strong strategy function, including staff with good problem solving and analytical skills
- Capability in partnership working and an understanding of value-based healthcare
- Intelligent healthcare payer understanding, to support a focus on value for money, the development of novel payment mechanisms and oversight of strategic resource allocation
- User involvement functions, to ensure services meet the needs of communities.

There is significant, unjustified variation in ICB performance[185][186]. Over the coming months, ICBs will deliver efficiency savings to become lean and agile and to cut duplication of functions with providers. We will reduce the number of ICBs from 42, with existing ICBs starting to cluster and live within the running costs cap from autumn of this year.

As outlined in NHS England's recent Model ICB publication[187], we will develop and deliver a national programme to support ICB capability, including a new commissioning framework. This will inform future assessments of ICB maturity.

As ICBs take on their role as strategic commissioners, we will take the opportunity to rationalise commissioning support functions. This will help drive efficiencies and give ICBs the skills they need to deliver strategic commissioning effectively. We will close Commissioning Support Units.

ICBs will be responsible for commissioning the best, most appropriate neighbourhood providers in their footprint. As well as commissioning, which will often involve 'market making', ICBs will need to actively cultivate strong providers. To support that, ICBs will be empowered to commission neighbourhood health services from a diverse range of providers, both within and beyond the NHS, drawing on different models of provision to develop effective contractual arrangements.

ICBs will be able to pool their commissioning arrangements to allow for at-scale commissioning of new provider networks or chains. Providers, including new ventures, will be expected to have a clear plan for ensuring financial sustainability and productivity, alongside service delivery. ICBs will place quality of care at the centre of their commissioning, and they will take decisive action to decommission services or terminate contracts where a provider consistently delivers very poor-quality care. This is the right thing to do for patients and taxpayers.

We will amend legislation so that provider organisations no longer sit on ICBs. We will make strategic authority mayors (or their delegated representative) board members of their ICBs, rather than local

authority representatives, to best align the opportunities for strategic planning between the NHS and the renewed commitment within local government to support the strategic authority as a key body for growth and prosperity.

Earned autonomy for providers

All NHS providers will continue to deliver NHS services based on NHS principles: universal care, free at the point of delivery, based on need and funded through general taxation. However, while these principles were intended to deliver a foundation of equity in healthcare, the NHS has never truly been equal.

Too often, the poorest services are in the poorest communities, where need is also highest. This is not right, and we do not accept it is inevitable. Our new operating model, and the more devolved NHS it will create, will help ensure the communities that most need high quality care, get it.

We will introduce a modern form of earned autonomy, which drove substantial improvements in the 2000s. Where local providers perform well, they will have greater autonomy and flexibility to develop services free from central control. Our ambition over a 10 year period is for high autonomy to be the norm across every part of the country. We will therefore support providers to achieve the requisite performance level needed to take on more freedoms. Where local services consistently under-perform, the NHS region will step in with the aim of supporting providers to a position from which they can deliver self-sustaining improvement.

NHS regions will use a rules-based process to determine where intervention and support to address poor performance is needed. It will be backed by a new failure regime, based on a new diagnostic process to better understand why persistent under-performance is taking place. That may be because services are configured in a sub-optimal way, because of structural financial problems, or because of failures in leadership and culture. Where we identify problems, we will then help solve them:

- In some cases, by supporting reconfiguration
- In other cases, by replacing the leadership team, and incentivising new, more effective leaders to take over and tackle the problems at hand
- By placing a failing provider into administration, so it can be taken over by another

Our priority will be to address under-performance in the areas with the worst health outcomes, such as rural and coastal communities, where we know access is often particularly poor. During 2025 to 2026, regions will draw up action plans for each failing provider in these areas and begin the process of turning them around.

Most parts of the country will have a mix of good and less good NHS services. We will provide more support to ensure they are assessed as moving from improving to good, or high performing. This support will include connection to national expertise, local expertise, peer review or peer support. The NHS will also establish its own self-financing improvement capability - drawing on the talent, innovation and energy of the best of the NHS.

With support, and over time, we believe all local NHS providers will be assessed as good or high performing. As a principle, we believe that such organisations should have greater autonomy, so they have the powers they need to improve local services for the communities they serve. This was the principle that lay behind the creation of NHS foundation trusts - but over the past decade, provider freedoms have since been curtailed. We view that as a retrograde step.

We will reinvigorate and reinvent the NHS foundation trust (FT) model for a modern, integrated health system. The core philosophy will be the same, but new FTs will have a

greater focus on partnership working and on population health outcomes, reflecting contemporary healthcare. Starting this year, we will restore the flexibilities at the heart of the FT model to existing FTs, where their performance on outcomes, access, quality and financial sustainability merits it. We will authorise a new wave of FTs in 2026. Our ambition is that, by 2035, every NHS provider should be an FT, maintaining the high standards of the application and reauthorisation bar, with freedoms including:

- Strategic autonomy: over performance and delivery issues
- Board composition: freedom to control board composition, where NHS trust boards are fixed under secondary legislation
- Financial freedom: FTs can retain surpluses and reinvest them (see chapter 9)
- Raising capital: FTs can borrow for capital investment

We will remove the requirement for FTs to have governors. While governors have provided helpful advice and oversight for some FTs, we expect the next generation of NHS FTs to put in place more dynamic arrangements to take account of patient, staff and stakeholder insight. This should include systematic measures of patient reported experiences and outcomes, as we detail in chapter 6.

FTs will use these freedoms and flexibilities to improve population health, not just increase activity. That is, they will be expected to look beyond their own narrow organisational boundaries. We outline how we will support this through a new approach to leadership in chapter 7, and through new financial incentives in chapter 9.

The authorisation process will be led by a new function within the new Department of Health and Social Care and overseen by a panel of independent members. We will ensure that there is clarity of role between this new function (focused on authorisation, assessment and re/de-authorisation) and the role of ICBs in commissioning services and regions in providing oversight. Trusts and FTs applying for, or seeking reauthorisation as, FT status will need to have demonstrated excellent delivery on waiting times, access, quality of care and financial management, as well as higher levels of productivity than their peers. This will also need to demonstrate a proven track record of, and commitment to, working in partnership to improve health outcomes.

For the very best NHS FTs - that have shown an ability to meet core standards, improve population health, form partnerships with others and remain financially sustainable over time - we will create a new opportunity to hold the whole health budget for a local population as an Integrated Health Organisation (IHO). If they provide high-quality care efficiently, they will be allowed to keep the savings to reinvest in better patient care, new capital projects, digital transformations, new partnerships or even commercial support for start-ups and SMEs with significant promise. Outcomes for patients would be secured through longer-term, capitation-based contracting and the model will be underpinned by both the ICB playing an active part as strategic commissioner and the refreshed FT governance model.

Our intention is to designate a small number of these new IHOs in 2026, with a view to them becoming operational in 2027. All new IHOs will be put through a rigorous authorisation process, and will be overseen in a proportionate, rules-based way by their NHS region. They will always and only ever be NHS organisations.

They will be required to support integration, shift resources from hospital to community, focus on population health and tackle inequalities. They will be free to contract with other service providers, within and outside the NHS.

This approach will help overcome the challenge that, in the NHS, interventions by one provider (e.g. a GP) accrues savings and benefits in another (e.g. a hospital). This means risk and reward is unbalanced, and particularly disincentivises prevention.

A New Plurality of Provision

No one part of the NHS has a monopoly on good ideas. GPs, NHS Trusts and NHS FTs, community services, independent sector providers, voluntary organisations and social enterprises all have the ideas, networks and drive to transform outcomes for patients.

They are held back by a bureaucratic system focused on controls and process, rather than incentives and outcomes. Our ambition is to create more diversity in the provision of NHS services. Our aims will be higher quality, better value, fairer outcomes and greater choice. We will support ICBs to develop a provider landscape that actively encourages innovation and is not bound to traditional expectations of how services should be arranged. That could mean GPs running hospitals, nurses leading neighbourhood providers or acute trusts running community services.

We will continue to use private providers to improve access and reduce waiting times, to return the NHS to its constitutional standards. As we outlined in our Plan for Change, we will not let spare capacity go to waste on ideological grounds. We will continue to make use of private sector capacity to treat NHS patients where it is available, and we will enter discussions with private providers to expand NHS provision in the most disadvantaged areas.

Our use of a plurality of providers - from within the NHS, the voluntary sector, the independent sector or social enterprise - will not be limited to elective care. Where there is such rapid innovation taking place today in how services can be transformed through advances in science and technology we want to broaden the eco-system of providers.

For example, the NHS in Gloucestershire has significantly advanced the shift of eye care from hospitals to neighbourhood settings. Hospital eye care records and images are shared with primary care optometrists, such as those working in Specsavers. This has reduced unnecessary hospital referrals, led to a 14% reduction in waiting lists and improved convenience for patients.

However, in working with independent providers, we will neither tolerate 'gaming' the national payment tariff to cherry pick the simplest, most profitable cases, nor any quality shortcomings. ICBs will be expected to monitor this, and act decisively where they identify problems as part of a wider duty to safeguard and ensure value for taxpayer money.

A new partnership with local government

To achieve the scale of ambition in this plan for integrated, personalised services and real progress on prevention, the NHS will need to work in much closer partnership with local government and other local public services.

Staff recognise that many people who are frequent attenders in emergency departments or their GP surgery often have other underlying needs unconnected to healthcare. They might need housing support, financial advice, or access to job or training opportunities. Too often in the past, talk of integration between the NHS and local government has been just that: talk about integrating public institutions instead of meaningful action to improve outcomes for people. Our ambition is for the investment that goes into local areas to be greater than the sum of its parts.

Since ICBs will be critical to establishing better partnerships with local government we will encourage them to adjust their boundaries to match those of new combined authorities. Our aim is that ICBs should be coterminous with strategic authorities wherever feasibly possible.

Although the NHS and local government have a shared purpose to improve the lives of local citizens, the multitude of plans, committees and measures have resulted in confusion, siloed working and inaction. In the future, a neighbourhood health plan will be drawn up by local government, the NHS and its partners at single or upper tier authority level under the leadership of the Health and Wellbeing Board, incorporating public health, social care, and the Better Care Fund. The ICB will bring together these local neighbourhood health plans into a population health improvement plan for their footprint and use it to inform commissioning decisions. As a result, to create clarity, we will abolish Integrated Care Partnerships.

We will also work with the Local Government Association to consider democratic oversight and accountability in light of the new NHS operating model, the role of mayors and reforms to local government.

Where devolution and a focus on population health outcomes are most advanced, we will work with strategic authorities as prevention demonstrators, starting with the Mayor of Greater Manchester, whose thinking in this area is most advanced. These will be a partnership between the NHS, single or upper tier authorities and strategic authorities to trial new innovative approaches to prevention – supported by mayoral 'total place' powers, and advances in genomics and data. We will support these areas with increased autonomy, including supporting areas through exploring opportunities to pool budgets and reprofile public service spending towards prevention.

The public health grant is a nearly £4 billion investment in local health outcomes[188]. It provides a range of critical local services, including stop-smoking, weight management, substance misuse services, and sexual health services. We have already confirmed a real-terms increase in the grant for 2025 to 2026, following a trajectory of cuts and decline since 2015, which were particularly severe in the most disadvantaged parts of the country[189].

The next step is helping local government achieve more for the investment. From 2026, we will set the expectation that every single or upper tier local authority participates in an external public health peer review exercise, on a 5-year cycle, with the results directly informing local plans. We will work with the Local Government Association and other improvement experts to help local government public health services improve and adopt best practice.

We will also reform the Better Care Fund from financial year 2026 to 2027. Reform will focus on providing consistent, joint funding to those services which are essential to deliver in a fully integrated way, such as discharge, intermediate care, rehabilitation and reablement'.

Pushing power out to patients and the public

The steps outlined in this chapter will push power from the centre to local systems and providers. This is a good thing in its own right: it is providers, not Whitehall, who know most about local need. However, it is only an intermediary in this plan's defining goal: a patient-controlled NHS, that provides real choice, real control and real convenience for patients.

To achieve that, we will introduce a new Choice Charter. It will be rolled out progressively across England, starting in the areas of highest health need. It will have 5 new mechanisms.

First, it will make NHS funding flows increasingly sensitive to patient voice, choice and feedback. Patient reported outcomes and experience data - as well as direct feedback - will be important determinants in how we appraise performance and award performance-related pay. As we outline in chapter 9, we will also trial new Patient Power Payments, where patients will be contacted after care and given a say on whether the full payment for the costs of their care should be released to the provider. This will be the start of the

trajectory of money flowing with patients, and being responsive to patient voice, over the course of this Plan.

Second, patients will have new powers over how they use NHS resources from our significant expansion of personal health budgets (PHBs). As we outlined in chapter 2, we will at least double the number offered one by 2028 to 2029, and make PHBs a universal offer for all who would benefit by 2035.

Third, patients will be able to exercise greater control over their health and care through the NHS App. As we outline in chapter 3, the App will revolutionise patients' interactions with the NHS. They will be able to get rapid advice, book appointments instantly, rate their experience, choose their provider and schedule appointments - all with maximum choice.

Fourth, over time and where safe and clinically appropriate, more patients will be able to directly refer themselves to more diagnostic services, removing often time consuming and inconvenient processes where patients are gatekept unnecessarily. In the future, we expect patients to be able to access lab testing via their phone (e.g. blood tests); to use AI to triage (e.g. via the NHS App) or to directly proceed to tests (also via the NHS App and where clinically appropriate) with tests available in the community via community diagnostic centres and neighbourhood health centres. A more pre-emptive NHS App and advances in wearable technology will, over time, support patients to self-refer confidently, including directly through the NHS App (see chapter 3).

Fifth, where patients need elective treatment, they will have a choice of different providers, allowing them to choose the provider that best suits their needs, with information available on journey times, waiting times, quality, outcomes and patient experience. We will facilitate this through the NHS App.

Conclusion

The NHS was founded to give power to patients. However, in the seven decades that followed, the reality is that power has been concentrated in Whitehall. The 2012 reorganisation was predicated as an attempt to fix this - in practice, it did entirely the opposite.

Our reforms will break with the past by pushing power out to places, providers and patients. The centre will be smaller, and its purpose will be clearer - not endless assurance and diktat to paralyse the rest of the system, but the facilitation of outcomes, partnerships and collaborative progress. This will be a culture shock for the NHS, but one that is fundamentally necessary.

Our operating model will be rules-based. Everyone will have clarity about their role and function. From those rules, those who perform well will have the freedom to innovate, partner and lead. We will incentivise and reward good performance. We won't hesitate to act on poor performance, including through a new failure regime.

Empowered providers and leaders will pass power onto patients. We will expect them to look to the public, not to the centre, to decide their plans and derive their accountability. We will strengthen the role of patient voice and choice in accountability, and we will create the means for providers to truly focus on the outcomes of the community they serve, rather than the narrow boundaries of their own organisation.

06

A new transparency of quality of care

Between 2005 and 2008, there was widespread neglect of, and alarmingly high mortality among, patients at Stafford Hospital. Later investigations uncovered horrifying accounts of patients left in their own waste, denied hydration and proper pain relief. The Francis Inquiry[190] would later report that 'staff treated patients and those close to them with what appeared to be callous indifference'.

The Mid-Staffordshire scandal is, tragically, far from an isolated incident. The NHS' history is blighted by examples of systematic and avoidable harm: the needless deaths of children undergoing heart surgery at the Bristol Royal Infirmary (1980s to 1990s); serious failings in maternity care at Furness General Hospital (2004 to 2013); Shrewsbury and Telford (2009 to 2019), East Kent Hospitals University NHS Trust (2009 to 2020) and Nottingham hospitals (2022 onwards); neglect and poor care of patients under the care of mental health services, including Essex inpatient services (2000-23), Tees, Esk and Wear Valleys NHS Foundation Trust (from 2017), the events leading to the tragic killings of 3 people in Nottingham (2023); and the Infected Blood Scandal (1970s to 1990s).

The failures that underpin each are consistent: incompetent leadership, toxic culture, rampant blame, workplace bullying, and a failure to learn from mistakes. There is also a fundamental lack of transparency, which means low quality or neglectful care does not come to light quickly; that the response is not fast or decisive enough; and that patient, staff and public attempts to sound the alarm go unheard. It is time for the NHS to learn.

We will usher in a new era of transparency, a rigorous focus on high-quality care for all and a renewed emphasis on patient and staff voice. We will do that on behalf of everyone whose healthcare has caused them unnecessary suffering, whether as part of scandals, or because they have received ineffective care from the NHS more broadly.

Our objective will be twofold: to universalise high-quality care and, in support of that, to make the NHS the most transparent healthcare system in the world. Our definition of high-quality care draws from that outlined by Lord Darzi in High Quality Care for All (2008)[191]: care that is always safe, effective at treating the health problem, and patient experience that is as positive as possible.

As well as preventing the worst cases of neglect, our focus on quality will drive up standards for everyone. For example, it will be through our quality agenda that we achieve our Plan for Change commitment to reduce the number of lives lost to the biggest killers, including cancer, cardiovascular disease (CVD), and suicide. And it will be how we ensure consistent adoption of the technology - from AI, to wearables - that promises to transform care quality in the 10 years to come.

This will make a transformative difference for patients. However, we do not underestimate the work needed to hardwire transparency and quality into the NHS. We will:

- put patient choice, voice and feedback at the heart of how we define and measure quality
- create and clarify accountability for high quality care - supported by new incentives to reward the leaders and staff who deliver it best
- streamline regulation, including a shift

to a more intelligence-based regulatory approach.

Power to the patient through transparency, voice and choice

The NHS is a service, funded by taxpayer money and accountable to the public. It has no right to leave them in the dark. We will publish all quality measures from all providers. This will be supported by AI, which is making it far easier to gather and curate large quantities of data.

Our commitment to transparency will be matched by a commitment to making data easy to understand for providers and patients. By July 2025 we will publish the oversight framework for 2025 to 2026, including NHS provider performance segments. From this summer, we will publish easy-to-understand league tables each quarter, which rank providers on a rounded set of indicators. Providers will be assessed and placed in a segment from 1 (high performing) to 4 (failing).

To help patients make sense of NHS data, we will make more information available about performance on quality and access in the places people live. The NHS largely reports on its performance within its own organisational structures, but these have little meaning to the public. As we build the Neighbourhood Health Service, providers and integrated care boards (ICBs) will be required to routinely publish information about quality of care and access to services using local authority boundaries.

There are multiple audits and reviews of quality of care routinely carried out within the NHS in England. These include, for example, 30 audits as part of the national clinical audit programme, 5 clinical outcome review programmes and the Getting it Right First Time programme. The data included in these programmes should be made available to the public and the Care Quality Commission will consider as part of their intelligence led approach to regulation. Better data and analytical capacity will enable far more

detailed and accurate case mix adjustment to allow for meaningful insights from the data.

We will make new tools available on NHS.uk to make it easier to access and interpret quality measures. Over time, and as outlined in chapter 3, the My Choices tool in the NHS App will allow patients to search and choose providers based on quality data - including length of wait, patient ratings and clinical outcomes.

We will supplement quality metrics with patient reported outcome measures (PROMs). These are already in use in specialities like orthopaedics and mental health. They are powerful tools to measure the impact of care from the patient's rather the clinician's perspective. We will also collect patient-reported experience measures (PREMs) in a more systematic and comparable way. By 2029, both PROMs and PREMs will be used universally, will be published in the public domain, and will be part of the data available to patients when choosing their provider on the NHS App.

Developing these indicators for maternity care will be our earliest priority. Listening to women and families is critical to support safe, personalised and equitable maternity care. While data on women's experiences is collected annually, lags in publication delay any response to their insights. Research due to be published in April 2026 will support the implementation of a new PREM that enables all women and families to provide feedback on their care from summer 2026 onwards.

> **"I recently had a baby. Really positive experience with community midwife and hospital, they were supportive, kind, took the time to listen to me and what me and my partner needed, and adjusted their care for us. It was clear the service was stretched though - especially in the hospital. I didn't receive any pain relief as the maternity ward was full and I happened to be in labour during shift change. You could tell everyone was tired and overwhelmed. Care after birth was less good - we had issues with breastfeeding, and we received a lot of contradictory advice and felt a bit lost in the system."**
>
> ***Maryam, public participant, via the Change NHS website***

However, given the systematic failures in maternity and neonatal services, we know we need to go further. We will set up a national, independent investigation into maternity and neonatal services with 2 core roles. First, it will conduct urgent reviews - by the end of this year- of up to 10 trusts with specific

issues. Second, it will systematically investigate maternity and neonatal care as a whole in England. This will include synthesising the findings and recommendations of all other reviews to recommend one set of national actions to drive the improvements needed to ensure high quality care.

We will also establish a National Maternity and Neonatal Taskforce, chaired by the Secretary of State for Health and Social Care. It will be made up of a breadth of independent clinical and international expertise, with family and charity representatives. Its work will inform the development of a new national maternity and neonatal action plan, which we will co-produce with bereaved families. It will lead to rapid improvement of maternity and neonatal quality and safety and ensure that any families in the future who are harmed or bereaved will get answers about what happened, see that lessons are learnt and that there is accountability.

Direct patient feedback will be core to our new approach to quality. Patient feedback is already collected by NHS organisations, but it is too often very high level - and pales in comparison to the granular, highly actionable feedback collected in other service industries. As outlined in chapter 3, the App will give patients the option to leave feedback on the care they receive. This will be viewable by others, nationally collated and translated as actionable recommendations to providers and clinicians to support continuous improvement.

Since their inception in 2012, Healthwatch England, working with local Healthwatch organisations, has gathered detailed patient feedback[192] and used this to influence debate around local service delivery.

While this has been valuable, we need to go much further. We will bring patient voice 'in house' - to give it a greater profile within a reformed Department of Health and Social Care. Specifically, we will create a new National Director of Patient Experience, responsible for overseeing the collection of more informed feedback from both patients and carers - and making it publicly available. This will incorporate the functions of Healthwatch England, as well as the work on patient experience adopted by the Patient Safety Commissioner (PSC).

The work of local Healthwatch bodies relating to healthcare will be brought together with ICB and provider engagement functions (chapter 5). Individual provider boards will be asked to ensure they have robust mechanisms in place to collect and use patient feedback, ensuring it is actively fed back to individual clinicians and clinical teams. This will be the norm across the NHS by 2026. Local authorities will take up local Healthwatch social care functions.

The NHS complaints procedure is far from where it needs to be. In our engagement, patients and carers expressed confusion about where and how to complain and told us about their struggle to get responses to their concerns. The number of formal complaints referred to the ombudsman for healthcare[193] is nearly 7 times higher than for railways[194]. This cannot be right.

The problem is that the NHS doesn't listen well enough. The most common reasons for complaints is poor communication.[195] We will update complaints regulations and increase the use of AI tools to ensure complaints data is collected - and responded to - far more quickly. One AI tool is already in development and being tested on the Federated Data Platform (FDP) and we will resource further expansion of this approach in 2025 to 2026.

"I had an accident in December 2023, where I injured my knee, and have since been left physically disabled and unable to walk without crutches. My entire personal and working life has changed in the past 11 months, and unfortunately I have not received safe, efficient and appropriate care [...] I have made 2 complaints to PALS (Patient Advice and Liaison Service) [...] I have since had a reply to a complaint I submitted in October 2024, and the response was in my opinion very passive aggressive, referring to the entire Darzi report, and not taking any ownership of the wrong doings that have happened to date, and there is no future plan for me to speak with anyone to discuss my surgery, I just have to wait for a date, which will likely be in another 12 months."

Ruth, public participant, via the Change NHS website

For those who have concerns about the care they are receiving, we will significantly improve the complaints process within all NHS commissioners and providers. We will set clear standards for both the timeliness and the quality of responses to complaints and expect these to be handled within patient experience and patient complaints teams, not via PALS or external advocacy services.

When patients and their carers have patient safety concerns, we will expect a personalised, rapid response where managers and clinicians listen carefully, engage compassionately, provide answers to questions, explore whether care was provided to a high standard and learn continuously.

We will change the time limit for the Care Quality Commission (CQC) to bring legal action against a provider, to allow more cases to be comprehensively reviewed and acted upon. We know that the current 3-year restriction has caused considerable concern to some individuals and families who have suffered harm. We hope this change will provide assurance and help bring victims confidence we have learnt from their experience to improve the system for families seeking justice in the future. Further to this, we have asked David Lock KC to provide expert advice on how we can improve patients' experience of clinical negligence claims.

Many of the NHS' worst scandals happened - or lasted longer -because staff were ignored, or did not feel able to speak up. We will act more quickly on staff concerns. The National Guardian for Freedom to Speak Up in the NHS trains and supports a network of 1,300 freedom to speak up guardians across England, offering guidance to encourage employees to share concerns about patient safety.

Now that these guardians have been established, we will do more to integrate their role. The National Guardian's work will align with other national staff voice functions, such as the existing freedom to speak up case management function - meaning the distinct role of the guardian will no longer be required. As part of its wider inspection responsibilities, a core function of CQC will be to assess whether every provider (and in time, ICB) has effective freedom to speak up functions, and the right skills and training in place.

Clearer accountability and stronger incentives for high quality of care

Everyone in the NHS is responsible for delivering high-quality care. The first responsibility lies with the individual clinician, accountable to their professional regulators and their employer. Clinical teams have collective responsibility for the quality of care they provide. And those who lead organisations are responsible for the quality of care provided by each of their services.

The last comprehensive strategy to improve quality was High Quality Care for All[196], published in 2008. We urgently need a refreshed strategy, fit for the next 10 years. To deliver this, we will revitalise the National Quality Board (NQB) and task it with developing a new quality strategy by March 2026. Whereas today the quality landscape has become crowded and unclear, the NQB will provide a single and authoritative determination of quality. All other bodies, including Royal Colleges, will feed into the NQB.

The NQB will bring together senior clinical and managerial leaders from the NHS and regulatory bodies, along with patients and patient representatives. It will be responsible for the oversight of quality measurement, transparency and improvement. The government supports the more detailed recommendations in Dr Penny Dash's forthcoming report[197] on patient safety across the health and care landscape, including on the role and responsibilities of a revitalised NQB, and on the importance of clinical leadership in driving quality improvement.

The NQB will also be responsible for developing a range of clinically credible outcome measures to better assess clinical quality. While in some branches of medicine, outcome measures are the norm, others still rely on measures of activity and input as the basis for assessing performance. This is not compatible with the focus on population outcomes we outlined in chapter 5. Over time, outcome measures will become the norm across all clinical practice and will be part of our approach to earned autonomy.

As well as an overall quality strategy, the NQB will, working with clinicians and patients, oversee the development of a new series of service frameworks to accelerate progress in conditions where there is potential for rapid and significant improvements in quality of care and productivity. Between 1997 and 2010, National Service Frameworks[198] were a clinically led and authoritative tool that supported sustained improvement in major condition outcomes, including by narrowing inequality and reducing unwarranted variation.

We will reintroduce and modernise this approach, publishing a first wave of 'Modern Service Frameworks' in 2026, which are accessible and transparent to all. Early priorities will include CVD, mental health (including severe and enduring mental illness), and - informed by phase one of the independent commission into adult social care led by Baroness Casey - the first ever service framework for frailty and dementia. These Modern Service Frameworks will:

- define an aspirational, long-term outcome goal
- identify the best evidenced interventions that would support progress towards this goal, with a focus on those with the best means to drive up value and equity
- set standards on how those interventions should be used, alongside a clear strategy to support and oversee uptake by clinicians and providers
- above and beyond the scope of original national service frameworks, set out 'challenge areas', where we anticipate significant progress being possible, but where innovative ideas and products are needed
- alongside a plan to partner with the wider eco-system,support the creation, adoption

and spread of novel new ideas.

Boards must take ultimate accountability for the quality of care provided by their organisations on a day-to-day basis and for when things go wrong. It is their responsibility to make sure they actively measure and manage the quality of care that is provided by their organisation to patients. It is only through continuous measurement and an open culture that these responsibilities can be fulfilled.

We believe it is important to recognise and reward high quality care – and to take decisive action where it is not good enough. In chapter 9, we describe how we will hand power over to patients by trialling new Patient Power Payments. For the first time in the NHS, these will give patients the power to recognise and reward high quality care - or hold back payment when care has not been good enough.

We believe that it is important to recognise and incentivise improvements in care in clinical teams and that NHS providers should be able to reward clinical teams that provide high quality care. We will therefore ensure that all providers have new flexibilities to make additional financial payments to clinical teams that have consistently high clinical outcomes and excellent patient feedback or are significantly improving care. NHS providers will have the ability to make these payments starting in 2027 in the parts of the country that have the highest health need. They will become the norm across the country by 2030.

Commissioners are responsible for acting on quality of care. In communities with high levels of health need, poor performance has been tolerated for too long. A new approach is needed. Persistently poor-quality care should result in the decommissioning or contract termination of services or providers no matter the setting; no matter whether the provider is in the NHS or independent sector; and no matter whether they are a GP practice or an individual NHS Trust.

As such, in line with our new operating model, poor performance will carry consequences. It is unacceptable that poor quality care is allowed to persist when the contractual levers exist for commissioners to act - including, by bringing in a new provider or leadership team. We will task, within the next 12 months, ICBs and NHS Regions with assessing where such action is needed across all services.

Streamlining regulation to focus on quality of care

Patients must always have confidence that they will receive high quality care. The rationale for independent regulation is threefold: the consequences of care failings often cannot be remedied after-the-fact; the interests of managers, clinicians and patients are not always aligned; and patient views need expert representation.

CQC is the principal regulator of quality of care. Its role is to be on the side of patients and to secure their interests. However, over the past 6 years, trust and confidence in CQC has declined precipitously. Its poor performance was confirmed in Dr Penny Dash's report[199] (October 2024) on the operational effectiveness of CQC, with reasons underlying this outlined in Professor Mike Richards' report[200] (also October 2024).

We have already taken the first steps to fix this. CQC is now under new leadership and a major change programme is underway. We will now deliver the reform needed make it the most effective, modern and patient orientated regulator in the world.

We will do this by shifting the CQC to a new intelligence-led model, supported by expansive new access to data. It will be given statutory powers to access all NHS and publicly held datasets relating directly or indirectly to care quality. Our introduction of a Single Patient Record (chapter 3), alongside other advances in data and analytics, will make it easier to identify concerns in the future.

To support this, we will establish a national

AI-led warning system building on the capabilities in the Federated Data Platform (FDP). This will mean we are able to analyse data to identify where quality issues are emerging in parts of the NHS. Where the AI system flags a concern, it could trigger a CQC inspection.

The new Maternity Outcomes Signal System (MOSS) will be in place across trusts from November. MOSS will use near-real time data to indicate higher than expected rates of stillbirth, neonatal death and brain injury, allowing more timely action to be taken when standards deteriorate. This delivers on a recommendation Bill Kirkup's report[201] on maternity and neonatal services in East Kent and has been developed with his input.

In common with other regulatory agencies that are concerned with safety, CQC will have 2 broad operating models for inspection:

- rapid response inspections, where concerns are identified, and inspectors are deployed to understand the nature and significance of problems
- routine planned inspections, where services are independently inspected by experts – generally on a 3 to 5-year cycle, depending on the level of risk.

Timeliness of data is critical for rapid response inspections to be able to protect patients from poor care. When concerns are identified, CQC will rapidly assemble inspection teams of highly qualified staff to assess service quality in greater detail. The inspections may take place on an announced or unannounced basis. Where concerns are validated, CQC will take immediate regulatory action where necessary and continue to closely monitor efforts to improve care through the development of action plans and their implementation.

CQC has recruited new chief inspectors who will lead specialised teams. Its peer-led Inspection model will once again involve senior clinical and managerial leaders from across the NHS, supported by people with lived experience of care, so that they are able to make credible judgements about the quality of care and the calibre of leadership of organisations. In future, following an inspection, CQC will provide verbal feedback at the end of the inspection, and written feedback within 2 days outlining any significant concerns. This will support providers to rapidly mobilise improvements where they are needed. A full report will be provided once any additional intelligence has been analysed.

In addition to CQC, there are many other bodies involved in the oversight and regulation of patient safety. The NHS is facing a regulatory tsunami that is overwhelming the system but has not led to sustained improvements in safety. Dr Penny Dash's review of patient safety across the health and care landscape, which will be published imminently, found over 150 organisations which currently carry out a mixture of assessing quality of care and providing guidelines related to quality. The number of organisations has increased over the past 10 years as the response to successive scandals around quality of care has been to launch an inquiry or to launch a new body.

This proliferation of organisations, undertaking assessments and issuing quality guidance in an uncoordinated way, is having the opposite effect of what was intended. For example, it has resulted in several new organisations focused specifically on safety and an extraordinary number of recommendations made to staff and organisations. We will rationalise the safety regulatory landscape to ensure a more consistent focus by CQC and to give specific responsibility for reviewing, analysing and taking forward recommendations to the NQB.

Two of the new bodies established in recent years include the Health Services Safety Investigations Body (HSSIB) and the Patient Safety Commissioner (PSC). The former was established to look at specific cases or incidents of severe harm, while the latter

was created to look at how patients and users could better report complications from medicines and medical devices to improve their safety. Over time, these organisations have expanded their scope. HSSIB has broadened into making systemic recommendations while the PSC has taken on a far wider role as an advocate for other patient safety topics. While this is done with the admirable intention of improving the safety of care delivery, it can create further complexity and confusion.

HSSIB will continue to be a centre of excellence for investigations. It will operate as a dedicated, expertise-led investigation facility that can be used in a responsive way to minimise the number of externally commissioned reviews and inquiries that might otherwise be required. It will agree the scope of its investigations with the NQB which will be responsible for taking prioritised recommendations forward. We will legislate to transfer its functions to CQC as part of a wider effort to simplify the regulatory landscape. Within CQC, it will continue to operate as a discrete unit and retain its independence for providers.

Similarly, the hosting arrangement of the PSC will be transferred to the Medicines and Healthcare products Regulatory Agency (MHRA) given the MHRA has direct responsibility to monitor the safety of medicines and medical devices. This will offer improved clarity about where responsibility for the voice of patients lies when it comes to the safety of medicines and medical devices and build on MHRA's current work to capture adverse events more effectively, such as through use of technology.

Conclusion

The NHS never has the right to keep the public in the dark. That it so often does so reflects the centralisation of power and disregard for patient voice we identified in chapter 5.

At its worst, this status quo means the most severe cases of systematic harm go unnoticed and unchallenged for years. The past 4 decades have seen a litany of tragedies. Each of them was avoidable. Each suggests previous lessons have gone unlearned.

That is why we will make the choice to deliver full transparency. We recognise this will be uncomfortable for some in the NHS. We expect transparency to highlight new failings, show new problems with quality of care, and to put a megaphone to the mouths of complainants that have otherwise felt they are shouting into a void. We do this because sunlight is the best disinfectant - there is no other way to restore public faith, and to drive up quality for all.

Transparency will be the foundation for our rigorous focus on high-quality care throughout the next 10 years. The NHS had lost its way on quality. We will make it clear what quality care looks like, through a revitalised National Quality Board. We will deliver intelligent inspection, with the most ambitious modernisation of regulators in recent history. We will make patient voice and experience core to how we define what high quality care looks like. And we will harness the huge power of technology to boost quality in the next 10 years, from AI that predicts need, to data that supports personalisation.

07

An NHS workforce fit for the future

The NHS will always be a people-based service. Without its staff, it would be little more than a collection of machines, buildings and beds. So, it will be through the NHS' workforce that the new power dynamic between patients and health service is forged, and this Plan's 3 shifts are really delivered.

However, today, staff have nothing like the foundations they need to deliver reform. As we heard in our staff engagement, they have been demoralised, treated as rota-fodder, and traumatised by COVID-19.

They have also been subject to the culture of top-down diktat we described in chapter 5. Increasingly detailed, prescriptive and sometimes contradictory guidance has diminished staff voice. A growing weight of bureaucracy has stolen joy from work and time from patient care. In many organisations, the trend has been towards far less professional autonomy.

Unsurprisingly, many experienced professionals have left the NHS as a result. They've moved to other sectors, other countries, or simply retired early. Those left behind told us throughout our engagement that they have little confidence things will get better in the future. Intrinsic motivation has declined, as evidenced by the sharp fall in discretionary effort in the past few years. We will restore hope for the future, by giving staff renewed means to create it.

Preparing for the future, breaking with the past

Healthcare work will look very different in 10 years' time. Population ageing will further accelerate the rise in chronic and complex health need. The 'baby boomer' generation will retire, generation Z will become more established in the workplace, and generation Alpha will enter it, fundamentally changing

> **"I left the NHS after 19 years, 22 years if you count my training as a Physiotherapist, which was funded by the NHS. I did not want to leave as I was always proud to work for the NHS and believe strongly in its founding principles of being freely available to all. I felt I had to leave because the focus of my work was no longer on best patient care and outcomes but was primarily financially and politically focused with increasing amounts of bureaucracy, red tape and 'box-ticking'. I had 4 managers in my final 4 years in post, largely due to constant re-structuring. I was prevented from using my clinical skills and expertise and required more and more to undertake essentially admin tasks and meaningless compliance tasks which had become completely removed from benefitting patients and all about ticking boxes."**
>
> ***Linda, health and care staff participant, via the Change NHS website***

attitudes to work. The digital revolution will change what work looks like across the whole economy, but particularly in healthcare. We need staff able to shape these trends with us, not powerless in the face of them.

That will mean we will need a very different kind of workforce strategy. But through its history, the NHS has repeatedly failed to prepare for exactly these kinds of future trends. Until 2023, it had never published a long-term workforce plan[202]. The one it did publish did little more than extrapolate from past trends into the future: concluding there was no alternative than continuation of our current care model, supported by an inexorable growth in headcount, mostly working in acute settings. As the Institute for Fiscal Studies showed at the time[203], it was a plan to increase NHS headcount by 60% by 2036 to 2037 - meaning 1 in 11 workers in England would be employed by the NHS. On that trajectory, by the turn of the century, every single working age adult would be working in health and social care. This future is a fiction, and we reject it.

Later this year, we will publish a 10 Year Workforce Plan that takes a decidedly different approach. Instead of asking 'how many staff do we need to maintain our current care model over the next 10 years?', it will ask 'given our reform Plan, what workforce do we need, what should they do, where should they be deployed and what skills should they have?'.

We will use digital technology and automation to free up clinical time to care, by reducing time spent on administration and clerical work. We will embrace skill mix and deliver training to equip staff with the skills they need to work at the top of their capability. The NHS will become a modern employer, led by a new tranche of top-quality leaders. We will carefully consider how staff are deployed, to support our shift into the community. And to harness the benefits of the revolution in science and technology we will expand roles in key areas like genomics and data science.

Overall, while there will be fewer staff in the NHS in 2035 than projected by the 2023 workforce plan, those staff will be better treated, have better training, more exciting roles and real hope for the future - and so they will each achieve much more.

We will harness digital technology to free up time to care

No industry in the world will be unchanged by automation. Many already have. AI chatbots support us when we shop or need help with our banking, and self- service machines have long been a feature in supermarkets.

The industries and businesses that thrive in the next 10 years will be those who anticipate

Securing the financial sustainability of the NHS

The NHS spends the majority of its budget on staff costs. There is no path to financial sustainability that does not include, and work with, professionals.

One of the most effective tools we have is freeing up time to care. By using technology to help staff focus on patients, we can improve care, staff experience and release time valued at £13 billion[217]. This figure is likely to increase markedly as technology develops.

Across the whole economy, it is clear that happier, healthier staff deliver higher-quality work. Beyond lower sickness absence, an evidence review by the International Public Policy Observatory, the University of East Anglia and Rand Europe[218] estimated the cost of poor mental health and wellbeing among NHS staff at over £12 billion per year. We will prioritise staff wellbeing both because it is the right thing to do, and also because it is common sense for public finances.

and harness the potential of automation, equitably. Those who fail to harness it, or ignore its potential, will fail. In the 21st century so far, the NHS has done the latter. It will now do the former.

Primarily, we will harness automation to free up clinical time. Through this Plan, we will make AI every nurse's and doctor's trusted assistant - saving them time and supporting them in decision making.

To achieve this, we will accelerate the adoption and spread of AI technology, such as AI scribes, by streamlining AI regulation, developing a new national procurement platform. We outline this in more detail in chapter 2.

Over the first half of this plan, we will implement a digital first HR strategy, automating many time-consuming processes. Staff will be able to access HR services anytime and anyplace, to book annual leave, or onboard to a new organisation digitally, with virtual assistants to improve both staff and manager experience. HR professionals will be more available to focus on complex issues, where human compassion matters most. At the same time, we will replace the old NHS payroll system with a new state of the art one.

We will use technology to increase clinical capacity in creative ways in the future. For example, we will explore opportunities to deploy UK-registered professionals working in other countries, to provide remote services to NHS patients.

This will give the NHS an opportunity to tap into global talent, deliver 24/7 access and increase productivity. The NHS will evaluate these approaches carefully to understand their impact on patient care, patient safety and system efficiency and will set out more details in the 10 Year Workforce Plan later this year.

We will ensure staff have the skills they need in a digitally enabled NHS

Our 10-year vision is for a workforce where every individual is supported to reach their full professional potential. As part of our objective to give the NHS the most AI-enabled workforce in the world, staff will be AI trained, digitally confident and have skills in modern leadership, transformation and innovation. Staff will be supported to develop new skills and operate at the top of their professional capability.

> **"…advances in technology are useless and pointless if staff do not have the skills and access to be able to use it."**
>
> ***Deepa, health and care staff engagement, via the Change NHS website***

Our first step will be to reverse the accumulation of centrally dictated training requirements, which irritate staff and add unnecessary burdens to their working day. It is often repetitive, irrelevant to the work that staff do and has little or no impact on the quality of care that patients receive. By April 2026 we will have completely reformed mandatory training. As we transform the centre and push power out to staff and citizens, we will work with providers and professionals to identify more opportunities to ease the burden on frontline workers, remove central edicts and allow a more flexible approach to workforce development.

We will work with regulators to identify opportunities across all care pathways to 'train to task', where safe to do so. For too long, we have trained 'to role' - often requiring individuals to complete years of training - when many tasks can be carried out with good supervision. While we will need the deep knowledge and judgement that

professionals develop through their training and professional lives, we know that there are significant opportunities to move beyond traditional professional boundaries in a safe and productive way.

Since the inception of the NHS, the mix of different health professionals has evolved to allow teams to adapt to new technologies and the changing needs of patients. The new model of care described in this Plan, particularly the Neighbourhood Health Service, will continue to see the creation of new mixes of skills and professions in different clinical teams.

Our design and implementation will learn the lessons from the forthcoming Leng Review[204] on the introduction of new roles. Whilst Professor Leng has highlighted the importance of multidisciplinary teams for the long-term sustainability of the NHS, she also identifies weaknesses in how this has been implemented, including a lack of clarity around roles, responsibilities, and accountability. We will build on the Leng Review to ensure the safe and effective introduction of new or expanded roles, so it is done in a way which ensures public, patient, and professional confidence is maintained and which learns the lessons from the introduction of medical associate roles. We will also set out clearly how these new team models will work, including where tasks can be safely delegated.

To support our skills drive, we will partner with world class technology firms and academic institutions and develop a new digitally led platform for education, skills and training. As part of our 10 Year Workforce Plan, we will introduce new 'skills escalators'. These will give staff a trajectory for clear career progression, with increasing autonomy. By 2035, even single member of NHS staff will have their own personalised career coaching and development plan, to help them acquire new skills and practice at the top of their professional capability.

The NHS appraisal system, and professional regulators' revalidation systems, need to transition to a world of real-time feedback and continuous skill development. We have asked professional regulators to renew their revalidation systems to that end. The Department of Health and Social Care (DHSC)

will agree modern appraisal arrangements with trade unions to replace a process that staff do not value, so that appraisal achieves a healthy combination of robust accountability and continuous self-improvement.

In line with these changes, over the next 3 years we will work with professional regulators and educational institutions to overhaul education and training curricula. This will future proof the NHS workforce, ensuring staff leave formal training fully prepared to work in a modern healthcare system and not just "fit for practice". Reforms to curricula will:

- provide comprehensive training in the use of AI and digital tools
- promote acquisition and retention of generalist skills required for the Neighbourhood Health Service

Alongside this we will embed a culture of lifelong learning with a focus on skills and competencies that can start delivering for patients as soon as they are acquired rather than trainees waiting until the end of a formal training period.

This will be supported by reforms to clinical placement tariffs for undergraduate and postgraduate medicine, as well as a targeted expansion of clinical educator capacity. The current tariff system was designed for a different era and provides limited ability to target funding at training where it is most needed to modernise delivery. We will reform the system to ensure it drives clinical placement activity in the right professions and settings - especially, community settings - and that it harnesses innovative approaches like simulated learning.

We will work with higher education institutions and the professional regulators as they review course length in light of technological developments and a transition to lifelong rather than static training.

To ensure changes in curricula quickly lead to changes in course content, DHSC and employers will work in much closer partnership with education providers to ensure that the provision of funding and clinical placements secures the changes we need to see as quickly as possible. Where existing providers are unable to move at the right pace, we may look to different institutions to ensure that the education market is responsive to employer needs.

Improving training and development for nurses

Applications to careers in nursing have decreased over the past decade – from around 3 applicants per post in 2014, to approximately 2 applicants per post in 2024[205]. Moreover, 11% of nurses and midwives do not complete their courses.

Reducing the leaver rate of student nurses and midwives by 1 percentage point would result in the equivalent of an additional 300 nurses and midwives joining the NHS each year[206]. We will therefore require education providers, working with employers, to urgently address attrition rates. Tackling this will also be a key objective of the Professional Strategy for Nursing and Midwifery being developed by the Chief Nursing Officer for England (CNO), to be published later this year.

We will help nursing students overcome financial obstacles to learning, including reducing delays to reimbursement for their placement travel and the time lag between course completion and its confirmation. This time lag delays newly qualified nurses from starting jobs. We will work with the NHS Business Services Authority (BSA) to reform and modernise the process of paying travel expenses before the start of the 2026 academic year. We will also work with higher education institutions to set a standard for confirmation of course completion by September 2026, so that newly qualified nurses can begin work as soon as they are able.

The CNO's strategy will build on this and ensure that every nursing student spends sufficient time across a range of clinical settings, to create a meaningful placement

experience that reflects modern practice, including a requirement for all students to have a high quality experience in neighbourhood and community settings and social care. We will work with NHS organisations and education providers to increase capacity in neighbourhood teams commencing with the 2027 to 2028 intakes.

In the past few decades, the range of clinical tasks done by nurses has increased to include prescribing, some diagnosis and assessment, management of complex wounds and administration of intravenous therapies. Beyond that, nursing has evolved into a more autonomous role. Advanced nursing and midwifery practitioners provide clinical leadership across the multi-disciplinary team, making independent and complex decisions.

Building on these foundations, we will develop advanced practice models for nurses, midwives, and allied health professionals (AHPs) that are aligned to the delivery of our 3 shifts, reflecting their essential leadership roles in a range of settings, including community and public health services.

In parallel, we will work closely with the Nursing and Midwifery Council (NMC), the professions, and employers to ensure that effective systems of accreditation and regulation for advanced practice roles are introduced as quickly as possible. As part of this, we will support the NMC to consult on advanced practice standards in 2027 to 2028. This regulatory framework will provide clarity for patients and the public, enhance patient safety, and strengthen career pathways thereby enabling nurses, midwives, and AHPs to continue delivering direct patient care with increased autonomy.

Nurse consultants and consultant midwives will play a vital role in the Neighbourhood Health Service, providing advanced clinical care and system leadership, driving improvements in care quality, and advancing professional practice. We will increase the number of nurse consultants, particularly in neighbourhood settings.

There will be a range of opportunities for nurses to lead in the Neighbourhood Health Service. For example, they will play a central role in the new genomic population health service, including by providing genomic counselling and support. We will introduce neighbourhood nursing and midwifery leads who will act across multiple neighbourhoods to coordinate local strategy, convene partners and represent the community's voice.

The CNO's strategy will set out how nurses and midwives can be supported throughout their careers — including progression into advanced practice and consultant roles. It will also set out how nurses and midwives in the NHS will be supported in their individual career journey through regular, structured professional career conversations that reflect continuing professional development and education opportunities, aligned to their annual appraisal process.

Improving training and development for doctors

The experience of doctors working in the NHS, particularly resident doctors, has deteriorated significantly in recent years. Under previous governments they have felt devalued and defeated by a loss of autonomy, by the difficulty securing postgraduate training and by the NHS' refusal to modernise its employment practices. They have gone unheard and have left for other industries and other countries.

We have commenced a Review of Medical Training in England, led by Professor Sir Stephen Powis and Professor Sir Chris Whitty[207]. Through this, we will modernise postgraduate medical education to better align with the evolving needs of patients, doctors and healthcare services. Reforms will target delivery, capacity and quality of training and will improve career progression and flexibility - while also supporting doctors to deliver the highest quality care possible.

"I work in secondary care, in an acute hospital as a resident doctor. There are many things which make our jobs more difficult...Wellbeing at work for rotating resident doctors is at an all-time low. We are not valued, not trained and treated like numbers on a rota. We are a second thought compared to more 'permanent' members of staff. We don't want to come to work because of this. The simple things need to be fixed – we need access to parking, spaces for work and spaces for keeping belongings, it shouldn't be so difficult to rotate hospitals every time (have to re-fill in the same paperwork and process it, payroll etc), we shouldn't have to pay out of pocket for our own training courses. We need to have dedicated provision for training as we are not being trained to become experienced clinicians."

Nathan, health and care staff participant, via Change NHS website

We will tackle bottlenecks in medical training pathways. Undergraduate medical places have been expanded without a commensurate expansion in postgraduate training places, compounded by the 2020 decision to open competition for postgraduate medical training to international trainees on equal terms with UK-trained graduates. As a result, competition ratios for postgraduate places increased from 1.9 applications per place in 2019, to nearly 5 per place in 2024[208]. While the NHS remains proud of its international workforce, we consider this an unacceptable way to treat doctors who are already serving and training in the NHS and whose education has had significant investment from taxpayers. We will therefore:

- work across government to prioritise UK medical graduates for foundation training, and to prioritise UK medical graduates and other doctors who have worked in the NHS for a significant period, for specialty training
- over the next 3 years, create 1,000 new specialty training posts with a focus on specialties where there is greatest need

Specialty, associate specialist and specialist ('SAS') doctors are an invaluable part of the

NHS team. Specialists are senior decision makers who have important generalist skills and can work autonomously in clinics in community settings including those areas with the most severe shortages. We will work with stakeholders to ensure a more streamlined and predictable pathway is in place for experienced specialty doctors to develop and operate at a specialist level. We will also work with the General Medical Council (GMC) to ensure a more streamlined pathway is in place for experienced doctors to obtain the registration to become a consultant.

Developing skills in research, innovation and system change

In chapter 8, we outline our ambition to transform the NHS into a global research and innovation powerhouse. Our success will depend on making research, development and innovation a core part of everyday clinical work - not a 'nice to have' activity for a small minority of academic centres and professionals. Analysts, commercial staff and change management experts will all be integral in the future, not least in supporting our new operating model.

In an NHS that is perpetually running hot, not enough people get the time to develop these skills. This is a triumph of the urgent over the important. Moreover, evidence shows that patients who receive care from professionals active in research have better outcomes. As we free up clinical time through automation, we will increase the amount of time available for research - as well as for patient facing care.

We will also work with professional bodies and the Royal Colleges to develop capability frameworks for innovation for all staff, introduce joint clinical research and innovation fellowship posts with industry, and expand the Clinical and Patient Entrepreneurs Programme, already the world's largest entrepreneurial workforce development programme.

We will reverse the decline in clinical academic roles through a new collaboration between government and major charity funders. This collaboration will fund a year-on-year increase in these roles, over the next five years. We are also encouraging additional funders to support Clinical Future Leader Fellowships as the scheme develops and matures.

We will open more research opportunities for nurses, midwives and AHPs. Their role in research is already expanding: 13% of National Institute for Health and Care Research (NIHR) money now goes to studies where nurses or AHPs are the lead researchers[209], but we want to go further. The NIHR Academy is supporting more dedicated funding opportunities for these professional groups across both its programme and fellowship funding. It will work closely with the NIHR Research Nursing Office and NIHR Research Support Service to provide academic and research leadership support and training to more nurses, midwives and AHPs.

We will support professionals central to the Neighbourhood Health Service - such as GPs and those caring for older people - to increase their research output. We will build research capacity in primary care through the NIHR School for Primary Care and the Primary Care Commercial Research Delivery Centres, which will open in 2026, and which will specialise in commercial clinical trials based in primary care. Neighbourhood providers will have the scale, data and representative population to take advantage of this opportunity.

The NIHR Research Delivery Network supports research across different health and care settings, including in social care. The new initiative for research inclusion, as a condition of NIHR funding -paired with supporting new investigators in under-represented areas, will ensure that innovative models in community, neighbourhood health and prevention are supported by research, evidence and innovation.

We will make the NHS a great employer fit for the modern age

Alongside skills, a modern workplace is a critical enabler to help staff reach their full potential. Staff have too often been treated as a commodity rather than as an asset. Staff have faced harassment, have gone without access to basics like food and hydration and have experienced high rates of short-term and long-term sickness as a result. Indeed, economic inactivity due to sickness is 66% higher[210] in health and social work than in education.

We will bring joy back to work so more people join, learn and stay. In many other sectors, employers are investing in a better staff experience, developing new approaches to flexible working, prioritising retention and supporting the health of their workforce. The NHS must catch-up with these standards. In the future, we do not just want the NHS to be the country's biggest employer, but also its best. The work some NHS employers have already done to rapidly improve staff experience gives us confidence we can achieve rapid progress.

> **"After 10 years as a senior midwife, I handed my notice in due to burn out/stress. I was offered zero support and even though I escalated my concerns, they let me leave like it meant nothing to them."**
>
> ***Freya, health and care staff participant, via the Change NHS website***

Delivering rapid improvements in staff experience

In line with our new operating model (chapter 5), we will place greater trust in local NHS leadership. While national guidance will

Improving staff experience in the NHS: Buckinghamshire Healthcare NHS Trust

Buckinghamshire Healthcare NHS Trust (BHT) has been an exemplar organisation in improving staff experience. The Trust has:

- Introduced dedicated career advice with expanded 1:1 career coaching, more leadership programme graduates, and career conversations.
- Designed new health and wellbeing initiatives – including a centralised reasonable adjustment process; a new occupational health and wellbeing hub providing specialist musculoskeletal and mental health support, alongside occupational health clinics; and a dedicated programme to reduce workplace bullying, harassment, and discrimination.
- Increased flexible working options with the number of flexible job positions increasing from 7.18% in May 2023 to 85.71% in January 2024.

As a result, the Trust has seen high levels of staff satisfaction and engagement with 65% of staff taking part in the National Staff Survey, compared with the national average of 49% of similar trusts. The Trust has seen its staff turnover fall, down from 14.6% in July 2022 to 10.4% in April 2025[219].

support consistent, informed workforce decisions, we do not expect leaders to defer to the centre on matters they are equipped to manage as employers. In return for autonomy, every NHS organisation must commit to treating staff with respect and ensuring they have the conditions they need to thrive.

A positive experience of work and the workplace should not be a 'nice to have'. We will work with the Social Partnership Forum to develop a new set of staff standards, which will for the first time outline minimum standards for modern employment. They will cover access to nutritious food and drink at work, reducing violence against staff, tackling racism and sexual harassment, standards of 'healthy work' and occupational health support, and support for flexible working.

We will introduce these standards in April 2026 and publish data on them at the employer level every quarter. They will underpin the NHS Oversight Framework[211], and poor performance on staff-related outcomes will act as an early warning signal for CQC.

Sickness absence rates are higher in the NHS (5.1%) than in other industries[212]. This is a significant driver of expensive agency use. We will aim to reduce sickness absence rates to the lowest recorded national average level (approximately 4.1%), saving a potential £200 million a year from reductions in temporary staffing costs[213]. To achieve this, we will roll out Staff Treatment Hubs, a high-quality occupational health service for all NHS staff that includes support for back conditions and mental health issues, both significant causes of long-term sickness absence.

Improving flexible working

Modernising the NHS as an employer means offering staff more flexibility and freedom to choose where, when and how they work. As patients increasingly seek more responsive care, at a time and in a place convenient for them, a more agile approach to staff deployment has the potential to help us meet changing patient priorities and population health needs.

By April 2026, to facilitate the multi-disciplinary working needed in the Neighbourhood Heath Service, we will simplify and standardise staff policies and make training portable when staff move organisation. In the longer-term, we will work with staff, trade unions and employers to modernise terms and conditions, to give staff more choice and control over their working lives, and employers more flexibility over how to deploy their staff.

> **"I would leave my organisation if there were no flexible working offer."**
>
> ***Eleanor, health and care staff deliberative event in Reading, February 2025***

Any member of NHS staff who has tried to onboard with a new NHS organisation, book a roster or simply find and fill in a maternity leave form will know that our HR services are clunky. As part of our new HR strategy, we will build a comprehensive, easy-to-use NHS staff app that will allow staff to access their records and support from HR and will include functionality such as flexible rostering.

Staff, trade unions and employers have expressed growing frustration over the years about the current national employment contracts in the NHS and the difficulties in ensuring that they adapt and evolve to meet everyone's expectations and aspirations. We will continue to work with trade unions and employers through established processes to reform current contracts, but at the same time we want to start a big conversation, to pave the way for sustained partnership working to undertake significant contractual change that provides modern incentives and rewards for accessible high quality and productive care.

This work will consider a range of options to ensure coherence across contractual offers to all NHS staff. This will be a complex undertaking and will mean some realistic conversations about pay that better recognises performance and innovation, and terms and conditions which enable the three shifts and a truly 24/7 service. Equally, employers will need to improve staff experience, and act to ensure consistent access to much more modern and flexible working arrangements. That will need strong social partnership between all health unions, the government and employers to negotiate and agree a new deal. It will take time to get right but is essential to ensure that the NHS can sustainably recruit, retain and motivate new generations of NHS staff for the future. We know to succeed this will need to offer good value to all staff groups, good value to employers, good value to taxpayers and good value to patients. We will dis-cuss how best to deliver this with unions and employers as a key part of the engagement on the new 10 Year Workforce Plan for the NHS.

We will work with NHS Employers to develop guidance on the best use of existing terms and conditions to ensure that staff are deployed efficiently, job evaluation and job planning are conducted effectively and that standards for pay progression are properly met, based on good appraisal and excellent line management.

Through our focus on flexible work, we will be able to significantly reduce the need for expensive extra-contractual work. We will eliminate agency staffing in the NHS by the end of this parliament, ensuring every pound spent delivers maximum value for patients. This will take a concerted effort to transition agency workers to staff banks. These offer flexibility, familiarity and better value, and must become the primary route for temporary staffing in the future. This will improve the quality-of-care patients receive and, we estimate, could release as much as £1 billion over the next 5 years.

We will put great leadership at the heart of our plans to transform the NHS

We know that great culture and leadership in healthcare can improve both staff satisfaction and quality of care. However, as we outlined in chapter 5, the extent of the NHS' centralisation means even the best leaders have little means and incentive to deploy their vision and skills. As a result, the NHS has become less appealing to, and less able to retain, world-class leaders.

In our staff engagement, we heard accounts of leaders with poor relational and

management skills, who had repeatedly been promoted regardless. To create an NHS fit for the future, we need leaders at every level who are bold, relational and capable of leading system change aligned to the 3 shifts. In some cases, that will mean removing the constraints from the NHS' best leaders. In others, it will mean developing staff with the potential to lead or recruiting new talent.

> **The biggest challenge and issue that I see that actively impacts the way we deliver services negatively is the consistency and quality of leadership…. I have also witnessed and experienced very poor leadership skills, leaders who are not honest, deceptive and appear to be out for themselves with little regard to the core purpose of the NHS."**
>
> ***Yusuf, health and care staff participant, via the Change NHS website***

Government has a role to play in setting culture and expectations, but real change never comes from top-down mandate - it is driven by leaders and managers at every level across the health system. These leaders need to be allowed to use their judgement to act with purpose, collaborate across boundaries and stay focused on what matters: better access, experience and outcomes for patients and communities. We will give leaders new freedoms, including the power to undertake meaningful performance appraisals, to reward high performing staff, and to act decisively where they identify underperformance.

While senior leadership is key, General Sir Gordon Messenger's Review of NHS Leadership[214] is right in its assertion that we need to improve both operational and clinical leadership and management at all levels, across all health settings. Most teams are led by an overlooked group of first or mid-level managers, who are squeezed between direction and demands from the top down, and unhappiness and discontent from the bottom up.

We will accelerate delivery of the Messenger review and, by April 2026, establish new national and regional talent management systems to ensure leaders with the greatest potential - at all levels - are identified and supported into future leadership roles. This will be supported by the publication of a new Management and Leadership Framework in autumn 2025, which will include a code of practice, standards and competencies from first-line manager to board level leader, and a national development curriculum. We will set clear expectations of the standards that aspiring leaders, clinical and non-clinical, need to meet if they are to progress. We will also establish a new College of Executive and Clinical Leadership which will sit outside of government to define and drive excellence.

To ensure we attract the best and brightest talent, we will expand the Graduate Management Trainee Scheme by 50%. Alongside that, we will increase its diversity and reform it to focus on the 3 shifts and system working. NHS employers and contractors will be required to facilitate the scheme as part of their core business.

Training curricula alone do not adequately prepare staff for the realities of leading and managing modern multi-disciplinary teams. World-class leadership needs to be an ethos in the NHS, not just a training module. This will be addressed as part of the professional regulators' review of curricula requirements, and an early priority for the new College of Executive and Clinical Leadership.

To embed better incentives, we will introduce new arrangements for senior managers' pay.

Senior leaders will benefit from enhanced pay where there is good performance, particularly in cases where leaders turn around failing organisations. Conversely, annual pay increases will be withheld from executive leadership teams who do not meet public, taxpayer and patient expectations on timeliness of care or effective financial management.

For senior leaders who let their profession and colleagues down - whether through dishonest behaviour, by silencing whistle-blowers or covering up unsafe practice - we will legislate to establish a new system to disbar them from ever taking leadership roles in the NHS again. We know from our engagement that both the public and staff want failure to have consequences, and for us to bring an end to trend of people 'failing upwards' in the NHS.

We will transform the NHS into a force for social mobility and local prosperity

As the country's largest employer, the NHS has a unique responsibility to catalyse growth and economic prosperity in the communities it serves. Too often, the NHS expects the proceeds of growth, without delivering on its means to create it.

We will therefore reorientate the focus of NHS recruitment away from other countries, and towards its own communities. Providers will recruit locally, supporting those who are unemployed or economically inactive to take up appropriate roles and expanding apprenticeships and accessible training, so that people can earn while they learn. We will actively support care leavers, building on action the NHS has already taken as a signatory to the Care Leaver Covenant. There is evidence that when the NHS recruits from the communities it serves, and relects its diversity, care improves.

To support the spread of these practices, we will publish employer level data on staff employment and recruitment, broken down by socio-economic status, sex and ethnicity, so progress can be monitored.

To further support progress, we will allocate £5 million of funding to 10 integrated care systems to act as widening access demonstrators. In 2025 to 2026, they will support 1,000 young people and individuals from the most deprived communities across the country into pre-employment programmes, and then onto substantive entry level roles or training posts within their local health and care providers.

To fulfil our ambition that more healthcare staff are recruited from the communities they serve, we will create 2000 more nursing apprenticeships over the next 3 years - prioritising areas with the greatest need.

To drive greater transparency and hold universities to account for widening participation, we will work with the Department for Education to publish data

Supporting people into work - Leeds Anchor Network

First established in 2018, the Leeds Anchor Network brings together 13 of the largest organisations in Leeds – including NHS trusts, local authorities, universities, colleges and regional utility firms. Together these organisations employ over 58,000 people.

Building on previous pilots, the Connecting Communities with Health and Care Careers[220] programme adopts a 'flipped recruitment approach' — a replicable model that moves away from traditional recruitment methods to make health and care careers more accessible within communities facing disadvantage.

As of March 2024, 203 individuals had been supported to improve their skills, enhancing their employability. Of these,192 people were supported into priority roles, with more than half previously unemployed. Notably, 73% were from ethnically diverse backgrounds, and the programme boasts a 96% retention rate after 12 months.

on the relevant background of university entrants, starting with medicine.

We need to dramatically improve access to the medical profession for those from disadvantaged backgrounds. Research from the Sutton Trust[215] suggests that only 5% of medical school entrants are from the lowest socio-economic groups. This does not serve the country or NHS well and as a government we will not accept it: someone's background should not be a barrier to becoming a doctor.

Working with the Sutton Trust, Social Mobility Foundation and other partners we will dramatically improve access to medicine by creating a more diverse pipeline of home-grown talent that meets the country's needs. Expansion of medical school places will be targeted at medical schools with a proven track record of widening participation. The admissions process to medical school will be improved with better information, signposting and support for applicants, and more systematic use of contextual admissions.

The cost of studying medicine is one of the important factors deterring working class students from applying to medicine. We will therefore, as part of our 10 Year Workforce Plan, explore options to improve financial support to students from the lowest socio-economic background so that they are able to thrive at medical school.

We will secure the future of the NHS through a more sustainable recruitment strategy

In designing a new workforce model, it is important we ensure it is sustainable. While the NHS has always welcomed recruits from abroad who have contributed to the service's rich history. Today, the NHS disproportionately relies on international recruitment in a world where the competition for international staff has never been fiercer. The world is projected to be short of over 11 million healthcare professionals by 2030[216].

That means it will neither be possible nor ethical to maintain our current levels of international recruitment. We will need to reduce the NHS' dependence on overseas staff from its current level - where 34% of new recruits have a non-UK nationality. That will involve NHS employers reaching into

their communities - rather than looking to international recruitment agencies - when they plan their future workforce. The 10 Year Workforce Plan will set out how we will act on retention, productivity, training and attrition with the ambition to reduce international recruitment to less than 10% by 2035.

Conclusion

To meet the needs of a changing population and a rapidly evolving world, we must create a workforce that is more empowered, more flexible and more fulfilled. It must have the skills - and be deployed in the places - to deliver reform.

By 2035, we will have fewer staff than projected by the 2023 Long Term Workforce Plan, but each professional will achieve far more. Their training will have been reimagined. The burden of unnecessary mandatory training will have been replaced with focused support for the skills staff most need - and the NHS will have the most AI-enabled health workforce in the world.

The NHS will be a modern employer and considered one of the world's best. Incentives will reward leaders for the best leadership. More staff will work in community settings, and the NHS will recruit more staff from the communities it serves, supporting local prosperity.

Our new workforce model rejects the fiction that we can recruit endlessly more staff. Instead, it chooses a future where they are empowered and have hope, where they can deliver more for their patients, and where the long-term financial sustainability of the NHS as a whole is assured.

08

Powering transformation

Innovation to drive healthcare reform

Of all the areas covered by this Plan, it will be the pace and scale of scientific and technological innovation that most tests and challenges our predictions and assumptions. Our aim is to be in the driving seat of the biggest industrial revolution since the 19th century.

The sheer pace of discovery presents a major opportunity for both health and growth. On the former, genomic analysis of liquid biopsies, advances in cell and gene therapy, and AI-enhanced imaging put significant progress on cancer survival within reach. Advanced wearables[221], biomarkers and regenerative medicine[222] will support our Plan for Change ambition to reduce premature cardiovascular disease mortality. New digital tools, digitised therapies and real-time suicide surveillance will improve mental health and reduce suicide rates.

On growth, health research and innovation has become a global 'race to the top'. Nearly every country in the world is grappling with the health consequences of an ageing population and a rise in chronic illness. The countries that provide the best solutions will reap substantial economic benefit from exports, private investment and the high-productivity jobs associated with the life sciences sector. That is why the life sciences are so central to this Plan, which has been developed in tandem and full alignment with the Life Science Sector Plan and the UK's Modern Industrial Strategy.

The UK has a competitive edge, but we are still falling behind

The NHS' founders could scarcely have imagined that the service they created in 1948 would be so uniquely placed to seize the future. As a single-payer provider, that covers each individual 'from cradle to grave', the NHS has huge advantages including:

- unrivalled, representative population health data
- an ability to procure once, at scale, at a good price
- the means to universalise the best innovation for all, equitably
- low transaction costs, meaning less money wasted on admin or marketing, when it could be spent on better care
- incentives to harness new predictive science - where insurance models compete to cherry-pick the least risky patients, meaning predictive analytics threaten to widen inequality, the NHS covers everyone.

Moreover, the UK has a strong life science ecosystem. We have some of the world's top life science universities. We are home to some of the biggest life science companies in the world, with 304,000 people employed in the sector[223]. We have among the highest public research and development investment in Europe. Our 15 Health Innovation Networks do important work; we will continue to fund and support them. Our genomics infrastructure is world leading, supported by the NHS Genomic Medicine Service, Genomics England, and world class institutions like the Wellcome Sanger Institute and the Francis Crick Institute. We should be leading the world on research, development and innovation - from laboratory bench to bedside.

The reality is, however, we are struggling

to keep pace. In an increasingly competitive global environment, despite our clear academic excellence, since 2010 the UK has fallen behind on inward investment, innovation adoption and spread and global reputation. The reasons for this were clearly articulated to us in the sector engagement that informed this plan:

- a lack of direction and clarity about our strategic aims: while we have a decent record on identifying disease states (e.g. Life Science Vision 2021[224]), we have a poor track record in specifying, adopting and spreading the innovations that will help drive progress on them
- a poor partner: the NHS has a reputation as a poor and unwilling partner. It views industry and innovators as sellers, not collaborators. This undermines the NHS' ability to harness innovation for its patients, and our ability to attract inward private investment as a country
- few incentives for innovation: the NHS does not do enough to encourage and reward innovation. All too often, it rewards risk-adversity and the quiet maintenance of the status quo. We do not incentivise leaders to be entrepreneurial, managers for disrupting healthcare delivery, or clinicians for creating or adopting innovation
- barriers to adoption and spread: we do not reliably apply streamlined and proportionate regulation to new products – often, demanding perfection from new products, even when the status quo is poor. Moreover, the NHS has a 'not invented here' mentality. Complex and needless bureaucracy makes it harder to spread even well-evidenced and rigorously assessed innovations across the whole service

These challenges are related to the problems with the NHS operating model we discussed in chapter 5. Its combination of centralisation and weak incentives hinder innovation - in favour of risk adversity, compliance and short-termism. Our proposals in this chapter are enhanced by our commitment to earned autonomy and meaningful devolution, as well as incentives for the best performers so that innovators are rewarded.

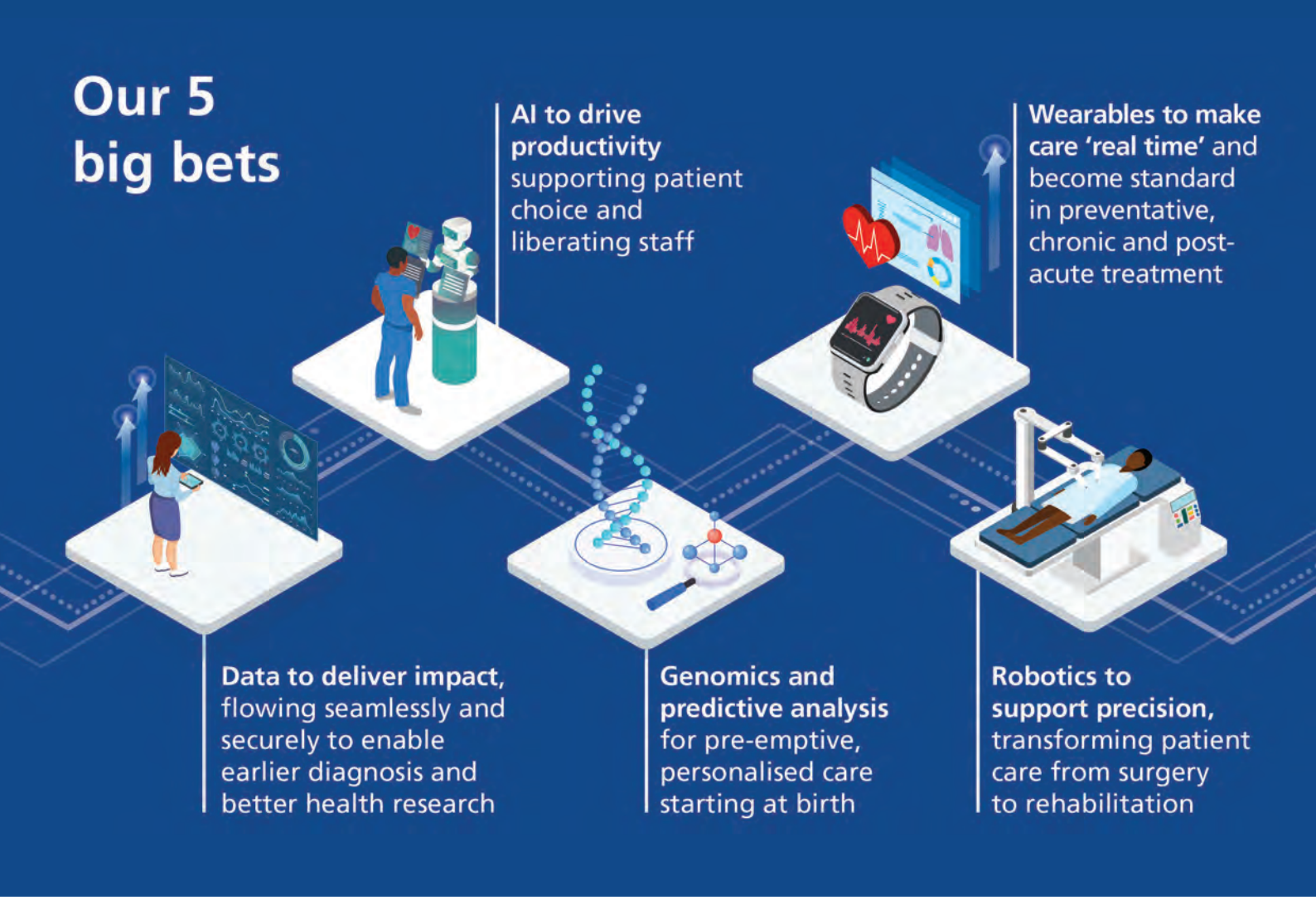
Securing the financial sustainability of the NHS

Our 5 big bets have been chosen both on their potential to accelerate healthcare reform but also to secure the financial sustainability of the NHS.

Data can help hospitals reduce average wait times for specialist appointments by identifying peak hours and reallocating resources. Studies[245] show gold standard analysis of bed occupancy rates and admission patterns can reduce patient diversions substantially. This kind of operational productivity will be key to our Plan for Change commitment to restore the 18-week constitutional standard.

AI can not only save time taken up by administration or data entry - but can boost the performance of highly skilled workers. One study found AI helped improve performance of highly skilled workers by 40%, in certain tasks achievable by AI, compared to those who didn't use it[246].

Genomics is helping diagnose cancers earlier, and avoid expensive adverse drug reactions[247]. Wearables have helped increase productivity in care management of Parkinson's disease through more timely diagnosis and treatment adjustments[248]. Robotics have a track record in boosting surgical productivity, with one recent study showing both total factor and labour productivity improvements[249].



5 big bets to drive healthcare reform

If the UK is to genuinely lead the world, we need an urgent change in mindset. In line with mission-driven government, we need to articulate the future we want to see, signal that with intent to industry, and show willingness to collaborate to achieve it. We must consign the NHS status quo of poor partnership, short-termism and risk-adversity to history.

To that end, we have identified 5 transformative technologies that we believe will be integral to our new model of care. By giving visibility and certainty to both the NHS and the market, our aim is to stimulate greater innovation and more rapid delivery of each of these technologies.

We will not be surprised if by 2035, the big bets we identify are 'old news' - having been achieved and superseded by the pace of change. One of the intended outcomes of our approach is accelerating the date these technologies transition from 'exciting prospect' to 'business as usual'. But for the foreseeable future, we will put the NHS at the forefront of:

- data to deliver impact: high-quality, interoperable health data, is the lifeblood for AI algorithms, the raw material for genomic discovery, and the context for wearable insights
- AI to drive patient power and productivity: AI will support patient choice, liberate the front line from admin and support a more sustainable future for the NHS. It will also be our means to interpret genomic data to deliver personalised prevention, precision care and enhance the effectiveness of diagnostics and robotics
- genomics and predictive analytics for pre-emptive, personalised care: personalised care and treatment, informed by genomics, dictates the most effective

interventions, which can then be delivered or monitored by AI, wearables, or even robotic systems - as well as care teams. It will also give us a better understanding of each patient's health risk, helping personalise care

- wearables to make care 'real-time': wearables bring the insights from data, AI, and genomics directly to the patient or clinician, enabling continuous monitoring, pre-emptive interventions, and more personal care delivery
- robotics to support precision: robotics have transformed surgery in recent decades. In the future, they will also transform patient care and support - from continuous monitoring, to rehabilitation, to prosthetic limbs to support recovery from neurological or musculoskeletal injuries.

There are other technologies - quantum computing and engineering biology among them - that hold significant promise. Government is accelerating these through its Digital and Technologies Sector Plan, which includes committing £670 million for the development and adoption of quantum computing and £380 million for research and innovation in engineering biology.

But our 5 big bets represent the most direct and impactful technological levers for transforming NHS care delivery over the next decade. We have selected them not just because they are areas where the UK can deploy its competitive edge to lead the world in science, but because the resulting innovation will accelerate the 3 shifts that drive this Plan.

These technologies will have 3 major benefits. For patients, they will offer significantly more personalised care, more precise prevention and the information and tools they need to more actively participate in their care. For the NHS, they offer a path to deliver a more modern, productive service through streamlined operations and optimised clinical pathways. For the economy, supporting innovators will secure private investment, strengthen British business and help create thousands of jobs across the country.

By 2035, the UK will not only have recovered from a lost decade on science and innovation[225], it will be a world leader. It will have created the means to modernise healthcare, in this country and beyond. In the rest of this chapter, we outline our aims and the policy steps we will take to build this new future

Big bet 1: In the NHS of 2035, your health data will flow seamlessly and securely

The Future of Healthcare: Every patient's complete health record, including genomic data and real-time insights from wearables, will be securely accessible by them, and their authorised clinicians, no matter where they are in the NHS. The data will be the basis of more coordinated care, real personalisation and over time, care that pre-empts need, rather than just reacting to it. Data will fuel continuous learning in the NHS, support research and improve care equitably.

Current application: The University of Birmingham's cardAIc group recently tested the use of commercially available fitness trackers and smartphones to continuously monitor medication response in patients with atrial fibrillation and heart failure[250]. Their research showed that the wearable tech provided heart rate data similar to an in-person hospital assessment. Further trials are needed but the work has promising potential to track patients' health at home and identify an abnormal heart rhythm much earlier, opening the way for more personalised care.

In 2017, IBM estimated that 90% of the world's data had been created since just 2015[226]. This demonstrates the unheralded pace of data creation in the modern world. It is this, combined with our increasing capability to use and interpret it, that gives it such value in the 21st century. If the primary 'factors of production' were once defined as land, labour and capital, then today and in the future data will be at least their equal.

In the next 10 years and beyond, industries and companies that do not harness data will be replaced by those that do. It is unthinkable for the NHS not to use its own data to transform healthcare for its patients today, and to drive its financial sustainability so it can meet the needs of its patients in the future.

In our engagement, the public told us that they readily accept the use of their data for applications beyond direct care, as long as strict privacy and security conditions are in place and met. They want to see it support the innovations that could, in future, save lives. We also heard that they would expect the NHS to derive value from its use. If NHS data supports a profitable product, the NHS should share in the proceeds.

This year we will create a new Health Data Research Service (HDRS) in partnership with the Wellcome Trust and backed by up to £600 million of joint investment. Deidentified data will be made available to scientists, research and entrepreneurs to help them discover new breakthroughs and develop new products for health promotion and early detection.

By unlocking the untapped potential of NHS datasets, we will help the health service make a far greater contribution to our national prosperity. We will more actively support companies and entrepreneurs apply their skills to solving health problems for the benefit of us all. Our approach will lead to:

- powerful new tools for drug discovery: we will be able to combine ever more types of data at ever greater volume; and use the power of AI to harness this and use it to aid the development of new medicines
- earlier and improved detection of infectious diseases: utilising new technologies and data science in the NHS to support the faster diagnosis of disease such as via government's partnership with Oxford Nanopore[227]
- new clinical tools: clinically specific tools to support discrete outcomes, such as diagnostic aids in radiology, dermatology and pathology. It is these tools that will make the shift of specialism from hospital to community and digital possible
- decision support tools: to assist clinicians in diagnosis, test ordering, referrals and prescribing. This will support the expansion of digital technology, including

via the NHS App - as well as our ambition to free up clinical time to care

- admin-reduction tools: to automate back-office functions. Data will help us automate processes around performance and quality where our choice of metrics have been poor due to data abstraction and weak curation.

HDRS will put in place a range of agreements to make sure that the NHS receives a fair deal for providing access to data for approved research. The service will also attract inward investment and make the UK a world leader in health data research. We will work with the public as we develop the details on this, but for the avoidance of doubt, this will never mean compromising on patient privacy. Data ownership will remain with the NHS or patient. Commercialisation is not the same as sale. In the longer-term, we will explore ways to derive commercial value from access to anonymous health data as well as from public assets like advanced analytics - which could include a mix of access charges and equity stakes.

AI will transform healthcare more than it will almost any other industry. It has the potential to redefine traditional approaches to diagnostics and medical imaging and it will support our ambitious plans to make the NHS App a gold standard tool for patient access, knowledge and choice.

Big bet 2: In the NHS of 2035, AI is each health professional's trusted assistant

The Future of Healthcare: AI algorithms will analyse scans with rapid speed and precision, detect subtle signs of disease years before symptoms appear, and help clinicians choose the most effective, personalised treatments. The administrative burden on staff will be lifted by AI scribes and intelligent automation, allowing each care team to focus entirely on their patients. AI advances will transform the NHS App into a 'doctor in your pocket' for each patient.

Current application: AI is already demonstrating its potential. For example, there is already significant application to support people with depression and anxiety[251]. Without it, the default for many patients in accessing mental healthcare is 'trial and error': they try several therapies in the pursuit of one that actually works, extending distress and delaying recovery. Funded by Mindlife UK and supported by NIHR, the University of Sheffield has developed a pioneering AI tool that helps NHS professionals personalise treatment plans for patients with depression. Tested through a 3-year clinical trial involving over 900 patients across Lancashire, Rotherham and Doncaster, the tool demonstrated significantly improved outcomes and has been shown to enhance existing treatments.

The combination of big data and AI will alter our approach to drug discovery. By allowing us to sift complicated biological datasets, design molecular structures more quickly, and predict compound interactions - it will speed up science substantially. Pharmaceutical companies and governments around the world are investing billions of pounds in AI enabled drug discovery for exactly this reason.

We will deliver faster and at-scale real-world evaluations of AI. We will make research studies and subsequent adoption quicker and more affordable, starting with AI for screening pathways. This will be supported by faster access to data, via the HDRS.

This year, we will review regulations, and in 2026 we will publish a new regulatory framework for medical devices including AI. This will create faster, risk proportionate and more predictable routes to market. We will collaborate with AI developers, regulators and the Department for Science, Innovation and Technology through the AI Opportunities Action Plan.

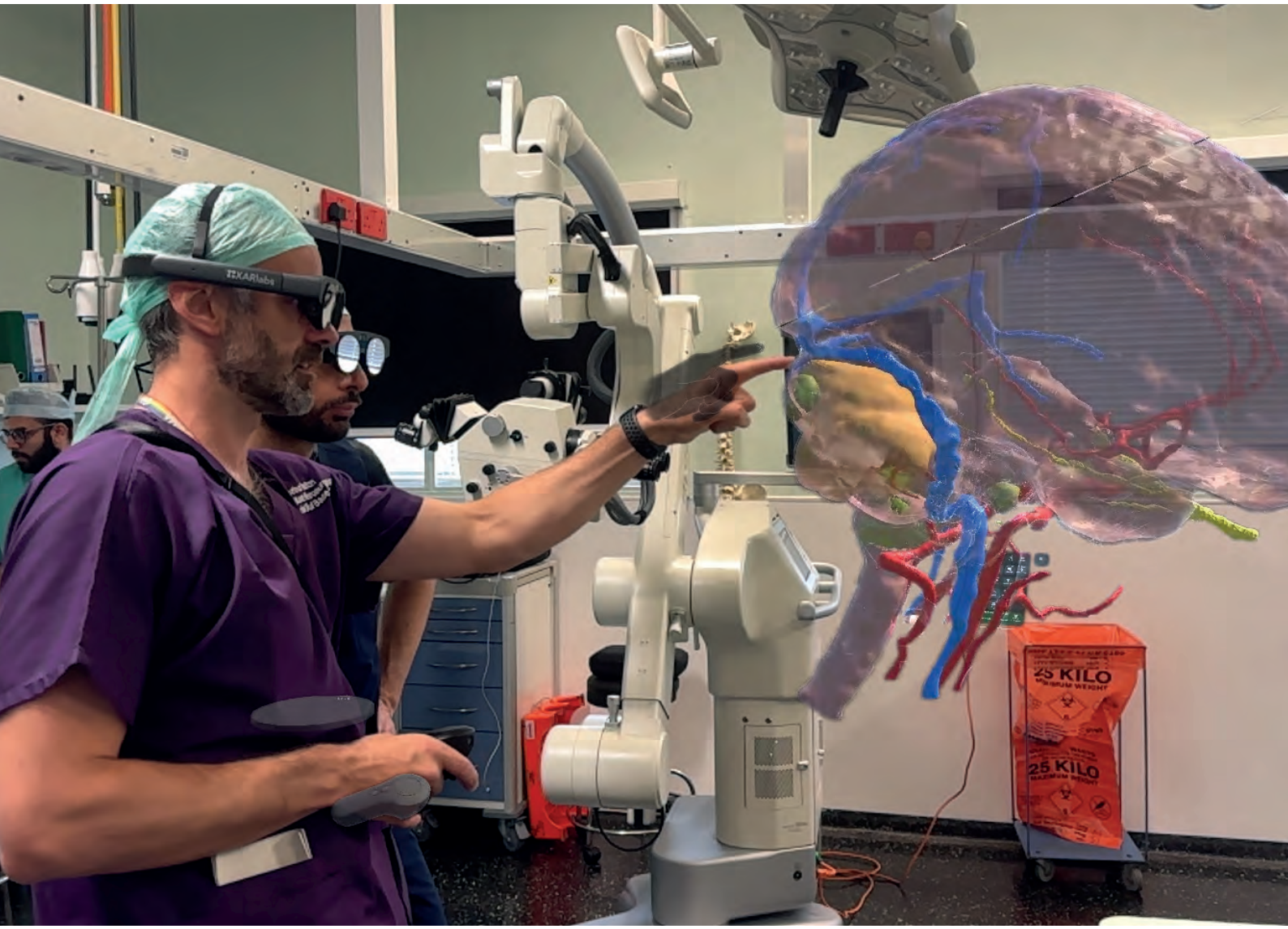
The Medicines and Healthcare products

Regulatory Agency (MHRA) has a strong reputation in AI and Software as a Medical Device.

It will capitalise on this to make us the fastest and safest place to regulate AI and software in the world. It will work with the sector, as well as the Regulatory Innovation Office, to consider how the ecosystem can support the use of AI in drug discovery.

In the first 3 years of this plan, we will invest in AI infrastructure. We will develop and implement an NHS AI strategic roadmap, that will enable clear ethical and governance frameworks for AI. As part of our ambition for all NHS staff to be AI trained, we will roll out new AI upskilling programmes for the workforce (see chapter 7). Starting in 2027, we will roll out validated AI diagnostic tools and deploy AI administrative tools NHS-wide, including AI-scribes.

We want to enable AI developers to build more intelligent models, that are able to integrate directly with electronic patient records in clinical settings. By 2035, AI will be seamlessly integrated into most clinical pathways, and generative AI tools will be widely adopted. AI algorithms will be continuously monitored and refined, and the NHS will be a global leader in deploying AI ethically.



Big bet 3: In the NHS of 2035, your personalised health journey will begin at birth

The Future of Healthcare: Newborns will undergo whole genome sequencing, identifying potential health risks and informing a lifelong personalised prevention plan. Not only will healthcare be provided free at the point of need, but free at the point of risk, meaning healthcare is delivered long before a long-term condition is diagnosed or an emergency occurs. Patients will increasingly have access to their personalised health risk scores on the NHS App, drawing from genomic, demographic and lifestyle data. Treatments and medicine decisions will be genetically informed, making them more effective and reducing NHS spend on adverse drug reactions or inefficient care.

Current Application: Whole Genomic Sequencing is already showing the promise to significantly improve cancer outcomes for patients with more accurate diagnosis and treatment[252]. Whole Genomic Sequencing for cancer involves analysing the entire DNA sequence of a tumour sample to identify every single mutation. This can help doctors understand the specific genetic make-up of the tumour. Between 2022 and 2023 Cambridge University Hospital used the NHS Genomic Medicine Service's whole genomic sequencing service for their sarcoma patients[253]. They found it added to the accuracy of the diagnosis in about one-third of patients and a third of patients had mutations found that could have made their cancer amenable to more personalised, targeted treatment.

By 2035, we anticipate half of all healthcare interactions will be informed by genomic insights and other predictive analytics.

The NHS was the first national health system in the world to offer whole genome sequencing as a part of routine care (via the NHS Genomic Medicine Service). It continues to show leadership in the adoption of advanced genomic testing options, that enable patients to benefit from earlier and more specific diagnosis of rare and inherited conditions, as well as cancers.

> **"Whole genome sequencing for rare disease diagnostics is an incredible success for both the NHS (many patients receiving earlier diagnosis in line with the UK Rare Disease Framework and Action Plans) and the research community (since data is made available to researchers through the National Genomic Research Library)."**
>
> ***David, health and care staff participant, via Change NHS website***

We will continue to build collaborations with industry and researchers to generate the evidence we need to inform commissioning decisions, accelerate adoption of new advances and ensure equity of access to genomic testing across England. We will use these insights to build the new genomics population health service (outlined in chapter 4). Studies run in community settings, such as pharmacies and GP practices, will help shape service models as we roll out the Neighbourhood Health Service.

Our Future Health[228] – established specifically to provide the evidence base for new approaches to prediction, early detection, early intervention and prevention of common chronic disease – will become the largest longitudinal health research cohort and clinical trials resource in the world. It will have up to 5 million consenting participants with linked primary and secondary care health data, genomic data and samples held in biobanks.

The Generation Study[229], a partnership

between the NHS and Genomics England, will continue recruiting and sequencing the genomes of 100,000 newborn babies with parents' consent.

This will facilitate earlier identification and treatment of rare genetic conditions and allow us to assess the risks and benefits of storing and tailoring care around an individual's genome over their lifetime. Insights from this study will inform our longer-term ambition to make genomic sequencing at birth a universal offer. It will help us to develop comprehensive guidelines for childhood genomic testing and treatments and interventions that are available and to consider how to handle complex consent scenarios.

As a next step to mainstream genomics population health for adults, this year we will launch a new large-scale study to sequence the genomes of 150,000 adults - and assess how genomics can be used in routine preventive care. The study will provide a 'rest of life' genomic resource for each participant. In turn, this will allow the generation of pharmacogenomic profiles to inform prescribing, as well as testing of risk prediction for major conditions like cancer or heart disease.

The NHS - through the NHS Genomic Medicine Service - will develop a unified genomic record integrating patient genomic data with relevant clinical and diagnostic data in near real-time; tools for clinicians to order genomic tests; and a digital Test Directory of national tests.

To test the true preventative potential of our genomics insights, we will work with a range of industry partners to launch a new globally unique set of studies, utilising Our Future Health, to explore personalised prevention of obesity and related conditions. This prevention trial platform will apply genomic and other insights to enable identification of people who are at the highest risk of developing obesity and its complications and could involve providing proactive support to prevent this. We will trial new service models including early access to GLP-1s (a hormone and a class of medications) alongside digital behavioural support.

Big bet 4: In the NHS of 2035, wearables are your personal health custodians

The Future of Healthcare: intelligent wearables will monitor your vital signs and biomarkers, providing personalised nudges for healthier behaviours and alerting your care team to potential issues before they escalate. This will enable virtual wards to become the norm for managing many conditions at home. Wearable technology will support an end to the current model where the point of need leads to a long wait for an appointment, and one where need is proactively identified and care pre-emptively organised.

Current application: wearable technology has already begun to transform the lives of people living with diabetes. The next generation of glucose monitors are being provided through the NHS to monitor patient's blood sugar levels. A small sensor worn on the body reads blood sugar levels automatically, and measures trends throughout the day. For some patients, the sensor can now also connect with an insulin pump which can take the data from the sensor and automatically deliver the right amount of insulin, making it easier for patients to manage their diabetes[254].

This data can also be shared with healthcare teams to inform diabetes management, on an on-going basis, including through virtual appointments. This can prevent hypoglycaemic episodes (via alerts for low blood sugar),, more precise insulin dosing and reduces the risk of long-term complications (e.g. nerve damage or eye damage). This is far better for the patient and supports NHS financial sustainability through better prevention.

New wearable technologies mean that we can measure and monitor our health and health behaviours like never before - from apps on our phones, to smart rings on our fingers, to continuous glucose monitors under our skin.

Over the next decade, these technologies will be used more widely and routinely. Many are already in the marketplace and, as of early 2024, around two-thirds of people surveyed reported tracking at least one aspect of their health using an app or a device[230]. Smartwatches are set to reach 10 million people this year[231].

This trend will accelerate. As well as wearables, we expect an expansion in the use of biosensors in the home, and even the workplace, providing a more constant flow of information. We will see miniature, highly accurate biosensors continuously monitor a wide array of physiological parameters (glucose, electrocardiogram, blood pressure, stress, complex biomarkers). Health monitoring will happen via smart fabrics and nanotechnology will enhance sensor capabilities. AI algorithms embedded in wearables will analyse data to detect early disease, predict adverse events and provide personalised coaching.

The NHS is beginning to harness the opportunities these technologies offer, but it needs to go further. The virtual wards programme[232], scaled-up during the pandemic, has changed the model of care, by allowing patients who would otherwise have needed to be in hospital to stay at home while they are remotely monitored by their care team. When people need help, teams respond proactively. In the first 3 years of this Plan, we will expand hospital at home programmes and expand National Institute for Health and Care Excellence's (NICE) digital programme to consider more medical-grade wearables.

As described in chapter 3, we will connect wearable devices and biosensors to the NHS App, empowering people with access to their own health information in real-time. We will bring it together in one place, so it can be easily shared with neighbourhood teams. Over time, citizens will be able to integrate their data from smartwatches and other devices, with their Single Patient Record. This will open up new opportunities for better care, as well as for research.

Building on the success of flash glucose monitoring in diabetes care[233], we are committed to transforming the management of long-term conditions through cutting-edge wearables and remote technologies. Our immediate ambition is to make remote monitoring for cardiovascular disease, using wearables and similar devices integrated into the NHS App, a standard part of NHS care by 2028. By empowering patients with real-time, actionable, health insights and seamless connectivity to their clinical teams, we will enable proactive self-management, earlier intervention, and ultimately, better health outcomes for millions across England.

To ensure fair and equitable access, we will make wearables available for patients that need them. Building on the success of the Wolverhampton Prevention Pilot[234], we will work with innovators to launch trials for real-world evaluation and development of the next generation of wearable technology and provide devices for free in areas where health need and deprivation are highest.

By 2035, wearables will be standard in preventative, chronic and post-acute NHS treatment. All NHS patients will have access to these technologies, which will be part of routine care.

Big bet 5: By 2035, robots will deliver care with unprecedented precision

The Future of Healthcare: surgeons will perform complex procedures with ever more sophisticated robotic assistance, enhancing precision, minimising invasiveness, and speeding up recovery. Pharmacy automation will ensure medication gets to patients quickly, easily and safely.

Current application: Bristol Southmead Hospital is using state-of-the-art surgical robots to carry out a range of procedures, including gynaecology and urology[255]. These robots have 3D visualisation and instruments with more degrees of motion than the human wrist. This has made more complex operations possible with minimally invasive techniques, translating to fewer complications and shorter hospital stays.

The NHS is committed to the adoption of robotic-assisted surgery as standard for an expanded range of procedures, over the next 10 years. In addition to enhancing surgical precision, robots can help automate operational processes in hospitals. That is, they can help deliver supplies, courier medications and samples, or deliver environmental sanitisation.

Beginning next year, we will expand surgical robot adoption in line with NICE guidelines. We will also support NHS trusts to increase robotic process automation. This is technology where robots mimic human actions to automate repetitive, rule-based tasks. In the NHS, that might mean they help with data entry, inventory control, referral management - and a range of other tasks that can free up the healthcare professional to focus on their patients.

From 2029, we will establish national registries for robotic surgery data and develop telesurgery networks. This will help us scale successful trials of assistive robotics. As outlined in chapter 2, we will also scale the use of robotics in pharmacy - where they can fill prescriptions far more quickly and accurately than humans.

> **"In August 2023 I had a total hysterectomy at [Hospital A] by robotic surgery and it's the best surgery I have ever had. Only 1 night in hospital and next day only needed paracetamol it was much better and easier than expected. Well done the NHS"**
>
> ***Bronwen, public participant via Change NHS website***

Enabling global excellence

These 'big bets' offer an opportunity to align research, investment and innovation to the technologies that have the greatest potential to transform healthcare. However, they will only realise their full potential if the NHS trials and adopts the science. We need to build the infrastructure to draw on all our assets - including the NHS - to deliver genuine global excellence.

To support this, we will run a new bidding process for new Global Institutes. Supported by NIHR funding, these institutes will be expected to marshal the assets of a place - industry, universities, the NHS - to drive genuine global leadership on research and translation. Their aim will be no less than becoming the world leading centre for their area of focus and attracting the most talented academics and innovators from around the world. They

will focus on discovery science and applied innovation, as well as bridging the gap between discovery and adoption.

The criteria for designating Global Institutes will have an equal science, health and growth component. That is, we will expect bidders to justify their potential for global scientific leadership; to support real-world patient outcomes; and demonstrate how they will help bring economic growth to areas most in need (e.g. by creating jobs in areas with less economic opportunity). We anticipate that this will lead to significant geographic spread of designated networks. This is intentional: we believe the UK will have a better chance to lead the world when all its assets are harnessed, not just those in one part of the country.

We will also establish Regional Health Innovation Zones, to give health systems the permission and flexibility they need to be more radical and forward-looking on innovation.

Empowered by devolutionary freedoms, the Zones will bring together existing entities, including integrated care boards (ICBs), providers, mayors and industry, to experiment, test and generate evidence on implementing innovation. They will have the means to experiment with new commissioning models (including commissioning industry to deliver services on a payment for outcome basis), to redesign patient pathways, and simplify procurement. Initially, 2 to 3 regions with strong life sciences, health and data assets will be selected as trailblazers. Our intention is to scale zones nationally over time.

Beyond Regional Health Innovation Zones, our financial reforms outlined in chapter 9 will support innovation across the whole NHS. We will introduce multi-year budgets, to support longer-term strategic thinking. Our new requirement that organisations reserve at least 3% of their budget for one-time investments in service transformation will make sure ideas that save money and improve outcomes are not held back because of a lack of transformation budget.

Leading on innovative medicines

We know medicines have tremendous promise. It is innovative medicines that mean patients with HIV have a similar lifespan to the general population and mean people with the most severe asthma can at last control their condition with an injection.

From personalised treatments to preventative medicines with huge population relevance (e.g. GLP-1 agonists), the pace of future discovery is even more exciting. Beyond their impact on health, many promise substantial societal and economic benefit, including by helping more people stay in productive work. We want to make sure the NHS patients have fast access to these medications.

We will be deliberate in our approach to innovative medicines from horizon scanning to implementation, so that NHS patients can rapidly benefit from game-changing treatments. In collaboration with partners across the public, private, and charitable sectors, we will support development and roll out of high impact medicines through the Healthcare Goals programme, including in cancer, obesity, mental health and dementia. Through the Dame Barbara Windsor Dementia Goals programme we intend to set up a public-private partnership to accelerate development and implementation of new dementia therapies. We will also be more proactive in preparing the system to implement medicines in areas like asthma, where new care models can shift care into the community.

To create more space for the myriad of innovations of the future, we will need to improve the outcomes and value we are delivering from innovations already in use. For example, an analysis of a therapy area by NICE showed that 30% of the costs of treatments are no longer good value for money. In others, such as chronic heart failure,

thousands of lives could be saved by treating people earlier in the pathway[235] [236].

To identify where we could improve outcomes and value, NICE will re-evaluate priority clinical pathways on a rolling basis, identifying where existing innovation should be retired, as well as instances when one technology should be sequenced after another to improve value. We will link NHS compliance with these decisions to core clinical standards, best practice tariffs and incentives.

We will only lead the world if we get the basics right

To realise the potential of innovation, we must also get the basic conditions right to promote innovation. This means speeding up clinical trials, future-proofing our regulatory landscape, streamlining procurement and accelerating adoption and spread. By fixing these things and introducing a more permissive operating model that allows innovators to thrive, we will set the system up for success.

Our new operating model will drive innovation, not stifle it

Our new operating model, will support the growth of the industries working with us on our health mission. Failure of the NHS to partner, and any sign of a 'not invented here' mentality, will not be tolerated.

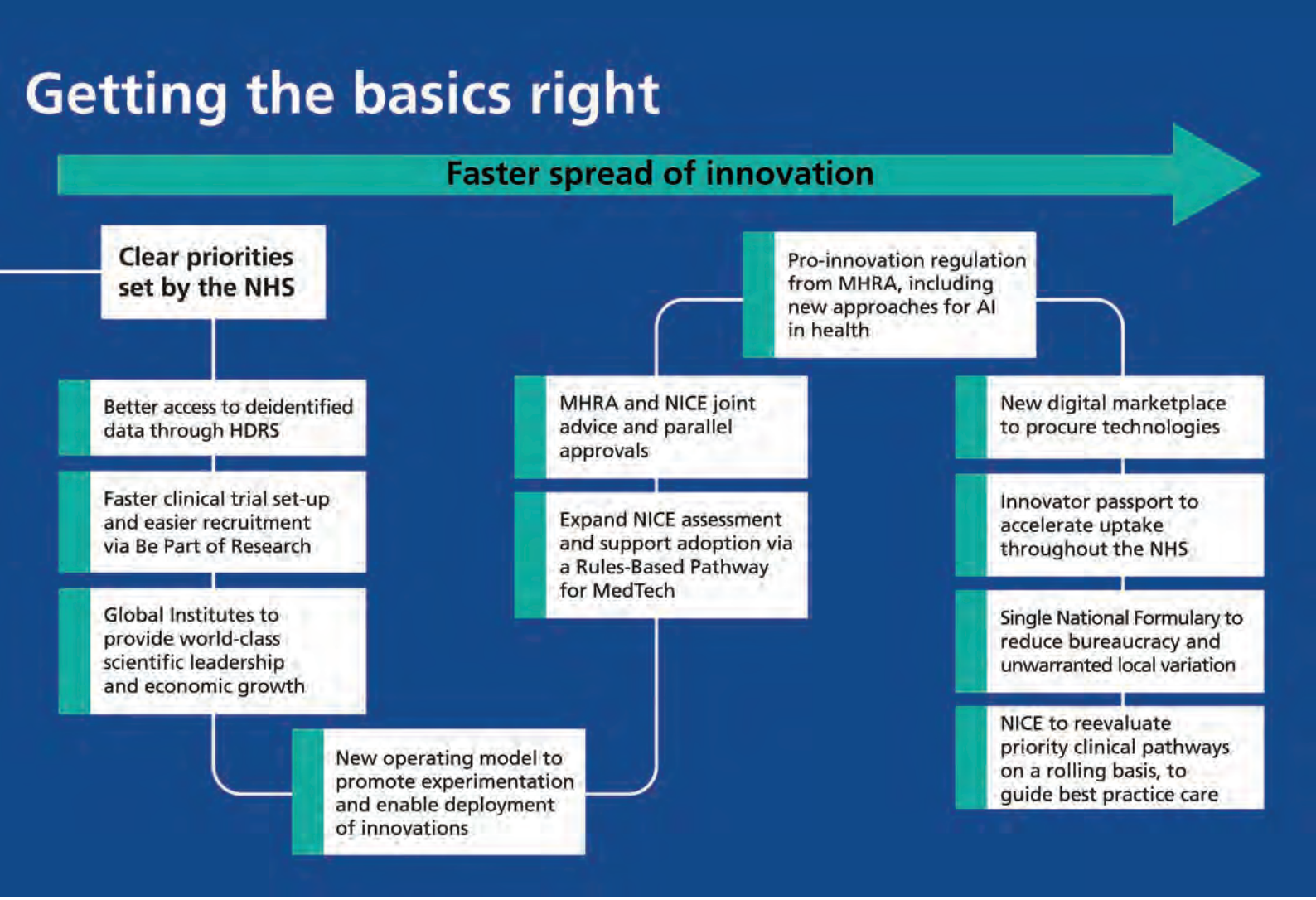
A more streamlined centre will focus on the things best done once and be agile enough to keep up with the pace of change setting national standards and holding more risk to give providers and commissioners more freedom to innovate. Adoption of innovation will be a criterion for how providers and commissioners are judged under a new regime of earned autonomy.

The new operating model will also:

- through IHOs, align investment and savings to occur in the same place for the first time - meaning collaboration and innovation are never blocked because the cost and the benefit accrue in different organisations or settings
- offer multi-year contracts - meaning innovation is not blocked because its return on investment takes longer than one year to realise
- expose variation in care through greater transparency, supporting more equal adoption of best practice
- help patients direct best practice, by telling them what good looks like via the NHS App, and letting them then make a choice based on what they value.

The new centre will ensure relationships with industry are genuine partnerships, where too often they have been transactional. We will expand the role life sciences and technology companies can play in service delivery.

For example, we will develop new commercial arrangements to speed up access to game changing medicines. Last year, the government announced a strategic collaboration with Eli Lilly, one part of which was to establish a world-first 'real world evidence' study evaluating the effectiveness of weight loss medication, including gathering data on health-related quality of life and changes in participants' employment status.[237]



"Within the current financial structures, it is very difficult to implement innovations where the investment required is in one part of the service and the benefit/saving is in another (for example, a primary care diagnostic for cardiac conditions, which requires effort and money in the GP surgery but could save money in acute care if conditions are diagnosed and treated earlier)."

Victoria, staff participant, Change NHS website

We will do more of these type of deals in the future, prioritising areas with the worst health outcomes. Similarly, we will work with ICBs to engage technology companies on developing new tech-led services for patient groups - such as older people with frailty - where the desired outcome is enabling a person to continue living independently in their own home, by deploying wearable and monitoring technology.

We will improve procurement

Our healthcare model gives us substantial negotiating power. To take advantage of this, we will have a clear national scheme for procurement.

For too long, we have been behind the technological curve - investing heavily in yesterday's solutions to today's problems. The approach has been top-down and slow: by the time that the NHS rolls out new technologies they have long been

superseded. It has been akin to investing in fixed telephone lines in a world dominated by mobile phones.

The NHS has mixed up its priorities when it comes to buying things. It has bought goods and services as if everything were a basic, interchangeable item, where only price matters. This means the NHS has focused too much on lowest cost, rather than best value and outcomes. In other industries, investing in technology has led to remarkable new ways of doing business, boosting productivity and delivering benefits for customers and companies alike. If the NHS is to achieve the same, we need a fundamentally different approach to procurement that is applied consistently across the health service. Early next year, we will introduce a standard value-based procurement guidance for devices and digital products.

New products to improve productivity will be procured once nationally and then made available through an internal marketplace. This open innovation approach will create a far better experience for patients and professionals while unlocking the extraordinary potential of our HealthTech and MedTech sectors.

Unlike for medicines, there is no national pathway to prioritise and nationally fund the highest impact HealthTech. As a result, we see significant unwarranted variation in uptake[238], weakening the perceived attractiveness of the UK market. From April 2026, building on and adapting our experience with medicines, we will begin expanding NICE's technology appraisal process, which includes mandated funding by the NHS, to cover some devices, diagnostics and digital products. This will focus on those that meet the NHS' most urgent needs and support financial sustainability (e.g. digital behavioural therapy for adolescents to support those on long Children and Adolescent Mental Health Service waiting lists).

It will provide accelerated commercial support, enable quicker and simpler access to NHS infrastructure for evidence generation, and intensive adoption and pathway transformation support.

We will future proof our regulators and reform how they operate

Regulatory bodies like the MHRA and NICE must continue to develop agile, risk-proportionate pathways for evaluating and approving all products. We will also align with international standards where appropriate to facilitate collaboration and innovation.

Under this government, the MHRA has already improved performance. All backlogs are cleared, and statutory performance targets are now being met. Building on this strong base of delivery, it will now focus attention on the most complex and potentially transformational treatments and modalities. This will include areas such as personalised cancer vaccines, and the regulation of AI and software with the expansion of the innovative AI Airlock regulatory programme.

MHRA will develop a more pro-innovation approach to regulation, while maintaining safety, and ensure that the UK is one of the best places in the world to develop and launch new products. To make sure patients in England are able to access medicines faster, by April 2026 MHRA and NICE will launch a new joint process, supported by information sharing and joint scientific advice, that will boost the speed of decisions and cut administrative burdens for the system and industry.

We will remove bureaucracy and barriers to adoption and spread

Perversely, adoption in one part of the NHS can cause others to reject an innovation[239], rather than embrace it. We will therefore create a new 'innovator passport' by 2026. Once an innovation has been robustly assessed by one NHS organisation, further NHS organisations will not be able to insist

on repeated assessments. This will help make sure innovations are available to everyone, while also reducing duplication and inefficiency across the health service. We will also introduce a new mechanism for a presumption of adoption for innovations that can demonstrate a step change improvement in quality, where they are cost neutral and improve quality of care.

The system for getting new medications to patients is needlessly complicated. The process by which each local area decides which drugs are available is bureaucratic and creates a postcode lottery. These local formularies do not make sense in a universal service that should provide a core standard of high-quality care to everyone.

We will therefore move to a Single National Formulary (SNF) for medicines within the next 2 years. We will create a new formulary oversight board, responsible for sequencing products included in the formulary based on clinical and cost effectiveness, supported by NICE. Local prescribers (such as clinicians and pharmacists) will be encouraged to use products ranked highly in the SNF but will retain clinical autonomy as long as they prescribe in line with NICE guidance. The intention of this policy is to ensure that we can drive rapid and equitable adoption of the most clinically and cost-effective innovations. We will work with industry throughout the implementation of these policies to make sure we realise these objectives together.

We will speed up clinical trials

In recent years, the UK has fallen behind as a global destination for clinical trials, meaning less patient and financial benefit[240]. Trial sponsors report that while it takes around 100 days to set up a trial in Spain, it takes 250 days to set up one in the NHS.

The Prime Minister has committed to clinical trial set-up time falling to 150 days by March 2026. This will be the fastest reduction in British history and will ensure that brilliant researchers can get life changing treatments to patients more quickly. The government is also committed to fully implementing the recommendations of Lord O'Shaughnessy's review of commercial clinical trials in the UK[241], and will go further.

Our first step will be full transparency on performance. From this year onward, we will publish a monthly scorecard for the NHS overall progress on clinical trials. We will collect provider level information for performance management and improvement. This will make clear to government, the public, investors and trust boards who is performing and who is not.

From 2025, we will make it far easier for patients to volunteer to participate in clinical trials by promoting 'Be Part of Research' and integrating it with the NHS App. Initially, this will allow patients to search the clinical research database and request to be contacted. We will enhance the service for commercial partners to link eligible patients who have signed up with available studies in target areas. In time, we will link clinical trial recruitment to the NHS App and SPR, so that patients can be proactively notified of clinical trials that might benefit them.

We will make it easier for NHS organisations to participate in clinical trials in future by improving the efficiency in set up and deliver of trials. Specifically, we will introduce a standardised contracting and approvals process which prevent duplication across organisations. We will expand the UK wide National Contract Value Review (NCVR) -which provides transparency and negates the need for any local negotiation on costing - into neighbourhood health services and other out of hospital settings by 2026. We will align NCVR with the NHS Payment System guidance and rules in England so that NHS Trusts can embed this process and research income in their financial payment process.

We will lead on health security

The recent experience of COVID-19 demonstrated how interconnected global

health is. If we want to protect health in the UK, we will need to support global health security.

As well as emerging infectious diseases, antimicrobial resistance (AMR) is a major threat both globally and to UK patients. Latest evidence[242] suggests it could kill almost 40 million in the next 25 years. In the UK[243], it is already implicated in over 35,000 deaths per year. High impact antimicrobial resistant infections include bacteria causing gonorrhoea, tuberculosis and methicillin-resistant staphylococcus aureus (MRSA). All translate to significant human cost, as well as additional NHS expenditure[244].

We will act. We will continue to deliver the National Action Plan on AMR. We will prioritise and deliver new vaccines that help prevent AMR progressing - for example, the NHS will begin rollout of a new vaccine for gonorrhoea from August for those most at risk. This government will also support the Fleming Institute in its work to bring research, behaviour change, public engagement and policy together to provide real-world solutions to AMR.

Conclusion

Our new approach to innovation strategy will focus on the areas where the UK has competitive edge, and where innovation can most drive healthcare reform. The ambition of this Plan demands every lever is pointed in the same goal: accelerating change.

That will mean the NHS working in a different way. It will be an active and collaborative partner in making that innovation happen. It will be a hotbed of innovation and a catalyst of global excellence. This is a mindset shift but a necessary one.

We will support the scale of this aspiration by getting the basics right. We will be a world leader in clinical trials and patient involvement in research. The UK will have a streamlined regulatory environment, fit to support entrepreneurs and scientists.

And we will be a world leader in global security and solutions to some of the world's most wicked challenges. We do this because the size of the prize for NHS financial sustainability, for economic growth and for our ambition to enable healthier lives for all has never been bigger.

09

Productivity and a new financial foundation

Over the course of this 10 Year Health Plan, the NHS will spend well over £2 trillion. In a single year, the NHS' expenditure is higher than the total economic output of Greece.[256] Today the NHS accounts for 38% of day-to-day government spending, a figure projected to rise to 40% by the end of the parliament.[257] Despite this, the assumption has taken hold that only more money can deliver better outcomes.

However, it is now self-evident that more money has not always led to better care. Over the past decade, spending has grown but outcomes have slipped, productivity has plummeted, waiting lists have soared and access has fallen. By contrast, 15 years ago, the UK spent less on healthcare as a share of government expenditure and less per capita but public satisfaction with the NHS was at a record high.

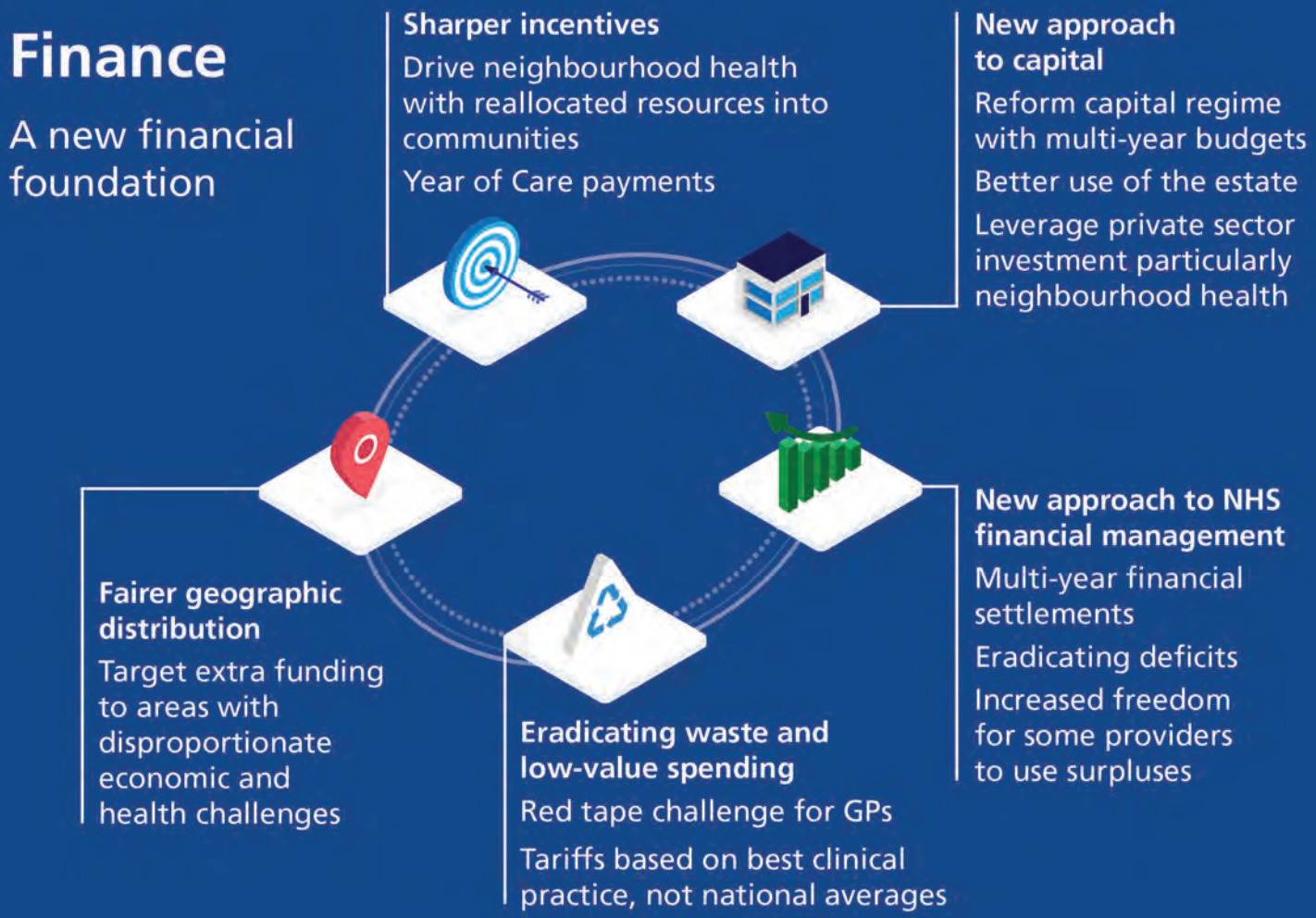
Of course, the NHS will need to continue investing, as demonstrated by the record investment in NHS funding announced by the Chancellor at the 2025 Spending Review. But the era of the answer always being more money, never reform, is over. It will be replaced with a new value-based approach, focused on delivering better outcomes for the money we invest.

The country is facing unprecedented pressures on public spending, from an ageing population to increasing global insecurity. If the NHS' share of public spending continues to escalate, it will undermine the UK's ability to deliver on other societal and economic priorities.

> **"I would agree that the NHS needs investment, but I think it's not just investment it needs because I think at the moment, if you were to throw a lot of money into the NHS, you'd be throwing good money after bad. I think at the moment there's money not being utilised in the right way. And I think that is a problem of such a large organisation."**
>
> ***Zak, public deliberative event participant in Folkestone, December 2024***

Moreover, failing to prioritise other critical public services makes the NHS less, rather than more, sustainable in the long run. The NHS' financial future depends on people getting a good education, on safe streets, on strong local government, clean air and better housing. And as we outline in chapter 8, it also depends on investment in science, discovery and innovation. Sustainability means a future in which the NHS does not crowd out the other public services, investment and infrastructure it depends on.

Our 3 shifts each promise not only better patient care, but clear routes to secure financial sustainability.



- Shifting from hospital to community: evidence is unequivocal that more care in the community is cheaper and more effective than defaulting to all care in hospitals
- Shifting from analogue to digital: as in other industries, a digitally enabled health service will mean better care, delivered far more productively, for far lower cost[258] [259]. It will free up capacity for those that still depend on in-person healthcare
- The shift from sickness to prevention: will help tackle major causes of illness - like smoking[260], obesity[261], worklessness and alcohol harm - which combined cost the NHS billions of pounds[262], unnecessarily, each year.

Our commitment to financial sustainability

Our aim over the next 10 years is to 'bend the cost curve' through a relentless focus on delivering value-based healthcare. Put simply, we will get far more out for what the taxpayer puts in ensuring every pound makes the maximum contribution to better outcomes, lower inequality and economic growth. We will bring down the cost of world-class healthcare, and in doing so make higher standards possible.

As detailed in chapter 1, the NHS' model has intrinsic advantages in delivering better value for taxpayers. Unlike insurance-based health systems, it does not need to spend money on excessive and unnecessary overheads like claims processing, marketing and sales. It has significant purchasing power. It does not need to administrate complex co-payment schemes.

However, to achieve high performance and financial sustainability, we will need to urgently resolve the NHS' productivity crisis. The one-off cash injection into healthcare during the COVID-19 pandemic, coupled with sharp cuts to activity, resulted in a 20% to 25% drop in

measured NHS productivity[263] from which we have not yet fully recovered. This is not just an issue for the NHS: the Governor of the Bank of England Andrew Bailey has publicly identified NHS productivity as a factor dragging down economy-wide productivity[264]. This is not sustainable. Improving productivity is a central goal of the reforms outlined in this plan.

The work on turning the tide has already begun. For the next 3 years we have set the NHS a target to deliver a 2% year-on-year productivity gain. This will mean, at a minimum, we return to pre-pandemic levels of productivity by the end of the parliament, a goal that external research has shown will substantially bend the NHS cost curve and decelerate its growth in spending relative to the size of the economy[265].

If we are to ensure the NHS' long-term sustainability for future generations, then bending the cost curve cannot be a one-off exercise. The reforms this Plan sets out give us confidence that NHS productivity in the future can mirror or exceed improvements in the wider economy. To ensure this, we have asked Andy Haldane, former Chief Economist at the Bank of England, to review productivity trends over time and our strategy for improvement. His review will inform the creation of a new Productivity Index against which both the NHS nationally and local systems and providers can be assessed. His conclusions will be available in autumn 2025, to inform NHS planning guidance.

In the meantime, there are areas we will prioritise to drive up productivity and develop a value-based approach:

- We have begun to cut excessive bureaucracy, through our Red Tape Challenge and the abolition of NHS England.
- We will ensure the best value medicines are consistently adopted everywhere by modernising our supply chain.
- The National Institute for Health and Care Excellence will have new powers to withdraw treatments that are no longer cost-effective, to ensure NHS resources are used where they deliver the greatest value. This change will allow the NHS to redirect funding from outdated interventions to more effective care.
- We will use technologies like ambient voice technology to free staff time to care. Evidence shows as much as 60% of what an individual NHS staff member does can be freed up by technology, giving more time for patient care and boosting productivity significantly[266]. It will also mean world-class care can be delivered without inexorable growth in staffing numbers. In a system that spends over half its budget on staff costs, this is vital to long-term financial sustainability.
- We have asked David Lock KC to provide expert advice on the rising legal costs of clinical negligence claims, ahead of a review by the Department of Health and Social Care (DHSC) in the autumn.

As we move to an NHS that is more digitally enabled, community-based and prevention-focused, the opportunity to save money, optimise resources and drive productivity will increase further.

In the next 3 years we will make a start on the journey to establishing a new financial foundation. The current financial framework for the NHS is characterised by unnecessary complexity developed over years of modifications, fixes and tweaks. The result is a financial regime that is so complicated that at best it fails to align with overall strategy and at worst is financially incoherent. Our first steps will deliver:

- a restoration of financial discipline
- a shift to long term financial planning
- a new focus on rewarding positive change through sharper incentives
- a fairer distribution of funds

- a new approach to capital investment.

Over the course of this Plan, we will reinvent the NHS' financial model. Our long-term aim is for funding flows to reflect a new compact between citizens and the state, made possible by better technology, data and participatory democracy. By that, we mean that money will increasingly follow patients, not just service to service, but through their life course. Providers will be rewarded based on how well they both improve the life course outcomes of each individual, as well as how well they involve them in the design of their care, rather than solely on whether they provide episodic instances of care on demand.

Supported by better data and a more sophisticated understanding of lifetime health risk, the NHS will allocate its funding more innovatively, to better maximise return. That is, we will be able to take a more actuarial approach to health funding, using anonymised health-care data to maximise healthy life expectancy by making predictions about future disease burdens and outcomes. Whereas such approaches in insurance-based systems are used to identify who to exclude from coverage, in the NHS they will help us pinpoint where prevention efforts are best focused, including to tackle inequalities.

As a partner in innovation, the NHS will not only set aside funding for transformation but will support and invest in the most promising interventions, for example, by providing public sector capital for equity stakes in the start-ups that promise to best transform healthcare. The NHS will not just benefit from markets but will actively shape them. Health will stop being solely a driver of higher government debt and start being considered an asset to drive growth.

These long-term changes will require a new financial framework for the NHS that we will publish later this year. We will begin the transition to these new approaches over the course of the next few years.

Restoring rigorous financial discipline

The NHS has developed an addiction to deficits. Where once they were an exception that indicated genuinely poor financial management, today they have become a widespread and accepted feature of health service management.

Worse, the centre has established the habit of rewarding organisations in deficit with additional funding. That has acted as a disincentive to better-performing organisations which feel their efforts are not recognised or rewarded. This is bad for patients as it means that resources are not focused on where health need is greatest.

To restore financial discipline, we will end the practice of providing additional funding to cover commissioner and provider deficits. This year, the £2.2 billion in deficit support funding will not go to systems that fail to meet their agreed financial plans. Deficit support funding will be phased out from financial year 2026 to 2027.

In its place we will introduce a transparent financial regime for this year that properly holds leaders to account for meeting their financial plans. This requires organisations to have a detailed analytical understanding of activity and cost so they can take actionable steps to improve. We will introduce enhanced oversight, escalating to regulatory interventions in cases of non-compliance.

From financial year 2026 to 2027, we expect all NHS organisations to deliver operational plans that are fully compliant with the NHS planning guidance. There will be no exceptions. As described in chapter 5, there will be a series of interventions which can be taken if financial or service performance does not meet expectations, but we are prepared if necessary to go one step further. If financial discipline does not become the norm across the NHS, we will take a new, stronger statutory approach to financial accountability, learning from how other parts of the public

sector, such as local government, manage overspending (i.e. as through legally capped budgets).

Over time, our aim will be for the NHS to move into surplus whilst delivering improved outcomes and experiences for patients. Surpluses are good for patients as they allow organisations to invest in innovation and operational improvements which support better outcomes and better value. By 2029 to 2030, most providers will be expected to generate a surplus, transforming the NHS into a driver of growth rather than a burden on public finances. Those providers that have been authorised as new NHS FTs will have the ability to use surpluses to reinvest in future capital projects, in agreement with their agreed annual plans.

A shift to long-term financial planning

For too long the NHS has lived with short-term fixes and short-term funding. That is no recipe for sensible long-term strategic planning of services. This Plan signals a shift to a new longer-term mindset, alongside a 3-year revenue and 4-year capital settlement from financial year 2026 to 2027 in the spending review.

While we recognise the financial pressures on the NHS, this new long-term approach provides the opportunity to take a strategic approach to planning health services. To break the old, short-term cycle we will ask all organisations to prepare robust and realistic 5 year plans and demonstrate how financial sustainability will be secured over the medium term. Every organisation will be required to continue to refresh their plans, aiming for most organisations to be in a sustainable surplus position.

Over time, we will require all organisations to reserve at least 3% of annual spend for one-time investments in service transformation. This might include pump priming transformation or change management. Too often, positive change is not pursued because of a lack of transformation funding to get it off the ground.

Rewarding changes through sharper incentives

How NHS money flows to organisations and individuals has a profound impact on behaviour and culture. To deliver the changes described in this Plan, the NHS needs to adopt a more consistent approach to using financial incentives to recognise and reward changes that deliver value and improve outcomes.

We will pay providers for delivering high value care

Many providers are currently paid on a block contract for services including urgent care, mental health and community services. This means they receive the same money irrespective of how many patients they see. There are very few incentives to deliver high quality care. We will change this to only pay providers for effective care which has been commissioned by an integrated care board (ICB) – and to withhold payment for poor quality care and/or pay a bonus for high quality care. This will require the evolution of analytical tools to support ICBs to carry out utilisation reviews and to work with providers to agree best practice care pathways, drawing on the modern service frameworks described in chapter 6.

We will change how tariffs work

To ensure providers are incentivised to focus on the most clinically and cost-effective care, we will start to move from national tariffs based on average costs to tariffs based on best clinical practice that maximises productivity and outcomes, with sensitivity to case mix (i.e. complexity of patient need). We will start with services that have sufficiently detailed, clinically evidenced service delivery models that can be used to calculate costs. This approach will ensure that providers are reimbursed for services at a price we know delivers best value for the taxpayer. Starting

from next financial year, we will increase the number of new best practice tariffs year on year.

We will introduce new financial incentives to drive neighbourhood health

Reducing hospital admissions is a key goal for the Neighbourhood Health Service. However, under current funding mechanisms the cost of new more efficient community-based services will be in one part of the NHS, whilst the savings are in another, typically hospitals.

This disconnect means there is no financial incentive to invest in services that improve patient outcomes and deliver better value. To fix this, we will create new funding flows and payment mechanisms that connect the savings from improved quality of care with the investment in new services in the community. We need financial incentives that support not just the creation of better services, but which also ensure the old service is replaced by the new.

To support the shift of care away from hospital settings towards neighbourhood care, we will develop year of care payments (YCPs), through test and learn approaches. These allocate a capitated budget for a patient's care over a year, instead of paying a fee for a service. This new payment mechanism will be calculated according to the health needs of the population being served and will allow providers to invest in high-quality, proactive and planned care for patients.

The YCP could include all primary care, community health services, mental health, specialist outpatient care, emergency department attendances and admissions. These will be consolidated into a single payment. The YCP will provide a sharp incentive to keep patients healthy and out of hospital because local NHS organisations will benefit from reducing emergency visits and reinvesting in community services.

These YCPs will be an important feature of our new payment system, and of the neighbourhood provider contracts described in chapter 2, for specified populations or services. Operating at a larger scale, Integrated Health Organisations, described in chapter 5, will take on budgets for the entire population being served.

From financial year 2026 to 2027, we will begin intensive work with a small number of 'pioneer' systems who are already further advanced in designing their new care model to implement notional YCPs. The development of both YCP and tariffs for community and mental health services will be dependent on the availability of good quality cost and activity data. To support this change, a suite of community and mental health service currency models have been developed and included in the 2025 to 2026 NHS Payment Scheme.

The introduction of YCPs in pioneer systems must go beyond setting prices and tariffs for neighbourhood care. Currently, the pricing and block contracting model for UEC is a barrier to redirecting resources towards community-based services and does not appropriately share the demand and supply financial risk between commissioners and providers. In 2026 to 2027, we will deconstruct block payments for urgent and emergency care (UEC), with the intention of realigning the activity being delivered and the funding being provided.

At the same time, we will develop new payment models that encourage a shift in UEC activity into the community. We will test, refine and roll out these new payment models, focusing on approaches that reward same-day and out-of-hospital care. This includes support for services such as same day emergency care, virtual wards, and urgent community response.

We will introduce new financial incentives to empower patients

The patient perspective is critical in linking how the NHS uses its money to deliver value for patients and the taxpayer. Patients have expertise about their own experience and what they value that is too often undervalued and underappreciated. When their voice is absent, the NHS is more likely to spend on needless procedures or low value interventions. Our reforms will make the patient voice more central to how we allocate funding, help more people be heard, and give patients more direct financial power in the NHS.

We will introduce more widespread tariff mechanisms so that the money in the NHS follows the patient. In addition, we will test a range of measures in specific specialties or geographies in 2026 to 2027 to test how patient voice can directly impact financial flows within the NHS. This may include using the Care Quality Commission's inspection results, patient satisfaction surveys, and experience data to directly influence payments to providers. This data could also guide decisions on funding for both revenue and capital.

We will also trial a new financial flow through which patients are given the power to decide whether a percentage of the payments that providers receive for services should be paid or whether it should be diverted to regionally held NHS improvement funds.

No money would leave the NHS, but individual provider organisations could be penalised if patients were dissatisfied. This will create a powerful incentive to improve the experience at an individual level and listen carefully to feedback. We call these Patient Power Payments.

We intend to trial this approach in selected trusts in a small range of areas of care. Patients will be contacted to ask them whether the full payment for the costs of their care should be released to the provider or whether a proportion should go instead to a regional improvement fund. We believe this will make providers pay much more attention to the experiences of their patients. These payments could be particularly powerful in clinical services which have failed to engage with and respond to patient concerns for too long.

We will incentivise excellence

We believe excellence should be incentivised and rewarded. Currently, it can feel like trying something new only has downside. To rectify this, we will introduce new incentives for the best NHS leaders, clinicians and teams. Over time, we will tie incentives to population health outcome measures and patient feedback (including that provided through the App, as well as patient reported measures discussed in chapter 6).

Fairer distribution of funding

The NHS is and always has been a health system organised around need. However, the current flow of NHS resources does not always match where the highest need is – meaning areas with high unmet need, including because of higher poverty rates, can be under resourced. In turn, that limits the NHS' means to tackle and narrow health inequalities.

From financial year 2026 to 2027, we will speed up moving the NHS locally much closer to its fair share of funding, based on health need. To ensure that the way funding is allocated reflects the latest evidence about changing health needs we will ask the Advisory Committee on Resource Allocation (ACRA) to independently review the findings of the Chief Medical Officer's recent reports on health across different communities and in an ageing society. We expect the ACRA review to report in time to inform allocation of resources to and by ICBs in 2027 to 2028 and, in the meantime, we will target extra funding to areas with disproportionate economic and health challenges. We will also review how health need is reflected in nationally

determined contracts, such the Carr-Hill formula for general practice.

Our plan to remove deficit support funding (worth £2.2 billion in 2025 to 2026) starting from financial year 2026 to 2027 will free up funding to allow us to move resources more quickly to areas of higher health need. Details of this policy including how deficit support funding will be redistributed, will form part of the medium-term planning guidance published this autumn.

Despite previous pledges to shift resource to primary and community care, hospital-based funding has risen. We will deliver a decisive shift in the pattern of health spending. Over the course of this Plan, the share of expenditure on hospital care will fall, with proportionally greater investment in out of hospital care. This is not just a long-term ambition. We will also deliver this shift in investment over the next 3 to 4 years as local areas build and expand their neighbourhood health services.

A new approach to capital investment

The ambitious proposals in this Plan, from the biggest shift of care from hospitals to the community, to the delivery of a genuinely digitally enabled NHS, will require significant and strategic capital investment to drive improvements in patient care and productivity.

We will deliver this against a historical backdrop of significant underinvestment in capital for the health service. While capital investment increased substantially during the 2000s, the 2010s saw a period of significant divestment from capital – as budgets were redirected to subsidise day to day spending. This has undermined productivity.

What is more, this underinvestment has been compounded by a capital regime which has widely been described as dysfunctional, with the National Audit Office concluding that it "made it difficult to plan and acted as a barrier to investment". One of the clearest signs of a broken capital regime is an NHS that regularly underspends its capital budget, despite having too little to begin with.

As a result, problems have been stored up for the future and the NHS in 2025 has crumbling buildings with care disrupted at 13 hospitals a day as a result. Some 44% of hospitals pre-date the creation of the internet in 1983 and 11% of the estate is older than the NHS itself[267]. Much of the primary care estate is not fit for modern requirements with 22% of primary care buildings pre-dating the foundation of the NHS, many of which are in converted residential properties[268]. Using both Organisation for Economic Co-operation and Development and industry benchmarks, the UK is far behind other countries in the levels of computerised tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET) scanners for its population.

We have already begun to tackle these problems through record levels of capital investment into the NHS. We have boosted the capital budget by £3.1 billion from financial year 2023 to 2024 to financial year 2025 to 2026 - and invested more than £2 billion in technology and digital to support higher quality and productive care[269]. We have also put in place a credible plan for the New Hospital Programme, representing tens of billions of pounds of investment, that will support our construction industry.

Our 10 Year Infrastructure Strategy takes a long-term approach and for the first time integrates health and social infrastructure alongside economic infrastructure. We have committed to 5 year capital budgets and to extending them every 2 years at regular spending reviews to avoid funding 'cliff edges' and to provide greater certainty. Yet the scale of the challenge requires us to go even further. We will do that in 3 ways, outlined below.

Reforming the capital regime

We will give more power to the frontline and simplify and accelerate the capital approvals process with a package of reforms including:

- introducing multi-year capital budgets, set on a rolling 5-year basis in line with wider government capital allocations. We will set out allocations up to 2029 to 2030
- those reforms published in our 10 Year Infrastructure Strategy, designed to give greater certainty to the NHS and industry on projects and programmes across the country and allow better coordination of industry and supply chains across government
- devolving more control over capital budgets to the frontline with fewer restrictions on what providers can spend their capital on and greater flexibility to spend funding between financial years
- radically streamlining the capital approvals process to foster dynamism and swifter delivery. We expect to have at most 3 approval levels on the very largest nationally significant schemes (one provider level, one regional/national and one cross government). We expect to reduce by at least 2 to 3 months the time that a typical scheme spends going through central approvals, and for smaller schemes the reduction will be 4 to 5 months. New NHS Foundation Trusts (FTs) will be able to progress larger self-financed schemes as long as they are consistent with overall financial planning.

In line with our approach to devolution and earned autonomy, set out in Chapter 5, we believe the best providers should be empowered to manage their own assets. Over time, new FTs will therefore no longer receive or be dependent on NHS capital allocations but will have the freedom to determine their levels of capital spend each year in accordance with their agreed plans, with their investment constrained by their ability to finance projects through cash generated from their operating activity. This will incentivise financial grip and delivery, requiring new FTs to focus on the total resources available to them, both revenue and capital, and ensure a relentless focus on affordability and productivity. Learning from previous financial regimes, we will work to avoid the freedoms for new FTs adversely impacting the ability of other NHS organisations to make necessary capital expenditure. New NHS FTs also need to set out capital spending plans as part of the planning process. We anticipate approval of these being automatic where spending is financed by operating activity (as opposed to drawing on the large and longstanding capital reserves of some FTs).

Where capital allocations and any associated cash are still required, these will generally flow in line with a fair and transparent formula directly to the accountable organisation best placed to prioritise and deliver value for patients. Funding for operational capital expenditure on routine maintenance and equipment replacement will flow to NHS providers in line with need. Funding to tackle maintenance backlogs will flow directly to all providers in line with the extent of their backlogs.

This will leave systems free to focus on working with regions to ensure investment of strategic capital in new services and capacity (such as neighbourhood and diagnostic estate) that supports their population health improvement plan. Capital allocations for this will be based around population health need. Only where there is an exceptionally strong case, such as for the New Hospitals Programme, will capital budgets be held nationally.

In addition, we will look to reform public dividend capital (PDC) charges. PDC is a unique form of financing provided to public sector organisations, principally NHS trusts and FTs which has often disincentivised new capital investment and the regeneration and consolidation of the estate. There is a case for

lowering this barrier to investment and we will consult with the NHS on these options

Making better use of the existing estate

As well as generating new capital investment, there is a huge amount we can do to support the local NHS to do more with the infrastructure we already have.

We will do more to align financial incentives to increase estates utilisation and dispose of under-used and surplus land. Many existing flexibilities are not well explained to trusts and need to be clear, predictable features of the framework so that the frontline can plan how to use them. We are clear that all trusts have the authority to:

- retain 100% of receipts from the disposal of land assets they own; these are a credit in excess of existing capital limits automatically in the year of disposal and require no additional authorisation
- use proceeds from disposals across multiple financial years by notifying DHSC by the end of the calendar year of disposal proceeds so that a transfer can be made
- access a bridging loan facility from DHSC to allow immediate capital investment that can be repaid from disposal proceeds in future years which allows some bringing forward of a sale benefit.

Harnessing new investment

In the 10 Year Infrastructure Strategy the Government committed to evolve its infrastructure finance models and set out that it will consider the use of Public Private Partnerships (PPP) in projects and sectors where there is a revenue stream, appropriate risk-transfer can be achieved, and value for money for taxpayers can be secured. Beyond that, it also committed to explore the feasibility of using new PPP models for taxpayer-funded projects in very limited circumstances where they could represent value for money, especially recognising the requirement in neighbourhood and community health.

In line with this, we will bring forward a proposal for a new programme to support our ambition of establishing a Neighbourhood Health Centre in every community across the country. We will start now, in some of the most deprived communities, by using public capital to update and refurbish existing, under-used buildings. However, we also need new facilities, developed through a rolling approach, to realise our ambition. We will co-develop this with the National Infrastructure and Service Transformation Authority (NISTA), building on the successful NHS Local Improvement Finance Trust[270] programme, and will look to drive competition in the market to incentivise others, including third party developers, to improve their offer to deliver better services at lower cost to the taxpayer.

We will engage with the market on this programme and support NISTA in its wider market testing of a new PPP model. We will progress rapidly, working across government, on a business case around Neighbourhood Health Centres that sets out the potential and an assessment of value for money so that a final decision on the approach can be taken by the time of Budget 2025 in the autumn. Our approach will build on models currently in use (for example, from the operation since 2017 of the Welsh Mutual Investment Model).

We will also work with NISTA to consider the opportunities for health that could be achieved through private financing of revenue-raising assets (such as key worker accommodation and car parks) – including the potential to access low risk pension fund capital for the development of such assets. The government will also consider where PPPs and other private finance models could be used to deliver decarbonisation projects – such as renewable energy generation – across the public estate, including the NHS, leveraging private sector expertise and investment.

In taking this work forward, we will learn from previous experience with the Private Finance Initiative (PFI). Its intentions were good and countless patients, visitors and staff have benefited from new buildings and facilities which, as the National Audit Office recognised, were generally delivered on time and on budget[271]. In other cases, however, PFI was a costly mistake[272] which represented poor value for money. Contracts were too complex and lacked proper transparency.

As the government considers new sources and models of private investment, we do so with this experience in mind.

Conclusion

There is no more important obligation on each generation than to ensure the sustainability of the health service for those that follow. That means the answer to every challenge the NHS faces cannot simply be more money, especially when more money is a fiscal fantasy. We believe a world class healthcare service can only be achieved through investment and reform. We will adopt an unwavering focus on value: investment will drive economic growth, productivity and better use of the taxpayer pound.

For some in the NHS, that will mean some new realities. It will mean the era of deficits being not only tolerated but rewarded, are over. It will mean incentives reward health creation and excellence, not maintenance of a failing status quo. But there will also be opportunities: autonomy for the best performers to retain surpluses to invest in transformation and access to new sources of finance for capital transformation. By 2035, we will have created a new model of care in the NHS founded on a platform of financial sustainability and high-quality care.

Afterword: Be the change

There are moments in our national story when our choices define who we are. In 1948, the Attlee Government made a choice founded on fairness: the principle that everyone in our country deserves to receive the care that you need, not the care you can afford.

That the National Health Service was created amidst the rubble and the ruin of the aftermath of war makes that choice all the more remarkable. It enshrined in law and in the service itself, our collective conviction that healthcare is not a privilege to be bought and sold, but a right to be cherished and protected.

Now it falls to our generation to make the same choice: to rebuild our NHS to protect in this century what Attlee's government built for the last: the provision of high-quality healthcare, not according to wealth, but according to need.

There have always been those who have whispered that the NHS is a burden. That it is too expensive for the taxpayer. That the market can do better. Today, those voices grow louder, determined to use the crisis in the NHS as an opportunity to dismantle it.

This government rejects the pessimistic view that the values of fairness, solidarity, and healthcare for all that could be afforded in the 20th century are now unaffordable in the 21st. So do the British people, but we know that unless the NHS changes, the argument

that the NHS is unsustainable will grow more compelling. It really is change or bust. We choose change and this Plan will make sure that the NHS really is financially sustainable for the long term.

NHS staff, and our social care workforce, are up for the challenge. I am sometimes told that they are resistant to change. In my experience, they are crying out for it. They have suffered the moral injury of turning up to work, slogging their guts out, only to leave at the end of the day feeling exhausted and demoralised by the conditions that patients are being treated in because of circumstances beyond their control. They are the ones driving innovation on the frontline and their fingerprints are all over some of the best ideas in this Plan.

The public are crying out for change, too. Each of us has our own story about the NHS and the difference it has made to our own lives and the lives of the ones we love, but we also know the consequences of failure: of what happens when the NHS isn't there for us when we need it. That is why we cannot afford to fail.

This Plan is a call to action. We need government, business and civil society to come together and mobilise their efforts behind our Plan – not just for the NHS, but for our national health. So much of what determines our health and wellbeing has little to do with the health service. The roots of sickness too often lie in poverty, poor housing, poor education, poor work and poor access to the things that make life worth living like culture, sport and recreation. We cannot continue to accept a Britain where health is determined by wealth, where your postcode matters more than your potential and where deprivation dictates your diagnosis. Together, we can be the generation that closes the gap in healthy life expectancy so that everyone can live well for longer.

To succeed, we need to defeat the cynicism that says that 'nothing ever changes', that 'they're all the same' and that 'the NHS cannot be reformed'.

The reason we know we can deliver the change offered by this Plan is because it is built on the success of those who are already showing us what the future looks like. We have toured the length and breadth of the country and scouted the world for the best examples of innovation and reform. If Australia can effectively serve communities living in the remote outback, we can meet the needs of people living in rural and coastal England. If Brazil can go door to door with community health teams to prevent ill health, so can we. If South Korea are already running AI-enabled hospitals, why aren't we?

We know we can build the neighbourhood health service, because teams in Cornwall, Camden and Northumbia are already showing us how to do it. We know we can lead the world in life sciences and medical technology because the UK is already pioneering modern medicine, leading the charge on using gene editing as a cure for blood disorders like sickle cell disease. We know there is an appetite to shift to prevention because supermarkets are willing us to support them and the public are demanding access to innovative weight-loss drugs.

We will take the best of the NHS to the rest of the NHS and we will apply the best examples of innovation from around the world to the benefit of millions of people here at home.

The science is on our side, with genomics, artificial intelligence, machine learning and big data offering us the potential to predict and prevent illness and personalise treatment. This Plan will unlock that potential, marrying the very best of British science and innovation with a reformed NHS.

Above all else, we will give power to the patient. For too long, healthcare in our country has been based on a model that says 'the NHS knows best' and 'you wait, we decide, you receive'. In a world of smartphones and same-day delivery, where

consumer services are designed around the customer, patients don't just want a service from the NHS, we want a say. We don't want the same as everyone else, we want care that meets our individual needs.

Equality does not mean uniformity, it means that every person receives the right care for them, not just what the system dictates is right for everyone.

This Plan will give you real choices, faster responses, and a say in how your care is delivered and where. It will fulfil Nye Bevan's commitment in 1948 that the NHS would put a megaphone to the mouth of every patient and make sure that the advantages enjoyed by the privileged few are available to all.

We know that you, the British people, are counting on us to make sure that the NHS not only survives, but thrives. We are determined not to let you down.

Delivering this Plan will not be easy, but neither was the creation of the National Health Service. If we succeed, we will be able to say with pride, echoed through the remaining decades of this century, that we were the generation that built an NHS fit for the future and a fairer Britain, where everyone lives well for longer.

Let's get to it.

The Rt Hon Wes Streeting MP

Secretary of State for Health and Social Care

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E03381504
978-1-5286-5807-2