NHS Confederation

Briefing

Ten-Year Health Plan: what you need to know

This briefing provides healthcare leaders with an at-a-glance view of the plan's key takeaways and offers the NHS Confederation's unique analysis on the detail.

It also sets out how we, as the membership body for the whole healthcare system in England, will be supporting members with the journey ahead.

July 2025

Key points

- The Ten-Year Health Plan is a landmark moment for the NHS and wider health and care system. The plan commits to key changes to deliver the government's three shifts. These shifts will be crucial for both the NHS and patients, as they should reduce demand on hospitals and NHS staff, reduce waiting times and save taxpayers' money, delivering high-quality healthcare without taking up an ever-growing share of national wealth.

- There is much to welcome in the plan, which the NHS Confederation has been calling for on behalf of healthcare leaders. This includes:

    - reforming the NHS operating model
    - overhauling the capital regime
    - introducing new public-private partnership models
    - moving to outcomes-based and capitated payment mechanisms
    - reviewing the Carr-Hill formula for general practice
    - fundamentally reforming the dental contract
    - supporting workforce development
    - strengthening NHS and strategic authority collaboration to improve local growth.

- These are all much-needed national changes that will empower local staff to deliver change – we applaud the plan's commitment to these policy measures. This is the right direction of travel. The challenge now is delivering it.

- Our members look forward to working with the government to develop the next level of detail on delivery, including in the upcoming operational planning guidance and subsequent plans, including the Long Term Workforce Plan and mental health and cancer plans.

Overview: the plan in brief

- **Analogue to digital**: The plan commits to expanding the use of digital, technology and innovation, including establishing the NHS App as the front door for all healthcare services, improving efficiency to help address rising demand for services. will be able to access their health data via a single patient record, enabling them to become self-managers of their own care and ultimately to live healthier lives. Patients and staff need to be supported to make use of these tools and patient choice will remain an important principle. Capital funding for infrastructure and IT remains key to delivery.

- **Treatment to prevention:** The plan outlines action on social, economic and commercial determinants of health to half the gap in healthy life expectancy between the richest and poorest regions. It aims to empower the public, politicians and professionals to make a shift to a preventative model of physical and mental health a reality. A more preventative model of care delivered at neighbourhood level, and the enhanced role of strategic authorities, will support the development of cross-sector partnerships that are rooted in communities, supported by pooled budgets.

- **Hospital to community:** The Darzi review revealed the stark need to rebalance more NHS funding to primary, community and other settings outside of hospitals. While we welcome the plan's explicit recognition of this need, the timeframe envisaged (by 2035, rather than the end of this parliament) is longer than hoped for. The share of expenditure on hospital care will fall over the next three to four years with proportionally greater investment in out-of-hospital care, including neighbourhood health centres. The shift, over time, from block payments to Year of Care Payments is a welcome change, offering hope that community service savings can be reinvested locally.

- **Establishing a Neighbourhood Health Service:** At the heart of the plan is the establishment of a neighbourhood health service – expansion of burgeoning integrated, multi-professional teams working in local communities and often co-located. This will help deliver a model of care that is preventative and better supports those most in need, including those with long-term conditions. We hope the planning process will ensure the NHS can meet added demand by bringing primary, community and allied services together under one roof. However, questions remain about the funding to deliver neighbourhood health centres (NHCs).

- **Operating model**: The plan commits to reform the NHS operating model to devolve to and empower local leaders and communities, which offers significant freedoms for the highest performers. Provider leaders will be able to become a new version of more empowered foundation trusts (FTs) and eventually become integrated health organisations (IHOs), which will hold outcomes-based contracts for a local population. Closer collaboration with local government, aligned planning cycles, and co-terminosity will be vital for supporting integration. Integrated care boards (ICBs) will become even more significant institutions, playing a central role in shaping the market.

- **Context:** The plan is the result of engagement across the sector over the past nine months. The process has included over 650 events, 1,600 organisation responses and more than 270,000 contributions to the Change NHS portal overall, comprising one of the biggest national conversations about the future of the NHS since its birth. This government has shown it is committed to both recovery and long-term transformation.

Analysis

There is much to welcome in the Ten-Year Health Plan. The NHS Confederation and our members strongly believe the three shifts and the policy enablers underpinning them hold the key to resetting the NHS. The plan includes many policy proposals we have been calling for on behalf of NHS leaders. These include reforming the NHS operating model, overhauling the capital regime, introducing new public-private partnership models, moving to outcomes-based and capitated payment mechanisms, fundamentally reforming the dental contract, ending annual deficit plans, supporting workforce development and strengthening NHS and strategic authority collaboration to improve local growth. We applaud the plan for committing to these policy measures.

At the heart of the plan is a **new NHS operating model** which devolves and empowers local leaders and communities, which we have long called for. Provider leaders will grasp the opportunity to become foundation trusts (FTs) within the new, empowered regime, with a renewed focuses on partnership and improving population health alongside operational and financial performance.

The move towards a **plurality of providers** is another significant opportunity for our members, as is the ability to eventually become **integrated health organisations (IHOs)** which hold outcomes-based contracts for a local population. Integrated care boards (ICBs) will become even more significant institutions, playing a central role in shaping the market. But providers and ICBs will need support to develop the capabilities needed to take on these new roles. There also needs to be a route for at-scale primary care providers to become IHOs, which the current restriction of only NHS organisations could hinder.

The commitment to hospitals taking up a **smaller share of the NHS's total spend** in future is essential to putting the NHS on a sustainable footing. There are clear and aligned policy measures to help achieve this:

- redeploying staff to primary and community settings through placements and new practice models
- 24/7 mental health neighbourhood pilots to bolster out-of-hospital services
- reforming financial flows, with outcomes-based and capitated contracts, including eventually integrated health organisations taking on population budgets.

Although the 2035 target is beyond this government's current term, the commitment to shifting investment towards neighbourhood health services in the first three to four years is a step in the right direction.

The plan outlines action on the **social, economic and commercial determinants of health** to empower the public, politicians and professionals to make a shift to a preventative model of physical and mental health a reality. A more preventative model of care delivered at neighbourhood level and the enhanced role of strategic authorities will support the development of cross-sector partnerships that are rooted in communities, supported by pooled budgets. The new peer-review mechanism for accountability on public health spending is welcome. Our work over the past two years shows how systems and providers

are excited about developing new payment models but need support from central government and ministers to experiment.

The neighbourhood health service will help to **move care into the community** and give patients a better service. Many of our members are already developing neighbourhood health care, such as Dorset and Derbyshire. Ideally these neighbourhood health services will have modern estates for their health hubs, providing integrated health services under one roof for local communities. Existing examples bring together services such as general practice, pharmacy, mental healthcare, community diagnostic centres.

Reducing elective care waits, building neighbourhood health centres (NHCs) and investing in new equipment and technology will require **sustained capital investment** (and to get better value out of revenue spending). The plan delivers many measures we have called for to overhaul the capital regime to get better value for public money. However, welcome earned autonomy in the form of new capital freedoms for foundation trusts must not lead to acute capital spending squeezing out investment in primary and community care within the limited overall capital spending envelope (CDEL).

It is welcome that, following on from the Ten-Year Infrastructure Strategy, the government will use public-private partnerships to assist in building the new neighbourhood health centres. At £1 billion made available for the total programme, however, this falls short of the money needed. We look forward to working with government to help shape and deliver the National Neighbourhood Implementation Programme.

Achieving a digital-first NHS will require sustained **rapid evolution of infrastructure and IT systems**. The expansion of the NHS App and its AI-powered features – such as My Companion and My Choices – will offer people greater choice and control over care, with improved access and more personalised care. The integration of primary care, acute care, and mental health services into the App is a significant step forward. It is encouraging that the plan recognises the importance of getting the basics right – particularly around data sharing, quality, and interoperability.

NHS leaders will welcome the **commitment to invest in AI infrastructure,** including the development of a strategic AI roadmap, with clear ethical and governance frameworks for AI, alongside staff training. The ambition to implement a single patient record (SPR) promises better-coordinated and personalised care, population health management, early intervention, and patient empowerment. However, electronic patient records, the Federated Data Platform and cybersecurity were **notable for their absence**. A Single National Formulary for medicines should reduce variation, speed up access to effective treatments, and free up local staff time to deliver change. However, careful management is needed to avoid bottlenecks and ensure frontline insights shape decisions.

It is positive that the Secretary of State has acknowledged that the Ten-Year Plan will not succeed without a proper plan for the **central role of social care** in our neighbourhoods caring for our families and elders. We look forward to supporting our social care colleagues in informing and responding to the work now being undertaken by Baroness Casey.

We welcome the stronger role for the public in **shaping and measuring care quality**, and in driving transparency to support informed choices and to inform how services are planned, delivered and improved. We hope that the reintroduction of the National Quality Board (NQB) will provide stronger leadership on quality moving forward, supported by a strong regulating body.

The NHS faces an inflection point. For over a decade, levels of funding and staff have struggled to keep up with demand. The public's satisfaction in the NHS is at an all-time low. This Ten-Year Health Plan sets out a vision to address the structural causes of this and should allow local leaders to build on existing work to deliver it. Many of the changes will take time and sustained commitment across multiple partners to deliver across the ten years of the plan and some will involve more specific delivery plans in due course. System leaders welcome the opportunity to co-develop these.

While recovery is an urgent priority, steps towards transformation need to be made from day one. We look forward to working with government to meaningfully drive forward the envisaged changes and to feed into subsequent plans, including the Long Term Workforce Plan and mental health and cancer plans. The vision is the right one, the challenge now is the delivery.

The plan in detail

Key takeaways from the plan's main chapters.

Introduction: It's change or bust – we choose change

- The Darzi review diagnosed the issues facing the NHS. The government has recognised that the current model is no longer fit for purpose and the NHS's founding principles – a taxpayer-funded, free at the point of need – are under threat. The Ten-Year Health Plan seeks to reinvent the NHS through transformational change to guarantee its future sustainability. The plan's ambition is to put power in patients' hands, empowering them to control their care.
- The plan will deliver change through three shifts: from hospital to community, treatment to prevention and analogue to digital. It aims to deliver the core principles and values of the NHS, but with enhanced partnership with a wider network of technology, life sciences, local government and third sector organisations to improve the nation's health. There is a strong focus on addressing class divides in healthcare.
- The plan identifies four structural challenges facing the future healthcare:
    - an ageing population living with multiple health conditions demands greater integration of services
    - changes in illness require greater continuity for those with long-term conditions
    - higher public expectations require rapid digitisation of services and enabling the public with more choice
    - increases in cost require a different solution to health spending taking up an increasing share of national wealth, through a value-based approach that delivers better value to taxpayers.

From hospital to community: the Neighbourhood Health Service, designed around you

The plan intends to end 'hospital by default' and sets out the Neighbourhood Health Service as the alternative. Neighbourhoods, multi-disciplinary and multi-provider teams working in local communities and often co-located, should end fragmentation and 'one size fits all' care. By 2035, the plan intends for most outpatient care to happen outside of hospitals. New neighbourhood health centres (NHCs), housing and co-locating neighbourhood teams, will be rolled out to bring tests, post-operative care, nursing and mental health teams closer to people's homes.

Building on the recent neighbourhood health guidance, the plan outlines the preventative principles 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.

The plan outlines the components to deliver the shift to neighbourhood care:

- **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. NHCs will be open at least 12 hours a day and six days a week.
- **Shift the pattern of health spending**, with the share of expenditure on hospital care falling and proportionally greater investment in out-of-hospital care. This shift in investment will be delivered over the next three to four years as local areas build and expand their neighbourhood health services. These centres can streamline patient access to services including general practice, dentistry, social care and employment support.
- **Redesign the Carr-Hill formula** to improve the allocation of primary care funding to address health inequalities, topped up by funds reallocated from system deficit support. This will reduce the impact of the inverse care rule, as the formula current seeing GP surgeries serving deprived parts of England receive on average 9.8 per cent less funding per needs-adjusted patient than practices in more affluent areas.
- **End the 8am scramble by training thousands more GPs** and building online advice into the NHS App. People will be able to get same-day GP appointments. As increasing GP training will take several years, the plan commits to short-term retention measures to ensure the sector remains stable as the new trainees qualify, although lacking further detail.
- **Review staff and skill mixes in integrated neighbourhood teams** through a new ten-year workforce plan due out later this year. The workforce plan will aim to address holistic care needs, including building pharmacy, dentistry, social care, mental health and local authority staff into neighbourhood hubs, as well as the need to upskill all staff in AI and data to match the technological goals of the report.
- **New contracts for neighbourhood health** to be commissioned on top of core GP contracts. The single neighbourhood providers contract maps onto the primary care network (PCN) model of 30-50,000 patients, while the second type, 'multi-neighbourhood providers' will be used to cover populations of 250,000 plus. The government expects to see at-scale providers, including primary care provider collaboratives and federations, taking on this contract and expanding their ability to support general practice to establish strong infrastructure and deliver at scale interventions using population health data. This new contract also supports areas which have chosen vertical integration models to contract acute, community or mental health trusts to coordinate and deliver neighbourhood health.
- **Preserve the partnership model in areas where it works well**, with alternative options available and at-scale models encouraged.
- **Ensure 95 per cent of people with complex needs have an agreed care plan by 2027** to support them to be active participants in their own care**.** The NHS App will allow patients to book appointments, communicate with professionals, receive advice, draft or view their care plan and self-refer to local tests and services.

- **Double the number of people offered a personal health budget (PHB)** by 2028 to 2029, offer one million people a PHB by 2030, and ensuring it is a universal offer for all who would benefit by 2035.
- **Empower neighbourhood teams with access to patient data** to deliver proactive, coordinated care. By 2035, wearables and remote monitoring will be standard in preventative, chronic and post-acute care, and all patients will have access to these technologies as part of routine NHS services delivered in the community.
- **Increase delivery of hospital-at-home functions by 2028,** including making use of home monitoring using wearables as a standard part of care and with the ultimate goal of virtual hospitals, with advice and guidance that connect patients and GPs to consultants through a national virtual pool by 2035. Virtual hospitals will further break down barriers at the primary/secondary care interface while supporting patients to stay well at home. These functions are likely to be delivered by at-scale primary care providers, using multi-disciplinary teams to work with patients to manage long-term conditions and recover from acute interventions.
- **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**, improving children's oral health and increasing the number of NHS dentists working and introducing tie-ins for those trained in the NHS.
- **Reform the dental contract from 2026/27**, matching funding to activity costs and reducing low-value activity. This commitment will be of significant benefit to our dental members, who have shared their concerns over the current unsustainable funding of the dental contract, which has driven the decline of access and the growth in dental deserts. These reforms have the potential to restabilise NHS dentistry and support increasing NHS capacity in practices, ultimately benefiting patients.
- **Expand same-day emergency care services** and co-located urgent treatment centres. Patients will be able to book into the most appropriate urgent care service for them via 111 or the NHS App before attending, by 2028.
- **Link paramedics to consultants remotely** through new technology, allowing for fewer ambulance conveyances via an expansion of See and Treat.
- **Develop more dedicated mental health emergency departments (MHEDs)** with up to £120 million, co-located (or close to) 50 per cent of existing type 1 A&E units.
- **Continue to transform community mental health services** into 24/7 neighbourhood care models, building on the six existing pilots, and 100 per cent coverage of assertive outreach treatment support for those with severe mental illness.
- **Introduce national procurement for a new platform for AI,** which will be available to all NHS provider organisations.

From analogue to digital: power in your hands

Digital transformation is fundamental enabler of the shifts from hospital to community care, and from treatment to prevention. In ten years' time, the NHS aims to become the most AI-enabled healthcare system in the world, leveraging cutting-edge technology, robust data infrastructure and innovative solutions to deliver more accessible, timely and high-quality care.

The NHS App – the digital front door

The primary vehicle for this transformation is the expansion of the NHS App, which will enable patients to:

- **Access a personal health account**: A patient-owned hub for health data, including self-testing results, NHS-approved wearable data (such as smartwatches), and eventually a comprehensive single patient record (SPR).
- **Manage appointments**: Book, modify and manage appointments with GPs and other services more easily and efficiently.
- **Receive information and notifications**: Get reminders for appointments, test results, vaccination alerts, health checks and provider performance data to support informed care choices. The app will also support digital patient-initiated follow-up (PIFU).
- **Use enhanced AI features**: Tools like My Companion (AI-powered advice), My Choices (service comparison and selection) and virtual mental health support.
- **Engage in preventative care**: Integration with digital health checks for over-40s, linking results with personalised AI tools for a holistic health journey.
- **Participate in clinical trials:** A new feature will allow users to search for and enrol in trials, reducing bureaucracy and increasing participation.
- **Enable data access and interoperability**: With patient consent, data will be securely shared across NHS-accredited providers to support coordinated care.
- **Access a digital 'Red Book':** A modernised, app-based version of the child health record, offering centralised access to developmental tracking, advice and support.
- **Mental health integration**: The app will support self-referral to talking therapies via the 'My Specialist' tool. For mild to moderate needs, virtual therapists will offer 24/7 support. For those with severe mental illness, remote monitoring could enable proactive crisis response.

These features have real potential to improve access and support more personalised care, by enhancing and leading a shift toward a more connected, efficient and responsive health service.

The single patient record

Through new legislation, a single patient record (SPR) will be introduced and accessible to patients from 2028. The SPR will:

- **Consolidate patient information** by bringing together a patient's health information, test results and letters into one unified and accessible place.
- **Allow coordinated care** by providing a comprehensive view of a patient's health history and when fully implemented, the SPR will offer real-time data sharing across different care settings, including primary, secondary and community care. This means that relevant healthcare professionals will have immediate access to the most up-to-date information, regardless of where the patient is being treated.
- **Enable improved population health management**, allowing for better understanding of health trends and needs across communities, earlier detection of health issues and more timely interventions.
- **Be interoperable between various NHS silos** and data systems, a critical step in overcoming the current fragmentation of patient data. It is closely linked to the

Federated Data Platform, which will serve as the national data infrastructure to connect and analyse data from multiple sources, including the SPR.

Wearables and virtual wards

The plan commits to expanding hospital-at-home programmes in the first three years and expanding National Institute of Clinical Excellence's (NICE) digital programme to consider more medical-grade wearables.

- Wearables will be 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. Wearables will monitor vital signs and biomarkers, providing alerts to care teams before issues escalate. This will be fed through the NHS App, which will act as a central hub for patients to view and share their health data with neighbourhood teams
- Virtual wards will be supported by wearables and biosensors, which will feed real-time data into the NHS App and the SPR. By 2028, remote monitoring for cardiovascular disease will be standard NHS care.
- Integrated care systems (ICSs) will be expected to plan virtual ward capacity in coordination with ambulance services and NHS 111, and population health data will be used to identify frequent A&E users and offer targeted virtual support.
- To ensure digital transformation is inclusive and equitable, the NHS will:
    - provide wearables for free in areas with high deprivation or health need
    - ensure the NHS App and digital tools are accessible, including support for
    - translation, screen readers, and British Sign Language
    - partner with libraries and community organisations to help people get set up on the NHS App
    - recruit App Ambassadors to support uptake and usage in underserved communities.

From sickness to prevention: power to make the healthy choice

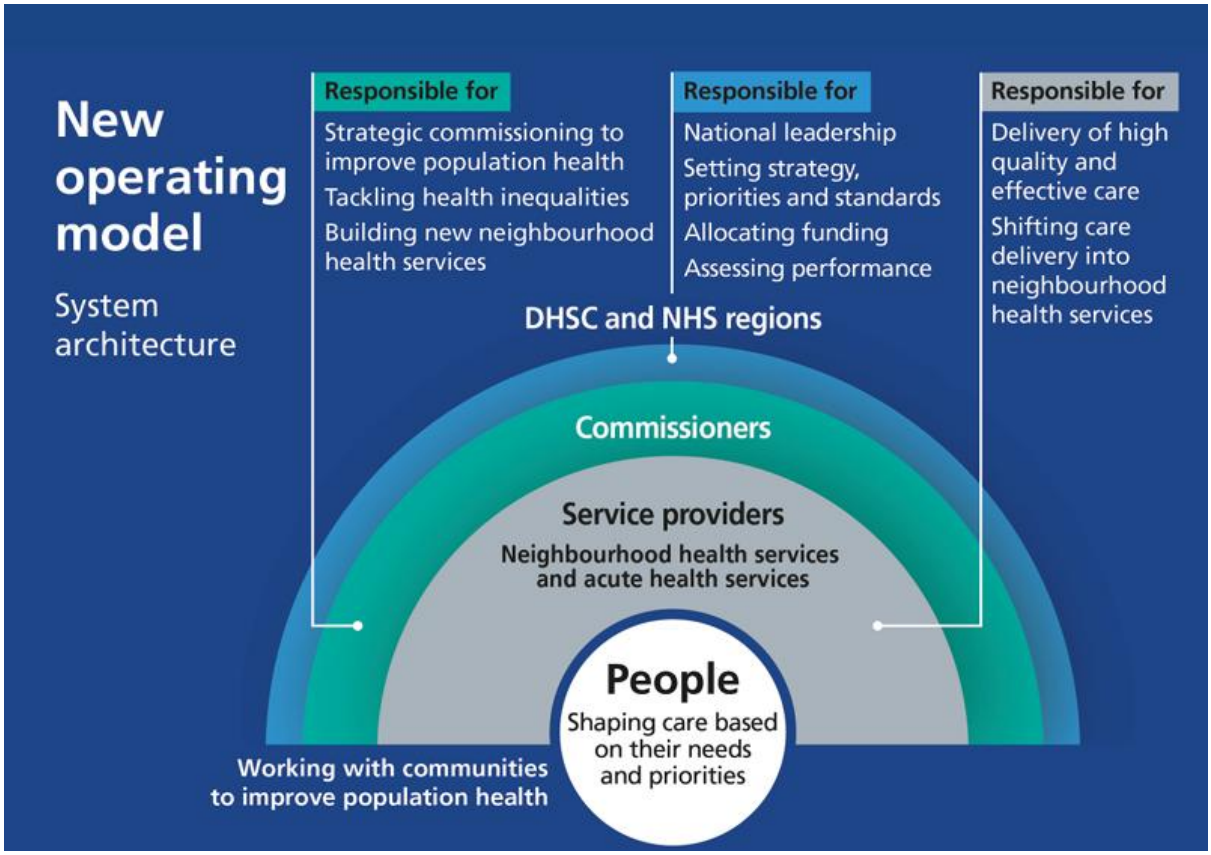
The plan outlines action on social, economic and commercial determinants of health to halve the gap in healthy life expectancy between the richest and poorest regions, aiming to empower the public, politicians and professionals to make a shift to a preventative model of physical and mental health a reality. There is a real-terms increase in the public health grant for 2025 to 2026 at the last Budget, and a nearly £4 billion investment in local health outcomes. Changes to support a move to a preventative model of care include:

- **Ban single use disposable vapes** and halt advertising and sponsorship of vapes and other nicotine products, through the tobacco and vapes bill. The bill will strengthen existing policies on reducing harm from smoking and progress towards a smoke-free society.
- **Tackle the obesity epidemic** in children and adults by:
    - restricting junk food advertising targeted at children
    - banning the sale of high caffeine energy drinks to under 16-year-olds
    - ensuring all schools provide healthy, nutritious food
    - supporting the poorest families and tackling child poverty by restoring the value of the Healthy Stat Scheme from 2026 to 2027

    - expanding free school meals to all children with a parent in receipt of universal credit
    - uplifting the Soft Drinks Industry Levy (SDIL), ending the exemption for milk-based drinks and reducing the minimum sugar thresholds.
    - introducing mandatory healthy food sales reporting for all large companies in the food sector
    - delivering innovative weight loss services and treatments, as well as working to increase physical activity.

- **Introduce a mandatory requirement for alcoholic drinks to display consistent nutritional information** and health warning messages to tackle harmful alcohol consumption.
- **Reduce air pollution from transport** by creating more charging infrastructure to support zero emission vehicle mandate.
- **Requiring social landlords to act promptly on damp and mould**, which can cause respiratory illnesses, improving the standard of rented homes.
- **Expanding health and growth accelerators**, if successful, and continue Work Well, as well the piloting of employment advisers and work coaches into the neighbourhood service.
- **Roll out of mental health support teams (MHSTs)** in schools and colleges by 2029/30, as committed to in Labour's 2024 manifesto.
- **Develop Young Futures hubs** so that children and young people can more easily access mental health support and help ensure there is no wrong door when seeking help.
- **Commitment to work with local authorities** to ensure that children and young people in residential care, with complex mental health needs receive appropriate treatment and support and so avoiding hospital admissions and emergency department visits.
- **Initiate prevention accelerators** in selected ICBs using community-led methods to tackle variation in high-impact cardiovascular disease and diabetes interventions.
- **Use genomics and predictive analysis supported by AI to improve early detection of disease** and enable personalised prevention and treatment.
- **Increase childhood immunisation rates** and reduce current inequalities by working will alongside local government, civil society and community groups to support the public trust in vaccines.
- **Increase access and uptake of cancer screening services**, with further detail set out in the upcoming cancer plan.

A devolved and diverse NHS: a new operating model



Source: Fit For the Future: 10 Year Health Plan for England. UK government

To mobilise change, the plan commits to a new NHS operating model which will deliver a more diverse and devolved health service. The operating model will address a lack of clarity in the system about roles and purpose, establishing clear priorities, mandating fewer targets and equipping local leaders to improve population outcomes.

The new operating model will include:

- **A smaller, more agile national centre**, focused on developing strategic frameworks and building partnerships.
- **Improved clarity on roles and purpose,** by establishing clear priorities, mandating fewer targets and equipping local leaders to improve population outcomes.
- **A new system of earned autonomy**, with a robust success-failure regime. The highest performers will be given new freedoms to innovate. Linked to this, pay will be tied to performance.
- **A move towards 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 as drivers of performance.** Providers and commissioners will be measured against clear metrics, ranked on performance and that information will be provided to patients, with priority given to patient reported outcomes, experience and feedback.

Reinventing the centre

- **Combining the headquarters of NHS England and the Department of Health and Social Care**. The process of abolishing NHSE will be complete within the next two years. By 2027, the combined headcount will fall by 50 per cent, with savings redirected to local systems.
- **Introduce proportionate and streamlined regulation and oversight**, overcoming a culture of bureaucracy that disempowers local leaders.
- **Make the NHS the best possible partner** by working closely with the private sector, local government, employers, VCSE organisations and trade unions and by creating the conditions for entrepreneurship.
- **Retain NHS regions**, responsible for performance management and oversight of providers alongside the national headquarters. Working with integrated care board (ICBs), regions 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

- **Reset ICBs as strategic commissioners** of local health services, responsible for all but the most specialised commissioning using multi-year budgets. They will be responsible for allocating funding to improve their population's health, reduce health inequalities and improve access to consistently high-quality services. 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.
- **Develop and deliver a national programme to support ICB capability, including a new commissioning framework**. This will inform future assessments of ICB maturity. ICBs will need excellent analytical capability; strong strategy function; strong partnership working and an understanding of value-based healthcare; user involvement functions and intelligent healthcare payer understanding, to support a focus on value for money, the development of novel payment mechanisms and oversight of strategic resource allocation.
- **Change ICB governance**, removing provider organisations from ICB boards and replacing local authority representatives with strategic authority mayors.
- **Close commissioning support units.**
- **Empower ICBs 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.

Earned autonomy for providers

- **Local providers performing well will have greater autonomy** and flexibility to develop services free from central control, with the ambition for autonomy to become the norm by 2035. 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** is needed to address poor performance. 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.
- **Government will focus on addressing underperformance in the areas with the worst health outcomes**, such as rural and coastal communities, with regions drawing up action plans for providers in these areas in 2025 to 2026. Issues will be resolved by the centre in three main ways: by supporting reconfiguration, by replacing the leadership team or by placing a failing provider into administration, so it can be taken over by another
- **Providers will be supported to become higher performing, including through connection to national expertise, local expertise, peer review and 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.
- **The NHS foundation trust (FT) model will be reinvigorated** and reinvented for a modern, integrated health system. Inclusion criteria will include evidence of partnership working and improving population health outcomes, as well as excellent delivery on waiting times, access, quality of care and financial management and higher levels of productivity than their peers.
- **FT flexibilities will be restored** to existing FTs whose performance on outcomes, access, quality and financial sustainability merits it from this year. A new wave of FTs will be authorised in 2026, with the ambition for every NHS provider to be an FT by 2035. The authorisation process will be led by a new function within the DHSC and overseen by a panel of independent members. ICBs and regions will also play a role in this process.
- **FTs will have freedoms over performance and delivery issues, to borrow for capital investment and to control board composition** (where NHS trust boards are fixed under secondary legislation), the ability to retain and reinvest surpluses, and FTs will no longer be required to have governors, with the expectation of introducing more dynamic arrangements to take account of patient, staff and stakeholder insight.
- **The very best NHS FTs can become integrated health organisations (IHO),** holding the whole health budget for a local population. These will be foundation trusts that have shown an ability to meet core standards, improve population health, form partnerships with others and remain financially sustainable over time. If they deliver high-quality care efficiently, they can retain savings to reinvest in patient care, new capital projects, digital transformations, partnerships, or support for promising start-ups and SMEs. Patient outcomes will be secured through long-term, capitation-based contracts. As strategic commissioners, ICBs will play an active role and regions will lead a rigorous authorisation process. A small number of IHOs will be designated in 2026, with a view to them being operational in 2027. Only NHS organisations can

become IHOs, but they will be free to contract with other service providers, within and outside the NHS. The aim of this approach is to overcome the challenge that, in the NHS, interventions by one provider (such as a GP) accrues savings and benefits in another (such as a hospital). This means risk and reward is unbalanced, and particularly disincentivises prevention.

A new plurality of provision

- **The government 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, for example, GPs running hospitals, nurses leading neighbourhood providers or acute trusts running community services.
- **Private sector capacity will continue to be used to treat NHS patients** where it is available, and partnerships with private providers will be explored to expand NHS provision in the most disadvantaged areas. However, ICBs will be expected to monitor independent sector 'gaming' of the national payment tariff to focus on the most profitable activity, and act decisively on any issues as part of a wider duty to safeguard and ensure value for taxpayer money.

A new partnership with local government

- **ICBs will be expected to align their boundaries with strategic authorities wherever feasibly possible**.
- **Neighbourhood health plans 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. Integrated care partnerships will be abolished to create clarity. The government will 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.
- **Strategic authorities will be allowed to become prevention demonstrators, pooling budgets and reprofile public service spending** towards prevention. This will be permitted for those strategic authorities that are most advanced at improving population health outcomes demonstrators, starting with Greater Manchester. These partnerships between the NHS, local authorities and strategic authorities will trial innovative prevention approaches, supported by mayoral powers, genomics and data. Selected areas will gain greater autonomy, including pooled budgets and reprofiled public spending focused on prevention.
- **All upper-tier local authorities will undergo a public health grant peer review** every five years, with findings shaping local plans, from 2026. This will be supported by the Local Government Association and other improvement experts to drive improvement and share best practice.
- **The Better Care Fund will be reformed to provide consistent, joint funding for key services that require full integration** – such as hospital discharge, intermediate care, rehabilitation and reablement, from 2026/27.

Pushing power out to patients and the public

- **A new Choice Charter will be rolled out** progressively across England, starting in the areas of highest health need. It will have five new mechanisms.
    1) It will make NHS funding flows increasingly sensitive to patient voice, choice and feedback.
    2) Patients will have new powers over how they use NHS resources through significant expansion of personal health budgets.
    3) Patients will be able to exercise greater control over their health and care through the NHS App.
    4) Over time and where safe and clinically appropriate, more patients will be able to directly refer themselves to more diagnostic services.
    5) Where patients need elective treatment, they will have a choice of different providers.

A new transparency of quality of care

The plan aims to improve the quality of care by making "the NHS the most transparent healthcare system in the world." This will be achieved by:

- putting patient choice, voice and feedback at the heart of how quality is defined and measured
- strengthening accountability and introducing new incentives for high quality care
- streamlining and establishing stronger and clearer leadership within the regulatory environment.

Greater patient transparency

- **Improve transparency by giving the public access to a broader range of quality measures** from providers, with ease-of-access and understanding the priorities. Key changes include:
    - NHS provider performance segments will be published as part of the NHS Oversight Framework – from segment 1 (high performing) to 4 (failing)
    - from summer 2025, easy-to-understand league tables will be introduced and updated quarterly
    - quality and access information will be available based on the areas people live and identify with – this includes a requirement for providers and ICBs to routinely publish information using local authority boundaries
    - quality data will be available to patients in the NHS App via the My Choices tool, allowing them to compare providers based on length of wait, patient ratings and clinical outcomes.

Patient feedback and choice are core tenets of the government's approach to quality

- **Give patients more ways to provide feedback on their experience** of care, helping others make more informed choices about which provider they want to treat them:
    - A comprehensive set of patient reported outcome measures (PROMs) and patient reported experience measures (PREMs) will be developed and published by 2029.
    - Patients will be able to provide direct feedback on their care via the NHS App.

- **Directly link patient experience to provider accountability and incentives** via patient power payments. The new pilot scheme will enable patients to financially recognise and reward high quality care or hold back payment when they perceive care to have been sub-standard.
- **Improve how patients experience the NHS complaints process** and clinical negligence claims, through:
    - updates to the complaints regulations
    - greater use of AI tools
    - shorter timeframes for the CQC to take legal action against a provider
    - expert advice from David Lock KC on improving patients' experience of clinical negligence claims.
- **Integrate Healthwatch England** into DHSC and appoint a new national director of patient experience. The work of local Healthwatch bodies related to healthcare will be brought together with ICB and provider engagement functions.

Maternity care is a key priority for quality improvement

- **Set up a national, independent investigation into maternity and neonatal services**. The review will have two main outputs:
    - urgent reviews of up to ten trusts with specific issues by the end of this year
    - a systematic investigation of maternity and neonatal care, with national recommendations to drive improvement across England.
- **Establish a National Maternity and Neonatal Taskforce**, chaired by the Secretary of State, to inform the development of a new national maternity and neonatal action plan.

Clearer accountability and stronger incentives for high quality of care

- **Re-establish and reform the National Quality Board (NQB)** to serve as the single, authoritative voice on healthcare quality, which all other bodies, such as the royal colleges, will feed into. Dr Penny Dash's forthcoming report on patient safety – described by the plan as 'imminent' – will provide detailed recommendations on the role and responsibilities of the NQB. Its immediate priorities will be to:
    - develop a new ten-year quality strategy by March 2026
    - oversee the development of a series of 'Modern Service Frameworks', building on the legacy of the National Service Frameworks developed under the previous Labour government – the first set, due in 2026, will focus on CVD, mental health and frailty and dementia
    - develop a range of clinically credible outcome measures to better assess clinical quality, supporting the move away from activity-based metrics.

- **Incentivise high-quality care by giving NHS providers new flexibilities to make additional financial payments to clinical teams** with high clinical outcomes and patient feedback or making improvements to care.

- **Require ICBs and NHS regions to identify services and/or providers delivering persistently poor quality care** within the next 12 months. Commissioners will be expected to act using their contractual levers, including bringing in a new provider or changing the leadership team.

A new and more data-led chapter for the Care Quality Commission (CQC)

In response to declining trust and confidence over the past six years, the CQC is now under new leadership and a major change programme is underway.

- **CQC will shift towards a new data-led model**, includes expanding the CQC's access to data, including via new statutory powers to access all NHS and publicly held datasets relating directly or indirectly to care quality.
- **CQC's operating model for inspections will be two-tiered**:
    - Rapid response inspections that look into acute concerns as soon as they emerge
    - Routinely planned inspections, generally on a three to five-year cycle.
- **A national AI-led warning system will be established** to help identify where quality issues are emerging to inform the accurate and timely deployment of rapid response inspections.
- **CQC will provide verbal feedback at the end of the inspection**, and written feedback within two days outlining any significant concerns to improve communication between CQC and NHS organisations following an inspection.

Streamlining the safety regulatory landscape

- **The Health Services Safety Investigations Body (HSSIB) will be integrated into the CQC**, where it will continue to operate as a discrete unit and retain its independence for providers.
- **The Patient Safety Commissioner (PSC) will be hosted within the MHRA.**

An NHS workforce fit for the future

The plan aims to empower and support staff to deliver the three shifts, moving away from a culture of top-down diktat which has diminished staff voice and taken time from patient care. It also aims to reduce NHS sickness rates from 5.1 per cent currently – far higher than the average in the private sector – to the lowest recorded level in the NHS.

New ten-year workforce plan

- **Develop a new NHS workforce plan** over next six months with NHS leaders, unions and employers as part of the Ten-Year Plan implementation.

The NHS as an employer

- **Every 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.
- **AI will become every nurse's and doctor's trusted assistant** – saving them time and supporting them in decision-making.

Employment standards and the 'Big Conversation'

- **The government will develop a new set of staff standards**, working with the Social Partnership Forum, which will outline minimum standards for modern employment. The standards will be introduced in April 2026 and data will be published on them at the employer level every quarter.
- The government will maintain, update and reform employment contracts, working with trade unions and employers, and consider significant contractual changes that provide modern incentives and rewards for high quality and productive care.

Staff experience

- **The government 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.
- **The government will significantly reduce the need for expensive extra-contractual work,** with a focus on flexible work. Agency staffing will be eliminated 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.

Performance

- **Gives 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.
- **Introduces 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 14 patient expectations on timeliness of care or effective financial management.

Workforce supply education and training

- **Overhaul education and training curricula** with the aim of future-proofing the NHS workforce over the next three years.
- **Shift a greater proportion of staff into community and primary care compared to hospitals,** reversing the trend seen in the last 15 years.
- **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.
- **Create 1,000 new specialty training posts** over the next three years, with a focus on specialties where there is greatest need.

- **Accelerate the delivery of the recommendations of the Messenger review** of health and care leadership and establish a new College of Executive and Clinical Leadership to define and drive excellence.
- **Reorientate recruitment away from dependency on international recruitment** and towards its local communities to ensure sustainability in an era of global healthcare workforce shortages. The government's ambition is to reduce international recruitment to less than 10 per cent by 2035.
- **Create 2,000 more nursing apprenticeships** over the next three 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 reform

The plan aims to harness technology to create a new model of care in the NHS, aligning with the forthcoming Life Sciences Sector Plan and Modern Industrial Strategy. The plan's commitments look to address UK's poor track record in specifying, adopting and spreading innovations that will drive progress on strategic aims; limited incentives for innovation or entrepreneurial thinking and barriers to innovation and adoption and spread.

To embed innovation, the plan commits to establish regional health innovation zones to give health systems the permission and flexibility to be more radical and forward looking on innovation. This will start with two to three regions, with the ambition to scale over time.

Empowered by devolutionary freedom, the zones will bring together existing entities including 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 outcomes basis. Health innovation networks (HINS) and other existing innovation infrastructure (such as NIHR infrastructure) across the region will work with and support their regional innovation zones as key partners and enablers.

The plan identifies five transformative technologies ('Big Bets') in areas of competitive advantage to personalise care, improve outcomes, increase productivity and boost economic growth.

Big bet 1: In the NHS of 2035, your health data will flow seamlessly and securely

To unlock the untapped potential of NHS datasets, and more actively support organisations to access data for research, where it would derive value for the NHS, the plan commits to:

- **Launch the (recently announced) Health Data Research Service (HDRS)** in partnership with the Wellcome Trust, backed by up to £600 million of joint investment to make deidentified data available to scientists, research and entrepreneurs.
- **HDRS will put in place a range of agreements to make sure the NHS receives a fair deal** for providing access to data for approved research. The government will work with the public to develop the details of the plan and is clear that this initiative will not compromise on patient privacy.

Big bet 2: In the NHS of 2035, AI is each health professional's trusted assistant and will be seamlessly integrated into most clinical pathways, with generative AI tools widely adopted

- **Accelerate the roll out of AI tools** on the NHS, starting in 2027 with the roll out of validated AI diagnostic tools and AI administrative tools including AI-scribes (Ambient Voice Technology), NHS wide.
- **Deliver faster and at-scale real world evaluations of AI**, supported by faster access to data via the HDRS.
- **Review regulations in 2025 and publish a new regulatory framework in 2026** for medical devices, including AI, to bring new products to the NHS faster. The government will work with the MHRA to make the UK the fastest and safest place to regulate AI and software.
- **Invest in AI infrastructure within three years, including the development of an NHS AI strategic roadmap** to enable clear ethical and governance frameworks for AI.
- **Roll out a new AI upskilling programme** for the NHS workforce.

Big bet 3: In the NHS of 2035, your personalised health journey will begin at birth

To accelerate the adoption of new advances in genomics and predictive analytics:

- **Expand of 'Our Future Health'** to be the largest longitudinal health research cohort and clinical trials resource in the world.
- **Develop a unified genomic record through the NHS Genomic Medicine Service**, integrating patient genomic data with relevant clinical and diagnostic data in near real time.
- **Allow parents and guardians greater ability to oversee and coordinate their offspring's care remotely** through the 'My Children' tool, improving access to children and young people's services. The adoption of NHS numbers as a single identifier for all under-18s will allow education, health, and local authorities to better link their services together.

Big bet 4: By 2035 wearables will be standard in preventative, chronic and post-acute NHS treatment and all patients will have access to these technologies.

To harness the opportunities of wearable technologies:

- **Expand NICE's digital programmes** to consider more medical-grade wearables.
- **Enable citizens to integrate their data from smartwatches** and other devices with their single patient record.
- **Make remote monitoring for cardiovascular disease, using wearables and other devices a standard part of care** by 2028.
- **Launch trials for real- world evaluation and development of wearable technology** and provide devices for free in areas where health need and deprivation are highest.

Big bet 5: By 2035, robots will deliver care with unprecedented precision.

- Adopt robotic-assisted surgery as standard for an expanded range of procedures.
- Expand surgical robot adoption in line with NICE guidelines from 2026.

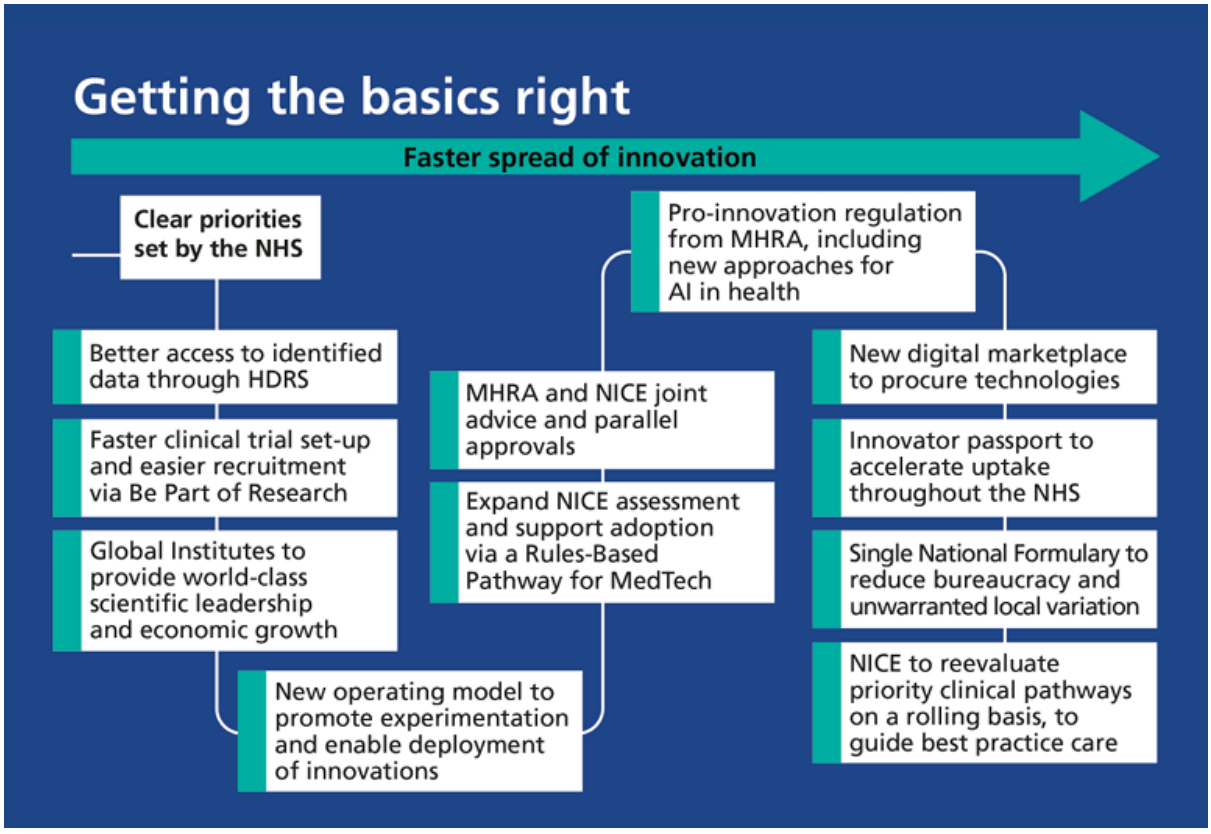
- Establish national registries for robotic surgery data to scale successful trials of assistive robotics from 2029.

Getting the foundations right to support medicines uptake and realise the potential of innovations

- **Realise the potential of innovation by**:
  - speeding up-clinical trials
  - future proofing the regulatory landscape
  - streamlining procurement, accelerating adoption and spread
  - introducing a new Single National Formulary for medicines.

- **Expand the remit for NICE technology appraisal process** to cover devices, diagnostics and digital products.
- **Introduce a more permissive operating model** that allows innovators to thrive, supported by a more streamlined centre focusing on the things best done once. Adoption of innovation will be a criterion for how providers and commissioners are judged under a new regime of earned autonomy.

Key commitments to encourage the faster spread of innovation include:



Source: Fit For the Future: 10 Year Health Plan for England. UK government

Productivity and a new financial foundation

The plan aims to 'bend the cost curve' through a relentless focus on delivering value-based healthcare over the next ten years, bringing down the cost of world-class healthcare making higher standards possible. It notes that today the NHS accounts for 38 per cent of day-to-

day government spending, rising to 40 per cent by the end of the parliament, an unsustainable growth that has not improved health outcomes.

The plan commits to two new reviews:

- **A review of productivity by Andy Haldane**, former chief economist at the Bank of England. This will contribute to 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.
- **A review of the rising legal costs of clinical negligence claims by David Lock KC** to provide expert advice, ahead of a review by the Department of Health and Social Care (DHSC) in the autumn.

New financial model and in-year planning

- **Publish a new financial framework** for the NHS later this year.
- **Provide public sector capital for equity stakes** in the start-ups that promise to best transform healthcare.
- **End the practice of providing additional funding** to cover commissioner and provider deficits. Deficit support funding will be phased out from financial year 2026 to 2027. If financial discipline does not become the norm across the NHS, they will take a new, stronger statutory approach to financial accountability, learning from how other parts of the public 133 sector, such as local government, manage overspending (i.e. as through legally capped budgets).
- **Expect most providers to generate a surplus by 2029 to 2030**, 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.
- **Set a three-year revenue and four-year capital settlement from financial year** 2026 to 2027 in the Spending Review.
- **Require all organisations to reserve at least 3 per cent of annual spend for onetime investments in service transformation**.

Changing the payment system

NHS England 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).
- **Begin intensive work with a small number of further advanced 'pioneer' systems** to implement notional Year of Care Payment, from financial year 2026 to 2027.
- **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.
- **Introduce new incentives for the best NHS leaders, clinicians and teams**.
- **Ask 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.

Capital investment

- **Introduce multi-year capital budgets**, set on a rolling five-year basis. They will also devolve 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.
- **Reform the approvals process with at most three approval levels on the very largest nationally significant schemes** (one provider level, one regional/national and one cross government). They expect to reduce by at least two to three months the time that a typical scheme spends going through central approvals, and for smaller schemes the reduction will be four to five months.
- **Enable new NHS foundation trusts (FTs) to progress larger self-financed schemes** if they are consistent with overall financial planning. 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.
- **Require new NHS FTs to set out capital spending plans** as part of the planning process. NHS England anticipates approval of these being automatic where spending is financed by operating activity (as opposed to drawing on the large and longstanding capital reserves).
- **Direct funding to tackle maintenance backlogs directly to all providers in line with the extent of their backlogs**. This leaves systems to focus on strategic capital. NHS England will also consult on reforms to public dividend capital charges.
- **Develop a business case for the use of public-private partnerships to develop neighbourhood health centres**, building on the Welsh Mutual Investment Model, ahead a final decision by the Budget 2025 in the autumn.

How we are supporting members

In the immediate term, we will be running sector-specific discussions to understand members' key priorities for implementation; alongside webinars focusing on the plan's key changes, implications for the sector and considerations around delivery. For more information, please contact Annie Bliss annie.bliss@nhsconfed.org

In the medium term, the plan refers to the establishment of its own self-financing improvement capability – drawing on the talent, innovation and energy of the best of the NHS. We plan to be at the heart of establishing and building this capability, bringing the improvement and transformation required to achieve the plan's ambitions into the mainstream business of organisations and systems.

Our national footprint and connections from the centre to the frontline enable us to support both implementation and improvement in local contexts and the scale and spread of best practice and innovation nationally. We will be contributing to the implementation of neighbourhood health, ensuring our members' voices continue to shape national policy.

Our range of bespoke leadership programmes, alongside our innovative improvement and peer learning solutions, place us in a unique position to support and empower leaders across all parts of the system, by providing a safe space to think, practical tools and the opportunity to connect on key challenges. Below is a summary of our leadership and improvement offers.

- **Leadership development:** Our systems thinking and leadership development programmes are designed to support leaders to develop their agency in navigating complexity, to connect, think differently, personally grow, and to drive innovative and sustainable change in service delivery across their organisations and communities.
- **Delivery models improvement support:** Working in partnership with the Q community we use our expertise to enhance our members' understanding of how they can practically deliver change within their system. Through a tailored service we help members carry out strategic analysis, convene and mobilise stakeholders, encourage peer-to-peer learning, and build leaders' confidence to deliver sustainable transformation through practical action planning to mobilise delivery.
- **Evolve Collaborative:** An offer to members for access to a state-of-the-art data analytics platform providing predictive forecasting bespoke to each trust and supported by learning communities of peers collaboratively problem solving and looking to provide better care.
- **Strategic commissioning:** Supporting ICBs to transition towards their new role as strategic commissioners through structured peer learning approaches to build understanding and embed change in their ICBs. A Strategic Commissioning Forum will help bring senior leaders together to understand their new responsibilities and ways of working, while a Population Health Management (PHM) Improvement Programme will seek to provide a framework through which digital and population health leads can shift their ICBs towards more data-driven commissioning.
- **Payment mechanism hands-on support:** We are working closely with the centre to support systems to develop and implement the new financial flows that will underpin

the delivery of neighbourhood health. This includes practical support to design new payment approaches and enabling peer learning across the country.

- **Neighbourhood health:** Our Community of Practice for neighbourhood health brings together leaders from across the country at Place, community provider and PCN levels in facilitated Action Learning Sets to jointly develop leadership skills and their local neighbourhood health programmes. This support sits alongside our programme of action research in partnership with Local Trust to explore community-led, hyperlocal approaches to health – funding and putting power in the hands of the people who know their neighbourhoods best to drive change and co-design solutions locally.
- **Peer learning and collaborative programmes:** Creating the space and inspiration to bring leaders together to learn, share, inspire and scale improvements. A tried and tested model, creating opportunities to work together on solutions, develop improvement and leadership approaches and connect with others. For instance, around improving the interface between services.

Our programmes are tailored to meet the specific needs of our stakeholders, ensuring they address the unique challenges faced by different sectors within the NHS. Our bespoke programmes are designed to cultivate essential leadership skills, such as values-based strategic decision-making at ICB level, effective team leadership and co-production skills, or supporting leaders to recognise their influence in improving quality and safety.

Aligned with key government shifts, such as the move towards prevention and community-based care, our programmes support leaders to navigate these changes and integrate services across care settings. Through collaboration with industry partners, we ensure that our leadership development initiatives are responsive to healthcare challenges and aligned with the NHS's ten-year vision for high-quality, sustainable care.

Visit our website or email us to access our member support forums, programmes, resources and more.

Appendix: Background

The Health and Social Care Secretary announced his intention to work with partners to produce a ten-year plan for health in September 2024, following the publication of the Darzi review. The independent investigation produced by Lord Darzi highlighted the need for 'fundamental reforms', that government have said will be set out in the plan, in order to build an NHS fit for the future. This echoed messaging from the Labour Party's election manifesto.

In October 2024, the Department for Health and Social Care (DHSC) and NHS England launched Change NHS - a consultation set up to seek views from the public, NHS staff and stakeholder organisations in the sector to inform the plan. Over a quarter of a million contributions were made via the online portal and at events and workshops across England. The government said this was 'the biggest ever conversation about the future of the NHS.'

In addition, 11 working groups were engaged to help shape the plan, with representatives from different stakeholder organisations. At the launch of the Change NHS in October, the Secretary of State made a point of saying he wanted to work with the sector as partners, not stakeholders, emphasising the desire for a more grown-up relationship.

The NHS Confederation has been highly active in helping to shape and inform this plan, including via private briefings, government and stakeholder engagements and member sessions, events (including numerous sessions at NHS ConfedExpo 2025), responding to the government's call for evidence, media stories, commentary and opinion pieces, parliamentary briefings, and products. Three or our staff members and over 70 of our members have been involved in the plan's working groups, with many holding deliberative events locally in their communities.

Elements of the plan have been trailed over previous weeks, with the Prime Minister's speech launching the plan focusing on the delivery of the Neighbourhood Health Service (a key pledge in the election manifesto). Key elements the government pre-announced include the introduction of innovator passports, AI technology developed to identify patient safety issues and a new healthy food standard. These announcements have covered the other two shifts for the NHS – moving from analogue to digital and treatment to prevention. A more controversial measure trailed has been the intention to tie hospital funding to patient ratings.

The government has framed the plan as the means to reform the NHS which is in 'a fight for its life' – referencing wider warnings about the implications of a future Reform-led government, who continue to outperform Labour in the polls, as well as mounting financial pressure to demographic changes. (Reform's official policy position is that the NHS would remain free at the point of use, though individual politicians and influencers within the Reform Party advocate for a move to an insurance-based system.)

The plan is being published amid a turbulent few weeks for the government, with them having to scrap and amend swathes of their landmark welfare bill to avoid defeat in parliamentary votes, speculation about potential reshuffles and blame games among the government's political operation. The government will be looking to the publication of the 10-year plan for health to demonstrate it is delivering its plan for change and to help its political fortunes.