NHS
Herefordshire
and Worcestershire

Fit For The Future: 10 year health plan

Meeting: Health and Wellbeing Board

Meeting date: Monday 15 September 2025

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Decision type

This is not an executive decision

Wards affected

(All Wards);

Purpose

To brief the Health and Wellbeing Board members on the key features of the Government's new 10 year plan for health.

Recommendation(s)

The Health and Wellbeing Board is asked to note the contents of this report and the requirements to review and approve the development of Neighbourhood Health Plans later in the calendar year.

Introduction

1. On 3 July 2025, the Government published its new 10 Year Plan for Health. The plan sets out the ambitions to radically transform how health care services are organised, how they will be accessed by patients and what they will focus on between now and 2035.

2. The first chapter, titled "Its change or bust", sets out the case for change. The NHS is described as standing on an "existential brink" and being in a "critical condition" with long waiting lists, low satisfaction, workforce pressures, and poor outcomes compared to peer countries. The conclusion is that healthcare needs radical transformation to be able to meet public expectations and be financially sustainable.

3. The plan goes on to set out some very significant ambitions for how things will look by the end of the plan, including achievements such as:

    a. Ending the 8am scramble for GP appointments

    b. Restoring the NHS constitutional standard of people beginning elective treatment within 18 weeks of referral

c. Making personal health budgets a universal offer for all that would benefit from them

d. Putting a neighbourhood health centre in every community

e. Raising the healthiest generation of children ever

f. Ending the obesity epidemic

g. Creating a smoke-free future

h. Creating a new genomics population health service

i. Putting the power back in the hands of the people and professionals

j. Creating the most digitally-enabled health service in the world

k. Giving patients real control over a single secure and authoritative account of their own health record

l. Making the NHS App a world leading tool for patient access.

4. Describing the further detail of how these ambitions will be delivered, there are a further eight chapters in total, with three focusing on the "Radical shifts to transform care", and other chapters focusing on the NHS operating model, workforce, transformational "big bets" and future financial arrangements.

Three Radical Shifts to Transform Care

5. The core content of the plan is built around driving three radical shifts in the NHS operating model, shifts that will transform how services are organised and how patients access care:

a. **Chapter 2: From hospital to community** – creating a Neighbourhood Health Service that is rooted in local access and makes care much easier for people to access. Over time there will be Neighbourhood Health Centres created in local communities that bring services together to join up care around people's needs. In dispersed rural areas such as Herefordshire, it will be important to spend time defining what local communities are and what is realistic in terms of establishing neighbourhood health centres. These will need to be much more than "NHS buildings", so work with partners in local authorities and the VCSE will be important if they are to truly become one-stop shops.

b. **Chapter 3: From analogue to digital** – establishing a fully digital, patient-controlled NHS which is built around the NHS App and makes much better use of AI-enabled tools to improve access for patients and productivity for staff. The NHS App has the potential to be a world-leading tool for patient choice and access to health services, but it needs considerable work to achieve this. The re-imagined App will provide people with the ability to book appointments, access timely and personalised advice, navigate pathways and services, view their health information and make choices about who provides their healthcare. The App will connect to a single, secure and comprehensive account of people's health records that can be connected to wearable health devices and which can ensure people can monitor their own health conditions more effectively.

c. **Chapter 4: From sickness to prevention** – shifting the focus of healthcare away from a model of "diagnose and treat" more towards a model of "predict and prevent". This ambition includes achieving a significant reduction in health inequalities by improving outcomes for all, by halving the health inequalities gap between those with the best and worst health outcomes. The core planks of this ambition will be built around helping people to make the healthy choice more often when it comes to lifestyle decisions. Specific steps include introducing the Tobacco and Vapes Bill to create a smoke-free culture and a number of joined up actions to tackle the obesity epidemic - from new food

labelling legislation, to changes to local planning controls for fast food establishments and roll out of medications to help people lose weight. Other actions are highlighted for reducing harmful alcohol consumption, improving air quality and creating a stronger connection between good work and good health. All of these interventions, when taken together, provide the platform to support the ambition of bringing up the healthiest generation of children ever and they also emphasise the importance of joined up working because no partner can deliver on these ambitions alone.

Transformation enabled by new ways of working

6. **Chapter 5 defines the New Operating Model** for the NHS nationally and locally. In summary the key points relating to this are:

   a. Amalgamation of NHS England and the Department for Health and Social Care (DHSC) into a single function, to deliver a more diverse and devolved health service that has clearer central leadership arrangements.

   b. Integrated Care Boards to reduce in size by 50% and become strategic commissioners that commission for improved quality, patient outcomes and reduced health inequalities. It is important to note that this reduction applies to the number of staff employed, not the commissioning budgets that are available to pay for NHS services. To enable this change locally, NHS Herefordshire and Worcestershire ICB will cluster with NHS Coventry and Warwickshire ICB with a single team running both Integrated Care Boards.

   c. NHS Trusts to have greater autonomy (and with it greater accountability) for delivering care locally, pursuing new ways of working and implementing innovative practices. This initiative will develop to re-launch the NHS Foundation Trust concept where provider boards can operate more autonomously from central NHS control. In the longer term, the highest performing providers will be able to develop into Integrated Health Organisations, whereby they take responsibility for multi-year whole health budgets for the local population rather than funding for specific services they provide. This will give them flexibility to innovate and invest for the longer term where population health outcomes may take a period of years to realise.

   d. A new partnership with Local Government in the delivery of health services. As well as working more closely together on addressing the wider social determinants of health, working more closely with public health, social care and children's services, this element of the plan will also involve Local Government taking a leading role in the development of Neighbourhood Health Plans and using Health and Wellbeing Boards to oversee them.

   e. Pushing power out to patients and the public, which will involve greater use of patient choice over who provides their care. This will involve a number of initiatives such as developing new methods for using patient reported data to monitor performance of NHS providers, expanding the use of personal health budgets, putting more services onto the NHS App. In the longer term, this will also involve introducing more self-referral pathways for patients to access services such as diagnostics. When coupled with greater use of the NHS App and AI-powered processes to help patients take control of their own health, this will reduce unnecessary waiting for services.

7. **Chapter 6 addresses quality of care**, with the main areas of focus being on using data more effectively to identify issues earlier, greater patient voice in identifying poor quality, clearer accountability and incentives for leaders to ensure that their organisations deliver the best quality care and greater use of technology:

   a. **Data**: Quality metrics will be published widely, including quality league tables to make it easy for the public to understand how well their local organisations compare to others. Quality metrics will be supported by expanded use of Patient Reported Outcome Measures (PROMs). These are currently used in some specialty areas and provide patients will the

power to report on the impact of their treatment from their own perspective, not just the clinician's perspective. For example, has the procedure enabled them to get back to work if it was previously preventing them from working.

b. **Quality monitoring**: Some functions currently performed by Healthwatch organisations will be taken "in-house" and given a greater profile in the centre of Government through the creation of a National Director for Patient Experience. Some other Healthwatch functions will be brought together and transferred to Integrated Care Board and individual provider boards. Finally, local authorities will pick up local Healthwatch social care functions.

c. **Accountabilities and Incentives**: The National Quality Board (NQB) will be asked to develop a refreshed national quality strategy by March 2026. This will include developing a new suite of clinically-credible outcome measures to assess clinical quality. From 2027, providers will be granted powers to reward clinical teams where they are shown to deliver high quality care through financial incentives and rewards. At the other end of the spectrum, where providers are consistently delivering poor quality care, ICB will be expected to decommission services from that provider and recommission them from elsewhere, as part of their strategic commissioning strategy.

d. **Quality regulation**: Independent regulation will remain a vital part of providing the population with assurance that they can access high quality care. Work will be undertaken to address reported concerns with how the current principal regulatory body (Care Quality Commission) operates. CQC will move towards an intelligence-led model of regulation and will be given powers to access a wider range of data to inform their regulatory work. This will be supplemented by an AI-driven Quality Warning System to identify concerns early. There will be rationalisation of other regulatory bodies to simplify the landscape, such as seeing the Health Services Safety Investigation Branch aligned to be a unit within the CQC and the Patient Safety Commissioner will be hosted by the Medicines and Healthcare Products Regulatory Authority (MHRA).

8. **Chapter 7 focuses on Workforce**: As with many other chapters in the plan there is a strong slant towards the importance of digital. For workforce, the benefit will come through harnessing digital technology to perform many of the manual and routine tasks to free up time to care, subsequently enabling staff to operate at the top of their license when it comes to clinical practice. This productivity and efficiency benefit will free up time for staff to see more patients, therefore increasing service capacity and enabling waiting times to reduce. To enable staff to make the most of the digital technology it is recognised that recruitment, training and development of staff will need to change. Staff will need to be skilled up to make the most of the technology.

9. Other areas of focus include developing the concept of "train to task" rather than "train to role". This means that certain tasks in a patient pathway that can be safely delivered by a lower qualified staff member can be done so safely. For example, Health Care Assistants doing tasks previously undertaken by trained nurses, or social workers undertaking tasks previously done by clinical staff. These changes will create further capacity and make better use of scare resources and skills to maximise the time available for direct patient care. The development of these concepts will be particularly noticed as the Neighbourhood Health Plans are developed, supporting the creation of more Integrated Neighbourhood Teams.

10. As well as focusing on direct patient-focused benefits of workforce reform, there is also a strong focus on improving the employee experience of working within the healthcare sector. This includes making better use of technology to make the administrative aspects of work easier, changing the focus of mandatory training and working to reduce the pressures that often result in high levels of sickness absence. Increasing the availability of flexible working will also be a key part of the employment offer to enable the NHS to reduce its reliance on agency staff, who often quote more flexible employment as the main reason they opt for agency work over substantive employment.

11. Other aspects of the workforce chapter focus on improving leadership through development and deployment of a new national talent management framework and creation of an Executive and Clinical Leadership College to define and drive excellence in healthcare leadership.

12. The NHS recruitment strategy will pivot away from international recruitment towards local recruitment, particularly from more deprived areas which have typically not been targeted with local recruitment plans. To enable this there will be more apprenticeships and accessible training, better support for care leavers, alignment to projects focused on work and health and stronger connection to wider local work to reduce health inequalities.

13. **Chapter 8 focuses on transformation**. Again, this chapter has a strong slant towards progressing digital opportunities to transform care. It focuses predominantly on five "big bets" for transformation:

    a. **Data**: High quality interoperable health data, supported by AI driven algorithms to harness the ability to predict health issues. The main focus being on bringing together all relevant health data for an individual in one place, which is securely accessible by the individual themselves and authorised clinicians. Patient-held records will present an opportunity to simplify the complex data sharing landscape that often prevents data that needs to be joined up to maximise health outcomes from being joined up.

    b. **AI**: Combined with data and understanding of people's risk factors, AI will be used to analyse scans with rapid speed and precision to lead to faster identification of health issues and provide recommendations for most effective treatments. The opportunity to use AI to scan vast datasets is beyond anything we could have imagined just a few years ago and its ability to translate massive analysis into targeted treatment will be game changing. Already, there are examples reported of AI discovering new drugs and treatments.

    c. **Genomics**: The ability to understand a person's risk of developing avoidable and treatable disease is transformed by genomics. Whole genome sequencing at birth has the potential to inform lifelong personalised prevention so that people can take action to avoid developing health conditions that would otherwise define how they live their lives. The 10 year plan includes initiatives to expand the current work on genomics to the point where in 2035 more than half of all healthcare interactions will be informed by genomic insights. It is most likely that this work will be coordinated on a national scale and not something that local ICS's will have responsibility for driving.

    d. **Wearables and biosensors**: The commercial market for wearable devices that monitor and report on people's health has grown massively in recent years. Relatively cost effective devices can inform people of changes in all sorts of health indicators and are commonplace in the fitness world where people try to optimise their health and wellbeing. In the health world they are more bespoke and tend to be focused on specific conditions such as monitoring diabetes and reporting on issues to a clinician. The opportunity that wearables present is to enable far more people to be more educated, informed and engaged in managing their own health. Alongside wearables, biosensors in the home, workplace and even on clothing enhance the opportunity to monitor health and provide an early insight into possible preventative measures to prevent, stop or delay the onset of illness. To ensure fair and equitable access, wearables and sensors will be made more readily available to people who need them, not just those that can afford to buy the commercial products.

    e. **Robotics**: Robotic assisted surgery is already the standard approach for some conditions, such as prostate surgery. In other areas of healthcare robots automate procedures, deliver supplies, deal with medicines and process samples. Expansion of robotic technology will be enhanced by inclusion in guidelines produced by the National Institute for Clinical Excellence.

14. Other areas of focus in this chapter include promoting more innovation, supporting the drive to discover more game-changing medicines, speeding up clinical trials, improving procurement and changing how regulation of innovation operates.

15. **Chapter 9**: **Funding and finance** is the final area of focus in the plan. 38% of government spending currently goes on healthcare and this is a figure that will only continue to rise without a shift from sickness to prevention. This chapter defines a renewed focus on improving productivity to ensure that the NHS recovers from the impact of Covid and an emphasis on restoring financial discipline, including how NHS deficits are dealt with. This will be supported by moving to a longer-term financial planning regime with three year revenue and four year capital settlements. These settlements will be allocated against local system five year financial plans which set out how organisations will move from deficit-based funding to sustainable financial plans.

16. The way in which NHS funding flows around local systems will also change. There will be less reliance on block contracts (where payments are the same regardless of volume or quality of service), with a move towards more incentive-based contracts where high quality care can be financially rewarded and poor quality care penalised. This will support the concept of "Patient-Power" payments, where healthcare commissioners can withhold funding from providers where patients are not satisfied with the services they have received.

17. A key change signalled in the plan will be how an effective neighbourhood health system is financially incentivised. The current issue arises in that investment in one part of the health system (ie primary care and GP services) should accrue benefits in another part (ie hospitals through fewer admissions). Enabling the finances to flow around the system to enable this change to happen whilst not leaving one provider in financial deficit (recognising the approach in paragraph 15 about how deficits are dealt with) is complicated. The approach proposed for dealing with this is to develop "year of care" payments, where a capitated budget is made available for population cohorts, rather than a "pay per use" model as is currently the case. This approach will recognise successful initiatives to prevent the escalation of ill health and will be trialled in a small number of areas on a test and learn basis before being rolled out more widely. Herefordshire may be well placed to be a trial area because of the solid foundations that operate through the One Herefordshire Partnership. If the opportunity to bid to become one arises then more details will be shared.

18. How core NHS funding is allocated to systems will be reviewed. Historically funding has been allocated according to a funding formula which weights different aspects of health need across a range of factors such as age, poverty, health inequalities, rurality etc. When changes are introduced, the key element that affects Herefordshire and Worcestershire are the weightings allocated to rurality and age profile. H&W ICS is currently considered to be an over-funded system according to the current funding formula and as such each year the system has some money taken off it as part of a plan to converge to the fair share allocation. If the funding formula changes this could reduce or increase the amount of money taken each year so the work of the Advisory Committee on Resource Allocation (ACRA) will be critical to future service plans.

19. A 10-year infrastructure strategy will accompany the plan to describe how capital will be invested over the coming years. This will include focusing on better use of the existing healthcare estate and get better financial returns from under-utilised estate, whether that is from sale or alternative use.

Implementing the 10 year plan

20. The scope of the plan is vast, so effective implementation planning will be vital. This will start immediately with the NHS Annual Planning cycle for 2026/27, which starts in September 2025. The core outputs from this process will be:

    a. Five year strategic commissioning plans (produced by ICBs).

b. Five year integrated delivery plans (produced by NHS providers).

c. Neighbourhood health plans (which will need to be developed in conjunction with local authorities approved by Health and Wellbeing boards before the end of the calendar year).

d. Planning template submissions (finance, workforce, activity and performance trajectories).

21. Further updates will be provided to the Health and Wellbeing Board as they become known.

Community impact

22. There will be widespread community impact from local implementation of the Government's 10 year plan but these factors will need to be considered and reported on through a case-by-case basis.

Environmental impact

23. There are obvious benefits to be gained from moving to a digital first approach and the neighbourhood health models, both of which are likely to reduce patient travel times and distances. However, these will need to be offset against the increased use of AI, which is known to be environmentally damaging due to the energy hungry data centres that are used to power the technology. It is inevitable that there will be environmental impact from local implementation of the Government's 10 year plan but again these factors will need to be considered and reported on through a case-by-case basis.

Equality duty

24. Delivery of the 10 year plan initiatives will be governed by the NHS Equality Duties and these will be factored into delivery plans and the various Impact Assessments that will be undertaken relating to any decisions that would be made under the remit of the plan.

Resource implications

25. There are no specific financial implications associated with the endorsement of this plan for the Health and Wellbeing Board.

Legal implications

26. There will be complex legal, ethical and regulatory implications associated with implementing the 10 year plan, which will need to be dealt with on a case-by-case basis.

Risk management

27. There are no specific risks to highlight in relation to this briefing paper.

Consultees

28. Not applicable to this briefing paper.

Appendices

No appendices

Background papers

A full copy of the 10 year plan can be accessed here:
10 Year Health Plan for England: fit for the future - GOV.UK