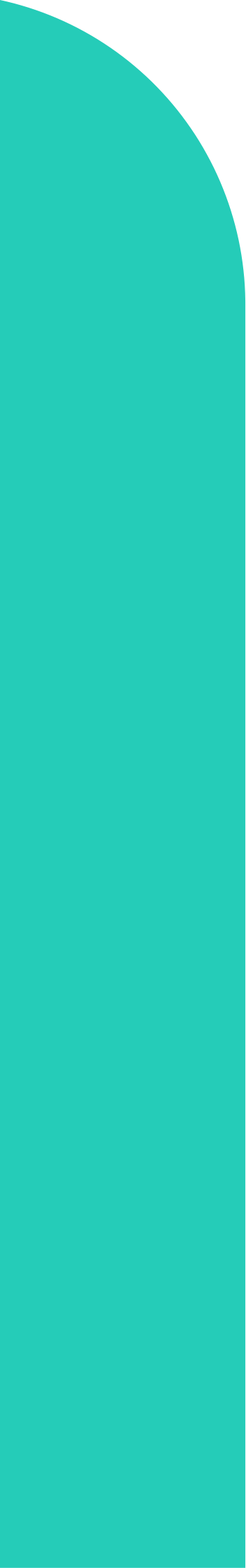


Briefing

Medium Term Planning Framework: what you need to know

Key points

- The Medium Term Planning Framework sets out performance targets and requirements for NHS organisations over the next three and five years, unlike previous annual planning rounds. Integrated care boards (ICBs) and providers must develop robust and realistic three- and five-year plans to deliver these priorities.
- The framework sets out next steps to deliver on the 10 Year Health Plan for England and aims to move away from short-term planning to a system that empowers local leaders to plan over the medium-to-long term, and which supports innovation to deliver long-term sustainability.
- The framework helps to bridge the gap between immediate pressure for recovery with deeper, but longer-term, reform. It does offer a path to recovery, but it is a narrow one with several big risks to navigate along the way, including a precarious financial position and potential unfunded costs to come alongside the need for additional private capital to be decided upon at the Budget in November 2025.
- Alongside the framework, NHS England will publish at least 20 additional guidance and resource documents for ICBs and providers over the coming months (see appendix), for areas from neighbourhood health to integrated health organisations, setting significant central direction.
- With 15 headline success measures over a three year-period, down from 18 in the 2025/26 Planning Guidance and 133 in 2023/23, the framework continues the recent trend of providing local leaders with greater focus to better enable

A large teal shape on the left side of the page, consisting of a vertical rectangle and a quarter-circle at the top left corner.

delivery. However, it includes many more requirements, albeit over a longer three-year period.

- Coming five months before the next financial year, it also provides more time for local leaders to build its expectations into realistic plans. However, with much information still to come in and so many pieces of further guidance promised, the framework only goes so far to inform planning.

Overview

The key elements, targets and requirements for NHS organisations over the next three and five years, are set out in the three sections of the framework, covering the financial context and requirements, reforms plans to realise a new operating model, and performance requirements of different sectors.

Key performance targets for ICB and providers for 2026-2029

Success measure	2026/27 target	2028/29 target
Electives, cancer and diagnostics		
1) Improve the percentage of patients waiting no longer than 18 weeks for treatment	Every trust delivering a minimum 7 per cent improvement in 18-week performance or a minimum of 65 per cent, whichever is greater (to deliver national performance target of 70 per cent)	Achieving the standard that at least 92 per cent of patients are waiting 18 weeks or less for treatment
2) Improve performance against cancer constitutional standards	Maintain performance against the 28-day cancer Faster Diagnosis Standard at the new threshold of 80 per cent	
	Every trust delivering 94 per cent performance for 31-day and 80 per cent performance for 62-day standards by March 2027	Maintain performance against the 31-day standard at 96 per cent and 62-day standard at 85 per cent
3) Improve performance against the DM01 diagnostics 6-week wait standard	Every system delivering a minimum 3 per cent improvement in performance or performance of 20 per cent or better, whichever level of improvement is greater (to achieve national performance of no more than 14 per cent of patients waiting over 6 weeks for a test)	Achieving the standard that no more than 1 per cent of patients are waiting over 6 weeks for a test
Urgent and emergency care		
4) 4-hour A&E performance	Every trust to maintain or improve to 82 per cent by March 2027	National target of 85 per cent as the average for the year
5) 12-hour A&E performance	Higher per cent of patients admitted, discharged and transferred from ED within 12 hours across 2026/27 compared to 2025/26	Year-on-year per cent increases in patients admitted, discharged and transferred from ED within 12 hours
6) Category-2 response times	Improve upon 2025/26 standard to reach an average response time of 25 minutes	Further improvement so that by the end of 2028/29 the average response time is 18 minutes, with 90 per cent of calls responded to within 40 minutes
Primary care and community services		
7) Same day appointments for all clinically urgent patients (face to face, phone or online)	90 per cent (subject to consultation with the profession on this new ambition)	
8) Improved patient experience of access to general practice (ONS Health Insights Survey)	Year-on-year improvement	

9) Deliver 700,000 additional urgent dental appointments against the July 2023 to June 2024 baseline period	Each ICB to deliver their share of the urgent dental appointment target every year (2026/27 to 2028/29)	
10) Address long waiting times for community health services	At least 78 per cent of community health service activity occurring within 18 weeks	At least 80 per cent of community health service activity occurring within 18 weeks
Mental health		
11) Expand coverage of mental health support teams (MHSTs) in schools and colleges (including teams in training)	77 per cent coverage of operational mental health support teams and teams in training	94 per cent coverage, reaching 100 per cent in 2029 (operational mental health support teams and teams in training)
12) Meet the existing commitments to expand NHS Talking Therapies and Individual Placement and Support	63,500 accessing Individual Placement and Support by the end of 2026/27	73,500 accessing Individual Placement and Support by the end of 2028/29
	805,000 courses of NHS Talking Therapies by the end of 2026/27 with 51 per cent reliable recovery rate and 69 per cent reliable improvement rate	915,000 courses of NHS Talking Therapies by the end of 2028/29 with 53 per cent reliable recovery rate and 71 per cent reliable improvement rate
13) Eliminate inappropriate out-of-area placements	Reducing the number of inappropriate out-of-area placements by end of March 2027	Reducing or maintaining at zero the number of inappropriate out-of-area placements.
Learning disabilities and autism		
14) Reduce reliance on mental health inpatient care for people with a learning disability and autistic people	Deliver a minimum 10 per cent reduction year-on-year.	
Workforce		
15) Reduce use of bank and agency staffing	Trusts to reduce agency and bank use in-line with individual trust limits, as set out in planning templates, working towards zero spend on agency by 2029/30	
	Annual limits will be set individually for trusts, based on a national target of 30 per cent reduction in agency use in 2026/27, and 10 per cent year-on-year reduction in spend on bank staffing	

Delivering for patients and the public

Financial discipline

- **Spending Review:** The framework notes that the multi-year funding settlement at the Spending Review provides 3 per cent real-terms increase in revenue and 3.2 per cent in capital funding, supporting a move away from annual planning cycles. Capital allocations alongside updated delegated limit guidance and technical guidance will be released later this autumn.
- **Financial discipline:** All ICBs and providers are expected to deliver financial balance or surplus in each year (without deficit support by 2029), including 2 per cent annual productivity gains.
- **Financial flows:** The NHS Payment Scheme will use best- practice tariffs, deconstruct fixed payments and use a new urgent and emergency care (UEC) payment model to better align incentives to enable more robust delivery.
- **Reform funding distribution:** ICB funding allocations will move to 'fair sharing of resources', alongside a review of the broader NHS funding formula.
- **Capital:** The capital regime will be reformed to get better value from public and private capital.
- **Data and metrics:** NHS England will combine PLICS, Model Health System and Health Expenditure Benchmarking to create a coherent and granular data set for providers.
- **UEC contracts:** Block contracts will be dismantled, with a new UEC payment model for 2026/27, comprising a fixed element (based on price x activity) and a 20 per cent variable payment and an incentive element of the UEC payment model to left shift with clinical, financial and operational groups.
- **Neighbourhood:** A financial / incentive model for neighbourhood health as demand for acute service reduces is currently being developed with pilot sites, available for adoption in 2026/27.

- **Tariffs:** Based on ongoing pilots, new best practice tariffs will be proposed as part of the 2026/27 Payment Scheme to incentivise a shift to day cases, outpatients and more efficient ways of working.

Productivity

- **Technical efficiency:** Reduce inpatient length of stay, improve theatre productivity and return to pre-COVID levels of activity per whole-time equivalent (WTE). This means delivering at a minimum the 2 per cent annual productivity target.
- **Analogue to digital:** Accelerate the shift to a digital-by- default across acute community, mental health, learning disabilities and autism services, and primary care.
- **Metrics:** NHS England will publish trust-level productivity measures and incorporate these into the NHS Oversight Framework. This will include dedicated measures for community health services, addressing previous unwarranted variation.
- **Urgent and emergency care:** Shift to digital-first UEC model, using clinical prioritisation and scheduling to improve reduce avoidable demand. Move away from traditional walk-in demand to models that support patients' access to the right care, in the right setting, at the right time, based on clinical urgency and individual need. This includes expanding digital and telephony-based triage and booking mechanisms and increasing access to same-day or next-day scheduled care where clinically appropriate.
- **Outpatients:** Shift to digitally enabled care by expanding use of advice and guidance and digital triage, and expanding PIFU, remote consultations and digital monitoring. This should deliver a reduction in outpatient follow-up activity (OPFU). Rather than a uniform national target, each ICB must: (1) model required OPFU reduction to accelerate delivery of referral to treatment (RTT) and long-way targets and then (2) submit bespoke plans.

A new operating model

The NHS Operating Model

- The centre sets national outcomes, codifies standards, builds shared platforms once and well, and removes barriers.
- regions are the leadership interface, with a single line of sight across performance, finance, workforce and quality, responsible both for grip and for support.
- ICBs are strategic commissioners, moving resources into prevention and community capacity, tackling inequalities and commissioning for value (quality of care and optimal efficient cost).
- Providers, through a revitalised foundation trust process, are responsible for collaboration, productivity and quality, with earned freedoms for those who deliver and proportionate intervention where standards slip.
- Integrated health organisation contracts will enable end-to-end redesigning of pathways, with efficiencies reinvested into better and more effective ways of working
- Neighbourhood teams will support communities and deliver proactive support for people with frailty and long- term conditions. They will provide urgent and acute community services, rehabilitation and prevention – and support improved access to care, especially general practice. Their work will be enabled by digital tools and shared care records

Commissioning

- **Strategic commissioning:** ICBs to implement the Strategic Commissioning Framework, which will be published in October 2025. A shadow set of outcome measures will be developed for 2026/27.
- **Delegated commissioning:** Commissioning responsibility for vaccination and screening will move to ICBs, likely from April 2027, subject to the passage of legislation. In 2026/27, NHS England will develop a commissioning and contracting framework covering these new responsibilities. NHS England will enable community pharmacy to deliver vaccinations off premises, where commissioned, subject to regulatory approval.

Draft frameworks for new foundation trusts (FT) and system archetypes, a model integrated health organisations (IHO) blueprint and updates to the oversight regime

- **New foundation trusts:** A draft FT trust framework will be consulted on in November. The government intends to re-empower boards by focusing on excellent governance, organisational self-awareness and transparency. New FTs will be required to demonstrate the ability to lead their own organisation while working in partnership, including as part of collaboratives.
- **Integrated health organisations:** A draft system archetypes document and Model IHO blueprint will also be published shortly. The planning framework confirms that IHOs are a capitated contract-based delivery method, not a new organisational form, and that the body that hosts this new form of capitated contract will be expected to work with the providers in their system, including through sub-contracting arrangements and delegation of commissioning.
- **Oversight:** There will be a new approach to oversight driven by improvement, not bureaucracy. As part of this, there will be a greater emphasis on peer support, tailored intervention and metrics that reflect system-minded behaviours, such as the left shift. The metrics in the Oversight Framework will be expanded to account for new models of service provision, the Care Quality Commission's definition of provider capability and governance and transaction adjustments for 2026/27.

Neighbourhood health

- **Immediate focus:** Neighbourhoods should improve GP access and reduce unwarranted variation, reducing unnecessary non-elective admissions and bed days from priority cohorts (frail, care home residents and end of life) and shifting planned specialised care closer to home. High-functioning systems can go further, setting up integrated teams for other cohorts including children and young people, mental health, learning disabilities, autism and ADHD.
- **Model neighbourhood:** NHS England will produce:
 - draft model neighbourhood framework, including definition, goals and scope for neighbourhood health
 - national neighbourhood health planning framework (co-produced with the LGA), setting out partnership with local authorities
 - model system archetypes, outlining archetypes for the commissioning and provision of neighbourhood health services, including the single (SNP) and multi-neighbourhood provider (MNP) contracts, and IHO contracts
 - model neighbourhood health centres archetypes, describing archetypes of neighbourhood health services to inform estates, including new builds.
- **GP capacity:** ICBs must identify GP practices where demand is above capacity and develop a plan to relieve pressure and improve access.
- **Local authorities:** ICBs should establish contracted-based integrated neighbourhood teams (INTs), working with local authorities to join up care for high-priority cohorts and reduce non-elective admissions.
- **Frailty:** ICBs should map care utilisation of frail patient cohorts and develop a plan to shift care from hospital to community, improve use of comprehensive geriatric assessments and deliver seven-day community care service.

Prevention

- **ICB five-year plans** must include the following:
 - **Obesity:** deliver new obesity services including provision of weight loss medication, providing access to NICE- approved weight loss treatment for 220,000 eligible adults by the end of June 2028, and hitting 25,000 annual referrals to the NHS Digital Weight Management Programme by 2029.
 - **CVD:** reduce CVD-related premature mortality by 25 per cent by 2035.
 - **Smoking:** implement opt-out models of tobacco dependence.
 - **Antibiotic resistance:** reduce exposure and address polypharmacy.
 - **Health inequalities:** demonstrate how they will reduce health inequalities.

Digital

- **NHP App:** NHS England will publish a roadmap for the NHS App including:
 - My NHS GP: using AI triage and data drive pathways to guide patients to bookings
 - planned care: giving patients one place to manage all appointments, referrals and interactions
 - health management: facilitating access to targeted prevention services and expanding point-of-care testing in the community.
- **Modern service frameworks:** ICBs and providers must ensure compliance with modern service frameworks, to be published, which will set out plans for digital-by-default care where clinically appropriate.
- **Online hospital:** Establish NHS Online, a new 'online hospital' to connect patients to expert clinicians from 2027. From April 2026, the NHS must:
 - make 95 per cent of appointments available the NHS app after triage and implement digital PIFU by 2029
 - onboard all acute, community and mental health providers into the NHS Federated Data Platform (FDP) by 2028/2029
 - move all direct-to-patient communication to NHS Notify by end of 2029
 - move to a unified access model, using AI assisted triage, delivered via the NHS App but with an integrated telephony and in-person offering
 - comply with standards in Digital Capability Framework as soon as

possible including 100 per cent coverage of electronic patient record systems

- implement services in forthcoming national productivity adoption dashboard by March 2028
- providers should deploy ambient voice technology.

Quality

- **Quality strategy:** National Quality Board (NQP) quality strategy to be published by March 2026.
- **Modern service frameworks:** Establish modern service frameworks (MSFs) setting out high-quality, evidence-based, digital-by-default care. The first three will be CVD, serious mental illness and sepsis. Further MSFs on dementia and frailty will follow. Frameworks to be co-designed with clinicians, people with lived experience and system partners.
- **Care delivery:** Publish National Care Delivery Standards by March 2026.
- **Paediatrics:** Launch Emergency Department Paediatric Early Warning Systems (ED PEWS) in 2026, with all hospitals adopting using it by April 2028.
- **Medicines:** Introduce a Single National Formulary for medicines by the end of 2027, prioritising efficiency savings from the use of Direct Acting Oral Anticoagulants, SGLT-2 medicines and adoptions of the wet AMD Medical Retinal Treatment Pathway.
- **Patient safety:** All ICBs must continue to implement the NHS Patient Safety strategy. This includes embedding the Patient Safety Incident Response Framework, appointing and training patient safety specialists and involving patient safety partners in governance.
- **Martha's Rule:** Fully implement in all acute inpatient settings as per the NHS Standard Contract.
- **Continuing care:** Use All-Age Continuing Care Services (AACC) data to reduce unwarranted variation to improve services. Re-engineer local process and workflow to make sure all colleagues are using digital systems and to remove duplicate paper-based processes.
- **Maternity services:** Implement best practice resources as they are launched, including maternity care bundles, new methods to prevent brain injury in childbirth maternity triage specification and SANDS national bereavement care pathway for stillbirth and neonatal death. Use the Maternity and Neonatal Inequality Dashboard to identify and reduced variation, participating in the Perinatal Equity and Anti- Discrimination Programme to support leadership teams to improve culture and practice. The Maternity Outcomes Signal System (MOSS) will provide real-time data to monitor safety indicators and trigger local

safety checks and should be implemented across all NHS trusts by November 2025.

- **Digital:** Re-engineer workflow to ensure all staff use digital systems, to remove duplicate paper-based processes and ensure maximum use of the NHS FDP.

Patient experience

- **Surveys:** All providers must complete at least one full survey cycle to capture the experience of people waiting for care.
- **Feedback:** All providers must capture near real-time experiences, on at least five wards / departments from patients who have received care in their organisation prior to their discharge. NHS England will publish a resource pack in October.

Workforce and leadership

- **Staff survey:** Every NHS board must use the 2025/26 staff survey findings to analyse free text comments, identify at least three areas with the greatest staff dissatisfaction and plan actions.
- **Discrimination:** Continue to tackle discrimination, racism and sexual misconduct, including regularly assessing progress on the Sexual Safety Charter,
- **Leadership:** NHS England will publish a new Management and Leadership Framework during autumn 2025, setting a code of practice of standards and competencies for clinical and nonclinical leaders and managers at five levels from entry level to board. ICBs and providers should use these in recruitment and approval. A national curriculum and interactive online modules will be published in 2026/27.

Genomics, life sciences and research

- **Clinical trials:** All providers should meet the site-specific timeframes of the government's 150-day clinical trial set-up target. Progress should be reported to boards six-monthly. From April 2026, ICBs should proactively support clinical trials by following standards and guidance set out in Managing Research Finance in the NHS.
- **Genomics:** Providers must deliver services in line with the NHS Genomic Medicine Service Specification from April 2026.

Operational performance and transformation

Elective, cancer and diagnostics

- **Waiting times:** Every trust must improve 18-week waiting times by 7 per cent or to a minimum of 65 per cent, whichever is highest, in 2026/27, rising to 92 per cent in 2029.
- **Advice and guidance (A&G):** GPs should prioritise the use of A&G instead of planned care referrals, with referrals receiving clinical triage through a single point of access. Use e-Referral Service (e-RS) for all A&G managed through the e-RS user interface by July 2026, and through third-party services by October 2026.
- **Specialist advice:** Expand access to specialist advice and direct access to diagnostics through neighbourhoods.
- **Demand reduction:** Reduce clinically low-value follow-up appointments informed by the Getting It Right First Time (GIRFT) programme.
- **Clinics:** Review and standardise clinic templates in line with GIRFT. Expand 'straight to test' pathways and one-stop clinics for all clinically appropriate specialities by 2029.

CYPs: Systems and providers must increase activity and improve performance for their CYP population, particularly in surgical hub settings, including ringfenced CYP capacity and running dedicated paediatric surgery days.

Cancer: Every trust to see 94 per cent of referrals within 31 days and 80 per cent within 62 days by March 2027, rising to 96 per cent and 85 per cent by 2029. Prioritise diagnostic and treatment capacity for urgent suspected cancer (USC) pathways, stratifying referrals in primary care, identifying alternative pathways to the USC pathway and diverting lower risk people to more appropriate access routes.

Diagnostics: Each systems has bespoke diagnostic activity and performance targets to achieve by March 2029. ICBs must commission sufficient activity for providers, including extending community diagnostic centre (CDC) opening hours where necessary, to reduce the percentage of patients waiting more than six weeks for diagnostics by 3 per cent each year, ensuring no more than 14 per cent of patients wait over six weeks by March 2027, down to 1 per cent in 2029.

Urgent and emergency care

- **Admissions avoidance:** Urgent treatment centres first and by default for patients less likely to require admission. ICBs and providers must ensure patients go to the most appropriate care for their needs, reducing unnecessary ambulance conveyances to hospital. Systems should deliver more urgent care in the community by expanding neighbourhood health services, aiming to reduce total non- elective admissions and bed days, with a specific focus on frailty.
- **Frailty:** ICBs should specifically assess total resources spent on frailty and shift a proportion of those resources to better community provision.
- **Core services:** ICBs and providers must fully use services such as 111 and increase the rate of impactful interventions such as 'hear and treat'.
- **Ambulance handovers:** Acute trusts and ambulance services must reduce ambulance handover times to an average of 25 minutes for category 2 patients, reaching an average of 18 minutes by 2028/29 (and with 90 per cent of calls responded to within 40 minutes).
- **New standards:** Acute trusts should implement to-be- published model emergency department and clinical operational standards for the first 72 hours in hospital to ensure 82 per cent of patients are seen within four hours by March 2027, rising to 85 per cent in 2028/29.
- **Paediatrics:** Use paediatric assessment units to improve ED paediatric performance to 95 per cent seen within four hours.
- **Delayed discharge:** Improve in-hospital discharge processes, making best use of community beds, and increasing home-based intermediate care capacity.
- **Vaccination:** Improve flu vaccination uptake among staff and the public.
- **Digital-first UEC:** Establish a structured, digital-first model for scheduling appointments to clinical prioritisation.

Primary care

- **GP access:** ICBs must plan to improve contract compliance and transformation, tackling unwarranted variation and supporting those providers that are struggling. This includes ensuring all GP practices are delivering the 2025/26 contract (including 1 Oct changes) and the 2026/27 contract from 1 April, including improving and providing good access through face-to-face, phone or online appointments. A target of 90 per cent has been proposed, subject to consultation with the profession. Providers will also be measured on year-on-year improvements of patient experience of access to general practice.
- **Out of hours:** ICBs must commission additional capacity for out-of-hours and surge periods.
- **AI:** ICBs must support primary care providers to use ambient voice technology.
- **Community pharmacy:** ICBs must continue roll out of pharmacy first, including introducing prescribing-based services in community pharmacies through 2026/27.
- **Dentistry:** ICBs and providers must deliver their share of 700,000 additional urgency care dental appointments by 2026, implementing dental contract reforms from April 2026.

Community health services

- **Capacity:** Increase community health service capacity to match expected demand growth of 3 per cent each year.
- **Waiting times:** Ensure at least 78 per cent of community health service activity occurs within 18 weeks by 2027, up to 80 per cent in 2029, and eliminate 52-week waits.
- **Productivity:** Improve productivity using digital tools, point-of-care testing, standardise core service provision, and expand use of digital therapeutics, such as for musculo-skeletal treatment. NHS England will publish community health service productivity measures by March 2028.
- **Addressing variation:** continue to standardise core provision in line with Standardising Community Health Services.

Mental health

- **Mental health strategy:** NHS England will work with local NHS mental health providers to develop a new, holistic overarching approach for mental health in 2026, including the upcoming modern service framework for severe mental illness and led by a new national lead for mental health.
- **CYPs:** Expand coverage of mental health support teams to 77 per cent of schools and colleges in 2027, reaching 100 per cent by 2029.
- **Emergency care:** Establish mental health emergency departments co-located with or close to at least half of type 1 emergency departments by 2029/30.
- **Talking therapies:** Use ring-fenced funding to expand access to NHS Talking Therapies, delivering 805,000 by the end of 2026/27 rising to 915,000 in 2028/29.
- **Individual placement and support:** Reduce mental-health- related economic inactivity through growing access to individual placement and support for people with severe mental illness, with 63,500 accessing individual placement and support by the end of 2026/27, rising to 73,500 in 2028/29.
- **Out-of-area placements:** Reduce or maintain zero inappropriate out-of-area placements by 2029.
- **Locked rehab inpatient services:** Reduce use of locked rehabilitation inpatient services. From 2027/28 ICBs should only commission mental health inpatient services for adults and older adults that align with the NHS commissioning framework.
- **Productivity:** Improve productivity, particularly for CYP community mental health services and reducing longest waits and reduce average length of stay in adult acute mental health beds.
- **Managing suicide:** Ensure mental health practitioners undertake training and delivery of care in line with Staying Safe from Suicide guidance.

Learning disabilities, autism and ADHD

- **Hospital admissions:** Reduce mental health inpatient admissions for people with a learning disability and autistic people by 10 per cent each year, focusing on the longest stays.
- **Autism and ADHD assessments:** Optimise existing resources to reduce long waits for autism and ADHD assessments, by implementing existing and new guidance.
- **SEND reform:** The government will publish plans for the reform of SEND in due course in consultation with ICBs and providers.

Workforce

- **Bank and agency staffing:** Reduce bank and agency staffing in line with individual trust limits, with zero spend on agency by 2029/30. Annual limits will be set individually for trusts, based on a national target of 30 per cent reduction in agency use in 2026/27, and 10 per cent year-on-year reduction in spend on bank staffing.
- **Sickness:** Reduce staff sickness absence rates to 4.1 per cent, down from 5.1 per cent.
- **Training:** Implement reforms to statutory/mandatory training (due to be published in March 2026).
- **Job planning:** Implement reforms to consultant job planning (with 95 per cent of medical jobs plans sign off) and achieve full tracking of job planned activity.

Analysis

NHS leaders will welcome much of this framework. They will share its ambitions to end short-termism, empower local leaders and set the path for sustainable improvement.

The number of success measures is down from 18 last year to just 15, with ten of the more specific targets carried over from 2025/26 - either with more ambitious goals or an expectation to maintain performance. Elective and cancer waiting times, access to general practice and urgent dental appointments, and efforts to reduce reliance on mental health inpatient care and agency staff are carried over.

The NHS Confederation has long called for multi-year planning and co-production with local leaders, so the three-year planning window and engagement over the summer are very welcome. However, with much information still to come in so many pieces of further guidance, the framework only goes so far to inform planning.

While the framework promises to create ‘the environment and headroom to fix the fundamental problems we face’, ICB leaders in the midst of cutting their running costs by 50 per cent without funding for redundancies, and provider leaders facing hefty corporate and staff cuts, will be forgiven for feeling this is not the case. The framework does not acknowledge the unfunded redundancies, which will consume significant time and attention of local leaders over at least the next year.

The framework attempts to bridge the gap between immediate pressure for recovery with longer-term reform. It does offer a path to recovery, but it is a narrow one, with several big risks to navigate along the way:

- **Prevention** – The treatment-to-prevention section is comparatively sparse despite excellent work by many systems showing what can be done. While the oversight regime pressures NHS leaders to turn their heads from preventing ill health tomorrow to concentrate on firefighting acute pressure today, the framework provides little countervailing force. Notably, Core20Plus5 is not included in the framework.
- **Primary care** – the new 90 per cent target for same-day access for clinically urgent patients fails to recognise the significant capacity constraints within general practice and will impede on their ability to deliver proactive care and

enable continuity to be delivered to those who need it. This is at odds with neighbourhood health, personalised care and care closer to home. Reinforcing the role of community pharmacy is welcome but more needs to be done through contractual and local commissioning to capitalise on the role of this sector.

- **Community** – The aim to expand community services capacity by 3 per cent per year helps to deliver the shift from hospital to community, but the relative focus in the document on acute care targets (which can focus behaviour and investment) and the limited acknowledgment of community and mental health waiting lists could make this harder.
- **Financial flows** – The proposed left-shift incentive in the UEC payment model is welcome, but much detail is still to come in the NHS Payment Scheme for 2026/27. The speed of reform to financial flows is still unclear.
- **Neighbourhood** – Next steps on neighbourhood health are focused on improvements to general practice, saying little on the role of community providers and local government. The absence of any reference to the National Neighbourhood Health Implementation Programme is surprising. The government's vision for neighbourhood health is now focused on increasing out-of-hospital activity. Neighbourhoods will need agency to tailor services to specific local needs. While the focus on frailty is important, some neighbourhoods may need to prioritise younger, more deprived populations where long-term conditions and mental health are driving poor outcomes and pressure on services.
- **Mental health** – Mental health providers will welcome the commitment to increase access to Individual Placement Support, NHS Talking Therapies and Mental Health Support Teams (MHSTs) through ring-fenced funding, but the removal of the Mental Health Investment Standard will feel like a setback for the sector. Cutting mental health investment to divert funds to acute recovery could be self-defeating, given the role of adequate mental health support in relieving other NHS services. Maintaining transparency on the share of spend for mental health - and more broadly on primary and community services – will help track the progress towards achieving the government's aim of the left shift in care.
- **Digital** – Including community and mental health sectors into the FDP platform will improve the ability to support better population health management. However, the exclusion of primary care risks big gaps in data, undermining the quality and effectiveness of insights from data from FDP. The financial position poses the biggest risk to deliver. The framework notes 3 per cent real-terms

increase in revenue funding over the three-year period, confirmed in the Spending Review, alongside assumed productivity growth of 2 per cent per year (the historical average is 0.9 per cent per year). If recurring rises in drug prices have to be funded from existing NHS budgets, this would destabilise delivery of financial plans that the framework celebrates having put back on track. In the more immediate term, the costs of strike action and ICB redundancies are still unfunded. Meanwhile, existing financial plans that bank on late end-of-year efficiencies still pose high risk. This is at the same time as expanding many services, including a 3 per cent annual expansion in community services and expanding out-of-hours general practice, while delivering overall financial balance.

- **Capital investment** – spending of £13.6 billion in 2026/27, rising to £14.6 billion by the end of the parliament, is still below the £14.9 billion¹ that the NHS Confederation estimated was needed back in 2023 to boost productivity growth to the 2 per cent per annum growth target – and in the meantime the estate backlog has significantly worsened. Much rests on the Chancellor's forthcoming decision at the November 2025 Budget on whether to approve a new generation of Public Private Partnerships to facilitate capital funding in neighbourhood health centres. The plan's cryptic reference to delivering improve value from private capital implies a positive decision may be forthcoming.

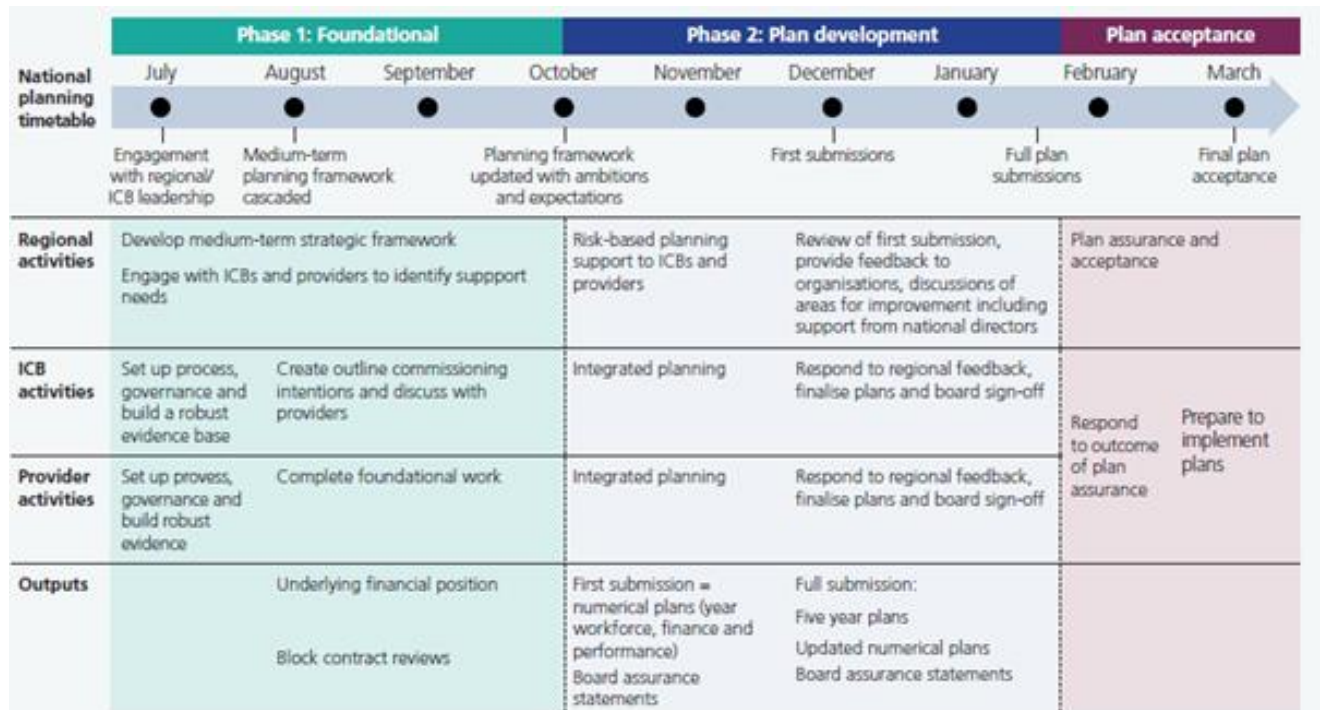
Oversight will shape delivery of the framework's aspirations. Twelve of the specific targets in the Planning Framework align with those in the 2025/26 NHS Oversight Framework (the 2026/27 NOF is yet to be published), including for elective care, cancer, diagnostics and UEC. There is also alignment around reducing out-of-area mental health bed days, the reliance on mental health inpatient care for people with a learning disability and autistic people and primary care access. The commitment to 'system-minded' oversight metrics is welcome. Given the NHS Oversight Framework will be updated with new productivity measures (including standardised community health metrics), the choice of productivity metrics will be key. If these are too short-termist and provider-specific (not looking at wider system factors), this could undermine collaborative working and the hospital-to-community and illness-to- prevention shifts.

Footnotes

1. Original £14.1 billion estimated capital need in 2023 adjusted for inflation up to £14.9 billion in August 2025 using the Bank of England inflation calculator. Future inflation will further erode planned increases in capital investment.

Next steps

ICBs and providers must develop robust and realistic five-year plans alongside three-year numerical returns for 2026/29, which outline improvement against these priorities, with first submissions before Christmas.



Submission	Requirement
First submission	3-year revenue and 4-year capital plan return 3-year workforce return 3-year operational performance and activity return - integrated planning template showing triangulation and alignment of plans - board assurance statements confirming oversight of process
Full plan submission	- updated 3-year revenue and 4-year capital plan return - updated 3-year workforce return - updated 3-year operational performance and activity return - integrated planning template showing triangulation and alignment of plans 5-year narrative plan - board assurance statements confirming oversight and endorsement of the totality of the plans

Appendix: Summary of forthcoming guidance and resource documents to be published

1. Trust-level productivity measures (monthly) and incorporated these into the NHS Oversight Framework
2. Technical guidance on multi-year revenue and capital allocations in autumn 2025, alongside updated guidance on new delegated limit and business case templates
3. Productivity and efficiency opportunity packs (updated regularly)
4. Strategic Commissioning Framework (October)
5. Resource pack for patient experience surveys (by end of October)
6. Draft foundation trust framework (for consultation in November)
7. Model neighbourhood framework (expected November)
8. System archetypes blueprint (explaining new contract models, autumn)
9. National Neighbourhood Health Planning Framework (co-produced with LGA, autumn)
10. SEND reform plan, by Department for Education
11. Management and leadership framework (autumn)
12. Model integrated health organisation blueprint (later this year)
13. 26/27 Payment Scheme in the autumn, including best practice tariffs, by March 2026 with consultation in autumn 2025.
14. National Care Delivery Standards (scope confirmed November, published March 2026)
15. National Quality Board (NQB) Quality Strategy (by March 2026)
16. Community Health Service Productivity Metrics (later this financial year)

17. Modern Service Frameworks (first set: CVD, serious mental illness, sepsis)
18. Holistic overarching strategy for mental health (in 2026)
19. Emergency Department Paediatric Early Warning System (ED PEWS) (launched 2026, transition by April 2028)
20. College of Executive and Clinical Leadership (curriculum/modules in 2026/27)
21. Single National Formulary (within 2 years)
22. National (digital) product adoption dashboard

For more briefings, reports, case studies and the latest podcasts from our experts in health and social care visit nhsconfed.org/publications

NHS Confederation
2nd Floor
18 Smith Square
Westminster
London
SW1P 3HZ

020 7799 6666
nhsconfed.org

Connect with us and join the conversation at:

LinkedIn: NHS Confederation
Bluesky: [@nhsconfed.bsky.social](https://bsky.app/profile/nhsconfed.bsky.social)