

10 Year Health Plan working group: mobilising change

Co-chairs' report

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Executive summary

The 10 Year Health Plan sets out a bold vision for transforming the National Health Service (NHS) to improve long-term health outcomes and ensure the sustainability of the health system. It identifies 3 major shifts essential for achieving this: a greater focus on prevention, strengthening community-based care and embracing digital innovation.

To realise this transformation, change must be owned and driven by frontline staff while being supported by system-wide alignment across health and care services, local government and the voluntary and community sector. This report advocates a move away from traditional top-down approaches toward co-produced, locally-led change that empowers staff and engages communities.

Key challenges and solutions

Mobilising change at scale: while there have been successful pockets of improvement, large-scale, sustainable transformation has often proved elusive. The report highlights systemic barriers - such as workforce constraints, financial misalignment and institutional inertia - that must be addressed to enable consistent progress.

Tackling health inequalities: health outcomes remain starkly uneven. The report emphasises that reducing disparities requires embedding health equity within mainstream service improvements and strengthening collaboration with public services, housing and education.

Aligning system incentives: structural misalignment across funding, performance frameworks and accountability mechanisms often slows transformation. The report recommends shifting from short-term activity-based targets to outcomes-focused measures and introducing multi-year financial settlements to enable long-term planning.

Guiding objectives

Four objectives underpin the recommendations in this report:

1. co-developing change with staff and communities - ensuring those delivering and receiving care shape reforms
2. empowering frontline staff - fostering leadership at all levels to drive service improvements

3. balancing rational and relational drivers of change - recognising that data and targets alone are insufficient without cultural transformation
4. decentralising decision-making while maintaining alignment - giving local systems the flexibility to innovate while ensuring consistency in national priorities

A new approach to leadership and learning

The report highlights the importance of relational leadership - built on trust, collaboration, and staff empowerment - as a key enabler of sustainable change. It recommends targeted investment in training, mentoring and leadership development, particularly for clinicians and community-based providers, to ensure improvement is embedded across all levels of the NHS.

To support large-scale learning and adoption of best practices, the report suggests developing a national NHS Learning System to systematically share high-impact improvements across the system rather than allowing them to remain confined to individual trusts.

A call for long-term commitment

Delivering the ambitions set out in the 10 Year Health Plan will require sustained focus, investment, and accountability. While some improvements could be seen in the short term, the most significant benefits, healthier communities, a more resilient NHS, and reduced demand on acute services, will only be realised if efforts remain consistent over the long term.

The report also highlights the wider public sector reform agenda and the forthcoming [Baroness Casey Review](#) into adult social care as key contextual factors. Ensuring deeper cross-sector collaboration, strengthening community partnerships, and embedding change at every level will be critical to building a healthier, more sustainable NHS fit for the future.

Introduction

The government's health mission is clear: to improve the long-term health and wellbeing of the population while ensuring the sustainability of the NHS. Achieving this requires more than just efficiency gains or incremental improvements, it demands a fundamental transformation in how care is delivered. The 10 Year Health Plan will set out 3 major shifts to achieve this: towards prevention, community-based care, and a digitally enabled service.

Delivering on these ambitions will require new ways of mobilising change, moving beyond traditional top-down policy levers to a more participatory and system-wide approach to improvement. Realising the full benefits of this transformation will take time, requiring sustained focus and commitment over the long term. Short-term gains may be visible early on, but the most significant rewards, healthier communities, a more resilient NHS, and reduced demand on acute services, will only be achieved if we stay the course. By maintaining a clear and consistent direction over the 10-year period, we can ensure that the ambitions introduced today translate into lasting improvements for future generations.

The 10 Year Health Plan is not just about improving the NHS - it will fundamentally change what it means to work in and interact with the health service. Over the next decade, we must shift from isolated initiatives to delivering change at scale, embedding new ways of working that transform the experience of staff and patients alike. Some changes will involve accelerating and scaling what already works, ensuring best practice becomes standard practice. Others, including aspects of the neighbourhood health agenda, will require bold experimentation and new models of care. Success will depend on how well we mobilise change, working with staff, patients, and partners to drive systemic improvements while making every day clinical practice better, safer and more effective. This plan is about harnessing the full potential of our workforce and our communities to create an NHS that is fit for the future.

The challenge of mobilising change

While in some areas NHS improvement efforts have yielded progress in pockets of the system; large-scale, sustainable transformation has often proved elusive. Given the financial realities, we must ensure providers can both adopt productivity-enhancing improvements and focus their efforts on delivering the 3 fundamental shifts needed to meet future demand pressures. Success will depend on embedding systemic improvements in ways that make everyday clinical practice better, safer, and more effective.

A critical part of this will be addressing health inequalities. Disparities in access, outcomes, and experience of care remain persistent and must be tackled as a core objective of the plan. Getting this right will have far-reaching impacts - not only improving health outcomes but also reducing worklessness, improving housing stability and enhancing skills. While some progress has been made at local and regional levels, past national efforts have often lacked the alignment and sustained focus needed to drive lasting change.

The working group examined past strategic plans, many of which shared similar ambitions but fell short in execution. We also looked at successful delivery approaches at local and regional level, including the transformation programme Healthcare for London strategy (2005 to 2010) which significantly improved patient outcomes and experiences for people

with life-changing conditions at a city level. A key lesson from these efforts is that success depends not just on the strategy and policy but equally on how change is developed, communicated, led and embedded across the system. This transformation cannot be driven by a single organisation or tier of the NHS alone - it must be owned and led at national, regional and system levels, with collective leadership ensuring alignment and sustained momentum. A shared commitment across all levels will be essential to embedding change in everyday practice and delivering lasting improvements.

Guiding objectives

This report explores not only how change should be co-developed but also how to cultivate the right conditions for its success. Four guiding objectives run through our recommendations:

1. Service improvements must be developed with, rather than done to, those delivering and receiving care, ensuring ownership, adaptability, and long-term success

Sustainable transformation depends on meaningful involvement of both staff and patients. Embedding public and workforce participation into service redesign and improvement will create a sense of shared ownership and responsibility for the future of the NHS.

2. Our driving force of change will be our workforce; our plans must maximise frontline staff agency

Frontline staff must have the agency to shape and influence care. Many NHS staff enjoy their work but feel unable to improve it - closing this gap will be critical. This is especially true for multi-disciplinary teams (MDTs) in community settings, which will play a pivotal role in tackling health inequalities and supporting the growing number of people living with long term conditions through locally tailored approaches.

3. Our plans need to balance rational and relational drivers of change

While metrics, targets and efficiency measures remain important, an overemphasis on activity and process risks overshadowing the deeper, collective effort required to improve patient experience, staff engagement, and population health. Particular attention will be needed on measures to transform the culture of the NHS. A more balanced approach is needed in how policy is implemented, what is measured and how change is led.

4. We should de-centralise where possible, whilst ensuring system-wide levers stack up behind our agenda

The 10 Year Health Plan must ensure that financial flows, performance incentives, and care models reinforce rather than work against each other. This includes ensuring that

efforts to reduce health inequalities are embedded within mainstream service improvements rather than treated as peripheral initiatives.

Aligning system incentives

While this report does not extensively cover all enabling factors, the working group is of the strong view that transformation will only be successful if supported by the alignment of broader system incentives, with levers from national to regional to local supporting everyone to 'pull in the same direction'. Key enablers include the following.

Ensuring there is a dual focus both on near term priorities (for example, accident and emergency waits), as well as our reform objectives, and this is reflected across system incentives, including planning guidance.

Replacing activity-based targets with holistic, outcomes-focused measures that balance rational and relational factors.

Introducing longer-term financial planning, moving toward 3 to 5 year settlements for both capital and revenue and paving the way for cross-sector planning and implementation of public sector reform.

Aligning performance incentives with delivery of system-wide improvements to outcomes.

Ensuring performance management frameworks support sustainable improvements, and assess leadership behaviours to support change through annual appraisal.

A workforce plan which increases staffing in primary and community care, expands outreach roles, and strengthens digital skills across the board.

This alignment is perhaps the most critical factor in mobilising change. Without it, even the most ambitious plans risk being undermined by competing priorities and misaligned incentives. Addressing this challenge is essential to unlocking the full potential of the 10 Year Health Plan and ensuring a lasting impact on patient and population health.

Change driven by public need and owned by frontline staff

The working group is clear that change must be owned and led by the NHS front line, in order to be successful. For new ways of working to take hold, they must be accepted, not just imposed. If staff are disengaged or sceptical, they are unlikely to adopt changes wholeheartedly, even if formally mandated. A recurring challenge in the NHS is the

disconnect between national policy and frontline experience; staff often perceive a gap between the strategic vision set by central leadership and the realities they encounter in their daily work. The idea that people working in national roles 'know best' feels disingenuous to them and takes away their agency; which is the reverse of what we want to achieve. Addressing this disconnect is critical to securing trust, engagement, and commitment to the plan's strategic direction.

Of equal importance is securing public buy-in for the direction of travel and proposed changes. The NHS is a public institution, and its long-term sustainability depends on a strong social contract with the people it serves. The 10 Year Health Plan must help instil a new way for the public to relate to the NHS, not just as passive recipients of care but as active participants in their own health and wellbeing. Furthermore, services co-designed with people and communities are far more likely to be accessible, relevant, and effective within the realities of their daily lives. A new relationship between the NHS and the public will be essential for tackling the growing burden of preventable ill health and ensuring the NHS can continue to provide high-quality care in the face of rising demand.

Establish a shared mission with staff and the public

First, therefore, the 10 Year Health Plan itself must present a compelling, well-evidenced, and resonant case for change, underpinned by a clear and actionable theory of transformation. There is then a role for areas to reflect that at system and place in a way that will resonate with staff, patients and the public. Establishing this shared mission will be crucial in creating the right conditions for successful implementation. Without a clear and commonly held diagnosis of the challenges facing the NHS, there is a risk that priorities will be misaligned, and efforts may not address the most pressing issues. While Lord Darzi's (2024) [Independent Investigation](#) has laid significant groundwork, the case for change must continue to be reinforced throughout the plan's development, finalisation and implementation.

Our change thesis should be articulated in a way that resonates with patients, citizens, local communities and staff, patients must understand how it will improve their care, communities must be able to see how it will impact on their health, wealth and wellbeing, and staff must see how it will enhance their working lives. We should guard against too strong an emphasis on productivity, efficiency or the NHS's financial sustainability without tying it to these outcomes; as these terms will likely fail to inspire or resonate with frontline staff who are clear that they have come to work to care. Similarly, if the public perceives changes as simply reducing services rather than improving care, efforts to transform the system will face significant resistance.

Crucially, all groups need to believe that the new model is realistic and achievable. The Change NHS national engagement exercise has established important insights in this

regard; for example, staff need to see funding and workforce challenges addressed, while the public need to see steps to improve access to core services if they are to view the plan as credible.

Recommendations:

Develop a clear and evidence-based case for change, and vision for the future which resonates and staff and the public. It should speak to the insights and experiences which have come through the 10 Year Health Plan engagement exercise. This should position our vision for change around improve care quality; described as patient and population outcomes - a motivation that aligns with the professional values of clinicians and the wider NHS workforce.

Establish a far-reaching and ambitious communications plan to accompany the launch of the 10 Year Health Plan. The explicit aim should be to build public and staff awareness of the plan's vision and ensure people with what the changes will mean for them. We may want to consider using patient archetypes to bring the changes to life for different communities. This should involve the voluntary, community and social enterprise (VSCE) sector and wider public services, leveraging their deep community ties and trusted relationships to engage diverse groups effectively.

Embed co-design at all levels: embed co-production across all levels of care in the NHS so that staff and patients have equal voices in how the new care model evolved. This includes individual care through personalisation, but should also take place at a service and strategic place level. This would enable people who share the same condition to have a stronger collective voice in shaping service commissioning. It would also draw in wider local communities, especially those who may experience poor health outcomes into the design of care which could remove barriers to access and better target preventative support.

Fostering a genuine sense of ownership and agency will require meaningful co-design, with staff, patients and local communities. This collaborative approach must extend beyond our initial national consultation and into the practical and ongoing design and implementation of changes at local level.

Bridge the gap between national strategy and frontline experience

Ensuring the 10 Year Health Plan remains relevant and effective requires retaining the voices of staff, the public and wider partners throughout its lifecycle. Change, especially in a complex system like the NHS, is dynamic and both innovation and frontline experience will evolve over time. Public expectations may shift in response to changing health needs, emerging technologies and system pressures. Without a mechanism for continuous

feedback, there is a risk that national strategy becomes static, disconnected from real-world implementation, and unable to keep pace with frontline realities.

To create a system that adapts in real time, implementation must include structured feedback loops that allow for continuous learning and refinement. National governance structures, regional partnerships and local engagement mechanisms should work together to surface insights, address challenges early and shape an approach that remains responsive to both new opportunities and emerging risks. By embedding staff, patient and partner perspectives into ongoing decision-making, we can ensure innovation translates into practical, effective change over the full 10-year period.

Recommendation:

Genuinely embed system partners into our 10 Year Health Plan implementation governance from the outset to ensure there is a regular feedback loop between frontline staff and government - as well as accountability for action. This should support us to continue to refine our strategy and approach over the life-span of the plan.

Partnering at the national level in this way will also set the expectation for how systems and places should work cross-sector - aligning health, care and wider public services in a more integrated, collaborative way. This sustained partnership approach will be critical to maintaining trust, momentum, and ultimately, delivering meaningful, lasting improvements in care quality and outcomes.

Ensure change is driven by patient needs and experience

Effective change also requires robust, accessible data to track progress against population health outcomes. Improving the availability and usability of pathway and patient experience data will enhance accountability and support evidence-based decision-making at all levels.

Recommendation:

improve data accessibility: invest in better data infrastructure to provide leaders and teams with real-time, actionable insights into pathway performance and patient experience, enabling more informed decision-making. We should set an expectation that integrated care boards (ICBs) must demonstrate how patient experience data is driving change in the quality of care being delivered. To achieve this ICBs may need to consider patient experience training across the system to ensure this can be delivered.

A new relationship with the public

For the NHS to change its relationship with the public, it must first change the way it behaves towards them. The goal is to make the NHS meaningfully accountable to communities - not just as patients but as citizens and taxpayers. As patients, people's priorities should drive treatment choices. Their decisions about where and how they receive care should influence how resources are allocated. Their voices should help shape services, and they should have real power through meaningful representation in NHS governance.

A core responsibility of the NHS must be to support people in making informed decisions about their health, decisions that are right for them and their families. The NHS should focus as much on helping people stay well as on treating illness.

A key tool in enabling this shift is a revamped NHS App, designed to be far more than just a transactional tool. Its primary purpose will be to support self-care and personal health management. In addition to booking appointments, ordering prescriptions and accessing medical records, the app will:

- provide reliable, artificial intelligence (AI) enhanced health information, including chatbot functionality
- offer personalised health planning, allowing users to create, track and share health improvement plans based on their medical history, lifestyle, and risk factors - including genetic data where relevant
- connect people with local support, including statutory and voluntary services, community groups, and digital health coaching
- offer tailored resources such as curated videos for physiotherapy and exercise, nutrition guidance (including recipes) and mental health support
- enable users to collect, record and share health data with their care team, ensuring a more joined-up approach to managing their health

For those who cannot access digital services, alternative support will be provided. neighbourhood health services will ensure people can still interact with the NHS through in-person, phone-based and assisted digital options, ensuring inclusivity and accessibility for all.

The future NHS must be one that 'works with' people, rather than 'does to' them. Patients should routinely have the opportunity to be as involved in decisions about their care as they choose to be. This requires a cultural shift, including changes to clinical training so

that shared decision-making becomes a core skill for all healthcare professionals. Patients and clinicians must be true partners in care.

Recommendations:

Establish a new social compact between the public and the NHS, underpinned by a reformed NHS Constitution. This should clarify mutual responsibilities, embed prevention and appropriate service use and be reinforced through national engagement, local co-design and aligned financial and policy levers to ensure sustainability and shared accountability.

Expand the NHS App to become a power 2-way tool for:

- supporting choice (when, where and how people receive care)
- enabling self-care, with clear, evidenced-based information on staying healthy and managing illness
- allowing people to create and track personalised health plans, both for preventions and treatment

Ensure all new information in the NHS App complies with the Accessible Information Standard and meets PIF Tick certification to guarantee that it is evidence-based, up to date, and easy to understand.

Publish more timely data on service quality to support patient choice and drive transparency.

Use patient-reported outcomes and experience measures as key indicators of NHS success, enabling the NHS App to become a real-time feedback tool. NHS performance should be judged not just on system metrics but on people's experiences and the outcomes the matter to them.

Achieving this shift requires a fundamental change in the relationship dynamic between the NHS and the public. For too long, NHS culture has been shaped by paternalism, where professionals take on a 'parent' role and patients are seen as passive recipients of care. A modern NHS must be built on an 'adult-to-adult' relationship with citizens, fostering agency, trust and shared responsibility for health.

Health and care eco-system pulling in the same direction

To successfully mobilise change, the 10 Year Health Plan must more clearly delineate the roles and responsibilities of key organisations at every level of the system. Establishing a well-structured 'decision-delivery chain', outlining who sets strategy, who co-ordinates efforts, and who implements change, will ensure decisions are made at the right level and effectively followed through. A clearer framework will help align national, regional, system, and local efforts, reducing duplication and inefficiencies.

Recommendation:

Remove duplication of organisational roles and in change mobilisation. NHS England's new operating model should clearly define the distinct responsibilities and unique value add of national, regional, system, place and provider organisations in leading change and driving improvement.

Reduce administrative burdens. Conduct a zero-based review of all data requests and contract management requirement from national bodies to integrated care systems (ICSs), trusts and NHS providers-ensuring they are necessary proportionate, and sustainable. This will streamline oversight, reducing administrative pressure and freeing up frontline capacity for transformation.

National and system-level organisations should focus on setting clear strategic outcomes and creating the conditions for innovation and improvement, rather than micromanaging frontline delivery. This includes streamlining bureaucratic processes to free up staff capacity for problem-solving and service redesign.

Balancing national and local priorities

The health and care system is currently overwhelmed by a vast number of targets, metrics, and performance measures, often pulling organisations in multiple directions. This complexity makes it difficult for leaders and frontline teams to focus on what matters most. To drive meaningful transformation, we need a smaller, more focused set of national priorities, high-impact, long-term goals that align the system behind shared outcomes. This approach would free up space for locally chosen priorities, ensuring that systems can respond to the specific needs of their populations, as discussed earlier in this report.

For the small number of national priorities, we must align system incentives to drive sustained change. At present, funding flows and performance frameworks do not always support long-term transformation, particularly in shifting care upstream. If we are genuinely committed to the left shift, we should, for example, hardwire financial flows to ensure

sustained and growing investment in primary and community services. Without structural alignment, there is a risk that national ambitions remain disconnected from local realities, and progress is fragmented rather than systemic.

Partnering with public services and communities at place level

The long-term challenges facing the NHS demand new forms of partnership beyond the institution - across places, with public services, providers, the voluntary and community sector, and, most importantly, with communities themselves. The work of [Professor Sir Michael Marmot](#) and others has shown that the root causes of ill health - social, environmental and economic factors - extend beyond clinical practice. While many of these determinants lie outside the NHS's direct control, healthcare cannot be detached from what happens in communities. Instead, the NHS must shift towards partnership-driven, asset-based approaches that empower people to participate in their own health outcomes. Achieving this transformation requires leadership and ownership from all partners, ensuring change is embedded at every level.

Moves towards integrated, place-based co-ordination have been developing for years, including the fourth purpose of ICSs to support social and economic development, the [Better Care Fund](#) pooling NHS and local authority resources, and the role of health and wellbeing boards. The 10 Year Health Plan will provide an important strategic context for the wider public sector reform agenda, recognising that sustainable improvements in health outcomes depend on cross-sector collaboration. It will also set the context for the forthcoming [Baroness Casey review](#) into adult social care, ensuring that the health and care system is working in tandem to deliver meaningful, long-term change. By strengthening local partnerships and embedding shared leadership across sectors, this plan will help drive a more integrated, place-based approach to improving population health and reducing pressure on acute services.

Recommendation:

Develop community participation and oversight of neighbourhood health services: new forms of community governance, drawing on the model of Canada's Community Health Centres can draw in the voice and influence of local residents facing poor health outcomes to share provision. Multi-agency co-location and asset-based practice can complement clinical practice by supporting local networks, drawing in community insight co-design services that remove barriers to access, better responding to the specific circumstances of communities locally.

Building community capacity: the NHS 10 Year Health Plan can also set a path towards building community capacity over the long term, as a route to sustainable upstream prevention. This would involve:

- shifting proportion of local health related spend towards the VCSFE sector as a core partner in prevention, with organisations deeply rooted in the neighbourhoods and networks that support good health and wellbeing
- investing in community-led capacity building, drawing on models such as Big Local, Local Area Coordination and Community Health Champions where community capacity is built to support health and wellbeing

NHS financial flows and accountability mechanisms need to be structured in a way that would enable the NHS to enter more ambitious local partnership, such as Total Place style approaches.

Embedded learning and improvement culture throughout the NHS

For organisations to successfully implement change, they must have the necessary capabilities, capacity and culture. However, NHS providers and commissioners vary significantly in all 3. Success in one organisation does not automatically translate to success in another; factors such as digital readiness, quality improvement expertise, access to data, and strong leadership at board level and across the organisation all influence outcomes. Without the time and space for strategic thinking, organisations risk being trapped in crisis management, making sustained change impossible. Prioritising resources for improvement efforts is therefore essential.

Case study: building a culture of continuous improvement - Berkshire Healthcare NHS Foundation Trust (BHFT)

In 2016, BHFT was rated as 'Good' by the Care Quality Commission, and the board were committed to improve further and become an 'Outstanding' provider. BHFT set out to establish, refine, and embed an approach to quality improvement (QI) that would deliver the improvement in care and outcomes required, but would also engage, motivate and empower colleagues to lead continuous improvement in their daily work. As a result, they could demonstrate results in some of their organisations breakthrough objectives (reducing inpatient falls, reducing self-harm incidents and increasing physical health checks for people with severe mental illness) as well as in team-level 'Driver metrics' (reducing wait to first appointment for CAMHS Common Point of Entry, for example). National staff survey results show improvement in questions in relation to colleagues' ability to make improvement and to be involved in how changes are made. Since 2022, BHFT have ranked in the top one to 2 per cent of all NHS trusts in these staff survey questions.

While patient safety initiatives such as the [Patient Safety Incident Response Framework](#) have demonstrated what is possible, improvement efforts across the NHS remain fragmented and inconsistently applied. If we want learning and improvement embedded across all levels of the NHS, this will require a system-wide commitment to continuous learning, supported by national policy and leadership - as well as dedicated improvement resources to provide structured support, underpinned by a consistent approach to evidence-based change methodologies.

Addressing barriers to an improvement culture

To foster a culture of continuous improvement, we must tackle the key challenges that currently hinder progress:

Institutional inertia: long-established structures, systems, and behaviours can make change slow and difficult to embed. A fragmented improvement infrastructure leads to inconsistencies in approach across different sectors.

Skills gaps: the post-COVID loss of experienced leaders and the rapid evolution of healthcare technology and data analytics have created a deficit in improvement expertise, from frontline teams to boards.

Leadership and management bandwidth and capacity: significant demand pressures, particularly in primary care, make it difficult for clinical and operational leaders to dedicate time to designing, leading, and delivering change.

Lack of system-wide improvement infrastructure: over recent years, the NHS has lost much of its structured improvement support, leading to multiple, small-scale initiatives rather than a coordinated, large-scale approach.

Fear of failure: a risk-averse culture, particularly in clinical settings, can lead to reluctance in adopting new models of care or innovative technologies, even when the potential benefits are clear.

Lack of data and evidence of what works well elsewhere.

Lack of seed funding to fund improvement activity (including capital).

Enabling frontline-led change at scale

Achieving the necessary scale and pace of improvement will require frontline NHS leaders to be empowered and equipped to drive change. A structured, system-wide approach, such as implementing NHS IMPACT (Improving Patient Care Together) at scale, can support this shift. NHS staff must be enabled to become adept problem solvers, identifying and addressing inefficiencies that frustrate both patients and staff.

Key enablers include:

Nationally defining best practice and principles of a high performing service to set the commissioning and improvement framework.

Embedding improvement capability as a core function of how organisations operate, rather than treating it as an isolated initiative, and setting an expectation that a proportion of spend is allocated to improvement.

Creating strong signals from national and local leadership that learning, adaptation and continuous improvement are core expectations, not optional extras.

Enhancing peer-to-peer learning opportunities, recognising that improvement spreads best through shared experiences rather than written reports alone.

Strengthening system-wide feedback loops, ensuring that learning is captured, shared, and applied effectively.

Being able to use real time feedback from patients, carers, and staff to validate change or adapt on the go.

Progression and succession rewards; how does success in delivering change, including great people management get assessed and valued?

A culture that says thank you and offers praise.

Recommendations:

Set an expectation and ensure that all organisations have an improvement approach where boards lead for improvement creating the conditions for success; that includes a suitably sized improvement programme for the scale and complexities of challenges faced, with a recognised improvement methodology.

An NHS Learning System should be established as a systematic approach to scale, spread and adoption. This would create an accelerated way of sharing the 'best of the NHS with the rest of the NHS' and support the best performing organisations to improve. This would involve centrally coordinated knowledge sharing platforms, to facilitate the rapid spread of innovation and effective models of care, peer learning networks and collaborative and communities of practice.

Create delivery vehicles to support improvement. In 2025 to 2026 NHS England will have national coverage of Learning and Improvement Networks that are used to share learning and best practice across urgent and emergency care, electives, and mental health. The intention is mature these through time to increase their ability to support improvement. The

scope and coverage of Learning and Improvement Networks will also increase to cover additional priority areas such as neighbourhood health, primary care, cancer and maternity.

Expanding change management capacity and capability

Most NHS clinicians, managers, and executives have limited first-hand experience of leading major transformation. While these skills can be developed, access to structured training and hands-on learning has been inconsistent. To ensure improvement becomes a core part of NHS culture, the system must embed proven methodologies such as Quality Improvement collaboratives, lean and human-centred design into everyday practice.

Historically, improvement capability has been concentrated in the acute sector, where resources and structured training programmes are more prevalent. However, many of the shifts we need to see in healthcare delivery - such as delivering more care in the community, improving integration between services, and supporting preventative health measures - require stronger change management skills in primary, community, and social care settings. Given the size and scale of the changes needed detailed capability planning is needed to ensure leaders have the right skills to successfully implement change. This can include areas such as 'systems thinking', simulation modelling, evaluation, and communications and engagement.

Developing these capabilities across multidisciplinary teams will be essential to ensuring transformation is sustainable and system-wide. This includes providing targeted training for GPs, social care leaders, and community-based professionals, who are central to delivering future models of care.

Recommendations:

Build improvement capabilities. Develop a national programme to enhance the improvement capability of staff and of leaders across NHS England and within ICBs. This should connect with locally developed improvement systems in providers, place partnerships, and throughout ICSs, utilising the NHS IMPACT framework. This programme should draw on best practice from international health systems and in other industries

Significantly increase staff's basic skills to drive improvement in community-based care, including primary care, and across place partnerships.

National framework developed by NHS England.

Introduce new nationally mandated, locally defined development programmes in QI for community-based staff and place partnerships. This includes building improvement capability in our community-based teams, including social care providers, primary care, public health and digital leadership teams.

There needs to be a process to professionalise improvement as a career pathway developing standard competencies through to board-level roles, with consideration given to setting up a faculty or society for this professional group. This could include the development on national competencies related to improvement for executive directors who hold the improvement portfolio. Ensuring that every provider and ICB has the required capacity to apply improvement.

Operational managers. Review and refresh the training and skills given to the operational management cadre in the NHS.

Expand national improvement offers. Expand existing national improvement offers such as 'Getting it Right First Time' (GIRFT) and other improvement teams to enable us to take a more robust improvement approach to helping systems and providers solve complex challenges, through short-term deployable resource (including improvement and subject matter expertise).

Funding to increase specialist improvement capacity. There should be dedicated funding to support the development of expert and improvement capacity and capability, such as dedicated improvement advisors with system engineering expertise to support high priority programmes, such as neighbourhood healthcare teams.

Empowering staff to drive change: the role of relational leadership

Lasting change in the NHS is driven by frontline staff, who understand the realities of care delivery and are best placed to identify solutions. The role of leadership is to create the conditions in which staff feel trusted, supported and empowered to innovate. Rather than directing from the top, leaders must enable improvement at every level, ensuring that staff have the resources, autonomy, and psychological safety to take ownership of change.

A culture of improvement flourishes when leaders prioritise relationships and foster trust. This means moving beyond traditional hierarchies and actively supporting frontline teams to test, learn, and refine new ways of working. Leaders must focus on removing barriers - whether operational, bureaucratic, or cultural - that slow progress. Crucially, they must champion a learning culture rather than a blame culture, reinforcing that continuous improvement is a collective effort rather than an individual risk. Psychological safety is the foundation of high-performing teams, yet hierarchical structures and, at times, bullying cultures have historically undermined this across parts of the NHS. A culture of continuous improvement will develop if leaders also address unacceptable performance and behaviours in fair, consistent, adult ways.

Change moves at the speed of trust. Staff engagement is not a 'nice to have' but a prerequisite for meaningful transformation. Change will only succeed if staff believe it is developed with them, not imposed upon them. Leaders must therefore listen, act on feedback, and align national priorities with the realities of frontline work. This means bridging the gap between 'work as imagined' and 'work as done' - ensuring that policies, targets, and initiatives genuinely support staff in delivering high-quality care.

Within provider settings, leadership must be embedded at all levels, not reliant on a handful of individuals. Ensuring visible and engaged leadership means creating mechanisms for regular dialogue between senior leaders and frontline teams, so staff feel heard and supported in driving improvements. This is not about leaders 'heroically' fixing problems - it is about removing unnecessary burdens, addressing systemic issues, and giving staff the confidence and space to lead change themselves. Research consistently shows that when staff feel supported in this way, morale improves, patient safety increases, and care outcomes are enhanced.

Embedding this approach requires equipping leaders at all levels with the skills to support improvement. From national policymakers to frontline managers, leadership development must focus on building trust, fostering participation, and enabling system-wide transformation. Emotional intelligence, active listening, and an understanding of improvement science should be core components of leadership training.

NHS England will launch leadership training in 2025 to 2026 to strengthen clinical and operational leaders' improvement skills, with an initial goal of reaching 21,000 people over the next year. A dedicated board development programme for improvement will also begin, ensuring leadership at all levels is equipped to enable frontline-driven change.

Recommendations:

Introduce a new national framework for leadership and management standards, which would include an expectation that all managers and leaders have an annual appraisal with clear behavioural standards to support the required behaviours for collaboration and partnerships.

Improve leadership skills and training to the front line. Existing leadership development offers in improvement and system leadership (as below) should be extended to ensure broader coverage - particularly to leaders working within primary care.

Embed the principle of 'learning together'.

Scale up training across clinical and operational managers. During 2025 to 2026 there is a programme to reach 21,000 managers to upskill in the fundamentals of management, leadership and improvement.

Provide a comprehensive board and executive leadership development programme for improvement ensuring all appropriate boards have completed the programme by March 2028. Such a programme will commence in 2025 to 2026.

Develop a clinical and operational training offer and a version of board and/or executive development for other sectors such as primary and social care.

Improvement to be embedded into executive development (for example, Nye Bevan, Aspiring Director) and ensure all key networks are doing the same (for example, chief executive officers, Proud2Bops, royal colleges).

An appropriate offer should also be developed for place partnership boards in conjunction with partners, such as the Local Government Association around system leadership.

Strengthen clinical leadership as a driver of change

Clinical leaders have the potential to play a critical role in driving sustainable transformation. For the public, clinicians are one of the most trusted voices that they look to for confidence in changes. For colleagues, clinicians leading and supporting change brings professional credibility and frontline experience that can help build wider confidence in new ways of working. Evidence from the [NHS Leadership Academy](#) suggests that peer-led change initiatives can be more effective than top-down directives, as clinicians can address concerns directly and advocate for improvements with professional authority.

Change in the NHS impacts on clinicians as much as on patients and other staff. And this means that of course clinicians can themselves also be anxious or reserved about change when it requires them to change their ways of working. And while it is right to acknowledge and address these concerns through the change process, this should not put clinicians in the position where they can frustrate much needed change that will bring benefits to patients.

Clinical leadership must facilitate, rather than hinder, transformation. The NHS must ensure that clinical leadership responsibilities include accountability for delivering effective change, helping to identify and overcome barriers to change. There remain unfortunately instances where individual clinicians act as a veto against necessary reforms - it is important that such resistance is addressed through robust performance management.

Encouraging innovation and continuous learning is a vital function of clinical leadership, but this must be accompanied by clear expectations for engagement in transformation efforts. While a culture of experimentation can empower teams to test new approaches, change should not be dependent on voluntary participation. To drive meaningful improvement, the NHS should align incentives for clinicians, such as Clinical Excellence Awards, with outcomes, rather than academic prestige alone, ensuring that clinical

leadership roles are focused on delivering tangible benefits for patients and the system as a whole.

Recommendations:

Embed clinical leadership in system transformation. Set a clear expectation that clinicians play a central role in shaping, leading and implementing change embedded in contracts and job plans.

Support clinical leaders. Provide structured training, resources, and mentoring to help clinicians lead change effectively. Ensure leadership training includes accountability for delivering system improvement, rather than just developing leadership skills in isolation. Consider linking completion of leadership training to progression opportunities or incentives.

Ensure contracted clinicians (for example GPs) have contracts that enable and require them to engage with system leadership and change. Contracts should include explicit provision for and expectations of participation in system leadership and service transformation. Review and adapt payment structure and workload models to enable meaningful involvement in leadership roles without negatively impacting patient care.

To embed and sustain change, clinical leaders must have access to structured training, mentorship and resources to support their development. However, leadership training should not be a substitute for accountability. Investing in leadership skills must go hand in hand with ensuring that NHS teams remain adaptable and focused on delivering improvements. This requires a shift in approach - where clinical leadership is not just an opportunity to influence but a responsibility to drive measurable change.

Conclusion: a healthier future, built together

The NHS stands at a pivotal moment. Over the next decade, the scale of transformation required is unprecedented - but so too is the opportunity. By shifting how change is mobilised, led and sustained, we can move beyond reactive reform to create a health service that is more adaptable, inclusive, and effective for staff, patients, and communities alike.

The key to success lies in ensuring that service improvements are developed with, rather than done to, those delivering and receiving care. This is not just a principle - it is the foundation of a sustainable NHS. By embedding public and staff involvement into the design and implementation of change, we will foster a collective sense of ownership, ensuring that new models of care are not only effective but truly embraced at every level.

Our workforce will be the driving force of this transformation. In 10 years' time, success must be measured not only by patient outcomes but by a demonstrable increase in staff agency - the ability of frontline teams to shape and improve care. Currently, too many NHS staff feel constrained by systemic barriers. By removing these obstacles, empowering decision-making at the frontline, and investing in leadership at all levels, we will unlock a more engaged and innovative workforce.

Achieving this requires balancing rational and relational drivers of change. While clear goals, data and accountability structures remain essential, they must work in tandem with a culture of trust, collaboration and continuous learning. A high-performing NHS in 2035 will not be one that simply meets targets - it will be one where patients feel genuinely cared for, where staff feel valued and heard and where improvements in experience and outcomes are driven by a shared commitment to excellence

To make this a reality, we must move away from rigid, top-down control and embrace decentralisation wherever possible. But this does not mean leadership is any less important, on the contrary, transformation must be actively owned and driven at every level: national, regional and system. Change should be led from the bottom up, with national leaders setting clear expectations on outcomes while creating the conditions for local innovation to flourish. Only through shared leadership and collective responsibility can we embed meaningful, long-term improvements that benefit patients, staff, and communities alike.

If we get this right, the NHS of 2035 will look and feel different - not just in its models of care, but in its culture and impact. It will be a system where staff have the freedom to improve care, where patients are active partners in their health, and where change is not something to be endured but something to be embraced. Most importantly, it will be an NHS that is not only stronger and more sustainable but one that remains true to its founding purpose: to provide high-quality care for all, now and for future generations.

Annex 1: list of recommendations

Theme: change driven by public need, and owned by front line staff

Recommendation	Primary owner	Cost (preliminary estimates)
Develop a clear and evidence-based case for change, and vision for the future which resonates with staff and the public. It should speak to the insights and experiences which	Department of Health and Social Care	No/low cost

Recommendation	Primary owner	Cost (preliminary estimates)
<p>have come through the 10 Year Health Plan engagement exercise. This should position our vision for change around improving care quality; described as patient and population outcomes - a motivation that aligns with the professional values of clinicians and the wider NHS workforce.</p>		
<p>Establish a far-reaching and ambitious communications plan to accompany the launch of the 10 Year Health Plan. The explicit aim should be to build public and staff awareness of the plan's vision and ensure people connect with what the changes will mean for them. We may want to consider using patient archetypes to bring the changes to life for different communities. This should involve the VCSE sector and wider public services, leveraging their deep community ties and trusted relationships to engage diverse groups effectively.</p>	<p>Department of Health and Social Care</p>	<p>No/low cost</p>
<p>Embed co-design at all levels: embed co-production across all levels of care in the NHS, so that staff and patients have equal voices in how the new care model evolved. This includes individual care through personalisation, but should also take place at a service and a strategic place level. This would enable people who share the same condition to have a stronger collective voice in shaping service commissioning. It would also draw in wider local communities, especially those who may experience poor health outcomes, into the design of care which could remove barriers to access and better target preventative support.</p>	<p>All</p>	<p>Not yet been costed</p>

Recommendation	Primary owner	Cost (preliminary estimates)
<p>Genuinely embed system partners into our 10 Year Health Plan implementation governance from the outset to ensure there is a regular feedback loop between frontline staff and government - as well as accountability for action. This should support us to continue to refine our strategy and approach over the life-span of the plan.</p>	<p>Department of Health and Social Care, NHS England</p>	<p>No/low cost</p>
<p>Improve data accessibility: invest in better data infrastructure to provide leaders and teams with real-time, actionable insights into pathway performance and patient experience, enabling more informed decision-making. We should set an expectation that ICBs must demonstrate how patient experience data is driving change in the quality of care being delivered. To achieve this ICBs may need to consider patient experience training across the system to ensure this can be delivered.</p>	<p>NHS England</p>	<p>Not yet been costed</p>
<p>Establish a new social compact between the public and the NHS, underpinned by a reformed NHS Constitution. This should clarify mutual responsibilities, embed prevention and appropriate service use, and be reinforced through national engagement, local co-design, and aligned financial and policy levers to ensure sustainability and shared accountability.</p>	<p>NHS England</p>	<p>No/low cost</p>
<p>Expand the NHS App to become a powerful two-way tool for:</p> <ul style="list-style-type: none"> • supporting choice (when, where and 	<p>NHS England</p>	<p>Not yet been costed</p>

Recommendation	Primary owner	Cost (preliminary estimates)
<p>how people receive care)</p> <ul style="list-style-type: none"> enabling self-care, with clear, evidence-based information on staying healthy and managing illness allowing people to create and track personalised health plans, both for prevention and treatment 		
Ensure all new information in the NHS App complies with the Accessible Information Standard and meets PIF Tick certification to guarantee that it is evidence-based, up-to-date, and easy to understand.	NHS England	Not yet been costed
Publish more timely data on service quality to support patient choice and drive transparency.	NHS England	Not yet been costed
Use patient-reported outcome and experience measures as key indicators of NHS success, enabling the NHS App to become a real-time feedback tool. NHS performance should be judged not just on system metrics but on people's experiences and the outcomes that matter to them.	NHS England	Not yet been costed

Theme: health and care ecosystem pulling in the same direction

Recommendation	Primary owner	Cost (preliminary estimates)
Remove duplication of organisational roles in change mobilisation. NHS England's new	NHS England	No/low cost

Recommendation	Primary owner	Cost (preliminary estimates)
operating model should clearly define the distinct responsibilities and unique value add of national, regional, system, place and provider organisations in leading change and driving improvement.		
Reduce administrative burdens. Conduct a zero-based review of all data requests and contract management requirements from national bodies to ICSs, trusts, and NHS providers - ensuring they are necessary, proportionate and sustainable. This will streamline oversight, reducing administrative pressure and freeing up frontline capacity for transformation.	NHS England	No/low cost
Develop community participation and oversight of neighbourhood health services: new forms of community governance, drawing on the model of Canada's Community Health Centres can draw in the voice and influence of local residents facing poor health outcomes to shape provision. Multi-agency co-location and asset-based practice can complement clinical practice by supporting local networks, drawing in community insight to codesign services that remove barriers to access, better responding to the specific circumstances of communities locally.	Integrated care systems	Not yet been costed
<p>Building community capacity: the 10 Year Health Plan can also set a path towards building community capacity over the long term, as a route to sustainable, upstream prevention. This would involve:</p> <p>Shifting a proportion of local health related spend towards the voluntary, community, faith and social enterprise sector (VCSFE) sector as a</p>	Integrated care systems	Not yet been costed

Recommendation	Primary owner	Cost (preliminary estimates)
<p>core partner in prevention, with organisations deeply rooted in the neighbourhoods and networks that support good health and wellbeing.</p> <p>Investing in community-led capacity building, drawing on models such as Big Local, Local Area Co-ordination and Community Health Champions where community capacity is built to support health and wellbeing.</p>		
<p>NHS financial flows and accountability mechanisms need to be structured in a way that would enable the NHS to enter more ambitious local partnerships, such as Total Place style approaches.</p>	<p>Department of Health and Social Care</p>	<p>Not yet been costed</p>

Theme: an embedded learning and improvement culture throughout the NHS

Recommendation	Primary owner	Cost (preliminary estimates)
<p>Set an expectation and ensure that all organisations have an improvement approach where boards lead for improvement creating the conditions for success that includes a suitably sized improvement programme for the scale and complexities of challenges faced, with a recognised improvement methodology.</p>	<p>NHS England</p>	<p>No/low cost</p>

Recommendation	Primary owner	Cost (preliminary estimates)
<p>NHS learning system. An NHS Learning System should be established as a systematic approach to scale, spread and adoption. This would create an accelerated way of sharing the 'best of the NHS with the rest of the NHS' and support the best performing organisations to continue to improve and support most organisations to improve. This would involve centrally co-ordinated knowledge-sharing platforms - to facilitate the rapid spread of innovation and effective models of care, peer learning networks, collaboratives and communities of practice.</p>	<p>NHS England, regional</p>	<p>£2.5 million</p>
<p>Create delivery vehicles to support improvement. In 2025 to 26 NHS England will have national coverage of Learning and Improvement Networks that are used to share learning and best practice across UEC, electives and mental health. The intention is mature these through time to increase their ability to support improvement. The scope and coverage of Learning and Improvement Networks will also increase to cover additional priority areas such as neighbourhood health, primary care, cancer and maternity.</p>	<p>NHS England, regional</p>	<p>Not yet costed</p>
<p>Build improvement capabilities. Develop a national programme to enhance the improvement capability of staff and of leaders across NHS England and within ICBs. This should connect with locally</p>	<p>NHS England</p>	<p>Funded as part of recommendation 25</p>

Recommendation	Primary owner	Cost (preliminary estimates)
<p>developed improvement systems in providers, place partnerships and throughout ICSs, utilising the NHS IMPACT framework. This programme should draw on best practice from international health systems and in other industries.</p>		
<p>Significantly increase staff's basic skills to drive improvement in community-based care, including primary care, and across place partnerships:</p> <ul style="list-style-type: none"> • national framework developed by NHS England • introduce new nationally mandated, locally defined development programmes in QI for community-based staff and place partnerships. This includes building improvement capability in our community-based teams - including social care providers, primary care, public health and digital leadership teams 	NHS England	£7.5 million
<p>There needs to be a process to professionalise improvement as a career pathway developing standard competencies through to board-level roles, with consideration given to setting up a faculty or society for this professional group. This could include the development of national competencies, related to improvement for executive directors who hold the</p>	NHS England	£1 to 5 million

Recommendation	Primary owner	Cost (preliminary estimates)
improvement portfolio. Ensuring that every provider and ICB has the required capability to apply improvement.		
Operational managers. Review and refresh the training and skills given to the operational management cadre in the NHS.	NHS England	£9 million - already committed in 2025 to 2026
Expand national improvement offers. Expand existing national improvement offers such as 'Getting it Right First Time' (GIRFT) and other improvement teams to enable us to take a more robust improvement approach to helping systems and providers solve complex challenges, through short-term deployable resource (including improvement and subject matter expertise).	NHS England	£12 million - already committed in 2025 to 2026 to expand these improvement offers in addition to existing budgets
Funding to increase specialist improvement capacity. There should be dedicated funding to support the development of expert improvement capacity and capability, such as dedicated improvement advisors with system engineering expertise to support high priority programmes, such as neighbourhood healthcare teams.	Integrated care systems to determine locally	£7.5 million
Introduce a new national framework for leadership and management standards, which would include an expectation that all managers and leaders have an	NHS England	No/low cost

Recommendation	Primary owner	Cost (preliminary estimates)
<p>annual appraisal with clear behavioural standards to support the required behaviours for collaboration and partnerships.</p>		
<p>Improve leadership skills and training to the front line. Existing leadership development offers in improvement and system leadership (as below) should be extended to ensure broader coverage - particularly to leaders working within primary care.</p> <p>Embed the principle of ‘learning together’ as part of all training and development.</p> <p>Scale up training across clinical and operational managers. During 2025 to 2026 there is a programme to reach 21,000 managers to upskill in the fundamentals of management, leadership and improvement.</p> <p>Provide a comprehensive board and executive leadership development programme for improvement ensuring all appropriate boards have completed the programme by March 2028. Such a programme will commence in 2025 to 2026.</p> <p>Develop a clinical and operational training offer and a version of board and/or executive development for other sectors such as primary and social care.</p>	<p>Various</p>	<p>£47.5 million</p>

Recommendation	Primary owner	Cost (preliminary estimates)
<p>Improvement to be embedded into executive development (for example Nye Bevan, Aspiring Director) and ensure all key networks are doing the same (for example chief executive officers, Proud2BOps, royal colleges).</p> <p>An appropriate offer should also be developed for place partnership boards, in conjunction with partners, such as the Local Government Association around system leadership.</p>		
<p>Support clinical leaders. Provide structured training, resources, and mentoring to help clinicians lead change effectively. Ensure leadership training includes accountability for delivering system improvements, rather than just developing leadership skills in isolation. Consider linking completion of leadership training to progression opportunities or incentives.</p>	Providers	Cost included as part of recommendation above
<p>Embed clinical leadership in system transformation. Set a clear expectation that clinicians play a central role in shaping, leading and implementing change embedded in contracts and job plans.</p>	All	No/low cost
<p>Ensure contracted clinicians (for example GPs) have contracts that enable and require them to engage with system leadership and change. Contracts should include explicit provision for and</p>	Department of Health and Social Care	Not yet costed

Recommendation	Primary owner	Cost (preliminary estimates)
expectations of participation in system leadership and service transformation. Review and adapt payment structures and workload models to enable meaningful involvement in leadership roles without negatively impacting patient care.		

Annex 2: group members

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Bob Klaber (Imperial College Healthcare NHS Trust)

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