10 Year Health Plan working group: 'I can access the high-quality and effective care I need, when and where I need it'

Co-chairs' report

Submitted to the Secretary of State: December 2024
Published: December 2025

Contents

Foreword

Over the next 10 years, major changes in our population will need to be matched with radical change in health and care services. England's communities will both grow and get older, with significantly more people living with multiple long-term conditions, and a higher proportion of people over 75 years old living in rural and coastal areas.

Our children and young people are suffering from poorer mental health since the pandemic, and we need a major shift in care for them including recognising and supporting attention deficit hyperactivity disorder (ADHD) and other forms of neurodiversity so people can play a full part in society, supported if needed by the NHS.

We need to tackle unwarranted variation in access to care and quickly improve services that are not performing consistently well, like maternity and dentistry. We need to bring waiting times down and get more of the basics right, including access to primary care. The public and NHS staff have told us that we need to move to delivering care closer to home, improve the patient experience, and reduce inefficiency in the NHS. They are aware that the current model is unsustainable.

By 2035, we need to move to a radical new model, where integrated neighbourhood health teams support people to stay healthy and to access the right care at the right time, significantly reducing demand on urgent and emergency services, and where diagnostics and planned care procedures happen quickly.

As well as fixing the basics, we have the opportunity to lay out a roadmap to achieving some huge ambitions. For example, imagine if by 2035, because we have better access to care:

- we halved the rates of avoidable sight loss
- people at high risk are automatically enrolled on the diabetes prevention programme, reducing their likelihood of developing the condition
- artificial intelligence (AI) tools support dementia diagnosis so no-one is left waiting for an assessment
- people who have a learning disability or who are neurodivergent have equality of outcomes with the whole population across physical and mental health

Alongside cross-cutting ambitions for how services could be delivered differently, there are ambitions for condition pathways in annex C of this report.

We must use new technology and take a major leap forward in developing and using a digital ‘front door’ to the NHS whilst still supporting those who do not choose this channel with traditional methods of contact.

The report that follows begins to set out how we can make this happen. This would not have been possible without the expertise, professionalism and hard work of our working group members and the group secretariat, who have our thanks.

Louse Ansari and Emily Lawson

Executive summary

In 2035 every person in England will be able to access high-quality care, when and where they need it. This will be achieved through four major changes, summarised below, that align with the shifts articulated by the Secretary of State.

This report sets out ten priority ambitions for 2035 that illustrate what it would mean to make these major changes a reality, showing the practical - and in some cases radical - difference it will make for people and communities.

Making these changes and delivering the reformed service offer described here will transform people’s access to and experience of healthcare. Services will be easier to find and navigate, better tailored to individual needs, and delivered in ways, times and places that are more convenient for users.

Woven through our vision is a commitment to equity and consistently delivering the highest standards of quality and safety, ensuring services remain accessible to all and free at the point of need.

In 2035 care will be:

Digital first for most people

The NHS App will provide a 24/7 service and ensure the NHS ‘starts in your pocket, not your practice’. It will enable people to monitor and manage their health and access: the most clinically relevant advice and information; the most appropriate services; and the latest trusted and proven medical technology.

The app will give people more convenience and more control of their care, enabling people to make informed decisions about how they access healthcare services, from managing minor illness to recognising symptoms of serious conditions. The range of services available online, the tasks that professionals can carry out remotely, and the use of AI to risk-assess, diagnose and inform will be dramatically expanded.

These digital services will complement face-to-face care and will be available for a person to use any time they need. Alternative access points will be available for those who need them, including through neighbourhood health services, ensuring no one is left behind. Digital service delivery will boost productivity, meaning everyone benefits.

People’s full care records will be accessible to them and all relevant providers who need it to make decisions about care, enhancing co-ordination of care, improving safety and eliminating the need for patients to repeat their story.

Delivered as close as possible to home

Care will be delivered in the most convenient setting that technology and clinical effectiveness, as well as cost, can allow. Most initial assessments, diagnostic services and ongoing support will be delivered in the community or at home, supported by expanded virtual care and remote monitoring. Care will only be delivered in hospitals if it is clinically necessary. This will maximise the capacity of hospitals and other physical healthcare facilities to provide emergency and specialist care, as well as complex treatment and support.

Patients will still be able to choose where to receive care - when clinically appropriate - with support for those who face barriers to accessing services.

Personalised by design

Care and support will be personalised, focused on clinically robust outcomes that matter to individuals, with shared decision-making the default. Care will be co-designed with individuals, their families and carers as needed, addressing emotional, social and practical needs alongside clinical care.

This will not depend only on the efforts of and behaviours of individual professionals. It will be an expectation designed into every part of the system, from the recruitment and initial training of staff through to the design of contracts, incentives and regulation.

Healthcare, social care, public health and other service providers will co-ordinate the support they provide to individuals and communities, across the public, voluntary, community, and social enterprise (VCSE) and independent sectors, underpinned by compatible IT systems. Those most at risk will be supported proactively by multidisciplinary teams, through a single point of contact.

People will be encouraged to provide feedback about their experience of care and can be confident it will be valued and acted upon.

Equitable, effective, and responsive

High-quality and safe care will be available to all, regardless of who they are, where they live, or their health status. Quality and safety improvement will be embedded in organisational operating models, part of every staff member's role and a core component of training and qualifications.

Multiple data sources, including patient feedback, will be used to drive improvement. Use of advanced data science and AI will create insights that will be built into reporting and learning, supporting a system that values patient experiences and acts on inequalities in access and outcomes. Services will also support innovation through research, enabling the NHS to contribute to advancements in health and care.

Published data showing performance on standards for waiting times and clinical outcomes will allow patients informed choice and support effective intervention to ensure timely, evidence-based care.

People will be supported to 'wait well', including having support for pain relief and anxiety, and will have excellent communications about when and where their treatment will happen.

Major changes and ambition statements

Digital first for most people

1. The NHS App will support most people to manage their health and wellbeing, providing a 'single front door' to access their neighbourhood health service.

2. Everyone will have a comprehensive and secure single care record. With consent, this will be viewed and proactively used by health and care service providers to improve care and outcomes.

Delivered as close as possible to home

3. No care will be delivered in hospitals unless it is necessary or the patient's choice.

4. Every member of the public will be able to access co-ordinated primary care services, regardless of who they are or where they live.

5. Every adult, child and young person will be able to access mental health and care support 24/7 - especially those in crisis.

Personalised by design

6. Those at high clinical risk and who are marginalised will have a health and care system that comes to them.

7. Anyone waiting for diagnosis or treatment will receive real-time information on waits and ‘gold standard’ holistic support to ‘wait well’.

Equitable, effective, and responsive

8. Services will prioritise improvement against health inequalities and what matters to patients, with service users invited to leave feedback on experience and outcomes as standard.

9. In an emergency, such as a heart attack or stroke, everyone who needs it will get the most clinically advanced treatment available, with faster standards of response time and care, leading to more lives being saved.

10. Effective palliative care services are available for everyone, providing people with safe, dignified and personalised end of life care in a setting of their choice.

Chapter 1: introduction

This paper sets out the report of the 10 Year Health Plan vision working group 2, which has focused on the vision statement: 'I can access the high-quality and effective care I need, when and where I need it.'

It sets out the response to the brief from the 17 working group members who met 4 times over a period of 5 weeks, combined with evidence gathered through the ‘Change NHS’ engagement exercise and from a range of NHS England (NHSE) and Department of Health and Social Care (DHSC) programme teams. While we have considered other relevant evidence and expert opinion, the working group activities form the main basis for our vision and recommendations.

Annex 1 provides a brief note on how we have approached the task, including definitions we have used, how we have interpreted the scope and assumptions we have made.

Based on that scope, we have focused on what it means to ensure that when people need to use healthcare services, they are easily accessible and well-co-ordinated and that people have a positive user experience, confident that systems are in place to keep them safe and ensure quality standards are met.

We describe the key features and components of a reformed service offer that we believe will help to make this true for everyone. We have illustrated the service offer in a set of 10 specific ‘ambition statements’ that describe how people could access and experience health and care services in 2035. These focus on features that have been common themes in the Change NHS engagement and our working group activities. For each ambition the working group has proposed a 2, 5 and 10-year roadmap toward realising the vision, using examples to illustrate what this could mean for people and communities if we do.

Annex 2 illustrates the 'ambition statements' through a range of hypothetical personas. We have also laid out some bold ambitions for certain specific conditions to illustrate the scale of change we could see on prevention, diagnosis and treatment by 2035. Details of these can be found in annex 3.

We have developed the vision in reference to a specific set of desired outcomes and system level impacts.

It is crucial to acknowledge here that, however they are organised, the extent to which a population ‘gains access’ to healthcare services depends on financial, organisational, social and cultural considerations that may limit their use by certain groups and individuals.

We recognise that vision working group 4 ('I am treated in a fair and inclusive way, irrespective of who I am') co-chairs' report has developed a set of principles for how care should be designed and delivered to significantly improve healthcare equity and address disparities in access, patient experience and outcomes. However, we see reducing inequalities in access to and the experience of care as fundamental to making our ‘I’ statement true and have reflected this in the outcomes we have identified below.

The development of a 10 Year Health Plan provides an opportunity to set out an ambitious and realistic roadmap for change. To provide direction to government, and the 10 Year Health Plan enabling working groups, this report sets out some of the conditions that will need to be met, and first steps to be taken on the road to realising the vision.

Chapter 2: how the population will change by 2035

While there is a lot that we are not able to predict for 2035, we have considered some of the projected demographic and social trends that will impact how people are likely to want and need to access health and care services in 10 years’ time.

We expect England’s population to both grow and to get older, and that there will be significantly more people living with a major illness or long-term condition.

The Office for National Statistics estimates that the population of England will grow to 62.2 million by 2035 from an estimated 57.7 million in 2023 - an increase of 4.5 million (or almost 8% more people). This includes an increase of 24.4% in those over 75 years old. Overall, there will be a shift to an older population, with 2.7 million more people over the age of 60. The Chief Medical Officer’s 2023 report also predicts changes in where people over the age of 75 will live in 2043, with a shift to rural and coastal areas.

The Health Foundation (2023) forecasts that there will be an increase to more than a third (37%) of people living with a major illness by 2040 - a projected additional 9.1 million people since 2019. Rates of obesity are increasing, with an estimated 35% of the population projected to be obese by 2030, a risk factor for cardiovascular disease, type 2 diabetes, many cancers, and other conditions (National Institute for Care and Excellence, 2024).

We also anticipate that continued advances in science and technology will transform how people manage their health and wellbeing. These include: genetics and personalised medicine; the introduction of new tests and drugs for conditions such as obesity and dementia; increasingly ‘smart’ devices; and greater capacity to process and use data. This will lead to radically different expectations about how they access and interact with healthcare services.

Our children and young people are suffering from poorer mental health since the pandemic (Office for Health Improvement and Disparities, 2022) and we need a major shift in care for them including recognising and supporting ADHD and other forms of neurodiversity so people can play a full part in society, supported if needed by the NHS.

In combination, these trends are likely to mean:

- a large overall increase in the number of older people and people with multiple long-term conditions seeking access to health and care services - requiring a different approach to manage demand in an affordable, sustainable way
- a major increase in the number of unpaid carers (to an estimated 10.3 million people providing some kind of high or low intensity care) who themselves need to be supported by the NHS and other services (Joseph Rowntree Foundation, 2024)
- a greater concentration of demand in rural and coastal areas where provider sustainability and access to specialist services can be challenging - requiring innovation in service models to balance access, quality and affordability

- more people who can use digital technologies, expecting a health care system ‘in their pocket’; with a growing gap between those who want to and can access care in this way, and those who cannot

- an increased expectation of personalised care - adapted to both personal circumstances and health status and/or genetic profile; again, with a potentially growing gap in levels of expectation and demand between those with good access to information and advocacy and those without

- an increased need for mental health diagnosis and treatment and/or support for conditions including ADHD, autism and dementia

Chapter 3: where we are now

The NHS was founded on the core principle of providing universal access to care at the point of delivery, based on people’s need, not their ability to pay. Seventy-seven years on, this principle resonates strongly with the public. In opinion polls, 19 out of 20 people say they want the NHS to remain free at the point of delivery (NHS England, 2023).

Today, the NHS provides care at an extraordinary scale, seeing millions of patients every day. Annually, this includes 24 million accident and emergency (A&E) attendances (NHS Digital, Hospital Accident & Emergency Activity 2021 to 2022) and millions of outpatient appointments and diagnostic tests, in addition to over 300 million appointments in primary care (NHS England, Next steps on the NHS Five Year Forward View).

But as the population ages and medicines and medical technology evolve to offer much improved but sometimes more expensive care; as we seek to better support people who have historically been underserved; as the profile and expectations of our workforce change; and as we deal with the ongoing impact of the COVID-19 pandemic and funding constraints, both the costs of - and the demands on - that universal service have increased. As a result, despite innovation in care and increasing activity, some services have become harder to access.

The world has become more digital, offering some potential solutions to these challenges, yet the NHS still has a long way to go to take full advantage of advances in technology, AI and data processing capacity.

The NHS is a system in which services are delivered through many different types of providers. This diversity is a source of strength but needs proactive management of interfaces and hand-offs. Too often people feel they are ‘bounced around’, that they have to explain themselves in every new interaction, and that the resources and expertise of providers, in particular VCSE organisations, are not optimally used.

We know that access to primary care services is particularly important to the public (a message heard throughout the 10 Year Health Plan engagement activity), as they provide both trusted, ongoing care and act as the gateway to other services. While many people can secure same-day access to GP appointments or advice this is variable across the country, and the experience of gaining access (often an ‘8am rush’) can be frustrating and inconvenient. Some primary care services are, in effect, not universally available - for example in areas that are currently ‘dental deserts’. And while community pharmacy services have historically bucked the inverse care law, there is a risk this is reversed due to closure of hundreds of community pharmacies, with a third of closures since 2015 to 2016 happening in the top 20% most deprived parts of the country (NHS Business Services Authority, 2024).

Access to urgent and emergency care is inconsistent, with waits still too long for many people. Whether waiting for an ambulance, in an emergency department, urgent care centre or elsewhere - waiting for urgent and emergency care services may cause harm and is often distressing. This can be a particular concern for parents with children, those with mental health needs and when the timeliness of intervention is critical to outcomes. Lord Darzi's (2024) independent investigation of the NHS specifically highlighted how nearly 10 per cent of all patients are now waiting for 12 hours or more in A&E, with the Royal College of Emergency Medicine estimating this likely causing an additional 14,000 more deaths a year.

Long waits for elective care have become commonplace. While some waits are inevitable the process of waiting is too often difficult and uncertain, characterised by limited or delayed communication, and for some people the risk of deterioration as they wait for care.

Care at the end of life is often over-medicalised and services in England are not always able to provide individualised, equitable and co-ordinated support that meets the holistic needs of people and their families (Health Services Safety Investigations Body, 2023).

People are often frustrated that their own poor experiences of access or care delivery sound similar to other cases they have heard or read about, but the service has not been adjusted accordingly. Though it is often actively sought, feedback tends to be provided inconsistently across different population groups, and is particularly low frequency from younger, minority ethnic populations. Even when it is sought, heard and understood, feedback can be challenging for staff to implement, through lack of capability, capacity, expertise, authority or energy (Powell and others, 2019).

Concerns about access and trust are particularly pronounced among certain groups and communities, and this risks further exacerbating health inequalities. As we set out later in the report, we need a clear and concerted approach to identifying and supporting ‘at risk’ or excluded groups who may not be engaged with services.

The challenge described here is felt deeply by the workforce. Staff are rightly proud of delivering high-quality care, but resource constraints, rising demand, and inadequate facilities have led to widespread morale issues. The 10 Year Health Plan engagement exercise highlighted that frontline staff feel a sense of moral injury when unable to meet patient needs, this is made worse by increasing expectations and the pressure to maintain high standards under challenging conditions.

Chapter 4: where we want to be in 2035. Our vision of accessible, high-quality care in 2035

The working group set out to articulate a high-level vision of accessible, high-quality episodic care by 2035. This section summarises the core features identified by the working group of a system that is delivering good and fair access for all and consistently high-quality services. These services are easier to navigate, better tailored to individual needs and delivered as close to home (or work, family, community) as possible.

The features relate to 4 major changes in how healthcare services should deliver for people, across different settings and conditions and population groups. These are based on what we have heard from working group members, as well as analysis of both public and organisational responses to the Change.NHS portal, as summarised in chapter 2.

The 4 major changes that will apply to all episodic care in 2035 are:

- digital-first for most people
- accessible and delivered as close as possible to home
- personalised by design
- equitable, effective, and responsive support

To make the vision tangible, we have developed 10 priority ‘ambition statements’ that describe how people will access the health and care system by 2035 if these changes are made. In annex 2 we illustrate this in relation to a range of different hypothetical personas. These 10 statements are not intended to be comprehensive, but represent priority areas for reform by 2035 - based on public, working group, staff and sector wide feedback - if we are to improve access to, and quality of, health services for all.

To provide some further granular detail, we have also included some ‘roadmap’ ambitions for specific conditions in annex 3. Again, though not comprehensive, these show what could be radically different in access to prevention, diagnosis, treatment and support over the next 10 years.

Our overall vision of accessible, high-quality episodic care in 2035

By 2035, everyone accessing health care services will engage with a system that is designed around their needs, compassionate and inclusive. Services will be easier to find and navigate, and available at more convenient times and places. Equitable and high-quality support will be available for everyone, everywhere - with NHS services remaining universally accessible and free at the point of need. There will not be unwarranted variation in access to care based on protected characteristics, geography, or condition.

Care will be safe and effective. Where there are developments in innovation and technology that can radically transform care, they will be available to everyone who needs them.

What will change to radically improve access to high quality episodic care

Digital-first access

What we have heard:

There are often multiple points of access to services currently, with potential for confusion and individuals to be ‘bounced around’.

We heard throughout the 10 Year Health Plan engagement that people, especially those with multiple or long-term conditions, are frustrated when they have to tell their story multiple times to different services because care records are not joined up:

> “I used a maternity app where hospitals and trusts should be able to get all the data together. A lot of the time it didn’t have the information; it would only show the bare minimum. They’re trying, but it’s not that great.”
>
> “It is imperative that money is spent on having an IT system that links to all parts of the NHS."

The vision

The NHS App will provide people with a 24/7 ‘health system in their pocket’, accessed through a digital front door, enabling them to manage their health and care in ways and at times that are convenient to them. The range of services available online, the tasks that professionals can carry out remotely and the use of AI to triage and risk-assess, diagnose and inform people will be dramatically expanded. People will be rapidly directed to the services which best meet their needs and will be enabled to choose when and where they want to access care.

Access to evidence-based health care will be follow more democratic principles. People will be able to use their own devices to: find clear, reliable and relevant information to help them make decisions about whether and when to access services, from recognising symptoms of serious conditions to managing minor illnesses; understand the breadth of assets available to support them through their neighbourhood health services, including in the VCSE sector; contact services and book appointments; monitor and assess their health and input into their own health record; share data to inform diagnosis and treatment decisions; and receive ongoing care remotely, with both automated prompts and/or alerts and online access to healthcare professionals when needed.

These digital and/or online channels to access information, support and care will be routinely available to complement face-to-face care. Alternative access points will be available, facilitated through neighbourhood health services.

The health and care system will finally become fit for the 21st century by having secure patient data that follows patients across services. This will open-up hugely exciting opportunities for better, more preventative and integrated care, as well as improved patient experience.

Data recording, coding and validation will be prioritised and supported in every local system. Data will be used to build and maintain a deep understanding of local population health, enabling effective risk-stratification and targeted intervention.

Priority ambition statements:

Ambition statement 1: the NHS App will support most people to manage their health and wellbeing, providing a 'single front door' to access their neighbourhood health service.

Though there has been encouraging take up and use of the NHS App, we are not currently taking advantage of the huge opportunity to put health in people's pockets.

By 2035, the NHS App will become a convenient point of access to the neighbourhood health service. For all those who can use it, it will include information and access to all services related to their health and wellbeing, including those offered by the voluntary sector and those available online, such as personalised telemedicine solutions. Existing, or alternative new points of access to services will be available for those who need them. These include phone and in-person booking systems, which many will still rely on.

The app will provide access to the NHS national offer, while being locally tailored and focused, providing users with additional information about resources in their own community. This will include links to other local services and support that VCSE organisations can provide, as well as information and advice on improving both mental and physical wellbeing.

The NHS App already allows people to access part of their health records and interact with healthcare providers, book appointments and receive results, in particular from their GP practices. By 2035, it will routinely provide access to their whole record, the most clinically relevant advice and information, the most appropriate services and the latest trusted and proven medical technology available, as and when people need it. This will be tailored to the individual based on both their health status and their communication preferences and accessibility requirements, which then will follow them across services.

Ambition statement 2: everyone will have a comprehensive and secure single care record. With consent, this will be viewed and proactively used by health and care service providers to improve care and outcomes

The current fragmentation of patient records between different data controllers in the health system is a fundamental barrier to improvements in the integration of services and quality of patient care. It results in inefficiencies in care and poorer clinical outcomes by preventing clinicians from having all possible information in front of them when treating patients.

By 2035, no patient should have to ‘tell their story’ to a healthcare professional more than once. Rather, patients will experience a seamless pathway of care. A single care record, with details about individual needs, preferences and health history, will reduce unnecessary repetition, save time and build trust. Patients will know that wherever they go within the NHS, their care team has the right information to provide safe, personalised care.

Every individual’s care record will include their full medical history, access requirements, and communication preferences, updating automatically as they interact with NHS services.

Delivered as close as possible to home

What we have heard:

Some people, particularly older populations, those in rural areas and those on lower incomes, find it hard to travel to care, particularly when facilities such as hospitals are far away.

People value care close to home or work and recognise there is high potential for diagnostics and monitoring to be delivered out of hospitals (including through Community Diagnostic Centres).

Access to primary care is a particular priority for people. Not being able to get a GP or NHS dental appointment are the 2 leading reasons why members of the public contact

Healthwatch, with particular concern about the numbers of people giving up on seeking treatment.

The vision:

Most initial assessments, diagnostic services and ongoing support will be delivered in the community or at home, facilitated by:

- decentralised diagnostics platforms and point of care solutions, including the roll out of smartphone-based imaging, sensing and diagnostic systems
- expanded virtual care models - with routine use of smart equipment (for example, smart beds and fall detection systems) and connected devices, allowing real-time remote monitoring and intervention through the ‘Internet of Medical Things’ (IoMT)

This will maximise the capacity of hospitals and other physical healthcare facilities to provide emergency and specialist treatment.

When face-to-face services are necessary, people will have choices about where to receive care (where clinically appropriate), including the option to travel for more rapid care and/or access services in a convenient location (for example, near family or work), with appropriate support for those who face barriers to accessing services. People will be supported to travel to and from care settings if they find it difficult to arrange or afford transport.

Priority ambition statements:

Ambition statement 3: no care will be delivered in hospitals unless it is necessary

Much of the care currently delivered in hospitals could be provided in or closer to people’s homes, leading to patients having a better overall experience, yet the long-held desire to shift care away from hospitals and into the community has not materialised.

By 2035, healthcare will be delivered at the most local level possible, including in a person’s own home. The ambition will be for no care to be delivered in a hospital at all unless it is clinically or economically necessary.

Achieving this ambition will rely on effective community-based alternatives to hospital care, increasing community diagnostic capacity and harnessing the potential of virtual care. This will include remote monitoring and digital consultations, where patients feel comfortable doing so. In-person services will be available for those who will benefit from them and/or who choose them.

Ambition statement 4: every member of the public will be able to access co-ordinated primary care services, regardless of who they are or where they live

Access to primary care services is a high concern for members of the public, with difficulties securing a GP appointment or NHS dentist being the top two reasons for contacting Healthwatch.

By 2035, everyone will be able to access a full suite of primary care services. This will include timely access to GP and dental services when required. It should also include convenient access to community pharmacy, with a ‘pharmacy first’ approach for minor conditions embedded in each system.

Primary care will be a central component of a neighbourhood health service that wraps support around individuals. Key to this will be co-ordinated primary care, with access to the same records and with seamless referral between services. The enabling working groups may wish to consider the possibility of integrated primary care commissioning as a means of improving access by 2035.

Ambition statement 5: Eeery adult, child and young person will be able to access mental health and care support 24/7 - especially those in crisis

A&E departments are a poor environment for someone experiencing a mental health crisis. Though some parts of the country already provide innovative crisis support, we need to give everyone nationally alternate points of access. Within 10 years, it is imperative that we bring ‘the best to the rest’.

By 2035, community based mental healthcare and crisis support will be available 24/7 to everyone who needs it, through telephone, online and in person services. This will offer an alternative to access through emergency services and reduce the need for inpatient care. People will be able to easily self-refer into crisis mental health support when they need it or be referred by other services.

Personalised by design

What we have heard:

At times, patients do not feel listened to during assessment and treatment.

Some demographic groups, including older populations, find it particularly hard to get to and from services. For other groups, such as low income and ethnic minority populations, trust can be a barrier to accessing services at all.

Data can help us anticipate which groups and/or individuals are most likely to present (and re-present) to A&E. Better and more consistent outreach to ‘at risk’ groups would benefit individuals and the system and help reduce health inequalities.

When people are not kept informed about the future of their care, they can feel forgotten, confused and frustrated about when and where they will be seen, as well as how they can access other services while they wait if needed.

The vison

People will be actively supported to build agency and capacity to manage their health and access services when needed. Services will be planned and co-designed with local people and communities, including ‘experts by experience’.

When using healthcare services, people - with their family or carers - will be equal partners in co-designing their own care, within a culture of shared decision-making and “doing care with” rather than “to”; and where people’s emotional, social and practical support needs are given equal priority to their clinical needs.

People will expect their care to be co-ordinated and their information available, when appropriate, to relevant providers across the health and social care system. With a shift to the neighbourhood health service, the NHS, local authority, VCSE and independent sector providers will work as one team, enabled by compatible ICT systems.

When people wait for treatment, they will not be left in the dark. They will know what to expect and receive advice on how to manage their health. Healthcare providers will have a good understanding of and actively signpost to the full range of community and neighbourhood assets that are available to support people while waiting.

Priority ambition statements:

Ambition statement 6: people at high clinical risk or who are marginalised have a health and care system that comes to them

While population health management approaches are well developed between the NHS, local authorities and their partners in some areas, they are not yet being used to their full potential across the whole country. There are many examples of services delivering high-quality proactive care to keep people safe and independent, and prevent avoidable deterioration or worsening of health conditions, but this is not yet the default model of care. Lack of trust in healthcare and other public services in some communities can mean services are not looked for or used when needed, worsening health inequalities.

By 2035, the whole population will be comprehensively segmented and risk stratified, using a standardised approach refined locally, drawing data and insight from a range of partners including VCSE organisations. This will be routinely used to identify people and communities who are likely to be most in need of health and care services, and/or may not proactively engage with healthcare services.

Service providers will work with trusted community leaders to contact and engage with those identified as highest risk. Where care and support is needed it will be delivered in culturally appropriate ways by a multi-disciplinary team, with a care co-ordinator identified as the single point of contact. Through proactive outreach, individuals at high risk of illness and/or deterioration, such as frail older adults, will be identified and supported before problems occur. Outcomes will improve for individuals while reducing pressure on services, for instance by reducing the frequency of unplanned hospital admissions.

This ambition should complement the work of vision working group 1 ('I can stay healthy and manage my health in a way that works for me').

Ambition statement 7: anyone waiting for diagnosis or treatment will receive real-time information on waits and ‘gold standard’ holistic support to ‘wait well’

Waiting is a common but often neglected aspect of people’s care that has significant impacts on experience and outcomes. People too often feel left in the dark as to their treatment pathway, and do not receive the information or support they expect.

By 2035, anyone waiting for care will be supported to ‘wait well’. Providers will treat waiting as part of an individual’s care pathway, with defined quality and safety standards to be met accordingly. These will have been developed through a process of co-design with service users to define a gold standard of ‘waiting well’. Standards are likely to include: having real-time information on expected waits and what to expect when appointments and procedures happen; advice and resources on staying healthy while waiting and on prehabilitation, such as exercise and diet; and signposting to mental health support and resources available from VCSE organisations, such as peer support and online communities. Communication will be regular, sensitive, and personalised.

Information will be available in real time through the NHS App, or other routes for those who choose them.

Equitable, effective, and responsive

What we have heard

We do not always know enough about which services work well and for whom. Patients, particularly those who are minority ethnic and from lower income backgrounds, do not currently leave feedback or complaints because they lack confidence they will be listened to or that services will improve.

Sometimes people are not treated as quickly as they should be during emergencies, which can lead to fatalities or long-term disability.

People want more to be done to support the quality of end-of life-care; the best end of life care is not always provided in a hospital setting.

The vision

Local services, professionals and institutions will have high levels of trust across all groups within their local communities.

When people need assessment, care or treatment it will be timely, with:

- rapid assessment, diagnosis and treatment in line with clinical standards when urgent or emergency care is required
- transparent standards for diagnostic and elective waiting times that are routinely met, a named contact while waiting and clear follow-up

People will be given high-quality information about their treatment and care options, aligned with NICE (National Institute for Care and Excellence) and other clinical guidelines, which are accessible to all.

Safe, effective care will be delivered by recovery-focused staff in therapeutic settings. People will be informed about and have opportunities to participate in relevant research.

Staff will be highly trained and aware of individual and social factors that may impact on individuals’ access, experience and outcomes (for example learning disability, neurodiversity, racism) and account for this in the design and delivery of care.

Feedback will be seen as indispensable for identifying healthcare inequalities and continually improving services. People will be asked about their experience of care and can be confident their feedback will be systematically collected, valued and acted upon.

Every health care organisation will have embedded systems for quality and safety improvement and clinical innovation. Every health and care system will have a quality governance pathway that operates across organisational boundaries.

Priority ambition statements:

Ambition statement 8: services prioritise improvement against health inequalities and what matters to patients, with service users invited to leave feedback on experience and outcomes as standard

Across other industries, feedback is a seen as an indispensable source of improvement. This should be true of the health and care system in England, yet feedback is continually ignored.

By 2035, members of the public will be accustomed to being asked for information on their experience and outcomes for every engagement with the health and care system. It will be made quick and easy, and there will be confidence in the data being aggregated and used to support continuous improvement on quality and access. National attention will be refocused on measuring and addressing inequalities in experiences and outcomes, not simply activity.

This should seek to build upon, and learn the lessons from, the use of the Family and Friends Test (FFT), which collected over 2 million pieces of headline data on patient experience in October 2024 (NHS England, 2024).

Ambition statement 9: in an emergency, such as a heart attack or stroke, everyone who needs it will get the most clinically advanced treatment available, delivered to faster standards of response time and care, leading to more lives being saved

At present, emergencies are not always immediately recognised as such, and this can lead to delays in accessing timely care. At the same time, some people who could be cared for at home or in the community are being directed through emergency services. In many parts of the country people are waiting longer than they should at each point on those emergency care pathways, with some coming to avoidable harm. There is variation in access to the right specialist at the right time and in the use of evidence-based treatments such as thrombolysis and thrombectomy in the case of stroke. This risks exacerbating health inequalities.

By 2035, front-door services, including 111 and 999, will be robust enough to guide people effectively to the right care pathway from the outset. Agreed standards for assessment, diagnosis and treatment will be routinely met. Time-critical interventions proven to be highly clinically effective in emergency situations will be consistently available to those who could clinically benefit, and people will be directed or taken to the most appropriate setting for these.

Ambition statement 10: effective palliative care services are available for all, providing people with safe, dignified and personalised end of life care in a setting of their choice

For many patients, end-of-life care feels reactive rather than planned, resulting in avoidable hospital admissions and inadequate support in community settings. VCSE organisations, including local charities and specialist hospices, play a vital role in providing the service but despite their contributions, access to high-quality palliative care is uneven, with significant disparities.

By 2035, there will be a universal palliative care offer that is personalised and provides a genuine choice as to where people end their life. Expanding and improving palliative care services may result in more patients choosing to have this care in the community, reducing avoidable hospital admissions and easing pressure on the wider health system.

This ambition comes amid urgent warnings about hospices across the country cutting services, posing a difficult challenge to the enabling working groups on how a new end of care offer will become a reality for all (Hospice UK, 2024).

For this vision of care to be delivered for service users, it is essential that the experience of people working in the health and care system is also transformed. In future, health and care staff will:

- be able to use their skills effectively and have more time to care
- be encouraged support people to access care at the right time and in right place, agnostic of professional and institutional boundaries
- be able to contact and get advice and support from colleagues in other parts of the system (enabling them to deliver the best quality care and manage risk in different ways)
- have access to modern technology that supports and enables their local operating model
- have more options to work remotely and in flexible ways that fit around their lives because they can access systems/tasks from their phone and/or home
- be treated with respect, with zero-tolerance of violence and/or abuse
- be supported to innovate and experiment to continually improve care

Realising the reformed service offer

The above ambition statements are described in more detail in annex 2. This includes example case studies of what these ambitions would mean for individual patients and roadmaps of how each ambition could be progressed over 2, 5 and 10 years.

Annex 3 also sets out illustrative roadmaps for achieving our vision across some of the most prevalent health conditions.

Chapter 5: what would have to be true to make the vision a reality

In this section we focus on what needs to be true to deliver the vision, mapped to the enabling working groups. Co-ordinated action will be needed across local and national organisations to ensure these requirements are being met, with regular review of progress and ongoing dialogue with the public over the next 10 years.

Here we draw out the some of the most important and cross-cutting actions that the working group members have identified as needed, to prepare for and support the change. This is our challenge to the enabling working groups to ensure the vision becomes a reality.

Direction for enabling working groups

Mobilising change

A new public compact: the model described in this report means care will look and feel very different for some people. While it means overall positive change for service users, staff and the population as a whole, implementation will involve trade-offs, with different impacts for individual people and organisations. To capture what this means (across the 10 Year Health Plan as a whole) and rebuild public consensus and trust, we will need a reset of the NHS Constitution or the development of a new public compact, aligned to the reformed service ambitions. As part of this, we need to re-calibrate (simultaneously raising and managing) the expectations of both service users and providers. This includes:

- establishing a definition of ‘reasonable access’ to care covering several key dimensions including: time, distance, choice, specialism and patient experience

- addressing what this means for service configuration and delivery - explicitly addressing trade-offs around distance, choice, expertise and costs - particularly in rural and coastal areas

- agreeing what aspects of access and quality are for national and local determination
- confirming what the default front door to healthcare services should be, building public understanding of this (using common language) and supporting associated behaviour change
- exploring what it means for people to take more responsibility for maintaining their own health, stay well informed and use health and care services appropriately
- agreeing where accountability and responsibility lie within the health and care system for an individual's access to services and the co-ordination of their care, how this responsibility is discharged and the associated incentives and levers

This framework should be created with the public and healthcare professionals and other staff in the next 3 years and supported with a full analysis of the costs and delivery requirements. We have referenced some standards in this report. On waiting times, for example, the compact should cover whether or not constitutional standards will be relevant in a new care model, and if so how they would be defined.

Social care reform

Working group members have emphasised that this vision for more accessible, higher quality healthcare services cannot be achieved without a comprehensive 10-year social care plan. We need a social care system that:

- supports people to live independently
- participate in social activity and work and maintain dignity, choice and involvement in decisions about their care
- helps to prevent unnecessary admission to hospital
- enables people to return home quickly with the right support

This will require reform and investment to bolster the social care system, enabling commissioners to address currently unmet need and providers to operate as a core part of integrated neighbourhood teams. The 10 Year Health Plan and social care plan should together address the desired future relationship between health and social care, and how they work together to deliver seamless, integrated care for individuals.

Whole system working:

The group also reflected the importance of co-ordination and partnership working with other public services, independent sector providers and the VCSE sector. The latter in particular play a vital role and one that could be expanded. VCSE organisations are not only health and care providers themselves but are a source of information, advice and community connection. They are advocates for people and communities with deep insight into how services are accessed and experienced and what could be improved. Partnership with a sustainable VCSE sector is critical to planning services effectively, tackling inequalities in access to and experience of care and ensuring service user feedback is heard and used. The 10 Year Health Plan is an opportunity to refresh our approach to make better use of currently untapped potential in this regard.

Independent sector providers will also make a significant and distinct contribution to achieving the vision. They will deliver both capacity and choice for service users, to ensure care is timely and convenient, in particular in the case of community and diagnostic services.

A range of other public services also have a role to play in, and depend on, people having good access to healthcare at the right time and place. There are particular interdependencies with education, employment and housing services and the criminal justice system. The mobilising change working group should consider how genuinely whole-system working can be incentivised and enabled so that interconnected services can support people to access each part of the system when they need to.

People and workforce reform

The vision will not become a reality unless we invest in staff and support them to lead and implement change across the system. Areas of critical capability shortages must be addressed as a priority through training, recruitment and retention; developing more innovative workforce models and new roles (for example, therapy assistants and support workers); and ensuring everyone is working ‘at the top of their license’ (for example, recognising the range of people who can carry out thrombectomy), as well as through improvements in efficiency and automation.

Clinical and professional training must prepare people from the outset to work in the ways described in this model, increasingly online and remotely, with different ways of assessing and managing clinical risk that this entails. More people need to be ‘trained for triage’ and the expansion of generalist roles should be considered to support the ‘left shift’ into the community. Staff need to be digitally literate and ready to adopt and use new technology as it evolves. They should expect and be supported to work across different locations and organisational boundaries without undue bureaucracy (for example, facilitated by staff passports). And we must support existing staff to develop and deploy new skills, change current practice and prepare to work in these new ways.

Action to build and maintain a learning and improvement culture must be prioritised in every system, with staff supported to be open and responsive to feedback and encouraged to experiment and innovate, to continuously design and deliver improvements in care.

A culture of person centred, compassionate care and coproduction must be embedded at every level of the NHS, from policy design through to service delivery. Healthcare professionals should be trained and supported to co-design care by default. We need to identify, develop and support leaders to drive reformed access to care.

Digital, data and technology

To make ‘digital-first’ access to healthcare a reality for most people, the digital front door must be expanded and made more accessible, widening engagement with groups who are currently or may in future be more digitally excluded. National and local leaders must invest in building awareness, digital literacy and innovative approaches to digital access, with mechanisms for everyone to benefit from the capabilities of a ‘health system in their pocket’.

The app must be developed to both support people staying healthy and enable individuals to access the most appropriate digital clinical advice when needed, ensuring that at least a third of all interactions with the NHS are digital first. The enabling working groups should identify stretching ambitions and targets at national and local level for the ongoing development of the NHS App and other digital tools.

The focus on embedding electronic patient records in every NHS provider, and scaling the use of Digital Social Care records, should continue. Work to ensure that each individual has in effect a single health and care record - with full access for citizens and, with consent, professionals in any part of the health system and country - should be accelerated. National policymakers and local leaders should set out and deliver strategies for this, with clear staging posts to measure progress between now and 2035. Supporting this they should focus on plans for ensuring IT systems used across the health and care system, and in some cases other public services, are fully interoperable and are used to their full capacity. This must include fixing basic digital infrastructure challenges to improve productivity and experience and making systems more cyber and data secure.

To improve understanding of access to all types of episodic care - beyond urgent and emergency care and consultant-led elective care - there should be a work to achieve data parity (collection, analysis and reporting of data, including patient-reported experience and outcomes) across services, pathways and user groups. Specific priorities for improving data (for example on community services) should be identified and pursued.

Research, life sciences and innovation

Greater service user participation in research should be promoted, in particular minority and under-served groups, to allow rapid and robust testing of new modes of care delivery, as well as specific treatments and interventions. Research and evaluation of the safety, efficacy and acceptability of remote or virtual services should be prioritised. The enabling working groups should provide specific recommendations on how the percentage of patients participating in research and clinical trials with this focus can be increased over time.

Local experimentation and innovation should be incentivised and supported. The 10 Year Health Plan should set a clear ambition and tangible action to enable the NHS to be a more dynamic and faster improving system to ensure people have access to high quality care. The current regulatory framework for medical technology should be reviewed, in partnership with those with lived experience, to ensure it enables swift development, adoption and scaling of innovation in the system. As part of this we need to resolve who takes clinical risk for use of medical technologies, while in development and as they are rolled out.

Work needs to start now to develop appropriate commercial arrangements and procurement frameworks that will facilitate a dramatic increase in the use of MedTech in an affordable and sustainable way.

Accountability, oversight and support

The service model described here will require a different approach to ensuring that the services people access are high quality, safe and effective. The quality governance strategy being developed alongside the 10 Year Health Plan will need to both strengthen and embed existing, evidence-based approaches to quality and safety improvement and set out the approaches we will need in a more networked, multi-disciplinary, online, home and community-based model of care.

The strategy should provide an updated definition of quality in this context, based on meaningful engagement with the public, patients and staff. Crucially, it must address how to build a clinical governance and risk management culture that supports the model of care described - and the different forms and ‘locations’ of risk this entails - while keeping people safe within it.

The national strategy or framework should support local organisations to develop clinical governance pathways that operate across physical and organisational boundaries - for example for the ‘team of teams’ involved in delivering neighbourhood care to determine ‘who’ line manages the team and ‘how’ clinical responsibility is held across different organisations.

Some policy and/or contractual changes may be required to shift clinical and information governance risks away from smaller providers that may not have the capacity to manage them.

Clear national oversight of the new quality strategy and safety framework will be required. This may include revamping and bolstering the role of the National Quality Board (NQB).

NQB should also identify a set of prioritised quality improvement recommendations and oversee their implementation, with subsequent evaluation of their impact. This might include commissioning a set of new national service frameworks and support for their roll-out through national improvement programmes and advising on the prioritisation of targeted support programmes, for example 'Getting It Right First Time' (GIRFT) to address unwarranted variation in clinical practice (such as the use of thrombolysis) in particular organisations, system or service areas.

Regulation of healthcare organisations and professionals will also need to evolve over the next 10 years to reflect the major changes and new service models we have described.

The national oversight framework for the NHS should hold commissioners and providers to account for year-on-year progress on reformed access and quality improvement, alongside specific performance improvements. Oversight of integrated care systems and neighbourhood health teams, where there are different forms of accountability for different organisations and services needs to be clarified.

Physical infrastructure

The model we have described, where much of the care currently delivered in hospitals and other health facilities moves outside those physical boundaries, requires a new way of thinking about the healthcare estate. Increasingly this will include people’s own homes, as well as shared community facilities and virtual spaces.

To deliver to ambition we will need a further scaling-up of community diagnostic capacity. This should be delivered not only through Community Diagnostic Centres (CDCs) but through the creation of wider diagnostics networks, enabling tests and investigations to be carried out in a rage of locations (including non-healthcare settings) depending on the technology and workforce requirements.

Additional, flexible physical capacity will also be required in neighbourhood health centres and hubs, enabling face-to-face care to be delivered closer to home when it is still needed, and staff to come together as multi-disciplinary teams. New models for estates development could be explored to facilitate this, for example, through integrated care boards (ICBs) owning more estate.

To maximise access to digitally provided NHS specialist elective services, a new NHS provider may be established.

Regional and local infrastructure planning needs to be integrated with workforce planning, so that capital and workforce investments complement each other.

Financial flows

Financial allocations and flows will need to be adjusted to deliver the reformed service offer described in this vision. The finance and contracting enabling working groups should develop recommendations on how financial flows can incentivise organisations to care for patients in the right place, reflecting the hospital to community shift. A reset of financial allocations should also be considered, including how investment can be progressively increased in preventative and out-of-hospital services, and how financial flows can be linked to health outcomes. The workstream should consider how contractual payments to individual providers and healthcare professionals could be linked to health outcomes, and how payments can incentivise reducing inequalities in diagnosing and treating underserved populations.

Priorities for investment

Further work will be required to model the capital investment requirements, recurrent costs and potential efficiency savings associated with our ambitions. This should test the proposition that more care delivered at or close to home, through a largely digitally enabled system, can both release capacity in urgent, emergency, specialist complex services and help to control spend.

We have identified some specific areas likely to require investment or financial reform if the ambition is to be pursued. These focus around digital, data and technology investment, and enabling integrated neighbourhood health services and capacity in primary and community care.

Digital-first for most people

Expansion of the digital front door including investment in development of the functionality of the NHS App to facilitate greater patient choice and care co-ordination

Building compatible data infrastructure and IT estate infrastructure to maintain security across services patients will interact with to enable truly digital first and co-ordinated service offer. This will facilitate integrated neighbourhood care at local level - interoperable across services to facilitate patient coordination. Additionally, all services will meet minimum technological/digitised standard that facilitates sharing a of single patient record.

Delivered as close as possible to home

Development of primary care, community services and estates to facilitate the work of integrated neighbourhood teams which includes:

- investment in equipment and estates to allow footprint of care at home and in the community to grow
- GP contract to enable and incentivise collaboration with other services at the neighbourhood level
- reform of dental contract to expand access
- sustainable community pharmacy network, with comprehensive access for patients nationwide
- evolved mental health investment standard to support community front door
- investment to reduce social care assessment and/or review backlogs through local government funding settlement

Personalised by design

Recruitment and training of care coordinators to sit across integrated systems. People, supported by enhanced digital capabilities, to facilitate patient care, act as single points of contact, and ensure join up between services.

Palliative care offer to include investment in community end of life care services, including remote clinical support, so those needing care have a real choice as to how and where they receive.

Equitable, effective and responsive.

Building new platforms for collating and/or aggregating patient feedback and feeding it into service improvement on an iterative basis.

Conclusion

In this paper we have briefly looked at how the population will change over the next 10 years and what this means for demand for NHS services. We have articulated a vision of what a radical improvement to access to care could look like, using the shifts of digital first and care closer to home. We have set out ambition statements that move this vision beyond restating principles to envisaging the real difference in how services could be delivered and how this will feel for patients and communities. We have outlined for some major clinical areas how pathways could improve. We have set clear tasks for the enabling working groups on areas including finance, workforce, technology, and the need for a new compact with the public to replace the outdated NHS Constitution.

We would like to sincerely thank the working group members, the policy teams in DHSC and NHS England and many organisations who gave us input, and most of all the secretariat and writing team who have worked hard on this report: Jo Lee, Jonathan Coverdale, Paul Callaghan, William Pett, Tom Bioletti, Joe Skelton and Elizabeth Wade.

Louise Ansari and Emily Lawson,
10 Year Health Plan Workstream 2 Co-Chairs

Annex 1: definitions, scope and assumptions

'I can access the high-quality and effective care I need, when and where I need it'

The working group brief was to:

- articulate a high-level vision for a health service that enables access to high-quality care in line with the wants and needs of the wider public, with a particular focus on episodic care
- set out policy options for making this vision a reality

Definitions

Care

The ‘I’ statement refers to accessing care. Most people receive most care and support to manage their health from family, friends and unpaid carers. And for many individuals and families, ‘formal’ care is provided through a range of different services including healthcare, public health, social care, education, housing, employment and many others, all of which have a role to play in supporting people’s health, wellbeing and independence.

For the purposes of this report, we focus primarily on access to a subset of care, that is: healthcare services commissioned by the NHS. Those services may be developed in partnership with and provided by NHS, other public sector, VCSE or independent sector providers.

We have taken this approach based on our understanding of the scope of the 10 Year Health plan, and the separate development of plans for primary prevention and social care. However, we fully recognise that from the perspective of people and communities services are not clearly delineated and experienced in this way. When we refer to the coordination of health and care services we mean the full range of services that need to interact effectively to provide holistic, person-centred support.

We recognise the particular interdependencies between healthcare and social care, which have become increasingly connected for both individual service users and for the health and care system as a whole. We propose that as part of the work to develop a comprehensive 10-year social care plan, the desired future relationship between health and social care services is clarified. Furthermore, we expect that intermediate care and the social care and NHS interface is a core component of neighbourhood health as this develops.

Access

Defining access to healthcare services is complex. The concept relates to the interface between potential and actual service users and health and care resources but might be understood in various different ways.

Based on a synthesis of the literature on this topic, Levesque, Harris and Russell (2013) describe access as the opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain or use health care services, and to actually have a need for services fulfilled.

The inclusion of the requirement that a need is fulfilled means this definition of access incorporates elements of quality (effectiveness, safety, and patient experience). This definition therefore helpfully summarises the different components of access and quality that we have considered as a working group.

It might be translated into an expanded 'I' statement as:

'I am able to:

- identify when I need health and care services
- find and reach the most appropriate services for my needs in a quick and straightforward way
- obtain or use those services when and where I need them

When I do:

- my experience is positive
- I am kept safe [protected from avoidable harm]
- the care I receive addresses my need in line with best evidence and/or agreed standards

Much of this is subjective. People will have different views on whether an interaction or process is ‘quick and straight forward’, when and where they need to receive care and what is convenient and acceptable to them, and whether the issues for which they have sought care are fully addressed. We have used the evidence from the engagement exercise and other sources of public and patient opinion to build a broad understanding of people’s priorities and expectations in these regards, now and looking ahead to 2035.

Quality

As a working group we have considered all elements of the ‘Darzi’ definition of quality, expanded by the NQB, and have woven into the vision a description of care that is safe, effective, responsive and personalised, caring, sustainable and equitable.

Noting that work is currently underway to develop a new quality strategy for the NHS and to review patient safety across the health and care system (the Dash review), we have not focused on definitions of quality or the detailed components of a quality and safety management system. However, we believe the vision we have described is a vision for high quality care, illustrated with examples of what this might look and feel like for particular cohorts and services areas. We hope that this will be used to inform the new quality strategy and any work to update the definition of high-quality care for all.

Scope

For people to have equitable access to episodic care, there must be an adequate and well-distributed supply of high-quality health and care services that reflect the profile of the population and the health outcome goals and service improvement priorities that have been agreed with the public.

In this report, we do not propose what those specific outcome goals or service improvement priorities should be (beyond meeting existing commitments). And we do not seek to define or model adequate service supply in 2035. We recommend that these goals and expectations are redefined through a re-set of the NHS Constitution or the development of a new public compact. As part of this, a framework defining ‘reasonable access’ on different dimensions (time, distance, choice, specialism) could be co-developed with the public, supported with a full analysis of the costs and delivery requirements.

The working group was asked to focus on episodic care. We have understood this to mean focusing on people’s experience of accessing services when they have no existing or recent relationship with a particular service provider, or where they require services from a team or professional that is not their usual provider of ongoing care. This would include, for example, seeking advice and support regarding a new symptom or concern; on managing self-limiting illnesses; in an urgent or emergency situation (for example, accident, injury, stroke); when experiencing a crisis or exacerbation of an existing condition, or for particular life events (for example, maternity services).

On this basis we have not concentrated on people’s experience of long-term, holistic integrated care and support to manage long-term conditions, which is the remit of vision working group 3. However, it is not possible to consider episodic and ongoing care completely separately, as people living with and receiving support to manage long-term conditions still need to access other services periodically and in the circumstances described above. Similarly, while there are other working groups specifically focused on health inequalities (vision working group 4) and prevention (vision working group 1), our members were very clear that good access to episodic care must be equitable and include access to preventative care. We therefore anticipate there will be significant overlap and/or interactions between the reports of the vision working groups.

Assumptions

Based on the views expressed by working group members, the future model envisaged retains certain fundamental features of the current health and care system, including universal, tax-funded healthcare services free at the point of delivery, with no new co-payments.

We have not assessed or modelled the costs of implementation for each statement or for the new service model as a whole. However, we have worked to an understood parameter that there must be a plausible case for delivering the changes in a way that is cost-neutral or cost-saving, compared to current projections of cost increase.

We have however assumed that over the period to 2035 there is on average real terms growth in NHS funding at least in line with the historic average of 3.6% per year since 1955 to 1956 (The Kings Fund, 2024).

Annex 2: ambition statements

Ambition statement 1: the NHS App will support most people to manage their health and wellbeing, providing a ‘single front door’ to access their neighbourhood health service

Case for change

The current model of care employed across much of the health system often involves passive waiting for treatment and guidance. The result is inequality and inefficiency built into the system, sometimes leaving patients carrying substantial risks when waiting for care. Though it is beginning to change, this passive approach could be swept aside through better use of technology. People should be able to more easily access better health and wellbeing information, as well as access services, through their phone.

Patient perspective

For most patients the front door of the NHS is their GP, yet access can be frustrating for many.

The NHS App should empower patients to access information and services quicker, making the experience feel smoother and less frustrating.

This should complement and not replace face-to-face care. The Change NHS public engagement exercise highlighted concerns the public have about an overreliance on technology which may result in a loss of skills amongst staff or empathy in healthcare.

Change will also need to be considerate of communities that have lower degrees of trust in institutions such as the NHS, so that digital transformation does not have the unintended consequences of worsening pre-existing health inequalities.

Service users also are aware that the VCSE sector is underpowered and could play a far greater role in keeping people out of hospital. Linking to the sector through the app as a single digital front door would empower the sector to provide the support it has the infrastructure and expertise to provide.

What this means in practice for service users

The NHS App will serve as a single digital triage for all non-emergency care, services, including those offered by the voluntary sector, community resources and wellbeing information, enabling citizens to choose how they access services.

The current approach to facilitating access too often represents a one size fits all structure, suited to the lowest common denominator of individual agency and capability. While the digital divide will still exist in 2035, that does not mean that we cannot build a system that is stratified so those that can, are enabled to access information and services without even leaving their home.

Alongside digital solutions, services will have to still provide over the phone and in person options. This full panacea of options represents revision of the ‘contract’ between the service and service user, where users are transferred far more agency.

Example: Noah - a 12-year-old with eczema

Noah, a 12-year-old boy, has been experiencing itching and discomfort for several days. His parents, Sam and Chloe, suspect this may be eczema.

They enter Noah’s symptoms into the NHS App, which advises that an appointment should be sought with a community pharmacist. The app allows this appointment to be booked immediately with a local pharmacy, with a map and information on the pharmacy as well as information and advice on what to do while waiting for the appointment.

However, Sam and Chloe instead choose a video consultation with a pharmacist, who reviews Noah’s symptoms and care record. They are happy with the advice and a prescription for topical corticosteroids is issued.

The medication is dispensed through an online pharmacy and delivered to Noah’s home the following day, allowing his symptoms to improve without the need for a GP or hospital visit. The diagnosis and treatment is recorded on Noah’s patient record and can be seen immediately on the NHS App.

Potential contribution to system financial sustainability

Marginal costs of treatment where patients are well informed and engaged in their health and care are expected to be lower, as problems can be resolved faster and earlier before they escalate or require specialist interventions. Greater use of the app could also divert demand from pressurised GP services. However, GPs currently play a critical role in triaging access into the wider system. Highly effective triage must likewise be built into all new digital access routes to direct people to the right services at the right time, to prevent unnecessary or inappropriate activity.

Progress roadmap

In 2 years, this would mean:

- start to build public awareness of shift
- public conversation about trust in the app
- co-production on what services the app should provide and how to build trust across population groups

In 5 years, this would mean:

- a clear strategy has been published on the future of the NHS App, based on extensive consultation
- 50% of population using primarily digital means when accessing healthcare

In 10 years, this would mean:

- a move away from a face-to-face, institution-based model towards one where health is ‘in the pocket’ of service users and interactive
- 80% of population using primarily digital means when accessing healthcare
- the app is no longer called the NHS App, but ‘My Health and Care’ or similar, reflecting that by now it brings together access to health, care and wellbeing services and not simply the NHS

Ambition statement 2: everyone will have a comprehensive and secure single care record. With consent, this will be viewed and proactively used by health and care service providers to improve care and outcomes

Case for change

The importance of high-quality patient care records was recognised in the NHS Long Term Plan (NHS England, 2019), which outlined ambitions for improved digital infrastructure and interoperable systems to support safe, efficient and patient-centred care. Since then, progress has been made, particularly in enabling more patients to access their full GP records through the NHS App and integrating digital tools like consultations and remote monitoring into routine care.

However, we must go much further. Different IT and data systems across different services still often operate in silos. Patients with complex or ongoing health needs continue to report frustration at having to repeat their medical history and preferences to multiple professionals. Patients have told us that this repetition is time-consuming, impersonal, and creates a sense of disjointed care. These challenges are exacerbated by organisational boundaries between health and care providers, which hinder the sharing of critical information.

High-quality and comprehensive shared records are the foundation of good clinical care. As the NHS increasingly integrates digital innovations, a fully compatible record system should help ensure that these tools deliver the safe, personalised care that patients expect.

Patient perspective

Patients have reported feeling like services are ‘fragmented’. For example, a person managing a long-term condition like COPD might attend their GP, a specialist clinic and community physiotherapy, yet find that these services lack access to shared records. This forces the patient to retell their story, increasing stress and reducing their confidence in the healthcare system. This can be particularly challenging for some people, potentially exacerbating healthcare inequalities.

By 2035, the ambition is for every patient to experience a seamless pathway of care. A single care record, with details about individual needs, preferences, and health history, will reduce unnecessary repetition, save time and build trust. Patients will know that wherever they go within the NHS, their care team has the right information to provide safe, personalised care.

For those with specific communication or accessibility needs, a unified record system will ensure that these preferences are respected across all services.

Importantly, this change will only take place if the patient consents to their data being shared, maintaining trust in the system.

What this means in practice for service users

Every individual’s care record will include their full medical history, access requirements, and communication preferences, updating automatically as they interact with NHS services.

Communication preferences, such as a preference for braille, a hearing loop, or communication in a specific language, will be embedded within the record. These details will be honoured across all healthcare services, ensuring a consistently dignified experience.

Patients will be able to access their comprehensive care record through user-friendly digital platforms. This could empower individuals to take an active role in managing their health.

Healthcare professionals will have quick access to vital information, such as current medications, recent test results and care plans. This will reduce the risk of errors, unnecessary duplication of tests and delayed treatments. The system will provide the right information at the right time, forming the backbone of high-quality care delivery.

Achieving this ambition by 2035 requires key enablers to be in place. We should establish national standards to ensure systems across health and care can share data securely and efficiently. We need to ensure we have appropriate data governance and security.

By embedding the principle of ‘one patient, one record’, the NHS could transform care delivery and ensure that every person has access to safe, high-quality, and personalised care when and where they need it.

Example: Priya, a 42-year-old woman living with type 2 diabetes and early-stage kidney disease.

Priya attends her GP practice for routine diabetes checks, sees a nephrologist at the local hospital, and occasionally requires podiatry and ophthalmology appointments. However, each service uses separate systems, and Priya often has to repeat her medical history and update professionals about her medications.

Under the single care record system, when Priya’s GP updates her diabetes care plan this information is instantly available to her nephrologist, who adjusts her treatment accordingly. Her podiatrist and ophthalmologist are also aware of key updates. There’s no need for Priya to remember or relay complex details herself.

Priya experiences a sudden drop in blood sugar and is rushed to A&E. The emergency team accesses her unified record, seeing her medical history, allergies, and current medications in seconds. They stabilise her quickly and adjust her insulin to prevent further issues.

Potential contribution to system financial sustainability

Implementing a single care record system could be cost neutral or saving in the long-term by reducing inefficiencies. Avoiding unnecessary duplication of tests and procedures, minimising administrative time spent collecting patient histories, and reducing errors caused by incomplete information could save resources. Enabling information sharing across care pathways could prevent costly delays in diagnosis and treatment.

Progress roadmap

In 2 years, this would mean:

- start by piloting unified care record systems across a small number of integrated care systems (ICSs)
- ensure that key services such as GP practices, hospitals and pharmacies are linked
- focus on patient consent processes and improving data security
- build patient understanding, trust and establish clear principles around consent, including opt out

In 5 years, this would mean:

- expand the unified care record system across multiple ICSs, ensuring that more services (for example, specialist clinics, physiotherapy, mental health services) are included
- all care records migrated on to the app
- remaining primary care providers (pharmacists, dentists, optometrists) have embedded service booking and advice in the app.

In 10 years, this would mean:

- achieve national coverage of the unified care record system, ensuring that all NHS services can access up-to-date and comprehensive care records for patients, including communication preferences and access requirements.

Ambition statement 3: no care will be delivered in hospitals unless it is necessary or the patient's choice

Case for change

There is evidence that moving care that has traditionally been delivered in hospitals into home and community settings (where this is clinically appropriate) leads to patients having a better overall experience. It also helps to ensure that care is more accessible, partly through freeing up capacity in hospitals for those who need it most.

For these reasons, moving care closer to home has been a long-term goal of successive governments. However, as the Darzi review concluded, the desire to shift money and resources out of hospitals and into the community (sometimes referred to as ‘the leftwards shift’) hasn’t materialised. In fact, over the last 15 years - the share of NHS spending on hospitals has increased.

Patient perspective

Public engagement over recent weeks has revealed strong support for this shift. When asked about what success would look like, people talked about quicker recovery times, reducing the pressure on hospital beds and increasing access to local care. One respondent stated that:

“When I had to get treatment and could sleep all night in my own bed, I recovered so much quicker. Think it’s important to be in hospital for the shortest time possible, as long as you have the support on the outside.”

What this means in practice for service users

We will need to be bold to make this long-held goal a reality and provide the public, and the health system, with clear and unambiguous direction.

Achieving this will rely on harnessing the potential that AI and tech offer on virtual diagnosis, care and support for individuals who choose it and are digitally enabled, as well as the scaling up of in-person community diagnostic capacity.

Example: Rohan, a 38-year-old with cerebral palsy.

Rohan relies on non-invasive ventilation (NIV) to manage his chronic respiratory condition. His care is now supported through a local community diagnostic centre and digital tools, reducing his need for hospital visits.

When Rohan experiences increased shortness of breath, he visits the centre for a same-day lung function test, avoiding a trip to the hospital. His care team reviews the results, sending them to him through his secure NHS App and scheduling an in-person follow-up with a respiratory specialist.

The app also enables Rohan to track his ventilator data and access tailored physiotherapy exercises designed to enhance his respiratory health. This allows Rohan to receive high-quality care close to home, improving his independence and quality of life.

Case study of current best practice - York Frailty Hub

This service is delivered to York residents when they are assessed as having the capacity to benefit from proactive frailty care.

The service is a multi-layered combination of pro-active admission avoidance, integrated crisis response, and discharge support - representing a join up of both existing teams and new services.

In the event that those identified by the service call 999 as they think they require hospital admission, the call is instead patched through to the frailty hub - which, if necessary, results in an urgent community response (UCR) team being dispatched.

The UCR provides an assessment, treatment if necessary and then arrange a comprehensive care plan for the individual in tandem with their GP.

All services within the hub have close links with third sector providers of support for dementia and palliative care.

The service is avoiding the need for hospital attendance in up to a third of referrals made to it.

Potential contribution to system financial sustainability

Further research is required on the financial impacts to the system of delivering more care at home and in the community. Though this would require investment in increasing virtual and community capacity, care delivered in this way should reduce demand on hospitals and free-up resources for complex cases. Early interventions close to home can prevent admissions for more expensive inpatient treatment.

Progress roadmap

In 2 years, this would mean:

- national clinical directors have set out a roadmap for what and how care can be delivered outside hospitals for each condition area

In 5 years, this would mean:

- members of the public are as likely to use community diagnostic centres, digital diagnostics and/or virtual services as a hospital site for outpatient care

In 10 years, this would mean:

- through harnessing innovation, spreading best practice and investment in community diagnostic capacity, patients are able to receive all outpatient care in the community (unless they choose, or it is clinically necessary, to be seen in a hospital)

Ambition statement 4: every member of the public will be able to access co-ordinated primary care services, regardless of who they are or where they live

Case for change

The GP Patient Survey shows that patients continue to value the service they receive through GPs (NHS England, 2024), and primary care services more broadly are less costly for the system to deliver than secondary and emergency care consultations (The Kings Fund, 2024).

However, poor access to primary care has become a top public concern. Difficulties getting a GP appointment and finding an NHS dentist are the top reasons for members of the public to contact Healthwatch. ‘Dental deserts’, where no practices are taking on new NHS patients, have become common and in 2023 community pharmacies closed at a rate of eight per week (Healthwatch, 2024). There is particular concern about lack of NHS dentistry and pharmacy closures in the areas of greatest deprivation.

Improving care for individuals, addressing health inequalities and reducing long-term pressures on the system will rely on ensuring that all primary care services are accessible for all individuals in all communities.

Patient perspective

Building on the data that Healthwatch receives on primary care access, analysis of the Change NHS online portal submissions reveals that GP access is one of the top public priorities to be solved in the short term. Improving access to dentists was also identified as a priority from the face-to-face public workshops.

Many of those who contact Healthwatch are frustrated about the lack of co-ordination between primary care services, for example issues being ‘bounced between’ services, notably pharmacy and general practice. There is also public confusion about their relationship with their dentist, with most people incorrectly believing that this works in the same way as registration with a GP, leading to confusion and frustration when patients are removed from the patient lists of dental practices (Healthwatch, 2024).

What this means in practice for service users

We must ensure that everyone across the country, regardless of where they live or who they are, has good access to the primary care services that help to keep them healthy and out of hospital.

A core, and co-ordinated, primary care offer will include timely access to GP and dental services when required, as well as convenient access to a local community pharmacy, which will operate as the front door for most minor conditions where clinically appropriate.

Example: Clara, a single working mother with 3 children, living in an area of high deprivation.

Given the hours Clara works and her child caring responsibilities, she doesn't have much time. It is therefore helpful that, through the NHS App, Clara can register her and her children to a local GP and NHS dentist - with clear information available to her on different available providers.

She also has clear information available to her through the app and online about the community pharmacies and optometrists in her local area, including live updates on opening hours and with notifications when any service will be temporarily or permanently closed.

When her or one of her children has a health issue, they are triaged to the most appropriate primary care service in her area - whether GP, dentist, pharmacist or optometrist.

Services are located close to Clara, so she doesn't have to walk or take public transport for more than 30 minutes to get to each. When she does visit them, they are aware of Clara and her children's care history, so she doesn't have to tell her story twice.

Potential contribution to system financial sustainability

While some cost benefits can be estimated from delivery of this ambition, more evidence is needed to look at longer term impacts. For example, the access benefits of extended GP opening hours, longer GP appointments for those with long-term conditions, and more minor conditions managed through Pharmacy First will all depend on utilisation and experience.

Evidence regarding cost-effectiveness must be evaluated alongside patient outcome and experience data, improvements to population health, the patient costs associated with attending primary care appointments compared with other service areas.

Progress roadmap

In 2 years, this would mean:

- agreement on longer term direction for primary care contracts, including requirements on co-ordination and new contractual model in dentistry

- halt the declines we have seen in GP practices and community pharmacies

In 5 years, this would mean:

- all adults and children in England are registered with a GP and have a right to dental check-ups every 24 months for adults and every 12 months for children

- all primary care services can provide 24/7 access to next day triage or same day information and signposting

In 10 years, this would mean:

- integrated primary care commissioning

Ambition statement 5: every adult, child and young person will be able to access mental health and care support 24/7 - especially those in crisis

Case for change

We know that whilst those experiencing mental health crisis represent a small proportion of attendees to A&E, they represent a disproportionately high proportion of very long waits. Unless they have corresponding urgent physical health needs, A&E is not the appropriate setting for delivering the care these patients need, and this has a knock-on impact on the efficiency and capacity of services for other people.

Beyond emergency care, we know that accessing mental health services is too difficult for too many people.

Patient perspective

Analysis of the Change NHS online portal submissions reveals that mental health stigma remains a barrier to people getting help, that there is variation in provision of mental health support, and that support is often not tailored to people's individual needs, preferences, culture and identity.

Patients have shared that A&E departments can be terrible environments for someone experiencing a mental health crisis. They think the NHS should provide alternate points of access, a simplified process and more joined up support.

What this means in practice for service users

Though some parts of the country already deliver innovative and easily accessible crisis support, everyone must be able to access support 24/7.

In future, those facing acute mental health crises will experience better care in a community setting, as an alternative to emergency and inpatient care when it is not the best option for the individual.

Example: Mia, a young person facing disruptions at home, with deteriorating mental health.

While staying with her aunt and uncle, Mia's mental health deteriorates to a point where urgent support is required to keep her safe.

Using the NHS App as a digital front door, Mia is triaged to into the local neighbourhood health service and can access a 24/7 mental health centre providing same day, integrated, holistic and person-centred care.

Due to having a single patient record, this local service can see her entire health and care history - so she is at no detriment accessing care near to her aunt and uncle as opposed to her own GP.

The community mental health service is also able to see all the information Mia entered on the NHS App at the point she was triaged to the service.

After being seen, the service provides Mia with a bespoke offer of self-management tools and links to voluntary partners.

This process and support being available at a first digital and then neighbourhood level means Mia’s aunt and uncle did not need to consider taking her to A&E.

Potential contribution to system financial sustainability

Providing safe and effective community services and care pathways for those experiencing mental distress will release capacity for people who require care in more specialist settings.

Progress roadmap

In 2 years, this would mean:

- waiting times are reduced and a set of waiting time standards are introduced in line with elective standards
- people can self-refer into crisis mental health support when they need it

In 5 years, this would mean:

- patients can access localised models of care, that are realigned to the international evidence base and adapted to their needs

In 10 years, this would mean:

- everyone can receive access to appropriate, personalised, timely mental health care, meeting their needs
- services will provide continuity of care that is person-centred, safe and therapeutic

Ambition statement 6: those at high clinical risk or who are marginalised will have a health and care system that comes to them.

Case for change

In most cases, individuals are required to ‘go to’ the NHS when they become ill. We believe this should change, with the establishment of a culture where the NHS reaches out to individuals before they get ill or deteriorate, particularly those at the highest risk.

The 2019 NHS Long Term Plan (NHS England, 2019) laid the foundation for using population health management to match services to areas of greatest need and address health inequalities. Since then, integrated care systems (ICSs) have begun adopting risk stratification tools to identify individuals at risk of adverse health outcomes. However, these solutions must go further to deliver equitable, proactive care.

A small percentage of the population accounts for a disproportionate share of healthcare costs, often due to repeated A&E attendances or unplanned hospital admissions. By identifying and supporting individuals at high risk of deterioration - such as frail older adults or those with unmanaged cardiovascular risk factors - before crises occur, we can improve outcomes for individuals while reducing pressure on services.

Crucially, people who are less engaged with healthcare, including those who are digitally excluded, often have the greatest unmet need. Without targeted outreach, they risk being overlooked in a healthcare system increasingly reliant on digital tools.

Risk stratification, combined with consistent and personalised outreach, offers the NHS an opportunity to transform care by delivering better outcomes, reducing inequalities, and improving cost-effectiveness.

Patient perspective

For patients at high clinical risk, the healthcare system can feel reactive and fragmented, with support arriving too late to prevent emergencies.

Imagine a frail older adult with early signs of heart failure who avoids visiting their GP due to mobility challenges or complex needs. Without proactive outreach, their condition may deteriorate, leading to avoidable hospitalisation. Similarly, a patient with undiagnosed hypertension might face long-term complications simply because they were not identified early or offered appropriate support in a way that worked for them.

By 2035, every person at high risk should receive personalised outreach tailored to their communication preferences. Whether through phone calls, home visits, or online, this proactive approach will make people feel valued, supported, and more confident in managing their health.

What this means in practice for service users

Risk stratification tools will identify individuals most likely to benefit from preventive and rehabilitative care, including those at high clinical risk or facing barriers to engagement.

Outreach will be through personalised communication methods, such as phone calls, home visits, or written correspondence, to ensure inclusivity, particularly for those who are digitally excluded.

Patients flagged by risk stratification tools will receive regular check-ins and tailored preventive interventions before crises occur, helping to reduce emergency admissions.

For example, individuals with unmanaged cardiovascular risk factors could be offered targeted lifestyle advice, medication reviews, and monitoring to reduce their risk of complications.

This approach will focus on groups often underserved by traditional healthcare systems, such as people experiencing socioeconomic deprivation or living in remote areas.

NHS services, local authorities, and voluntary sector partners will collaborate to deliver outreach and preventive care in a holistic, person-centred way, making better use of data and resources to reduce health inequalities.

Example: Mary and Alan, an elderly couple living in a rural area. Mary, 84, has early-stage dementia, while Alan, 86, experiences frailty and mobility issues.

Through neighbourhood-level risk stratification, their healthcare team identifies them as being at high risk of health deterioration. A community nurse visits regularly to check on their wellbeing and co-ordinate care, ensuring they receive the right support. When Alan’s mobility worsens, the nurse arranges for a home visit from a physiotherapist, while Mary’s doctor provides a tailored medication review to manage her dementia symptoms.

Thanks to proactive outreach, the couple’s health is stabilised, avoiding hospital admissions.

Potential contribution to system financial sustainability

Proactive outreach through risk stratification could be cost-effective over the long term by delaying the need for treatment or reducing the frequency of unplanned hospital admissions and emergency attendances among high-risk individuals. Early identification and targeted support, such as providing personalised care for frail individuals can prevent costly complications and long-term health deterioration.

Progress roadmap

In 2 years, this would mean:

- begin identifying high-risk individuals through population health management tools and risk stratification. Introduce targeted outreach methods, including home visits and phone calls, for those digitally excluded. Train healthcare professionals to engage effectively with high-risk patients
- establish cross-sector partnerships with voluntary and community services to support high-risk groups

In 5 years, this would mean:

- expand proactive outreach services across all ICSs, ensuring regular check-ins for individuals at high clinical risk
- improve data integration to better target interventions and personalise care

In 10 years, this would mean:

- this ambition may look significantly different in 2035 due to advances in AI and technology, which are hard to predict and articulate today
- however, we should seek to achieve universal coverage for proactive outreach for high-risk individuals, with all patients receiving tailored, person-centred care that addresses their specific needs and preferences
- reduce hospital admissions for high-risk individuals through early intervention, improving health outcomes and reducing healthcare costs

Ambition statement 7: anyone waiting for diagnosis or treatment will receive real-time information on waits and ‘gold standard’ holistic support to ‘wait well’

Case for change

The current experience of waiting for care in the NHS can often be a poor one. The system can and should do far more to support people whilst they’re waiting, and this will have health benefits. The process of waiting may have detrimental impacts on conditions if they are worsening, and there can also be second order effects such as deteriorating mental health. More consistent care navigation could help patients and service users access the right service at the right time. Communication should be regular, sensitive and personalised - with the underutilised VCSE sector enabled to play a far greater role in support and rehabilitation.

Patient perspective

Feedback through the engagement exercise has told us that patients are too often left ‘in the dark’ about the future of their care. They can feel forgotten, confused and frustrated about when and where they will be seen, as well as how they can access other services while they wait if needed.

What this means in practice for service users

There will be a gold standard of what ‘waiting well’ looks like, co-designed with patients.

When waiting for any form of planned care patients will receive personalised communication as set out in NHS guidance with information in the right format and in line with patients’ preferences. This will extend to a named contact to speak to if they need whilst waiting, and signposting towards relevant VCSE resources such as support groups and guidance.

Beyond these communication expectations, patients should be supported to live as well as possible for the duration of the time they are waiting for treatment. This includes prehabilitation, such as advice on diet and physical activity. This can improve clinical outcomes and prevent deterioration in health whilst waiting. Patients should also expect proactive support with additional costs, including travel for quicker out of area treatment, and comprehensive signposting and access to community health services and community support for example, financial and housing advice, peer support.

Example: Farah, a middle-aged women diagnosed with breast cancer.

After feeling a lump and reporting it through the NHS App, Farah is referred to a community diagnostic centre for a scan.

English is Farah’s second language, and she is able digitally receive resources in advance of her appointment regarding what she can expect to happen when she attends the CDC.

Farah attends the CDC which acts as a community ‘one stop shop’, with no separate steps between primary care and diagnostics which would otherwise add time to her treatment pathway.

Whilst waiting for her results, she receives personalised communication as to what the potential outcomes of her scan are.

Following a diagnosis of stage 2 breast cancer, Farah is referred on to treatment and commences this within the 31-day target. During this wait, she is directed towards local community VCSE resources and support groups, where she can meet with people facing a similar situation to her.

When she starts to receive treatment, this is targeted, informed by genomics and she moves through a pathway where decision making is enhanced by improved data systems and AI integration.

Following discharge and receiving the all-clear, Farah is provided with a ‘warm’ hand off to community services for continued support and suggested rehabilitation, including counselling, as the experience has led to a deterioration of her mental health.

Potential contribution to system financial sustainability

A gold standard for waiting will ensure patients are informed and better supported to navigate the NHS following a referral for diagnosis or treatment. Given some of the key reasons for missed NHS appointments include poor NHS communication, cost barriers, and work or caring responsibilities, a more personalised approach to waiting and booking appointments could lead to fewer missed appointments with cost benefits to the NHS.

Proactive VCSE, community and prehabilitation support may keep more people on waiting lists in work, providing wider economic benefits. There are also estimates that reducing waiting list numbers would bring financial benefits (IPPR, 2023).

Progress roadmap

In 2 years, this would mean:

- all patients can see, through the NHS App, data on their expected waiting time until treatment commences, and alternative options for where treatment may be quicker

In 5 years, this would mean:

- VCSE sector is fully integrated into care pathways to provide support to those waiting for care
- all those waiting for care are assigned a point of contact
- constitutional standards are being met for cancer and elective referral to diagnosis and treatment targets
- providers are delivering a gold standard of waiting well to all patients.

In 10 years, this would mean:

- people will have a supported experience whilst waiting for treatment and will not experience harm or anxiety while they wait

Ambition statement 8: services will prioritise improvement against health inequalities and what matters to patients, with service users invited to leave feedback on experience and outcomes as standard

Case for change

While the public want responsive health services they can access where and when they need them, they also care about how care is delivered.

Through the public face-to-face workshops to inform the 10 Year Health Plan, members of the public indicated that a priority was receiving care that is ‘warm’ and high quality. This means services being welcoming, kind and having the time to listen to the patient about all their concerns, with nobody feeling dismissed.

However, while we have comprehensive data on NHS activity, we know far less about how accessible services are, how positive people’s experiences are of using services, how these experiences differ between demographic groups and why.

Patient perspective

Feedback on NHS services, including through complaints, is not always made easy for the public. There are multiple ways to leave feedback and the public lacks confidence that these mechanisms have any impact on service improvements.

Forthcoming Healthwatch England research, for example, will show that while around 1 in 4 have had a poor experience of using an NHS service in the last 12 months, the majority took no action (that is, leaving feedback or a complaint). The main reason given for this by members of the public was because they did not have confidence that their feedback would have any impact on improving services.

What this means in practice for service users

Across other industries, feedback on experience is gathered as frequently as possible, with feedback mechanisms made as easy as possible for service users. This feedback is seen as an indispensable source of improvement. Like any successful institution, the NHS should be doing the same as part of an ongoing improvement process.

This data would be collated by service to enable refocused national attention on measuring and addressing inequalities in experiences and outcomes.

Example: Gavin, a 55-year-old man living with multiple long-term conditions.

Though he appreciates the excellent care he receives from healthcare professionals, Gavin has had frustrations accessing his GP through the NHS App.

Because he is prompted to quickly leave feedback about different parts of his care after he has his appointment, Gavin can state that he is satisfied with the care received but leaves a comment that he was dissatisfied with the malfunctioning booking system.

Gavin’s feedback, along with that of other patients is picked up by the practice and by the ICS. An AI tool used to analyse feedback informs both the provider and commissioner that the booking system is the cause of negative feedback and the issue is quickly investigated and resolved.

Through end of year reporting, GP teams, trusts and other healthcare providers summarise the feedback on access and patient experience they have gathered over the previous 12 months and how they have acted upon it to improve services.

There is comprehensive and publicly available data on patient satisfaction with access, care received, coordination of services, the referral process and administration of their care. This can be broken down by providers, services and geographies, as well as by user demographics, so that there is a clear picture on which services are working for which users.

Potential contribution to system financial sustainability

Understanding patient experiences can lead to service improvements and efficiencies. For example, learning from and improving experience of referral processes can lead to needs being met before conditions deteriorate, providing cost benefits to the NHS.

Additionally, it has been estimated that learning from and addressing health inequalities can save the NHS in the region of £5 billion in treatment costs, and lead to productivity improvements of between £31 to £33 billion per year (Health Financial Management Association, 2024).

Progress roadmap

In 2 years, this would mean:

- through consultation with the public and the sector, patient experience and access metrics are agreed
- access metrics begin to be rolled out through the NHS App and non-digital methods after every user’s interaction with health and care services

In 5 years, this would mean:

- comprehensive data on access and patient experience is routinely collected and publicly available

- this data sits alongside activity data as a key source of improvement for providers and commissioners

In 10 years, this would mean:

- service user experience is embedded in improving quality

Ambition statement 9: in an emergency, such as a heart attack or stroke, everyone who needs it will get the most clinically advanced treatment available, to faster standards of response time and care, leading to more lives being saved

Case for change

Emergencies like heart attacks and strokes require rapid, specialist intervention to prevent death and long-term disability. While the NHS in some locations has made strides in establishing centres of excellence which can treat patients in such emergencies, some patients continue to experience delays due to uneven access, which exacerbates health inequalities and limits outcomes.

For conditions like stroke, time-critical interventions such as thrombectomy are not yet consistently available across the country. Although thrombectomy has been described as a "miracle treatment" that transforms outcomes, in many parts of the country, access is poor. The percentage of suspected stroke patients who receive the necessary brain scan within an hour of arrival at hospital varies from 80 per cent in Kent to only around 40 per cent in Shropshire.

By 2035, the NHS must ensure that as many people as possible can rely on equitable, rapid access to specialist care in emergencies.

Patient perspective

During a medical emergency, patients and families need to feel assured that they will receive the best possible care without delay. Currently, some patients experience avoidable harm because they are not treated quickly or by the right specialists.

What this means in practice for service users

Transparent national standards should be developed which set clear expectations for response times and treatment pathways. These standards will be published and measured regularly to ensure accountability.

Example: Amara, a 74-year-old grandmother living in Preston, Lancashire.

One evening, while at home with her family, Amara begins experiencing severe weakness on one side of her body and struggles to speak. Her family think fast and call 999, suspecting she is having a stroke.

The paramedics arrive within minutes. They use digital tools to share Amara’s preliminary assessments with the nearest specialist stroke unit en-route. They also identify that Amara is a potential candidate for thrombectomy. In hospital, Amara is assessed quickly. The team confirms she is eligible for thrombectomy and proceed with the procedure. The intervention is successful, significantly reducing the risk of long-term disability.

Amara recovers well and regains her independence.

Potential contribution to system financial sustainability

Investing in timely access to emergency care can lead to long-term cost neutrality by reducing the burden of long-term disability and the associated care needs. Rapid interventions such as thrombectomy not only save lives but also enable patients to recover with significantly less dependency on rehabilitation services or social care. In turn, this can enable individuals to return to employment more quickly. By centralising specialist care in appropriate centres (for example, specialist stroke units in London) the NHS can optimise resource use and improve outcomes, reducing downstream costs from avoidable complications and prolonged hospital stays.

Progress roadmap

In 2 years, this would mean (with an illustrative focus on stroke):

- undertake audit of where specialist centres should be for example stroke centres
- integrate technology and digital tools that are available now so paramedics can assess more effectively (for example a lateral flow test for stroke) liaise with specialist centres (for example, pre-hospital video triage)
- return to pre-pandemic clinical and access standards
- re-set people's expectations and perceptions of being able to rely on emergency care to promote access when needed

In 5 years, this would mean:

- roll-out modern effective treatments such as thrombectomy across more areas
- reduce variation in access to effective treatment (such as thrombolysis) through targeted improvement programmes

In 10 years, this would mean:

- ensure routine, 24/7 access to effective treatments such as thrombectomy across all towns and cities

Ambition statement 10: effective palliative care services are available for everyone, providing people with safe, dignified and personalised end of life care in a setting of their choice

Case for change

The 2019 NHS Long Term Plan (NHS England, 2019) set a commitment to improving end-of-life care, recognising the critical importance of personalisation and proactive care planning. The NHS has relied on partnerships with local authorities, VCSE organisations, and specialist hospices to deliver care that reflects individual needs and preferences. However, the NHS has much further to go to enable equitable access and consistent quality. An estimated 100,000 people in the UK that could benefit from palliative care die without receiving it each year (UK Parliamentary Office of Science and Technology, 2022).

Death and dying are inevitable, and how we care for people at the end of life reflects the values of a society. Public engagement has shown that people care profoundly about this issue, with recent discussions in the media highlighting the need for compassionate and effective palliative care.

By 2035, the ambition is to ensure that palliative care is universally available, personalised to reflect the priorities, preferences, and wishes of each individual. This will improve not only the quality of life for people living with dying but also the experience of bereavement for their loved ones.

Patient perspective

For many patients, end-of-life care feels reactive rather than planned, resulting in avoidable hospital admissions and inadequate support in community settings. Families often feel overwhelmed and unsupported, particularly when care is fragmented or services are hard to navigate.

VCSE organisations, including local charities and specialist hospices, play a vital role in bridging these gaps, providing compassionate care, bereavement support and expertise in symptom management. Despite their contributions, access to high-quality palliative care is uneven, with significant disparities based on geography, socioeconomic status and cultural needs.

By 2035, every individual nearing the end of life should have confidence that their care will be proactive. Patients should experience care that is planned in partnership with them, tailored to their preferences and supported by integrated services.

This transformation is essential not only for adults but also for children and young people with palliative care needs. This should include young carers who provide support to a parent or loved one. Addressing the unique and complex requirements of children, young people, and their families must remain a priority for the NHS, ensuring that their experience is as dignified and compassionate as possible.

What this means in practice for service users

Individuals nearing the end of life will have proactive, personalised care plans created in collaboration with healthcare teams, families and carers. These plans will address their medical, emotional and spiritual needs while respecting their priorities and preferences, including the choice of where to receive care and die.

While a small number of patients will still die in hospital, local community services, including GPs, hospicesmand VCSE organisations, will work together to provide 24/7 support in people's homes or other chosen settings where appropriate. Holistic care will extend beyond symptom management to include emotional and practical support for families and carers.

NHS staff will be equipped with enhanced training to recognise when individuals are entering the last years) of life and to initiate meaningful, compassionate conversations about care preferences. This will enable early identification and proactive planning for end-of-life care.

Steps will be taken to address disparities in palliative care access. This includes ensuring appropriate care for diverse communities and equitable support for vulnerable groups, such as those with disabilities or in deprived areas.

The NHS will prioritise children's palliative care, working closely with specialist providers to meet the distinct needs of children and their families. This will ensure that children facing life-limiting conditions receive care that is as dignified and personalised as it is for adults.

Example: Lawrence, a 78-year old terminal cancer patient and his daughter, Josephine, from Cornwall.

Lawrence has been given a diagnosis of stage 4 bowel cancer and has been told that he has a few weeks or at most a few months to live

Lawrence sees his GP, who works with him and his daughter Josephine on an end-of-life care plan. During a sensitively handled and compassionate conversation, Lawrence is given time to explain what is important to him during his end-of-life care. Though he is offered a choice of care at local hospices, most of all he wishes to end his life at home, in comfort and with his daughter with him.

The end-of-life care plan, which Lawrence is happy with, is added to his patient record and can be seen by every member of a multidisciplinary team, managed through the neighbourhood health service.

During the last weeks of his life, both Lawrence and his daughter are kept up to date on his treatment and care, which is delivered through district nurses, social care teams and palliative care specialists. He is regularly asked if the care he is receiving is meeting the expectations set out in his end-of-life care plan.

Potential contribution to system financial sustainability

Sufficiently bolstering end-of-life care will require significant investment in the short term, and we welcome the government's recent investment into the sector (Department of Health and Social Care, 2024).

Over time, investing in community-based palliative care could be cost-neutral and some international evidence points to savings for the wider system. Better supported community palliative care could reduce avoidable hospital admissions and short stays for those who do require acute care.

Proactive, personalised care ensures resources are aligned with patient preferences, avoiding unnecessary interventions while improving quality of life. Strengthened partnerships with VCSE organisations and hospices also provide cost-effective, high-quality support, easing pressure on NHS services.

Progress roadmap

In 2 years, this would mean:

- conduct a national audit of current palliative care access and identify gaps in service delivery
- roll-out training for NHS staff on end-of-life care planning and recognition

In 5 years, this would mean:

- expand proactive, personalised care planning to ensure all patients with end-of-life care needs have comprehensive plans in place

In 10 years, this would mean:

- achieve universal access to personalised palliative care across the UK, with all patients able to receive care in their preferred setting

Annex 3: what are the ambitions for some of the most prevalent health conditions

Below gives an idea of some of the ambitions for condition pathways including diagnosis, waiting times, treatment and after care. This is not a comprehensive list but is indicative of some of the transformation in services needed for conditions as well as the structure of services themselves. We have also included the progress needed on sickle cell anaemia to illustrate a rarer disease.

Cancer

In 2 years, this would mean:

- year-on-year performance improvement maintained
- faster diagnosis standard (FDS) met at 80% from March 2026, 31-day standard met by March 2027 and 62-day performance improved
- first phase of radiotherapy replacement complete

In 5 years, this would mean:

- meeting all cancer waiting time (CWT) performance standards to give patients confidence in timely diagnosis and treatment
- targeted treatments informed by genomics are more widely used
- pathway processes and/or decision making is enhanced by improved data systems and AI integration

By 2035, this would mean:

- CWT standards are consistently delivered in all trusts
- capacity to meet anticipated demand and targeted outreach to support earlier diagnosis
- technological developments in diagnosis and treatment rapidly adopted to improve quality of care with linked data and AI integration supporting case finding, diagnosis and treatment

Musculoskeletal (MSK)

In 2 years, this would mean:

- prompt access to community MSK services for triage, therapies, rehabilitation. Establish a MSK Community Delivery Programme

- implementation of a prevention package for people with MSK conditions

- focus on primary and secondary prevention of fragility fractures including expanding access to fracture liaison services

In 5 years, this would mean:

- increase access to MSK digital therapeutics, for example, greater use of digital consultations, patient-initiated follow-up and educational videos to ensure patients are not making unnecessary visits to hospital

- expand provision for children and young people with MSK conditions

- consistent national chronic pain pathways

By 2035, this would mean:

- redesigning services so patients can be treated in primary or community settings, supported by services co-designed with patients, reducing delays in their treatment

Dementia

In 2 years, this would mean:

- achieve a 67% dementia diagnosis rate, with timely diagnosis within18-weeks. This includes advancing blood-based biomarkers, improving imaging access, reducing diagnosis variation, ensuring better treatment access, training staff to support caregivers, implementing a nationwide care co-ordinator model and expanding dementia trial participation

In 5 years, this would mean:

- enhance diagnostic capacity, with timely, high-quality diagnoses, including sub-type identification

- integrated health pathways, annual care plan reviews and a dynamic dementia patient registry will drive progress in clinical trials and treatment adoption

By 2035, this would mean:

- reduce dementia prevalence through improved prevention and early diagnosis using standard blood biomarkers

- equitable access to NICE approved treatments, well-trained staff delivering consistent diagnoses and better support for unpaid family carers

- services will be fully integrated across health and social care

Mental health

In 2 to 5 years, this would mean:

- reducing waiting times and introducing a waiting time standard, within 2 years, which is on par with elective standards which will support improving access and reduce the acuity of patients' needs when seen by services

- patients can start to access new models of care that are localised, realigned to the international evidence based and adapted to their needs

- implementation of the reformed Mental Health Act, to provide a modern framework for detention and treatment of patients with improved safeguards and a greater emphasis on patient voice

By 2035, this would mean:

- everyone, of all ages and irrespective of their characteristics, can receive access to appropriate, personalised, timely mental health care and have their needs met

- ensuring mental health is considered equally to physical health is vital to achieving both national and patient outcomes

- mental health services will provide continuity of care that is person-centred, safe, and therapeutic and transformed models of care have been rolled out across the country

Oral Health

In 2 years, this would mean:

- expand water fluoridation to additional 1.6 million people

- targeted universal supervised toothbrushing programme in place across England

- services in place to deliver 700,000 urgent care appointments, increasing levels of access to urgent and emergency dental care for patients in need

- better access to NHS appointments in areas that need them most - through more dentists employed in underserved areas
- implementation of interim changes to existing dental contract including regulatory changes

In 5 years, this would mean:

- a new dental contract in place which has been designed with the support of the profession, incentivises prevention as well as high quality routine and urgent care, and prioritises care for those with the greatest needs
- increase in dental activity and increase in percentage of patients able to get an NHS appointment of those who try

By 2035, this would mean:

- expansion to cover more of the population to meet unmet need
- reduction in decayed, missing and/or filled teeth as measured by oral health surveys. Impact on hospital admissions attributable to dental decay
- more people in study to become a dentist/dental care practitioner
- higher proportion of NHS dental care being delivered through therapists and hygienists
- digital transformation /integration of dentistry and oral health into neighbourhood health service

ADHD

In 2 years, this would mean:

- the backlog is clearing and waits approaching under 13 weeks
- signposting to specific supports offered to all on waiting list
- needs based support universally available
- joined up care across health, education, social services
- a simple and transparent pathway follows consistent standards of stigma-free care
- technology supports clinical assessment and management

In 5 years, this would mean:

- specialist primary care services diagnose, treat and manage non-complex ADHD as part of whole-person, neuro-inclusive care
- secondary care pathways support those with complex needs and/or limitations
- regulated independent providers who meet strict quality standards are partners within NHS-led pathways
- NHS-wide awareness of ADHD
- all NHS services are free of stigma

By 2035, this would mean:

- ADHD is recognised, diagnosed and supported earlier in life across different population groups
- NHS and population prevalence aligns
- neuro-inclusive society supports people with ADHD to thrive
- fully integrated mental health and neurodivergence pathways are readily accessible with specialist input
- neurodivergent people have equal outcomes across physical and mental health

Cardiovascular disease (CVD)

In 2 years, this would mean:

- people who are at risk are detected (including evaluating the effectiveness of case-finding through dental and optometry pathways and use of point of care testing for cholesterol), treated and then optimally managed
- optimised NHS Health Check identifying a greater number of people at high risk of CVD, and treatment initiated and optimised with home testing for cholesterol available on demand, and improved access to testing through pharmacy pathways

In 5 years, this would mean:

- for those with heart disease, increasing focus of attention on health inequalities, and developing insights and strategic approach to improving medicines adherence and to a cardiorenal metabolic (CRM) approach

- trialling innovative approaches, focused on community and at home care

- increasing access and reducing inequalities to treatments and early interventions (Automated external defibrillator cardiopulmonary resuscitation training) for cardiac arrest, heart failure and heart attack

- digital NHSHC used to widen access to those who can engage digitally. Care at home models where clinical teams are able to provide remote monitoring of higher risk patients

- ensuring all patients who experience cardiac arrest, heart failure or heart attack, receive rehab

- increasing access to sodium-glucose co-transporter-2 inhibitors and glucagon-like peptide-1 receptors agonists for people with cardio-metabolic risk factors and overweight or obesity and post CVD events

By 2035, this would mean:

- achieving the government's ambition of reducing CVD mortality by 25% in under 75s in a decade, supported by optimal detection and management of CVD risks, and rapid access to services post cardiac event

- to reduce health inequalities in access to CVD care to reduce the life expectancy gap between the most and least deprived quintiles in men and women

Type 2 diabetes mellitus (T2DM)

In 2 years, this would mean:

- Diabetes Prevention Programme (DPP), Type 2 Diabetes Path to Remission (T2DR) and structured education expansion supports greater numbers of people, including people with risk factors beyond Non-diabetic hyperglycaemia (NDH)/ T2DM.

- proactive care provides improved access to pharmacological, healthy lifestyle and/or behavioural interventions, glucose monitoring tech, online structured education and self-management support

- safe inpatient care widely available and enabled by an upskilled workforce and use of technology (for example, networked blood glucose monitoring) and rapid access to support for complications through multidisciplinary teams

In 5 years, this would mean:

- wider adoption of the diabetes information record standards across the pathway
- greater choice of diabetes technologies for the type 2 population, including hybrid closed loop (HCL) for targeted populations, significantly improves access
- people who are assessed in primary care as being demographically at high risk of diabetes (for example, Black or Asian and aged over 30) automatically enrolled on the diabetes prevention programme unless they opt-out
- expanded access to SGLT2s and GLP1s (including for weight loss) as part of routine diabetes care

By 2035, this would mean:

- people who are at risk of T2DM based on data held in their integrated care record (linked to NHS App) are automatically advised that they are at higher risk and offered the opportunity to access a range of lifestyle interventions, including weight management and diabetes prevention programme

Stroke

In 2 years, this would mean:

- rapid diagnosis and conveyance of patients to the right place at the right time through wide scale use of pre-hospital video triage
- increased adoption of the national stroke imaging pathway and AI decision-making tools to improve timely access to time-dependent specialist stroke acute interventions
- increased access to community stroke specific rehabilitation to reduce disability (which includes a stronger focus on psychological wellbeing and support to return to work)

In 5 years, this would mean:

- all eligible ischaemic stroke patients receiving thrombectomy and thrombolysis for brain clot removal

- implementation of a care bundle approach for all patients with intracerebral haemorrhage for anticoagulation, blood pressure lowering and neurosurgery

- increased intensity and duration of stroke rehabilitation in hospital and at home, to reduce disability and increase independence

By 2035, this would mean:

- every person following a stroke is rapidly diagnosed, is admitted to a stroke unit, receives timely and appropriate interventions to remove the brain clot or stop bleeding, receives intensive and needs-based stroke rehabilitation which starts in hospital and then at home with a seamless transfer of care, to address complex motor, psychological, cognitive, communication disability needs, is supported to manage their health over the longer term to prevent a further stroke, and to increase independence and quality of life

Chronic obstructive pulmonary disease (COPD)

In 2 years, this would mean:

- integrated neighbourhood health centres aimed at delivering community-based care: providing access to multidisciplinary teams under one roof (doctors, specialist nurses, physiotherapists and support for employment)

- adoption of digital tools for remote monitoring, allowing patients to self-manage symptoms with support and improving accessibility with wearable technology possibly introduced to further support this

- pilots in hand to assess wider viability of linking COPD diagnosis pathways and automatic initiation of tobacco dependence treatment on an opt out basis for smokers through the targeted lung health check

- low-cost delivery of biologic or biosimilar medication reducing time spent in hospital

- expansion of preventative strategies - focusing on early detection

In 5 years, this would mean:

- expansion of preventive care programmes focussing on early diagnosis of COPD and management of exacerbation risks, including expanding the targeted lung programme to include COPD diagnosis pathways and automatic initiation of tobacco dependence treatment on an opt out basis for current smokers

- wider implementation of centralised digital health records, improving care coordination and reducing delays in accessing treatment
- achieving equitable access, particularly in neighbourhoods

By 2035, this would mean:

- full integration of personalised management plans based on data analytics and progression models
- ensuring community based preventative care is well established, to prevent progression and optimum adherence to the NICE guidance
- significant components of respiratory support digitally delivered - for example, exacerbation prediction, exercise and activity promotion, medication concordance, education
- respiratory disease audit established with linked primary care and secondary care data

Sight

In 2 years, this would mean:

- 75% of all integrated care boards (ICBs) to have key elements of the eye care transformation model with single point of access in place to deliver more care closer to home through a digitally enabled model of care

In 5 years, this would mean:

- 100% of ICBs will have rolled out the new care transformation model which includes: eyecare pathway and data co-ordination, designing a digitally enabled hub which co-ordinates clinical support for consulting, testing, reviewing, diagnosing and referring to improve patient outcomes in an efficient sustainable way (single point of access)
- more care to be delivered at or closer to home
- high street optometry and diagnostic hubs

By 2035, this would mean:

- digital products supporting patient initiated follow ups established and clinically assured, with attendance at hospital now not the norm

- AI can support diagnostics, detection and regional and community screening for populations with greatest unmet need with emphasis on prevention
- people no longer lose their sight due to a lack of access to appropriate care and services can effectively manage patient demand

Sickle cell anaemia

In 2 years, this would mean:

- recommendations of existing reviews are well analysed and implemented through smart action plans
- momentum is maintained on raising awareness in health and care professions and schools and developing expert patients
- mechanisms are in place to effectively capture the experiences of sickle cell disease (SCD) patients and identify priority areas for further action and research
- the specialist workforce is increased
- a prioritised list of research questions to improve outcomes

In 5 years, this would mean:

- access to care that by passes emergency departments during an uncomplicated crisis is made standard
- care in the community is enhanced and supported
- research to improve treatment options and outcomes is funded
- all people living with SCD receive high quality care in an equitable and timely manner from well informed healthcare professional community

By 2035, this would mean:

- high quality, well-coordinated care is provided to all people with SCD and wider rare diseases in the NHS
- effective feedback mechanisms for patients are in place
- there is a well-established education and research agenda that aims to cure, improve and progress healthcare and quality of life

- trust is rebuilt in the care the NHS is able to provide

References

10 Year Health Plan Working Groups 10 Year Health Plan working groups - GOV.UK

Chief Medical Officer 2023 Chief Medical Officer’s annual report 2023: health in an ageing society - GOV.UK

The Health Foundation, 2023 Health in 2040: projected patterns of illness in England | The Health Foundation

National Institute for Care Excellence (NICE), 2024 Prevalence | Background information | Obesity | CKS | NICE

Joseph Rowntree Foundation 2024

NHS Business Services Authority (NHSBSA), 2024 https://opendata.nhsbsa.net/dataset/pharmacy-openings-and-closures/resource/d9622d30-a967-4798-85f3-f3e5ecc3a14b

Lord Darzi. 2023 Independent investigation of the NHS in England - GOV.UK

Health Services Safety Investigations Body, 2023 Investigation report: Variations in the delivery of palliative care services to adults

Hospice UK, 2024 Urgent call to save end of life care as 20% of hospices threatened by cuts | Hospice UK (accessed 23 June 2025)

Levesque JF, Harris, M.F. & Russel, G. 2013 Patient-centred access to health care: conceptualising access at the interface of health systems and populations | International Journal for Equity in Health | Full Text

The Kings Fund, 2024 The NHS Budget And How It Has Changed | The King's Fund

Office for Health Improvement and Disparities, 2022: 4. Children and young people - GOV.UK

NHS England, 2023 NHS England » The NHS in England at 75: report summary

Powell and others, 2019 https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr07380#/abstract

NHS England, 2019 Long Term Plan NHS Long Term Plan » The NHS Long Term Plan

GP Patient Survey 2024, NHS England

Key facts and figures about the NHS, 2024, The King's Fund, NHS: Key Facts And Figures | The King's Fund

Pharmacy closures in England, 2024a, Healthwatch England, Pharmacy closures in England | Healthwatch

Access to NHS dentistry, 2024b, Healthwatch England, Access to NHS dentistry 2024 - findings | Healthwatch

Waiting for prosperity: Modelling the economic benefits of reducing elective waiting lists in the NHS | IPPR

How cost teams are helping to reduce health inequalities, 2024, Health Financial Management Association: 'How costing teams are helping to reduce health inequalities, 2024'

Palliative and end of life care, 2022, UK Parliamentary Office of Science and Technology, Palliative and end of life care - POST

Biggest investment into hospices in a generation, 2024, Department of Health and Social Care, Biggest investment into hospices in a generation - GOV.UK