Department of Health & Social Care

Impact statement: the 10 Year Health Plan for England

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Introduction

The 10 Year Health Plan for England ('10YHP' or 'the plan') is part of the government's health mission to build a health service fit for the future. The plan describes 3 shifts to reinvent the NHS: from hospital to community, from analogue to digital and from sickness to prevention, supported by a wider set of system changes to improve population health and make the NHS fit for the future.

This impact statement explains the rationale for, and potential effects of, a number of measures outlined in the plan. It broadly follows the same structure as the plan and should be read alongside that document to understand the proposals and their context more fully. The plan sets the overall strategic direction for the whole NHS and individual proposals are at different stages of development and specificity - many of them to be designed and implemented locally. Therefore, at this stage, a full costings and benefits assessment is not feasible, and this document is not intended as a full options appraisal. Further assessment of detailed national-level policy and legislation will be set out at the appropriate times.

The pace of delivering the commitments over the full 10 years of the plan will be subject to future decisions such as future government spending reviews or wider changes in economic and fiscal circumstances. For many longer-term proposals, it is not possible to robustly quantify future costs given that choices over implementation will affect costs and benefits. Most proposals apply to England only as decisions about the running of the NHS are taken by the devolved governments in Scotland, Wales, and Northern Ireland, with a small number of proposals - typically on promoting innovation - applying UK wide.

Reform plans - from hospital to community

Summary and rationale for intervention

The plan sets an ambition to have fewer services delivered in hospitals and more activity conducted remotely and in the community. This shift, in general terms, has been a longstanding policy aim for the NHS. The National Health Service and Community Care Act (1990)[1] aimed to move away from reliance on hospital-based care, towards a more community focused approach by promoting the provision of care in people's homes and community health centres.

The plan's proposals are centred around developing the neighbourhood health service. This new service model is designed to provide more care, including prevention, in primary and community care settings. Neighbourhoods are expected to cover around 50,000 people, with services that require working over a larger geography (for example end of life care) organised across larger populations of 250,000 or more. Particular approaches to service delivery will be designed around groups with similar needs that the plan identifies as "most failed by the current system".

[1] UK Public General Acts. 'National Health Service and Community Care Act' 1990.

To achieve the neighbourhood health service, proposals include:

- increasing GP capacity by training more GPs and freeing GPs' time from administrative tasks to allow for more patient facing time
- a newly reformed NHS dental system providing more accessible and quality care including better prevention by requiring newly qualified dentists to practice in the NHS for a minimum period and making better use of the wider dental workforce
- increasing the use of multidisciplinary teams (MDTs), working together in neighbourhoods to meet the needs of their populations
- activating patients to have a greater role in their care through care plans for those with complex needs and expanding uptake of personal health budgets (PHBs)
- more services available in community settings in neighbourhood health centres (NHCs), building on recent initiatives including community diagnostic centres and more services delivered by community pharmacists. This will also include extending Start for Life services to run from conception to age 5
- freeing up hospitals to focus on treating severe needs including by redesigning outpatient and urgent and emergency care services to reduce hospital visits and increasing capacity for urgent mental health care.

Proposals in this chapter also include modernising the way hospitals operate, discussed further in the digital and innovation chapters below.

Overview of costs and benefits

The neighbourhood health service is an ambitious major system change. This shift aims to both support the sustainability of the NHS and improve services for patients. This could include more convenient and comprehensive healthcare access close to home, health benefits to patients from MDTs taking a more holistic view of patient health needs, and improved patient satisfaction and wellbeing.

Healthcare system costs, benefits and risks

There is a strong logic case for shifting more care into the community both for improved patient outcomes and value for money, for example:

- community services that enable more streamlined access to care that is delivered in more convenient settings can improve patient experience, speed of access to tests and treatment and more joined up care pathways to improve outcomes. These all lead to improved patient outcomes

- providing more support and monitoring in the community can improve conditions management and self-care and therefore reduce hospital attendances and admissions. These all lead to improved patient outcomes. Exacerbation of long-term conditions can result in emergency hospital admissions, which reduces patients' independence. Better health monitoring provided by the neighbourhood health service can help reduce unnecessary admissions

- providing more support in the community can be expected to improve accessibility of services to the patient and support both access and quality

Our literature review about shifting services from hospital into the community found mixed impacts on health service costs as shown by the following evidence:

- a review of the academic literature by the Nuffield Trust (2017) suggests that many of the initiatives identified could improve patient outcomes and experience but only some were associated with cost savings while others were cost neutral or increased costs[2]

- studies, such as an NHS Confederation report[3], found that systems that invested more in community care saw on average 15% lower non-elective admission rates and 10% lower ambulance conveyance rates, together with lower average activity for elective admissions and A&E attendances

- an evaluation of initiatives to integrate primary, community, social and acute services in Mid-Nottinghamshire by the Health Foundation[4] also found reductions in emergency care use (4.3% fewer A&E visits and 6.7% fewer emergency admissions per 10,000 people per month). Notably, it took between 2 and 6 years for lower rates of hospital utilisation to emerge

- a literature review by Monitor[5] also found that moving services from hospital settings into the community has the potential to reduce hospital admissions though findings were mixed and the strength of evidence is not consistently strong

- a recent evaluation[6] of England's Vanguards integration programme in 2024, found the most notable early reductions in emergency admissions occurred in care home-focused sites. However, these reductions diminished quickly once funding was

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[2] Nuffield Trust. 'Shifting the balance of care: Great expectations' 2017.
[3] NHS Confederation. 'Unlocking the power of health beyond the hospital: supporting communities to prosper' 2023.
[4] The Health Foundation. 'The long-term impacts of new care models on hospital use' 2020.
[5] Monitor. 'Moving healthcare closer to home: Literature review of clinical impacts' 2015.
[6] Wattal V and others. 'What remains after the money ends? Evidence on whether admission reductions continued following the largest health and social care integration programme in England' Eur J Health Econ 2024: Volume 25.

stopped. Areas with high hospital utilisation prior to Vanguards integration, experienced the greatest net reductions in comparison to non-Vanguard sites

The plan outlines a role for patients to influence the neighbourhood health service and ways they will be supported to do so. This includes the expansion of personal health budgets (PHBs). The increased use of PHBs could benefit the health system, both in terms of reduced spending and improved patient outcomes and efficiency, provided they lead to a better allocation of spending and risks that they are cost-additive are mitigated. For example:

- a University of Kent evaluation found that following the introduction of PHBs, total spending fell for people with high levels of need and some groups spent less time in hospital when they had a personal health budget[7]

The neighbourhood health service is also intended to provide the opportunity for redesign of hospital services. By releasing capacity in hospital settings, the plan aims to enable hospitals to restore access standards and meet the needs of people requiring hospital care by freeing up capacity and using technology to drive efficiency, discussed further in the digital and innovation chapters below. The plan also describes making patient-initiated follow-up a standard approach for all clinically appropriate pathways by 2026. This could be expected to safely reduce the number of follow-up appointments[8].

While some studies have identified cost savings from moving services into the community, there are cases where these have been offset by increases in service volume and loss of economies of scale[9]. In line with the plan's goals, it will therefore be important for ICBs to allocate resources carefully and cognisant of this, to ensure that the neighbourhood health service is successfully implemented to deliver a more sustainable NHS.

Reform of this type, and on this scale, has not been delivered previously. The evidence base is therefore only partial, and the scale of impacts is very difficult to assess. As services develop, ongoing work will be required to assess the funding and value for money implications of the neighbourhood health service, as well as legislative changes required. Some of this work will be iterative given the interactions between system change and NHS budgets, as well as due to the intention to learn from and adapt as we go.

Variation in existing patterns of supply of services and demand and need for healthcare across different local geographies will present a range of challenges and opportunities for implementing the neighbourhood model. A 'test and learn' approach may help make sure

[7] Jones, K and others. 'Personal Health Budgets' 2017 and 2018.
[8] Nuffield Trust. 'Patient-initiated follow-up: will it free up capacity in outpatient care?' 2022.
[9] Journal of Health Services Research & Policy. 'Shifting care from hospitals to the community: a review of the evidence on quality and efficiency' 2007. Volume 12, Issue 2

the most successful approaches are rolled out nationally, accounting for where different models are needed, such as in rural and coastal settings. The factors that drive cost-effectiveness of shifting to community settings are likely to differ between urban and rural settings and by service type. For example:

- a systematic review[10] of 11 studies of community paramedics found that economic outcomes were dependent on a consistent number of patients being seen per shift. In rural areas where few patients were seen, one study found a negative effect on costs over 4 months. Other studies found net healthcare system savings per attendance provided a minimum threshold of demand is met

Financial incentives may have historically conflicted with a stated ambition to move activity into primary and community settings. For example, historical use of tariffs in acute settings incentivise more activity whereas block contracts in primary and community settings can incentivise the reverse. Previous efforts to move care closer to home were considered to have been hampered by insufficient scale of change in moving resources between settings. For example:

- a 2024 survey by the NHS Confederation found that 9 in 10 integrated care system leaders were concerned that plans to shift more care out of hospital were constrained by a lack of long-term investment.[11] See the finance chapter for more detail

The plan seeks to mitigate this risk by designing new financial flows to incentivise and support the neighbourhood health model with organisations supported to collaborate in prioritising prevention and improved primary or community interventions and so reduce the need for avoidable hospital care. The aim is to avoid a fragmented funding system which has hampered previous attempts at integrating care. From April 2026, several integrated care boards (ICBs) will be trialling new financial flows through a test and learn approach that will enable them to receive some of the resources they will save.

As well as the vision above to reform primary care, the plan aims to transform the NHS dental system. This includes a requirement for newly qualified dentists to practise in the NHS for a minimum period. Data from 2024 show that almost one-third of registered dentists are not contributing to NHS dentistry (around 11,000 out of around 35,000 registered) and may only be undertaking private practice[12]. Increasing the number of NHS

[10] Journal of Health Services Research & Policy. 'Shifting care from hospitals to the community: a review of the evidence on quality and efficiency' 2007. Volume 12, Issue 2
[11] NHS Confederation. 'NHS must be given long-term financial security to move more care closer to home' 2024.
[12] "Around 11,000" is calculated by taking away the c. 24,000 dentists practising in the NHS from the c. 35,000 registered. “c. 24,000” is from NHSBSA Statistics and Data Science. 'Dental statistics - England 2023/24' (viewed on 1 July 2025). "Around 35,000 registered" dentists is from General Dental Council. 'Annual registration reports' (viewed 1 July 2025).

dentists will increase costs to the NHS of contracted activity but will constitute an additional return on the taxpayer investment of up to £200,000 per dentist on education and training[13]. The scale of these impacts will depend on the number of dentists in scope and the length of time they are required to spend in the NHS, intended to be at least 3 years.

Making better use of the wider dental workforce could also create costs, associated with upskilling staff and changing ways of working to integrate with neighbourhood teams. There are potential benefits to the health system such as better patient access as staff working to the full scope of their practice could improve performance against dental services contracts. Timely access to dentistry for more people, if achieved, would be expected to reduce repeat urgent appointments and the burden on emergency departments.

- a study from 2022 analysed urgent dental care attendances in primary care across the North East and Cumbria between 2013 and 2019 and found that 16.15% of urgent dental care visits were repeat appointments[14]

The shift to the neighbourhood health service needs to happen at pace in order to release funding to sustain the approach. The parallel changes to ICBs could create a risk to delivering this transformation at the speed required. ICBs are required to reduce headcount by 50%, equivalent to 12,500 jobs[15] and reorganise, with a reduction in the current number (42) of boards. These activities could limit their capacity to provide the necessary strategic leadership to drive this change. However, over the longer term, such changes to ICBs could result in system benefits as the streamlining and refocusing of ICBs on to strategic commissioning may facilitate delivery of the neighbourhood health service.

Infrastructure costs, benefits and risks

The expanded scope of services available in community settings will be facilitated by establishing neighbourhood health centres (NHCs). The way these are created will vary by area, either requiring existing buildings to be repurposed or in new buildings.

The size and scope of the neighbourhood health centres will be determined by local systems, and they will be expected to assess and maximise the value of capital expenditure. Where they are based in existing buildings, there will be costs associated with repurposing, upgrading or refurbishing to meet appropriate standards and suit their new use. These changes could range from light refurbishment to more extensive

[13] Department of Health and Social Care. 'Proposal for a 'tie-in' to NHS dentistry for graduate dentists' 2024.
[14] Currie C and others. 'Urgent dental care use in the North East and Cumbria: predicting repeat attendance' 2022.
[15] Nuffield Trust. 'How will staffing numbers be affected by abolishing NHS England?' 2025.

reconfiguration. Where new buildings are required, these could be met through a range of delivery options including re-purposing existing buildings, adding capacity through private finance or rental routes, or constructing new buildings. The costs for NHCs that utilise existing buildings will be lower than in communities where new buildings are required. For all facilities, there will be ongoing maintenance costs.

These buildings are expected to be used more intensively and flexibly than much of the current primary and community estate due to plans for NHCs to be open longer hours and to provide a broader scope of services. Effective use of longer operating hours is contingent on having suitable staff contracts to operate longer hours and patient appetite to utilise the offer. Where sites are used in this way, it would act as a counterbalance to the additional pressures on the estate from the shift to community.

The shift to more community services will also change the type of services delivered in hospitals and the way hospital buildings are used. Over time, there may be costs as hospital buildings and equipment are reconfigured to deliver care differently. This is likely to be more cost-effective if combined with wider refurbishments as they are needed. Where estate is no longer utilised it may be available for disposal, to return resources to the NHS.

The shift to community would likely represent an efficiency saving in capital terms if NHCs deliver activity that would have taken place in secondary care settings. Publicly available, up to date, information is limited but based on the relative costs of building and maintaining primary care properties compared to secondary care buildings in the 2010 Healthcare Premises cost guide[16], construction costs were up to 30% higher in an acute setting than a primary/community one. This difference will have been subject to change since then, and it will depend on the complexity of the build involved.

These efficiency gains may only be realised in the long run, given increased short-term expenditure to establish the NHCs. Furthermore, the scale of difference in other capital costs between NHCs and hospital settings will depend in part on the extent that community centres require similar equipment as in hospitals as they take on these services, as well as technological change. Work is ongoing to design the funding and delivery model for NHCs.

As well as new facilities to operate as NHCs, the plan also earmarks £120 million for additional capital investment in mental health emergency departments (MHEDs). The plan aims to increase the total number of MHEDs to 85. There are currently 12 centres piloting the approach across England. Work is underway with input from ICBs to identify

[16] Department of Health. 'Healthcare Premises Cost Guides (HPCGs), Appendix 1' 2010.

appropriate sites based on local service provision, population needs and existing crisis pathways. The process aims to ensure equitable distribution of funding and alignment with system demand.

In respect of proposals on digital telephony, most GP practices already have the infrastructure, are already using cloud-based telephony systems[17] and many have online consultation and messaging platforms and appointment booking systems. There is variation in the quality of these systems and practices' capability to make best use of them so there may be costs to integrate digital care navigation tools and AI-driven chatbot interfaces into GP telephony systems. Costs relating to the broader expansion of digital and technology are discussed in the digital chapter below.

The plan also sets out intentions for more patients to book into an appropriate urgent care service, via 111 or the App, before attending. If implemented successfully, and utilised by patients, it will help clinical professionals triage patients and could support flow in Urgent and Emergency Care. There is some international evidence in countries that have implemented booking, such as the Netherlands and Denmark, of benefits from these approach[18].

Workforce costs, benefits and risks

The plan carries significant workforce implications, which will be developed and assessed in a new 10 Year Workforce Plan.

As well as seeking efficiency gains to free up GPs' time, the plan commits to training more GPs. If future funding is available to increase GP numbers, these new trainees will help to meet future demand for primary care services. The Personal Social Services Research Unit (PSSRU) estimates that the cost of training an individual GP in 2024 was a total investment of £504,000. This includes salaries paid to the trainee during the foundation stage while they are working, living expenses and other costs of training. This includes costs borne by both the wider NHS and the individual undertaking the training[19].

Increases in other staff groups will be needed to manage the neighbourhood health service offer. There will also be additional capacity required to meet commitments such as for same day digital or telephone consultations for those that need them and to ensure that people with more complex needs have a care plan. Recent data shows that around 20% of

[17] NHS England. 'GP practices improve access by embracing technology and increasing appointments' 2025.
[18] Thijssen WAMH and others. 'The Impact on Emergency Department Utilization and Patient Flows after Integrating with a General Practitioner Cooperative: An Observational Study' Emergency Medicine International 2013.
[19] University of Kent. 'Unit Costs of Health and Social Care 2024' 2025. (viewed on 4 June 2025)

people with long-term conditions have a care plan[20], with an aim to reach 95% of people with complex needs by 2027. Nurses currently spend around 20% of their time on activities such as care planning[21]. We expect that over time, care planning will be more efficient, including through use of artificial intelligence (AI). The degree of, and timing for realising these efficiencies is uncertain as time is taken to learn and improve the use of such tools to maximise their value.

Proposals for the neighbourhood health model include options for the involvement of social care staff in MDTs. Social care staff will be an important part of the care service in the neighbourhoods, particularly in playing a role in more regular health monitoring to reduce exacerbations of health conditions. Their ability to become meaningfully involved is likely to incur workforce costs, given these activities would increase the scale and scope of their work.

In addition to these costs, we would anticipate transition costs including those associated with:

- integrating functions delivered in an MDT which are currently delivered separately
- setting up services across multiple neighbourhoods where GPs opt to coordinate neighbourhood working over larger geographies, particularly for services where a larger scale is needed (for example palliative care)
- additional training and support to adapt to their changed responsibilities. For example, staff may need to learn new skills to adapt to routinely working as MDTs and staff working in hospitals will need to adapt to their changing roles as the services provided evolve

A risk to delivering the neighbourhood health service in the short-term is ensuring sufficient funding for GP places to deliver the service model. If there is insufficient demand to recruit GPs upon their completion of training, or inadequate funding to support the new hires, the training risks being an inappropriate use of health care system, and trainees' resources. In the short term, the government is seeking to mitigate this risk through Additional Roles Reimbursement Scheme (ARRS) funding[22] as part of the GP contract. As the service scales up, the intention is that demand for acute care will fall with increases in community services and associated funding and resource shifts between the settings.

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[20] Based on 41.5% of patients with a long term condition saying they had a conversation with a healthcare professional from their GP practice, and of those individuals, 44.8% had agreed a care plan having had this conversation. Q44 and Q45. NHS England. 'GP Patient Survey 2024' 2024. (viewed on 26 June 2025)
[21] University of Kent. 'Unit Costs of Health and Social Care 2024' 2025. (viewed on 4 June 2025)
[22] NHS England 'Changes to the GP contract' 2025 (viewed on 4 July 2025)

Public and patients - costs, benefits and risks

A change to settings in which care is delivered will create a period of transition for patients and the public as people take time to familiarise themselves with the new arrangements and adapt to where the services they need are located and how to access them. There are also likely to be some costs to the NHS in communicating the information local populations need to understand the new service model.

The neighbourhood health model aims to improve patients' access to services by using technology and driving efficiency improvements to increase capacity in primary and community settings. Where equivalent capacity is then available in downstream services, patients may be able to access subsequent treatment more quickly, leading to expected improvements in health outcomes as conditions are prevented, treated earlier or managed better. This could enable patients to have their health concerns addressed by professionals more quickly, improving people's wellbeing. These improvements have the potential to disproportionately benefit disadvantaged groups who experience poorer health outcomes.

Proposals to improve access to GPs could also improve patient satisfaction if successfully delivered. Challenges with 'the 8am scramble' are frequently cited as an issue by patients. For example:

- research has suggested a statistically significant relationship between the number of GP appointments a practice delivers and patient satisfaction[23] with satisfaction increasing by 0.14 percentage points for every additional 1,000 GP appointments

The neighbourhood health service aims to support people to manage their conditions by improving access to care professionals, from more GP appointments to neighbourhood teams and community pharmacy. Where patients respond to such support they can be expected to benefit from improved health outcomes. For example:

- more effective treatment for adults with high blood pressure: an estimated 30% of adults have untreated high blood pressure, a condition associated with around 50% of heart attacks and strokes[24]

- improved management of diabetes: around 1.9 million people suffered complications from diabetes in 2022 such as amputation, strokes and heart attacks and heart

[23] British Journal of General Practice. 'Relationship between the volume and type of appointments in general practice and patient experience: an observational study in England' 2025.
[24] British Heart Foundation. Heart Statistics Publications. (viewed on 4 June 2025).

failure[25]. Poor diabetes condition management is estimated to result in around 7,000 deaths per year[26]

There may also be health benefits to patients from MDTs taking a more holistic view of patient health needs and addressing them in a single setting, combining actions to improve health directly with improvements in wider determinants of health[27]. This focus on proactive care has the potential to accelerate access, improve treatment pathways and avoid unplanned hospital admissions. The evidence we found on the effectiveness of MDTs is mixed:

- the logic case, and anecdotal experience of those running integrated primary and community MDTs, is that the integrated working breaks down organisational and professional silos and enables front-line staff to collaborate. This improvement in joint work and reduced hand-offs between services can result in the patient experiencing much more joined-up and holistic service

- the Fuller Stocktake emphasises the role of integrated teams and their ability to improve patient care, manage service demand more effectively and build a more sustainable service[28]

- however, a Health Foundation briefing[29] reviewing MDTs for adults with complex health and care needs in 2015 or 2016, found that MDTs did not reduce emergency hospital use and may even lead to short-term increases. Longer-term evaluations of the broader programmes in which these teams were implemented found some evidence of reductions in emergency hospital use, but this took between 3 and 6 years. The broader evidence review in the same study found limited and mixed impacts of community-based MDTs though some studies suggest broader integrated care interventions can improve patient satisfaction, perceived quality of care and access

The neighbourhood health service will change the way that care is delivered in future to adapt to the different needs of particular groups of people. Further details of the specific patient groups and the potential impacts, such as improved health outcomes and wellbeing, are described in annex A.

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[25] Diabetes UK. 'Diabetes is Serious - recovering diabetes care: preventing the mounting crisis (PDF, 8.44MB)'. 2022. These statistics are calculated from per week figures on page 9 of the report.
[26] Diabetes UK. 'Diabetes is Serious - diabetes care: is it fair enough?' (PDF, 17.3MB). 2023.
[27] Re:State. 'Designing a neighbourhood health service' 2025.
[28] Next steps for integrating primary care: Fuller Stocktake Report. May 2022.
[29] The Health Foundation. 'Realising the potential of community-based multidisciplinary teams' 2023.

Improving access to dentistry should improve health outcomes. In the 2 years leading up to June 2024, only around 40% of the adult population had seen an NHS dentist[30], and those who manage to get NHS services are often not those with the greatest need for them[31]. Timely access to dentistry is expected to reduce missed work and school days as people need fewer urgent appointments and spend less time in discomfort or pain. Ease of access is also likely to improve user satisfaction and experience.

Children will benefit from additional support on tooth-brushing. An independent evaluation of the Scottish Childsmile supervised toothbrushing scheme showed it decreased rates of dental caries among 5 year olds in Scotland from 32% in 2014 to 26% in 2020, with the programme particularly effective among socially disadvantaged groups[32].

Reform plans - from analogue to digital

Summary and rationale for intervention

The plan sets an ambition for the NHS to be the most digitally accessible health system in the world. Increased use of data and modern technology, including artificial intelligence (AI) is intended to improve outcomes for the population as well as driving financial sustainability of the NHS. Technology can put upward pressure on health system costs, both by increasing the scope of diagnostics and treatments available for use and by driving increases in life expectancy[33]. Technology also carries delivery risks and risks of obsolescence, so careful strategy and programme management is important to achieve value.

Digital health innovations offer opportunities to enhance care in various ways, from tools that support people to manage their conditions, to increasing the information available to healthcare professionals when making treatment recommendations and giving staff access to technology that can make their jobs easier and improve productivity. Examples include:

- the NHS App, which is already helping more patients access care and treatment. It is increasingly used, for example, to get repeat prescriptions including by a growing number of older people[34]

[30] Department of Health and Social Care. 'DHSC annual report and accounts: 2023 to 2024' 2024.
[31] Public Health England. 'Inequalities in oral health in England: summary' 2021.
[32] University of Glasgow. 'Childsmile evaluation: shaping national child oral health improvement programmes across the world'.
[33] Marino A and Lorenzoni L. ' The impact of technological advancements on health spending: A literature review' OECD Health Working Paper 2019: Volume 113.
[34] NHS England. 'NHS App reaches record users on fifth anniversary' 2023.

- existing NHS pilot projects show the potential for population health management through analysis of population data. These work by identifying high risk groups to target interventions. Improved data interoperability and rigorous data infrastructure is needed to realise the full potential of this approach.[35]

- research from the 'Nursing in the Digital Age' report has shown that the community nursing workforce currently suffers from many technological issues, including mobile connectivity, a lack of compatibility between different computer systems and device battery life.[36]

The plan includes proposals to:

- establish a new single patient record (SPR) to provide a universal record across all care settings with functionality to include information from social risk assessments and people's wearable devices

- increase the use and functionality of the NHS App to become a source of 24/7 access to the NHS and supporting self-service, including the ability for patients to manage their medicines, view their data, book and hold their appointments, communicate with their health team and draft their care plan and for carers to access the app on behalf of people they're caring for

- increase the spread of, and access to, technology enabling wider reform and supporting productivity. This includes both (i) improving the infrastructure to use data and technology, such as providing necessary tools and capabilities for community-based services, and (ii) accelerating the implementation of AI in the NHS (for example through ambient voice technology or the drafting of care plans or discharge summaries)

Overview of costs and benefits

If successfully implemented, there are 2 key categories of opportunity from increased use of data and technology:

- increased productivity. Improved data quality and access to data could support targeting of high-risk patients and groups leading to system efficiencies

[35] The London School of Economics and Political Science. 'The Promise of Population Health Management in England: From Theory to Implementation' 2022.
[36] The Queen's Institute of Community Nursing. 'Nursing in the Digital Age' 2023.

- increased patient empowerment. If patients engage with their health and care this could lead to increased knowledge, empowerment, and healthy behaviours

Healthcare system costs, benefits and risks

Single patient record

Establishing the single patient record (SPR) is expected to take several years based on evidence from previous major digital programmes in the NHS. It is possible that the project takes longer than expected and the HM Treasury Green Book notes that there is a systematic tendency for project appraisers to be overly optimistic both in terms of costs and duration[37]. Costs will include product development, technology and data integration including alignment with external vendors, delivery and administration (for example business case development, engagement, clinical and system input) and commercial costs. The broad scope of the SPR means it will require investment to ensure that staff such as paramedics and community pharmacists have the same access to their patients' data as those working in GP surgeries and hospitals. Depending on the approach to the SPR, in order to maximise its value, activities may need to include translating the medical terminology in care records into plain English so that they can be readily understood and used by the patient, and to digitise historic patient information.

The proposal to include personalised social risk assessments in patient records will create further revenue and capital costs. Capital costs will also be incurred through development of data collection to the NHS App and tools to integrate the information with other datasets. There will be costs to develop and implement social needs screening, referral protocols, and to train staff to be able to effectively use these. There will also be ongoing maintenance costs such as administering social risk questionnaires, making referrals and tracking patient outcomes.

The SPR could reduce variability in NHS services by supporting automated triage of patients into the correct care setting as result of risk stratification and social risk information. A social risk assessment within the SPR could also be used to help clinicians proactively identify whether someone is experiencing barriers to accessing services. If implemented successfully, clinicians could tailor care to the needs of an individual, potentially improving clinical patient safety. By having access to a patient's whole record, the clinical workforce can make more informed decisions that could improve outcomes. Successful implementation could also reduce more expensive downstream healthcare costs, such as development of long-term conditions, hospital admissions and A&E high intensity use. For example:

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[37] HM Treasury. 'Green Book supplementary guidance: optimism bias' 2013.

- research by Queen's University Belfast[38] estimated that the London Care Record (a secure way to share patient information with health and care professionals across the city) potentially saved a total of between £7.9 million and £44.4 million between April 2020 and March 2023, as a result of saving health and care professionals' time, helping them to provide safe and effective care more quickly

However, there are risks to delivering the single patient record due to the magnitude and complexity of the programme and integration with legacy systems. These risks include reliance on a single provider and de-facto vendor-lock (where the cost of switching becomes so high that provision is essentially locked into the original supplier). While many clinicians would support data sharing for the purposes of improving care, there may be a risk of clinical resistance to changes to data sharing if safeguards are perceived to be insufficient.

NHS App

The NHS App will incur both development costs and costs related to broader digital infrastructure, pathway redesign, and the systems which the App connects. The highest costs are expected to be associated with the underlying infrastructure, such as modernising platforms and improving network coverage rather than developing the App itself.

There are risks were the NHS App not to become a widespread 'first choice' option as this could limit the scale of transformation to health service access that the plan aspires to. Step changes to improve the functionality compared to the current look and feel of the App aim to increase the likelihood of its use. For example:

- one survey by NHS England[39] of 239 General Practices found that key barriers to adopting the NHS App included 'patients preferring to contact by phone or in person', 'staff lacking the skills or confidence' and App functionality not meeting both patient's and practice's needs'

Artificial intelligence

Adoption and scaling of new technologies will incur upfront costs and require funding. For example, the government is backing 3 UK-based research projects by investing £37.5 million in the Research Ventures Catalyst (RVC) programme, with a further £44.7 million coming from co-investment. This funding is being distributed between 3 projects to

[38] Queen's University Belfast. 'New Queen's research highlights benefits of digitising NHS healthcare' 2023.
[39] Underlying data will be made available on: https://digital.nhs.uk/data-and-information/supplementary-information

research how AI can target hard-to-treat diseases and improve diagnosis and treatment. However, over time, the vision is that many technologies become cost neutral or cost saving as existing, less efficient, diagnostic models can be scaled down or retired.

AI technologies could be cost saving in the long run due to operational efficiencies. Examples include:

- recent data suggests that NHS Trusts have improved activity by around 26%[40], while only increasing workforce by c.8%, partly as a result of diagnostic technologies. More widespread use of AI could continue or accelerate this trend

- use of AI in CT scans is currently being piloted across half of English hospitals and is very likely to reduce reporting time and support triage of patients[41]

- AI has helped achieve National Optimal Lung Cancer Pathway (NOLCP) times, in some instances allowing same-day CT scans before the patient leaves the department. Informed by advice from clinical experts with experience of piloting these types of technology, if deployed across all NHS services these could ultimately deliver an additional 555,000 X-ray reports and 80,000 CT reports annually

There may be some secondary benefits where AI helps to address poor data quality by standardising the way clinical information is recorded. This could reduce variability and errors in data entry within electronic patient record (EPR) systems.

Risks include slow uptake of AI due to implementation delays caused by the upfront cost of new technologies. If ambient AI and generative AI have only a modest impact, they will improve efficiency but will not be sufficient to transform clinical pathways. As local healthcare systems reconfigure to reduce costs, there is a risk of a lack of skilled digital and data staff available to drive implementation. There are also inherent wider risks of artificial intelligence, which will need to be mitigated - including safeguarding patient data and training models using high quality evidence that is reflective of different population groups and equalities considerations.

Public and patients - costs, benefits and risks

Single patient record

[40] NHS England. 'Monthly Diagnostic Waiting Times and Activity' (viewed 26 June 2025)
[41] United Lincolnshire Teaching Hospitals NHS Trust. 'Faster diagnosis and treatment for Lincolnshire's lung patients' 2019.

Benefits to patients could include easier access to information, which could improve patient experience. Giving patients control over their records could help support transparency, accuracy and portability as well as engaging patients in their own care.

Patients will need to have trust in those that use and control their data. The 10YHP confirms that steps will be taken in the design of the SPR to address the public's privacy and security concerns. As an example of people's views:

- in the 2024 NHS England 'Public attitudes to data in the NHS and social care' survey, 83% of the 2,200 people surveyed trusted the NHS to keep their patient data secure[42]. The same survey found that the most common concerns cited were that NHS IT systems may be vulnerable to cyber-attacks (35% strongly agreeing) and concerns that the NHS might make mistakes with their patient data (49% strongly agree). Half of all respondents either strongly or slightly agreed that they were concerned the NHS would sell data to other companies without their permission

NHS App

The number of people using health care online has increased over the last decade. For example:

- the GP Patient Survey, shows that around 7 in 10 respondents have used an online GP service in the past year. This trend is increasing over time. In 2015, 6.8% of those surveyed said they had booked an appointment online; by 2024, the figure was 41%[43]. There is evidence that more people are using the NHS App to get repeat prescriptions, including by an increasing number of older people[44]

Patients will need to spend time familiarising themselves with new data and digital solutions as well as understanding their personal care record.

For some, the NHS App could offer greater empowerment resulting in better patient experience and a better understanding of their own health and care. These benefits would only accrue to those with the time, inclination and capability to engage with such new tools and so there remains a risk of digital exclusion. The plan outlines measures such as App Ambassadors aimed at mitigating this risk.

Artificial intelligence

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[42] NHS England Digital. 'Public attitudes to data in the NHS and social care' 2024.
[43] 41% of those surveyed stated they had Booked Appointments online. Q5. 'GP patient survey 2024' 2024.
[44] NHS England. 'NHS App reaches record users on fifth anniversary' 2023.

Patients could benefit from AI where it increases the time clinicians spend face-to-face with patients. If AI successfully reduces administrative burdens, this may make in-person appointments more effective, with clinicians focussed on the patient rather than administration[45]. This was found in:

- interim data from pilots, including from NHS England-funded studies in London (led by Great Ormond Street Hospital) have shown that ambient AI tools can drive efficiencies in the NHS, including reduced administrative burden and reduction in appointment times[46]

There will also be benefits to overall population health if new technologies support earlier diagnosis or more efficient care. For example, integrated data from wearables could benefit patients through improved health outcomes. Data, if available for a representative group of the population, could be used to identify disparities in health outcomes across diverse groups and target interventions to relevant group(s).

Evidence suggests the public has an increasing appetite for using technology to self-manage their care:

- 4 in 5 people said they would be happy to use technology to manage their health if recommended by the NHS, and more than 7 in 10 say they would use technology to avoid a hospital admission[47]

However, patients still value choice in how to access services. For example, when asked about what was important when booking a GP appointment, the second most important consideration was having a face-to-face appointment (alongside getting an appointment quickly)[48].

Research[49] [50] indicates that patients are open to the use of AI but want to retain the human element, required to address the risk of patient harm caused by software errors going undetected. There are risks that such technology exacerbates existing disparities due to digital exclusion arising from inequalities in digital literacy and access to technologies like personal wearable devices as well as differing levels of patient appetite to engage with health information. The plan will trial approaches to provide devices for free

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[45] Marino F and others. 'Digital technology in medical visits: a critical review of its impact on doctor-patient communication' Frontiers in Psychiatry 2023: Volume 14.
[46] Nelson Advisors > Healthcare Technology Thought Leadership. 'NHS braces itself for the AVT revolution: Ambient Voice Technologies set to unlock productivity and efficiency gains' 2025.
[47] NHS Confederation. 'Patient empowerment: what is the role of technology in transforming care?' 2023.
[48] The Health Foundation. 'Public perceptions of health and social care: Polling results' 2025.
[49] Tran, VT, Riveros, C and Ravaud, P. ' Patients' views of wearable devices and AI in healthcare: findings from the ComPaRe e-cohort' 2019.
[50] The Health Foundation. 'AI in health care: what do the public and NHS staff think?' 2024.

in areas where health need and deprivation are highest, which would support mitigation of this risk.

Workforce costs and benefits

The ways that the workforce are expected to be supported with the adoption of new data flows and technology are outlined in the workforce reform chapter below.

The SPR would give clinicians a single shared version of a patient's clinical history. This could improve efficiency by reducing duplicative activities and create time savings from removing the need for patients to describe their medical history repeatedly when seeing different care staff.

There may be benefits to researchers and analysts across the NHS and wider society. Access to an aggregated dataset of deidentified patient records would reduce the need for time spent on data linkage and provide better quality data for service improvement and research.

The NHS workforce could benefit from more efficient digital systems allowing them to spend more time on value-adding activities. This could include supporting them to communicate more effectively and dedicating more time to better quality care. There are some examples of this occurring already:

- a long-term review of UK 'teledermatology' services found that up to 50% of GP referrals could be discharged with advice, while 14% could be enlisted directly for surgery, significantly focusing consultant dermatologists' efforts during face-to-face clinics in reviewing only the patients who would benefit most[51]

However, the successful implementation of new digital solutions in the health sector requires good adoption and spread among the workforce. There is evidence that some groups have limited confidence in the likelihood of such change being successful, for example:

- a British Medical Association (BMA) survey found that nearly 76% of doctors ranked 'interoperability of systems' as a 'significant barrier' to digital transformation. 68% of doctors are 'not very confident' or 'not at all confident' that seamless and instant data

[51] Mehrtens, SH, Shall, L and Halpern, SM.'A 14-year review of a UK teledermatology service: experience of over 40 000 teleconsultations' 2019. Volume 44, Issue 8.

sharing will be the reality across UK health services in 10 years, with only 5% of doctors expressing strong confidence this will be the case.[52]

There are some risks for the workforce associated with these proposals such as automation bias leading to overreliance and deskilling among the clinical workforce. As such, there will be costs associated with developing, delivering and attending training programmes for the new digital solutions implemented across the NHS. The Plan's engagement concluded that staff understood the importance of new technology and wanted to be at the centre of the change process to drive successful implementation. They pointed to the importance of protected time for staff to get training and support to use new systems and processes effectively. In the event that such time or training is not available, this could lead to slow adoption of new technologies.

Reform plans - from sickness to prevention

Summary and rationale for intervention

Prevention of ill-health helps people to live longer, healthier lives. Over 1 in 5 of all deaths in England and Wales in 2022 were considered avoidable.[53]. These were people under 75 years of age who died from causes that are considered either preventable or treatable given timely and effective health care services and public health measures. Of this overall avoidable mortality rate, about two thirds is preventable, driven by risk factors like obesity, smoking, physical inactivity and alcohol consumption.

A healthier population can also support the economy via a more productive workforce with those in better health taking fewer sick days and remaining economically active for longer.

A shift to prevention is not new, but to date, action to eliminate or mitigate risk factors have failed to curb the growing burden of illness. For example, obesity rates have been rising and mortality wholly caused by alcohol consumption.[54] increased significantly during Covid-19 and has not returned to pre-pandemic levels.

The plan proposes to:

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[52] BMA Digital infrastructure. 'Building the future Getting IT Right: The case for urgent investment in safe, modern technology and data sharing in the UK's health services' 2024.
[53] Office for National Statistics. 'Avoidable mortality in England and Wales: 2021 and 2022' 2024. (viewed on 4 June 2025)
[54] Department of Health and Social Care. Alcohol Profile - Data | Fingertips | Department of Health and Social Care (viewed on 22 December 2025)

- encourage healthy diets in low income families, through increases to weekly payments to the Healthy Start scheme and in the nutrition of children's diets more broadly

- support people of all ages to make healthier choices, including working with industry to introduce mandatory healthy food sales reporting for all large companies in the food sector, using the nutrient profile model in advertising and promotion of less healthy food and drink and introducing mandatory new standards for alcohol labelling

- increase physical activity and access to weight management services including by expanding access to the Digital Weight Management Programme, and offer financial motivation for people to change their behaviour through a points scheme

- tackle harmful behaviours, including tobacco use

- testing of a new programme Prevention Accelerators to build the evidence base for the future neighbourhood delivery models

- address the impact of health risks arising from the places people live, including measures aimed at reducing air pollution, delivering greener transport, and reducing emissions from domestic burning

- build on and continue to expand programmes supporting people to find good work

- support children's mental health by achieving national coverage of mental health support teams in schools and embedding relevant services in Young Futures Hubs

- make progress in reducing cancer deaths by expanding HPV vaccinations to school leavers, supporting the development of multi-cancer early detection tests and increasing access and uptake of screening - including the roll out of lung cancer screening to all those with a history of smoking

- expand the NHS Genomics Medicine Service across the population. This includes universal cancer genomics and integrating pharmacogenomics into routine clinical practice

- encourage a shift in focus of health research and development to focus on primary and secondary prevention, as well as multiple long-term conditions to drive innovation in preventative healthcare products and services

Overview of potential costs and benefits

There is a strong economic case for shifting to a more preventative model of care:

- applying known, evidence-based preventative interventions earlier and more broadly could add 20 more healthy days per person, per year, in the UK - a 33% reduction in ill health – unlocking around £320 billion rise in GDP over 20 years[55]

- improved health can affect employment, GDP and government spending. The Tony Blair Institute estimates that a 20% reduction in the incidence of 6 major disease categories (Cancer, cardiovascular disease, chronic respiratory illness, diabetes, mental-health, and musculoskeletal disorders) would raise GDP by 0.74% (£19.8 billion) within 5 years of achieving that reduction and by 0.98% (£26.3 billion) within 10 years

- research by the Health Foundation[56] suggests that highly activated patients - those with greater inclination and capability for self-management - use less health care. However, most patients are not highly activated and prevention measures which require greater self-management may not be capacity releasing and should be considered through a behavioural-change lens

The benefits for many of these proposals rely on individuals to change their behaviour and behavioural responses to incentives can be unpredictable. As many people and patients are not highly motivated in these areas, measures requiring a lot of self-management may not be capacity releasing for the health system as people require ongoing support. Such support will be required to maximise the effectiveness of the interventions and could present an ongoing system cost in order to realise the benefits of prevention measures.

It will be important for as many people as possible to be persuaded of the value of public health interventions. While many people are in favour of different prevention measures[57], one of the most common concerns cited on the Change NHS website about an increased focus on prevention in future was in relation to “Personal freedom, or that individuals have the right to choose or to privacy”. The measures in the plan aim to encourage and support people in their personal choices, making it easier for them to choose healthier options such as what they eat and drink. Even if not supported unanimously, some public health interventions can still have positive impacts on behaviours with resultant benefits for both individuals and the health system.

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[55] Partners in Care and Health, Newton and Atlantic. 'The Future of Prevention Programme: Exploring how to deliver proactive prevention at scale Interim update' 2024. (viewed on 4 June 2025)
[56] Barker I, Steventon A, Williamson R and Deeny SR. 'Self-management capability in patients with long-term conditions is associated with reduced healthcare utilisation across a whole health economy: cross-sectional analysis of electronic health records' 2018.
[57] Ipsos 'The public are largely supportive of government public health interventions' 2025.

Healthcare system costs, benefits and risks

Primary prevention efforts can in principle contribute directly to reducing pressures on the NHS by reducing the incidence of disease. For example:

- Nesta estimate that by halving the growth of chronic conditions to 0.5% annually, the government could avoid total health spending growth in the order of £200 billion by 2040.[58]

However, effective and sustained prevention will require action across society, including by other government departments, individuals and businesses. The plan aims to coordinate such action from across government and wider society as part of delivering government's Health Mission.[59].

Increasing weekly payments under the Healthy Start Scheme is an economic transfer from government to recipients. The values of the scheme will increase, with pregnant women and children aged 1 to 4 receiving an extra 40p per week (£4.65 from £4.25), and children under one allocated an extra 80p per week (£9.30 from £8.50). The annual exchequer cost of this proposal is expected to be around £10 million per year based on current scheme costs. For further details see annex B.

Costs for the government to implement mandatory healthy food sales reporting for all large companies in the food sector primarily relate to monitoring and enforcement of the policy. These costs will be contingent on the design of the scheme, determined by factors such as the complexity of reporting requirements and scope of businesses included.

The plan sets out a range of proposals aimed at supporting people to make healthier choices by giving consumers more information about the health risks of alcohol consumption. Alcohol is also a risk factor contributing to 200 health conditions, including cancers, cardiovascular conditions, depression and liver disease.[60]. Where the initiatives are effective in reducing alcohol intake there could be associated health system benefits through reduced demand for services associated with alcohol consumption. For example:

[58] Nesta. 'How to save the NHS: get serious about primary prevention' 2024.
[59] HM Government. https://www.gov.uk/missions/nhs
[60] World Health Organisation. 'Global status report on alcohol and health' 2014.

- studies have estimated that between 10% and 16% of all ambulance contacts[61] [62] and between 21% to 35% of emergency department attendances [63] [64] are alcohol-related, increasing to 70% of A&E attendances at peak times on the weekends (between midnight and 5am).[65] In 2023 to 2024, an estimated 1,018,986 hospital admissions were from conditions related to alcohol consumption in England, which was 6% of all hospital admissions that year[66]

Data and digital infrastructure will be needed to implement both 'HealthStore' and a new NHS points scheme. Learning from much smaller schemes shows that the main ongoing cost for points schemes relates to the rewards offered to individuals. For example:

- running the 2023 ‘Better Health: Rewards Pilot’, in Wolverhampton (a city around 0.5% the total population of England), which was much smaller and limited in scope, cost DHSC £3.8 million. There would also be a cost to conduct a market engagement exercise before launching the NHS Points scheme

There is some positive evidence supporting the NHS points scheme initiative though the novel nature of the proposal means that current evidence is limited. For example:

- a 2015 public health initiative in Singapore involving over 1 million adults aged over 17 was found to successfully incentivise incidental daily walking[67]

- the Wolverhampton ‘Better Health: Rewards Pilot’ successfully engaged typically hard to reach target audiences and achieved small but statistically significant behaviour change on daily fibre, fruit and vegetable intake (+21g), steps (+256) and exercise minutes (+1.9 minutes) because of financial incentives[68]

There will be costs to government associated with paying community pharmacies to deliver HPV catch-up vaccinations and to purchase the vaccines. As an indication, the

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[61] Martin N, Newbury-Birch D, Duckett J, Mason H, Shen J, Shevills C and Kaner E. 'A Retrospective Analysis of the Nature, Extent and Cost of Alcohol-Related Emergency Calls to the Ambulance Service in an English Region' 2012. Volume 47, Issue 2
[62] Manca F and others. 'Estimating the Burden of Alcohol on Ambulance Callouts through Development and Validation of an Algorithm Using Electronic Patient Records' 2021.
[63] Hoskins R and Benger J. ' What is the burden of alcohol-related injuries in an inner city emergency department?' 2012.
[64] Cabinet Office. Paper on the economic costs of alcohol misuse, 'Alcohol misuse: How much does it cost?' 2003.
[65] Nuffield Trust. 'Alcohol-specific activity in hospitals in England' 2015.
[66] Office for Health Improvement and Disparities Official Statistics. 'Alcohol profile: short statistical commentary, February 2025' 2025.
[67] Chew L, Tavitian-Exley I, Lim N, Ong A. 'Can a multi-level intervention approach, combining behavioural disciplines, novel technology and incentives increase physical activity at population-level?' 2021.
[68] Behavioural Insights Team. ‘Evaluation of a financial incentives scheme to support healthy eating and physical activity’ 2025

payments to pharmacies for administering vaccines is typically below £10[69]. The overall cost effectiveness of the HPV vaccination depends on the vaccination strategy and vaccine uptake rates[70].

Previous attempts to shift the NHS to targeting prevention have had limited success. Achieving the shift now requires the NHS to overcome persistent barriers. The NHS Confederation[71] suggests these include: the capacity to shift resources, clarity about aims and the lack of a framework for monitoring progress, as well as short-termism in operational and financial planning. The plan sets the vision for prevention in the NHS and includes proposals aimed at addressing other barriers, such as through longer-term planning and improved data availability.

People and patients - costs, benefits and risks

Increased prevention activity is likely to reduce inequalities across population groups. For example, people in working class communities are currently more likely to be diagnosed with a preventable health condition earlier in their life; they are more likely to die prematurely - that is, before age 75 - and they are more likely to suffer severe economic harm after the onset of a new health condition[72].

Several proposals are designed to support getting more people into work in poorer areas, delivering improvements in health inequalities and other benefits, for example improving prosperity. People remaining healthier for longer will also reduce welfare costs, increasing opportunities for government expenditure on other priorities.

Proposals for the expansion of Individual Placement and Support (IPS) schemes are also intended to help people with substance dependency and severe mental illness to find good work. In August 2024, 38,704 people had accessed the IPS service for severe mental illness in the previous 12 months[73]. For alcohol and drug treatment IPS, full rollout was anticipated in 2024 to 2025 with the aim of supporting 13,000 people per year[74]. For example:

- a study from January 2024 evaluated the cost-effectiveness of IPS for both groups. Based on the randomised controlled trial outputs, researchers estimated there was a

[69] NHS England. 'Community Pharmacy Enhanced Service COVID-19 vaccination programme: 1 September 2024 to 31 March 2026' 2023.
[70] Datta S and others. 'Assessing the cost-effectiveness of HPV vaccination strategies for adolescent girls and boys in the UK' 2019.
[71] NHS Confederation. 'Unlocking prevention in integrated care systems' 2024.
[72] The Health Foundation. 'REAL Centre Health inequalities in 2040: current and projected patterns of illness by deprivation in England' 2024.
[73] NHS England Digital. 'Mental Health Services Monthly Statistics, Performance August 2024' 2024.
[74] NHS England. 'Individual placement and support for severe mental illness' 2023.

52% probability that IPS was cost-effective for participants with alcohol dependence, with a 97% probability of cost-effectiveness for the 'other drug' dependence group. However, IPS was found to be ineffective for the opioid group finding employment and insignificant in cost-effectiveness for this group.[75]

While prevention overall is expected to narrow health inequalities, it is not a given that all public health initiatives will reduce inequalities. There is the potential that, for some initiatives, technological or health literacy could widen inequalities under certain circumstances, while still improving outcomes for all. The plan aims to mitigate issues that would widen health inequalities through measures such as App Ambassadors and trialling, giving wearable technology to those in deprived areas at no, or low, cost.

Obesity

More than 1 in 3 children (35.8%) aged 10 to 11 years is now living with overweight or obesity, and obesity prevalence for children in the most deprived areas is more than double than in the least deprived areas (NCMP, 2023 to 2024)[76]. This is despite existing government policies focussed on improving the food and drink environment targeting children. Where people respond to the incentives for a healthier diet and physical activity, this can help to reduce the risks a wide range of chronic conditions, including cardiovascular disease, metabolic disorders such as type 2 diabetes, and some forms of cancer.[77]. Physical activity and exercise can reduce the risk of early death and major illnesses such as coronary heart disease, stroke, type 2 diabetes and cancer.[78] [79].

The proposal to increase the value of the Healthy Start Scheme will support low-income households to increase their consumption of healthy foods. In April 2025, Healthy Start supported over 330,000 pregnant women or children aged under 4.[80].

Implementing mandatory healthy food sales reporting and related targets to increase the healthiness of sales is expected to lead to improved diets where the policy results in a healthier average of overall food purchased. Increasing the share of healthy food in people's diets could reduce daily calorie consumption, with impacts for the number of people living with obesity. The government will work with companies to design a scheme that considers inequalities in communities across the UK and is not just pointed at areas

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[75] Office for Health Improvement and Disparities research and analysis. 'Individual Placement and Support - Alcohol and Drug study: main findings' Updated 2024.
[76] NHS England Digital. 'National Child Measurement Programme, England, 2023/24 School Year' 2024.
[77] NHS. 'Eating a balanced diet' 2022.
[78] NHS. 'Benefits of exercise'.
[79] Posadzki P, Pieper D, Bajpai R, Makaruk H, Könsgen N, Neuhaus AL and Semwal M. 'Exercise/physical activity and health outcomes: an overview of Cochrane systematic reviews' 2020.
[80] NHS Healthy Start. 'Uptake Data - England' 2025. (viewed on 4 June 2025)

that are already responsive to health initiatives. The design of the target will be subject to consultation with industry, and it will overlap with wider policies to tackle obesity.

A material impact on food sales could have a large impact on obesity. In an indicative and optimistic scenario of a reduction in calorie purchasing of 40 to 50 kcal per day, childhood obesity could be reduced by up to 340,000 and adult obesity by around 2 million, over the long term[81]. For further details, see annex B.

The plan intends to update the standards underpinning current advertising and promotion restrictions by moving to the new Nutrient Profile Model (NPM) to determine the nutrient content of food and non-alcoholic drinks. The policy will be subject to consultation. The following evidence illustrates the potential impact of the policy. The NPM currently in use is based on the 2004 to 2005 scoring system, but a new definition was proposed through consultation in 2018. Applying the new model would bring more products in scope of the restrictions, further reducing children's exposure to less healthy products of concern for childhood obesity, strengthening the impact of existing policies. As with the existing policies, it would also have significant spillover benefits for adults. For example:

- indicative analysis suggests that tightening the restrictions for food and drink advertising and promotion using the proposed NPM 2018 could reduce calorie intake by up to an additional 30% compared to the current model. This is equivalent to reducing cases of childhood obesity by up to 170,000 and adult obesity by up to 940,000[82]. For further details, see annex B

Children living with obesity are around 5 times as likely to live with obesity as adults[83]. Therefore, applying the proposed NPM 2018 to the child-focused advertising restrictions and promotions restrictions policies could help to further reduce disparities in childhood obesity because there is evidence that some children in deprived areas are exposed to more HFSS advertising to children in more affluent areas.

There is little evidence to assess the impact of introducing nutritional targets on consumer prices. Nesta argue that due to competitiveness in the sector, businesses will pursue methods of achieving the target that do not increase food prices. While enforcement

[81] Blueprint by Nesta. ' Regulate large retailers to change their sales-weighted converted NPM score to ≥ 69 across their entire food product portfolio' 2024.
[82] Indicative DHSC Analysis informed by published impact assessments for HFSS Advertising and Location and Volume Price Promotions. The BMI Prevalence Model (see reference 235) is used to convert calorie reductions into a change in obesity prevalence
[83] Simmonds M, Llewellyn A, Owen CG and Woolacott N. 'Predicting adult obesity from childhood obesity: a systematic review and meta-analysis' 2015.

approaches are yet to be determined, they would be unlikely to increase prices as businesses would lose customers to their nearest rivals who did achieve the target[84].

Alcohol consumption

UK trends in alcohol-related harms are going in the wrong direction, such as:

- while the average rate of premature death and ill-health due to alcohol-related liver conditions decreased over the last 30 years for most of Western Europe, the UK rate has increased by 70%.[85]. In England, the death rate due to alcohol is the highest on record.[86]

- alcohol has become increasingly affordable over time in the UK, being 91% more affordable in 2023 than in 1987.[87]. The estimated cost of alcohol harm to society in England is £27.4 billion per year (2021 to 2022 prices), the equivalent of 1.22% of GDP in 2022. This includes an estimated £5.1 billion to the wider economy due to lost productivity.[88]. The following evidence illustrates how the proposals relating to alcohol may reduce consumption. The evidence linking these policies to improved health outcomes is less well-established

Mandated alcohol label content would ensure important information is available to consumers at the point of purchase and consumption, going beyond existing requirements. There is evidence that health warnings increase knowledge of health impacts, which could slow the rate of alcohol consumption.[89].

No and low alcohol products could help to reduce alcohol harms if consumers substitute these products for standard strength alcoholic drinks. The evidence base for such impacts is limited as this is a newly emerging policy solution for tackling alcohol related harms.

Air quality

Almost everyone in the country would benefit from steps to reduce exposure to air pollution. Almost everywhere in England is now below England's 2040 target for PM2.5 (tiny particles that penetrate deep into the lungs) but still falling short of the WHO's more

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[84] Nesta. 'Targeting the health of the nation: an economic assessment. The economic case for health targets on grocery retailers' 2024.
[85] Office for National Statistics. 'Alcohol-specific deaths in the UK: registered in 2023' 2025.
[86] Department of Health and Social Care. Alcohol Profile - Data | Fingertips | Department of Health and Social Care February 2025.
[87] NHS England Digital. 'Statistics on Public Health, England 2023' 2024.
[88] Institute of Alcohol Studies. 'The Costs of Alcohol to Society' 2024.
[89] Zuckermann AME and others. 'The effects of alcohol container labels on consumption behaviour, knowledge, and support for labelling: a systematic review' 2024.

stringent recommended limit, with 96% of the population above this threshold[90]. For example:

- epidemiological studies have shown that long-term exposure to air pollution (over years or lifetimes) reduces life expectancy, mainly due to cardiovascular and respiratory diseases and lung cancer. Short-term exposure (over hours or days) to elevated levels of air pollution can also cause a range of health impacts, including effects on lung function, exacerbation of asthma, increases in respiratory and cardiovascular hospital admissions and mortality[91]

Mental health

Expansion of workforce will likely be required to increase the number of mental health practitioners in the community, specifically the mental health support teams in schools or Young Futures Hubs. Prevalence of mental disorders in children and young people has increased since 2017, rising from 12.5% of 8 to 16 year olds having a probable mental disorder in 2017, to 20.3% in 2023[92]. There are long waiting lists for services, with nearly 360,000 children and young people referrals still waiting for contact with NHS mental health service at the end of April 2025, of which 10% have been waiting over 861 days[93]. Without timely access to appropriate support, some children and young people may experience a worsening of their mental health, potentially requiring more intensive and costly interventions later[94] [95]. For example:

- research on Youth Information, Advice and Counselling Services (YIACS) open access hubs found[96] comparable clinical outcomes, such as more accessibility for those particularly from marginalised backgrounds, significant short-term reduction in psychological distress and high levels of service satisfaction, to those accessing therapy through Children and Young People's Mental Health Services (CYPMHS) or school

[90] Institute for Fiscal Studies. 'Air pollution in England reaches 20-year low but inequalities persist' 2024.
[91] Public Health England. 'Health matters: air pollution' 2018.
[92] NHS England Digital. 'Mental Health of Children and Young People in England 2023 - wave 4 follow up to the 2017' 2023. (viewed on 1 July 2025)
[93] NHS England Digital. 'Mental Health Services Monthly Statistics' (viewed on 1 July 2025)
[94] McCrone P and others. 'The economic impact of early intervention in psychosis services for children and adolescents' 2013.
[95] PBE. 'The impact of waiting lists for children's mental health services on the costs of wider public services' 2021.
[96] Duncan C, Rayment B, Kenrick J, Cooper M. 'Counselling for young people and young adults in the voluntary and community sector: An overview of the demographic profile of clients and outcomes' 2018.

Other benefits related specifically to open access hubs include reducing youth offending, improving engagement in education and employment, and keeping them safe from harm[97].

The continued roll out of mental health support teams in schools and embedded support in Young Futures Hubs could increase the number of children and young people accessing NHS funded support, reduce wait times and make progress towards the eating disorder waiting time standards[98].

Smoking

The harms of smoking disproportionately fall on deprived communities, for example:

- research of weekly expenditure and income for 5,000 UK households using 2016 to 2017 Living Costs and Food survey data found that smoking exacerbates poverty in low-income households. The study proposed that it is the pivotal factor behind why an estimated 230,000 UK households live in poverty[99]

- there are also large geographical variations in rates of smoking during pregnancy from below 2% in parts of London to over 10% in parts of Lincolnshire[100]

Businesses costs and benefits

The proposal to implement mandatory targets for the largest companies in the food sector is being designed in partnership between the government and industry. The government is determined to keep costs to companies low; many already have health sales reporting systems and most have internal targets. Businesses will be given flexibility on how to achieve the target, and this is expected to keep costs down. Both Tesco and Sainsbury's have voiced support for this policy[101]. Analysis of a similar proposal by Nesta indicated a one-off cost of £45 million for retailers to transition operations and bi-annual costs of £3.3 million for periodic product assessments[102]. More work is planned with the affected businesses, including to agree a timeline for transition that will further limit the likely cost impacts.

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[97] Youth Access. 'The outcomes and impact of youth advice' 2011.
[98] NHS England. 'Access and Waiting Time Standard for Children and Young People with an Eating Disorder Commissioning Guide' 2015.
[99] Nyakutsikwa B, Britton J, Langley T. 'The effect of tobacco and alcohol consumption on poverty in the United Kingdom' 2020.
[100] See Table 5: Smoking status at time of delivery by Lower Tier and Upper Tier Local Authority of Residence and Local Authority Region 'Statistics on Women's Smoking Status at Time of Delivery: England, Q4 2024/25' (viewed 1 July 2025)
[101] Department of Health and Social Care 'Healthy food revolution to tackle obesity epidemic' 2025.
[102] Blueprint by Nesta. 'Introduce healthiness targets for large retailers' Updated in 2024.

There will be impacts on business from strengthening advertising and promotion restrictions for less healthy food and drinks. These were explored in the impact assessment for the existing advertising restrictions[103] and will be assessed further in the forthcoming consultation. This could include familiarisation and reformulation costs and a shift in revenues from unhealthy to healthier product lines. As well as benefits to businesses through likely increased healthy food sales, they, along with wider society, would see workforce benefits where the prevention proposals are effective in improving the population's health. Studies have consistently shown that employees who are in good physical and mental health are more engaged, motivated, and efficient, such as:

- a 2023 report by the World Health Organisation (WHO), companies that implement effective health and wellbeing programmes can see a productivity increase of up to 20%[104]. This is because healthy employees are less likely to take sick leave and more likely to perform at their best, leading to higher overall output and a better quality of work

Further work is needed to understand the longer-term impacts that the policies relating alcohol might have on alcohol sales and producer and retailer revenue. The introduction of warning labels on alcohol containers would incur one-off familiarisation, redesign and printing costs for producers, plus one-off and ongoing costs of calculating nutritional information. Further work with industry is needed to understand adequate lead in times as well as exact costs incurred by producers. Mandatory health warnings and nutritional information could result in an associated reduction in revenue from alcohol sales, but this could be offset if consumers switch to different products, which producers could encourage through reformulation or new product innovation.

Small and micro business impacts

Smaller manufacturers and retailers will be impacted by the proposals that incentivise people to buy fewer unhealthy products such as sugary drinks and alcohol. The extent that these changes affect profits for retailers depends on consumer behaviour in terms of switching consumption to other products and the relative profit margin of these products compared to the basket of goods each business sells[105]. These impacts will be fully assessed prior to implementation.

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[103] Department of Health and Social Care, 2021. 'Impact Assessment: Introducing a 2100-0530 watershed on TV and online restriction for paid advertising of food and drink that are High in Fat, Salt and Sugar (HFSS) products'.
[104] IGPP. 'The Growing Importance of Health and Wellbeing in the Workplace' 2024.
[105] Department of Health and Social Care Impact Assessment. 'Restricting checkout, end-of-aisle, and store entrance sales of food and drinks high in fat, salt, and sugar (HFSS)'

Enablers - operating model

Summary and rationale for intervention

The overall ambition of changes to the NHS operating model is to devolve power, putting decision-making closer to patients and local communities, where their needs are best understood.

The plan confirms the future 3-tier structure of the NHS in England with a headquarters within DHSC, 7 regional teams and integrated care boards (ICBs) as strategic local commissioners. Structural reforms are intended to support the invention, spread and adoption of innovation in the NHS by devolving power from the centre to local providers, frontline staff and patients, bringing in clear rules as necessary to allow for wider freedoms for organisations around them. Giving more freedom to providers is intended to lead to more innovation and better care for patients.

The plan describes the following changes to the NHS operating model:

- the centre will be smaller, combining the headquarters of the NHS and the Department of Health and Social Care

- reducing the number of ICBs and them operating as strategic commissioners and with flexibilities to pool arrangements to commission services. Their role will also include building stronger relationships with local government

- using multi-year budgets and financial incentives to enable investment in population health outcomes, not just into inputs and activity

- giving high performing providers greater autonomy and flexibility to develop services, and supporting providers to achieve this requisite performance level; a new failure regime will address poor performance and a reinvented NHS foundation trust (FT) model will give the strongest performing providers more freedoms

- more diversity in the provider landscape to drive better value and more choice, through private providers as well as the voluntary sector and social enterprise

- a new Choice Charter giving patients more power and control through more engagement, control over their data and budgets, direct referrals for diagnostic services and choice of elective provider

Overview of potential costs and benefits

The costs and benefits of the work underway to combine the NHS headquarters into DHSC and abolish NHS England are not covered in this impact statement. The government's expected benefits of the change are outlined in the Secretary of State's statement to the House of Commons, including efficiency gains from reduced duplication of effort, reducing bureaucracy across the system and increased autonomy for NHS providers to innovate and deliver better care for patients[106]. Future legislation to formally abolish NHS England will consider the costs and benefits of doing so in the usual way.

Healthcare system costs, benefits and risks

The plan intends to reduce the number of ICBs from 42 to create clearer lines of accountability, reduced duplication and more effective working at the centre of government. This will create staff turnover with potential costs associated with employment frictions such as redundancy costs for exiting staff, search and recruitment costs to hire new staff and short-term productivity losses associated with the loss of corporate knowledge from staff leaving and time taken for new staff to upskill. For all staff to adapt to their new roles and functions there are likely to be training and skills development costs, including opportunity costs of staff time to complete required learning and development to fulfil their roles. Other potential associated costs include changes to data platforms and digital solutions to ensure staff have access to the information required to fulfil their roles.

The requirement for ICBs to increase user engagement through new participation methods is likely to create costs for some local areas, including for example to report and act on concerns and ideas raised. The precise approaches for implementing this are to be determined and so costs remain uncertain.

If successful, the reforms to ICBs may help to support more effective healthcare delivery. As outlined in the plan, the aims of ICB reforms are to deliver both health system benefits, by driving efficiencies, and benefits for the health and wellbeing of the population by improving health outcomes, reducing health inequalities and improving access to consistently high-quality services. Strengthening the commissioning capabilities of ICBs and upper tier local authorities through periodic peer-review could help to maximise the value of the NHS budget and the public health grant by more effective commissioning. The scale of this opportunity is unknown.

[106] Department of Health and Social Care and The Rt Hon Wes Streeting MP Oral statement to Parliament. 'NHS England: Health and Social Care Secretary's statement' 2025.

There may be some net savings due to improving the efficiency of NHS organisations by winding down Commissioning Support Units (CSUs) and abolishing integrated care partnerships, though these are currently unquantified.

In general terms, organisational change creates both opportunities and risks. Making simultaneous changes to multiple layers of the NHS hierarchy creates a risk that there is insufficient capacity to accelerate change.

The plan outlines changes to the operating model for NHS providers by reinvigorating and reinventing the FT model. The stated ambition is for all NHS trusts to become FTs during the 10 years of the plan, giving them more autonomy to drive local innovation that will improve efficiency and care quality. Around 70% of NHS provider trusts are foundation trusts (143 of 205)[107]. In the short term, these changes will create costs both for providers and regions, with a view to achieving long term benefits in efficiency and outcomes. For example, regions will need to draw up action plans for each failing provider with tailored solutions. To support the subsequent process of turnaround, national involvement, including coordination across regulators is likely to be needed. There is a risk that ongoing challenges with performance and financial balance in the provider sector mean there are limited incentives in the short-term for some organisations to participate.

Implementing a rigorous authorisation process for FTs and a regular reassessment and reauthorisation process will create costs both to provider organisations for their applications and the regional and national NHS organisations to oversee and implement the process. Providers will face costs in preparing their applications and time to be assessed against the required standards while regions will invest time to oversee and support applications. These costs could be higher than currently if more trusts seek to become FTs as intended. The government is seeking to free up resources by reducing duplication in the centre and ICBs which would contribute to offsetting these costs. The operating costs of NHS Improvement may provide an indication of the scale of costs to oversee, support and regulate the new FT model. Prior to its abolition in July 2022, NHS Improvement fulfilled several of the functions that may be required in the new model having been responsible for overseeing NHS foundation trusts, NHS trusts and some independent providers. It held providers to account and was the sector regulator for health services in England. It also had roles in overseeing the NHS payment system, patient choice and regulatory requirements.

Other proposals in this chapter put new responsibilities on organisations. These include the process of agreeing neighbourhood health plans at single or upper tier authority level and ICBs translating those into a population health improvement plan, as well as proposals

[107] NHS Providers. 'The NHS provider sector'.

for peer review and establishing improvement capability within the NHS provider sector. It is not clear to what extent these measures will require organisations to recruit additional staff to carry out these functions or whether they represent an opportunity cost with staff time diverted from other current activities. Broader efforts across the system to build partnerships and reduce duplication may free-up resources to carry out some of these functions.

Public and patients - costs, benefits and risks

Increased patient power in the new operating model will create some time costs for those choosing to actively participate. For example, in exercising their right to choose, patients needing elective care are likely to spend more time sourcing and utilising information to decide which provider to use for treatment. The plan intends to make this process as straightforward as possible, with clear and accessible information to minimise the time spent by individuals.

Proposals that improve the effectiveness of the health system will generate benefits for population health outcomes. For example, increasing the efficacy of health-related budgets will increase the services available for a given budget. Therefore, costs and benefits to the public and patients will largely be felt via improvements or disruption to health system efficiency and effectiveness. If healthcare delivery is made more efficient and productive as a result of these changes the members of the public and patients will experience this through changes to access, quality and healthcare outcomes.

Increased use of population health data and patient insights combined with collaborative development of neighbourhood health plans at local authority level is expected to create health systems that better meet local needs and offers them choices about where to receive care. A study by the King's Fund found that choice has an intrinsic value to patients in terms of knowing that they can choose[108]. All else being equal, it is possible a regime that provides and encourages patient choice creates benefits over one without such flexibility.

There may be differential impacts for patients and members of the public who are more or less health literate and have more time or opportunity to engage in such choices.

Business costs, benefits and risks

The plan aims to build on and expand the diversity of providers involved in the future delivery of healthcare services. The opportunities for non-statutory organisations include

[108] The King's Fund. 'Patient choice: how patients choose and how providers respond' 2010.

provision of elective services to reduce waiting times, with a particular focus on increasing capacity in disadvantaged areas, as well as providing other services in the community. Organisations will benefit from increased market access and the associated income generation.

Greater provider diversity also has potential benefits for the wider health system. The Health and Social Care Select Committee has suggested that there are times when non-statutory providers can better target and meet unmet needs, as well as creating incentives for other providers to improve[109]. The King's Fund emphasises the value to the health system of the voluntary, community and social enterprise (VCSE) sector both in service delivery and as a route to working with different communities and providing intelligence and insights for the wider system. Workforce implications have not yet been assessed ahead of the 10 Year Workforce Plan.

Enablers - transparency on quality

Summary and rationale for intervention

International comparisons show the UK to have relatively poor performance on care quality compared to OECD peers. Of OECD countries, the UK ranks[110]:

- in the worst third for mortality after a stroke or heart attack; for age-standardised 5-year lung cancer survival; and for hospital admissions for asthma and COPD
- in the worst third for the proportion of patients reporting being involved in decisions by their doctor
- in the middle third for hospital admissions for diabetes
- in the best third for hospital admissions for heart failure

The overall ambition is to transform the NHS by embedding transparency and high-quality care at its core. The proposals aim to empower patients and strengthen oversight, with a rigorous focus on high-quality care for all and a renewed focus on patient and staff voice. The plan signals alignment of new proposals with other recently announced initiatives such as the new National Maternity Taskforce.

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[109] House of Commons Health and Social Care Committee. 'Integrated care: organisations, partnerships and systems. Seventh Report of Session 2017–19' 2018.
[110] Data sourced from OECD 'Health at a Glance' 2023 or OECD health statistics portal All data from 2021 or nearest year (viewed on 1 July 2025)

Proposals in this chapter include:

- improving access to, and understanding of, published data to understand the performance of the NHS, including publishing easy-to-understand league tables and ranking providers against key quality indicators
- improving the way that patient feedback is used and that their concerns are raised and addressed
- expanding and making publicly available patient reported outcome and experience measures
- revitalising the National Quality Board with a set of new responsibilities including development of a new quality strategy, outcome measures and service frameworks
- stronger accountability at ICB and provider level to act by rewarding high quality and addressing poor quality care
- using technology, data and AI to improve monitoring and measurement of care quality
- building on the existing change programme of the Care Quality Commission (CQC) to transform its operating model and expand its data access
- changing the time limit for the CQC to bring legal action against a provider, to allow more cases to be reviewed and acted upon
- rationalising other organisations focussed on safety by bringing the Health Services Safety Investigations Body (HSSIB) into the CQC and transferring the hosting arrangement of the Patient Safety Commissioner (PSC) into the Medicines and Healthcare products Regulatory Agency (MHRA)

Overview of potential costs and benefits

The aim of these proposals is to benefit patients and service users through improved care quality resulting in better outcomes.

There is limited information to assess the scale of these impacts, and their effectiveness will depend on the extent to which organisations take action to rectify issues or drive improvements.

Healthcare system costs, benefits and risks

Transparency of data

Commitments to the public availability of data include:

- putting all quality measures from all providers in the public domain
- publishing health data according to local authority boundaries rather than solely by NHS organisation

There will be material transition costs for the NHS to collect and publish relevant data to meet the commitments above. Further work is needed to assess the scale of the proposed changes and the associated cost implications. The typical costs associated with developing and publishing data sets include setting and monitoring data standards, creating digital platforms for data to flow, and time to record and clean them.

Particular actions relating to data include expanding the use and availability of patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs). Information published to support a 2016 consultation about the PROMs programme stated that collection of the 4 nationally mandated PROMs generated an annual cost to NHS provider organisations of £1.1 million (2024 prices)[111], equivalent to around £275,000 per measure, in addition to central NHS costs. Expanding the use of PROMs to more specialties will carry a cost in terms of collecting, processing and utilising more data though future costs per collection could be expected to be lower over time due to increased digitisation. There will also be costs to individual provider organisations in improving the systematic collection of PREMs data and these data will be made available within the NHS App.

The plan also sets expectations for organisations to have robust mechanisms for collecting and using patient feedback data which will create costs where they don't currently exist.

Once data is available, there are costs associated with reviewing and acting on it. These include staff time to analyse data, interpret findings, and agree actions. The subsequent costs of changing and improving services will depend on the steps required and a focus on outcomes metrics also requires a common understanding of the questions and purposes that the data can most usefully address[112]. As with any system of performance measurement, there is a risk that organisations focus attention on these objectives, with deterioration in aspects of performance that are not measured or monitored through the system.

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[111] NHS England Citizen Space. 'National Patient Reported Outcome Measures (PROMs) Programme Consultation' 2016.
[112] O'Connor DP and Brinker MR. 'Challenges in outcome measurement: clinical research perspective.' Clinical orthopaedics and related research 2013, 471(11), 3496–3503.

Better availability of data about the health system can help to drive performance improvements. For example, PROMs provide an indication of the outcomes or quality of care delivered to NHS patients, enabling providers, commissioners and other stakeholders to make informed changes to the delivery of their services. NHS England and the Department of Health and Social Care use PROMs data to monitor progress towards strategic objectives[113]. Similarly, PREMs are typically used at organisation level, focussed on improving quality of front-line care and in some cases have been found to be used for performance improvement[114].

There could be a risk that some clinicians will resist full transparency on clinician-level data.

Revitalising the National Quality Board

There are several proposals tasking the National Quality Board (NQB) with creating new outputs. The NQB has an existing role in the healthcare system, bringing together arm's length bodies across the system with priorities in 2025 to 2026 including the development of a quality strategy and reviewing system recommendations[115]. The net cost of revitalising the board, including changes to membership and expanding its role has yet to be assessed. However, in high level terms, there are at least 2 key benefits to focusing on outcomes:

- incentivising better health for patients - by understanding how effectively the system is delivering better health and longer lives

- improving efficiency by identifying and then reducing or stopping low value interventions

Regulatory reform

The plan outlines several ways that the role of the CQC will be expanded and strengthened which will create additional resource requirements for the CQC. For example, the CQC will assess whether all commissioners and providers have effective freedom to speak up functions, including appropriate skills and training, and increased time limit for the CQC to bring legal action against a provider. Costs to provider organisations to implement these functions are expected to be low as a network of freedom to speak up guardians has been established though new processes may be

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[113] NHS England. 'Background information about PROMs' 2024.
[114] Gilmore KJ and others. 'The uses of Patient Reported Experience Measures in health systems: A systematic review' ScienceDirect 2023: Volume 128.
[115] NHS England. 'National Quality Board position statement: remaining focused on quality in times of change and financial challenge' 2025.

required in commissioning organisations. Other changes for the CQC are to the tools available and approaches to inspections.

In simplifying the regulatory environment there will be costs to the transfer of functions. The Health Services Safety Investigations Body (HSSIB) and The Patient Safety Commissioner (PSC) will transfer functions into the CQC and Medicines and Healthcare products Regulatory Agency (MHRA) respectively. While roles aren't expected to change, there will be transition costs associated with merging organisations. These vary in magnitude and include: legal costs; periods of reduced productivity while staff adjust to the new arrangements; time taken to develop the culture and vision of the new organisation and for that to bed in; costs of aligning IT functions, (such as file transfer for knowledge retention), aligning back office functions such as HR and IT support as well as access to shared office space.

In pursuing longer term, ongoing benefits of better regulation in health and care, there is a shorter term, transitional, risk that changing the requirements of the CQC at the same time as it undergoes organisational transformation risks slowing the pace of change as staff time and effort is diffused across competing priorities.

Incentives for high quality care

A number of policies relate to the roles for regional teams and ICBs in improving quality. These organisations will incur costs in reviewing all services to identity areas where contractual levers are needed to end contracts for poor performing services. To illustrate the potential scale of this task, evidence from NHS Cheshire and Merseyside ICB shows that in May 2023, the commissioner held a total of 4,722 separate contracts[116]. The subsequent costs of taking action will depend on the steps needed in individual cases and extent of under-performing services across England. Ongoing costs are likely to be associated with collecting and monitoring contract information.

Decommissioning services and replacing providers will take time within ICBs and regions and could create short-term service disruption while new suppliers are found and bed-in. The credibility of threats to decommission services or terminate contracts where services are not meeting the required standards will be dependent on the availability of alternative providers to replace the incumbent provider to continue service delivery.

The plan introduces additional flexibilities for local employers to make performance-based incentives for clinical teams. These are intended to reward stronger performers and incentivise staff to improve care and deliver good outcomes. Depending on how this policy

[116] Cheshire and Merseyside. 'FOI response Ref: FOI/00417/CMICB ICB Contracts' (2023)

is implemented, there may be additional costs that are expected to be absorbed by local NHS organisations, wider research suggests:

- that collective performance-related-pay systems can influence group processes and cooperation, leading to increased ideas generation and better working methods, improving organisations' performance.[117]

However, research on the impacts for clinical teams shows mixed results, for example:

- a qualitative synthesis of research on such models, including UK and international studies found that such schemes can create both positive and negative perceptions by staff in terms of the incentives and performance measurement as well as their roles in influencing the quality of care and workplace dynamics.[118]

Public and patients - costs, benefits and risks

The intended benefit of these proposals is better care. The availability to patients and the public of more information about the quality of NHS services can help them to make more informed choices about their healthcare and potentially reduce information and outcome asymmetries across different societal groups. Realising the benefits of using this information depends on the extent to which patients have meaningful choice between service providers. Where new data is being published with the intention that it is used by the public and patients, those who choose to seek out, review and act on the data will face costs to their time in doing so. Those individuals who have the time, inclination and capability to engage with the system on issues relating to quality will be most impacted by these proposals both in terms of costs and benefits.

The plan aims to increase the weight that NHS providers place on delivering a high-quality user and patient experience. Where organisations respond as intended, for example by reviewing and acting on patient feedback to improve service quality, patients and service users will benefit from better experiences of the NHS and potentially improved outcomes. Where patients have concerns about the care they receive, it is proposed that in future they will be supported by rapid response teams. For example:

- Healthwatch England found that over half (56%) of people who made a formal complaint to the NHS were dissatisfied with both the process and the outcome of their complaint. This proposal is also expected to address response times for complaints,

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[117] Wood S and others. 'Collective performance-related pay systems may have more effect than individual performance-related schemes' Human Resource Management Review 2023: Volume 33.
[118] Martin B and others. 'Health Care Professionals' Perceptions of Pay-for-Performance in Practice: A Qualitative Metasynthesis' Inquiry: The journal of medical care organization, provision and financing 2020: Volume 57.

which ranged from 18 to 114 working days (average 54) in data provided by ICBs to Healthwatch as part of their recent research[119].

Utilising the contractual levers to decommission or terminate services or providers is also intended to improve the quality of care offered to patients. Insufficient information is available about the scale of this issue to assess the likely benefits for patients. Similarly, where patient feedback is acted on, and actions are taken to rectify any quality concerns raised, these proposals will deliver a better patient experience and improved quality.

It may be that the quantity of information published as a result of these proposals signals a plethora of new concerns from the public about quality and safety in the NHS. In most cases this should be beneficial in highlighting areas that need improvement or reform. However, the system will need to be careful to correctly interpret such information. For example, risks could arise from misinterpreting increases in reporting as increases in adverse outcomes. The availability of a wealth of information without sufficient understanding of meaning or impact could undermine public confidence in the NHS and the 10YHP reforms.

Business costs, benefits and risks

These proposals will impact businesses in the provider sector that are regulated by the CQC. The CQC has over 5,000 registered independent healthcare organisations[120]. These organisations will be impacted by adapting to the new ways that the CQC will execute its regulatory and inspection functions. The CQC is primarily funded by fees charged to the organisations it registers[121], any change to these fees will impact both private and NHS providers.

Enablers - workforce reform

Summary and rationale for intervention

Around 1.5 million people are employed in the NHS[122]. In addition, around 9% of people in England provide unpaid care[123]. Pressures on the health and care system and those involved in care delivery are expected to grow in the coming years as illustrated by

[119] Healthwatch. 'A pain to complain: Why it's time to fix the NHS complaints process' 2025.
[120] Independent Healthcare Providers Network. 'Quality and safety in the independent healthcare sector' 2024.
[121]Care Quality Commission. 'Annual Report and Accounts 2022/23' 2024.
[122] NHS England. 'NHS Workforce Statistics 2024 (Including provisional statistics for March 2024)' 2024. (viewed on 1 July 2025)
[123] Office for National Statistics. 'Unpaid care, England and Wales: Census 2021' 2021.

projected increases in the ageing population, with associated increases in levels of multimorbidity and frailty[124]. The number of people aged over 85 will grow by over 800,000 by 2040[125].

Challenges facing the NHS workforce in England include poor staff wellbeing and experience as well high rates of sickness absence. In the 2024 NHS Staff Survey, a third of respondents said that they found work emotionally exhausting, and nearly 30% said they did not have enough energy for friends and family during leisure time[126]. The overall sickness absence rate is 5.1%[127], still higher than the 4.8% pre-pandemic rate (January 2020)[128].

As well as impacting staff, these challenges have consequences for NHS productivity. Measures of NHS productivity fell by more than 20% in 2020 to 2021 as the NHS responded to the pandemic[129]. Since 2020 to 2021, productivity has been recovering but in the acute sector in 2024 to 2025 it was still estimated to be around 8% lower than the pre-pandemic level[130].

The plan outlines a series of actions and initiatives relating to the workforce that will be developed in future. These include:

- making more use of digital technology to free up clinical time including more use of AI (see innovation chapter below) and making greater use of automation in NHS HR services

- improving and changing the approach to training, such as: a new digitally-led platform for education, skills and training; simplifying and increasing flexibility of staff mandatory training; and, work with higher education institutions to adapt the system to support 10YHP reform vision

- increasing opportunities for graduates through prioritising UK medical graduates and increasing specialty training posts

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[124] The Health Foundation. 'Health in 2040: projected patterns of illness in England' 2023.
[125] Office for National Statistics. 'Population projections 2020 to 2040 for ages 65 to 84 and age 85 plus 2023.
[126] NHS Staff Survey. 'NHS Staff Survey National Results' 2024. (viewed on 1 July 2025)
[127] Based on a 12-month rolling average sickness absence rate to February 2025. NHS England. NHS Sickness Absence Rates - NHS England Digital 2025.
[128] NHS England. NHS Sickness Absence Rates - January 2020, Provisional Statistics - NHS England Digital 2020.
[129] Office for National Statistics. 'Public Service Productivity, healthcare, England: Financial year ending 2022' 2022.
[130] NHS England. 'NHS productivity update' 2025. (viewed on 22 June 2025)

- improving staff experience, underpinned by a new set of Staff Standards, rolling out high-quality occupational health services and improved flexible working

- NHS employers and contractors will be required to facilitate a 50% expansion of the NHS Graduate Management Training Scheme, refocussed to align with the service model in the 10YHP

- new financial incentives and legislation to ensure NHS senior leaders operate consistently with the standards expected of them by (i) withholding annual pay increases from those who do not meet required standards and (ii) bringing forward legislation to disbar senior leaders from working in such NHS roles where they are found to have behaved unacceptably

- reorientating NHS recruitment to local communities, across all types of NHS organisation and across roles from administration to nursing and medical professions

The plan also signals how the NHS workforce will operate in future with the detail of these changes to be developed through a series of future initiatives. These include:

- replacement of the long-term workforce plan with a new 10 Year Workforce Plan during 2025

- the Chief Nursing Officer for England's strategy - setting out new approaches to developing professional training and career pathways

- a new Management and Leadership Framework, including a code of practice, standards and a development curriculum in autumn 2025

A programme of work with professional regulators and through consultation is also outlined to maintain, update and reform employment contracts and appraisal arrangements, and to reform education and training curricula.

Overview of potential costs and benefits

Healthcare system costs, benefits and risks

Proposals to improve staff experience that will be captured in the new set of staff standards will create implementation and ongoing costs. The standards are in development and so the costs are not yet known but they are expected to vary by organisation, depending on how far they already comply with the new standards. Examples of potential costs include: changing building food supplies and catering arrangements to ensure staff have access to nutritious food, training, information sharing and access to support to tackle racism and sexual harassment and steps to reduce violence against staff.

There may also be transition costs associated with the design and implementation of new practices, such as workforce culture shifts in response to increased flexible working. Tools such as e-rostering are expected to reduce the ongoing administration costs of these changes.

Improving the occupational health offer to NHS staff through rolling-out access to treatment hubs will create costs associated with providing the treatments that staff require following their referrals and the time for them to access these services. These costs will vary depending on the nature of treatments provided.

Where the measures in the staff standards are effective, they could benefit the healthcare system by improving morale and that translates into an improved working environment and productivity. For example:

- research from 2017 has found that a one standard deviation increase in overall staff engagement was associated with a decrease of 0.9% in spend on agency staff (which works out to a saving of approximately £1.7 million) and a saving of approximately 2,000 sick days per year (which works out at approximately £365,000 less in salary costs due to sickness absence).[131]

Increasing flexible working arrangements in the NHS can benefit the healthcare system, as well as staff, through higher staff-retention rates and reduced sickness absence as staff have more control over their shifts. Depending on the service offer, the occupational health hubs could also reduce sickness absence as staff receive support to remain fit and healthy to stay at work. Where this proposal successfully improves staff retention, the system will face reduced costs associated with turnover i.e. recruitment processes and use of temporary staff. Retaining staff longer-term can also improve service delivery due to the retention of corporate knowledge and established team working.

Analysis by NHS England indicates that policies to support the working environment including flexible working can reduce leaver rates.[132]. More than half of NHS leavers are voluntary resignations and the top reasons given are to improve work life balance or because of health issues. The number of staff recorded as leaving for these reasons has more than tripled since 2013 to 2014.[133]. Flexible working is supported by the Royal College of Nursing.[134] and NHS providers.[135]. Making it easier for staff moving between organisations as a result of policies such as portable training and standardised policies will

[131] NHS England. 'Employee engagement, sickness absence and agency spend in NHS trusts' 2018.
[132] NHS England. 'People Promise Exemplar Programme: Cohort 1 close of programme evaluation report' 2025.
[133] The Kings Fund. 'NHS workforce in a nutshell' 2024.
[134] The Royal College of Nursing. 'Flexible Working' 2025. (viewed on 1 July 2025)
[135] University Hospitals Birmingham NHS Foundation Trust. ' Why we should say 'Yes!' to flexible working'.

also support the health system, reducing the time and costs associated with onboarding new staff where they are coming from another NHS organisation.

There will be digital transformation costs associated with greater digital automation of the NHS HR service and developing and implement single sign-on functionality for staff to access all of their work-related systems with one set of log-on information. Work is ongoing to quantify the costs of this digital transformation.

The NHS will also face costs associated with increases in training roles. These costs will include funding the training and support required for these programmes, both financially and freeing up staff time to undertake the training, and future salary increases for those completing the training. The actions relating to education and training will require education providers, working with employers to take urgent action to address attrition rates in nursing and other professions. There will be associated increases in costs relating to pay and education for DHSC.

There will be costs associated with expanding the NHS Graduate Management Training (GMT) Scheme, from the current headcount of 400 on scheme to 600. Based on internal evidence about current scheme costs, once the scheme is scaled up, annual costs could be around £8.6 million higher per year (based on 2 cohorts being funded at any one time). NHS England is aware of demand for increased access to the scheme from NHS provider organisations. Expanding the scheme is likely to increase the scale at which the NHS attracts, recruits and employs a diverse range of graduates. It has the benefit of providing consistent management standards across the system. The key risk with expanding the scheme in the short-term is the capacity for NHS England to support an increased number of GMTS trainees while in their roles due to organisational changes.

The proposals relating to leadership will generate costs where actions are taken to withhold pay or disbar those who have behaved unacceptably. Costs are likely to be for administration, HR and legal services where these actions are pursued. These actions may only be taken rarely, with benefits to both organisations and individuals of resolving issues before they escalate to these stages. Removing senior leaders and deterring unwelcome behaviour by senior leaders should improve organisations' performance, potentially including financial performance, achievement of objectives and/or patient outcomes. There is a risk that these approaches could hinder ambitions towards a learning environment if people are not open and honest about failings that could result in a penalty, but these risks are expected to be outweighed by the benefits of embedding good leadership.

Public and patients - costs, benefits and risks

Workforce improvements can be expected to benefit patients receiving NHS services, through improved access to high quality care from a combination of more effective use of

staff training time, time freed up for care delivery, and improved staff wellbeing. For example:

- research by Maben and others (2012) found that staff wellbeing is a precursor for delivering good patient care and experience[136] and West and Dawson (2012) have demonstrated the link between higher staff engagement and lower patient mortality rates, with an increase of one standard deviation in overall engagement associated with a 2.4% drop in patient mortality[137]

The recruitment of more staff from local communities can increase the diversity of candidates for roles, including those who may currently be underrepresented in the workforce of the organisation. This more diverse workforce can better understand the needs of the populations they serve.

The proposals to expand apprenticeships and accessible training to resident populations and broadly across society could particularly benefit disadvantaged groups, including people with chronic conditions, care leavers and others. Supporting people into employment offers a route out of poverty and ill-health. In 2021, 75% of medical school entrants came from higher socioeconomic backgrounds with only 5% from the lowest socioeconomic group[138].

While health service delivery and improving patient's health is the main role of the NHS, it is also an ‘anchor institution’ in local communities. In this role, the NHS aims to be a good inclusive employer and create opportunities for people to develop skills and access jobs[139]. Where carried out successfully, this role can indirectly support improvements in the wider determinants of health, such as by widening access to employment in the local community.

Workforce costs, benefits and risks

Staff are likely to face transition costs as they adjust to changes in the digital systems that they use daily, as well as familiarising themselves with new HR functions and future training and skills development. If these new systems are successful in improving access to HR services, staff will be expected to benefit from improved experience and possible time savings, for example through simpler processes for rostering and leave booking.

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[136] Maben J and others. 'Patients' experiences of care and the influence of staff motivation, affect and wellbeing' NIHR Service Delivery and Organisation programme 2012.
[137] The Kings Fund. 'Employee engagement and NHS performance' 2012.
[138] The Sutton Trust. 'Unequal Treatment? Access to medicine for socio-economically disadvantaged students' 2025.
[139] NHS England. 'Anchors and social value'.

Proposals relating to HR functions, including the NHS single-sign-on and increasing flexible working are designed to improve staff experience and wellbeing. Flexible working arrangements can improve work-life balance by supporting people to accommodate family commitments as well as other personal pursuits, including activities such as education. Increased access to occupational health services through the national roll-out of Staff Treatment hubs can support staff to stay healthy and in work[140].

These workforce reforms require a different mix of staff aligned to the way that new technology will be used in the system in future, and so clinicians will need appropriate training to fully exploit these opportunities. For example, aligning training with skills required for the future service model of the NHS, including the increased use of digital solutions and AI will equip staff to fulfil their roles and could support further development and career progression.

Enablers - innovation

Summary and rationale for intervention

Over the past decade (financial years 2013 to 2024), NHS spending on drugs for specialised services has grown at 8.9 per cent a year, while for devices it has increased at 10.2 per cent annually[141]. This far outpaces the rate of growth of the total NHS budget, meaning that specialised services account for a growing share of expenditure. While it means more diseases and conditions can be treated - such as putting England on a trajectory to eliminate hepatitis C ahead of the rest of the world[142] - it potentially gives rise to opportunity costs in other areas of healthcare.

The Office for Life Sciences publishes Life sciences competitiveness indicators annually[143]. The latest data shows that:

- as a percentage of GDP, the UK government's budget allocation on health research and development declined as a share of GDP from 2020 to 2021 (similar to the trend in some other countries) but remained the second highest proportional allocation among comparator countries[144]

[140] NHS Employers. 'Occupational health for NHS staff' 2023. (viewed on 25 June 2025)
[141] Darzi A. 'Independent investigation of the NHS in England' 2024.
[142] UK Health Security Agency. 'Hepatitis C in England 2024' 2025.
[143] Office for Life Sciences. 'Life sciences competitiveness indicators 2024: summary' 2024.
[144] Comparator countries were USA, South Korea, Australia, Italy, France, Japan, Germany and Spain.

- the UK's global share of patients recruited to commercial trials increased, ranking in fourth place among comparators

- the estimated value of inward life sciences foreign direct investment (FDI) to the UK fell in 2023, ranking eighth against compactors and reflecting a second year-on-year decline

The plan describes 5 'transformative technologies' for the health system:

- health data. Users, including researchers and entrepreneurs will be able to access deidentified NHS datasets to solve health problems

- expanded use of AI to transform diagnostics, analysis and drug discovery supported by a new regulatory framework for AI, infrastructure and implementation of the NHS AI strategy

- the integration of patient genomic data with relevant clinical data to drive proactive and personalised care; a new large-scale study to sequence the genomes of 150,000 adults

- increased use of wearables, biometric sensors or smart devices with equitable access for health monitoring; over time integrating data from these products into the NHS App

- increasing the adoption of surgical robots to enhance surgical precision, and assistive robotics to transform patient care and support

The plan proposes a set of steps to support these ambitions:

- expanding NICE's technology appraisal process to cover devices, diagnostics and digital products, and introducing re-evaluation of priority clinical pathways

- a new bidding process for global institutes to drive global leadership on research and translation, and establishing regional health innovation zones to test implementing innovation

- improving procurement for innovation with a clear and coordinated approach focussed on value and outcomes with principles to support the adoption of technology

- a more pro-innovation approach to regulation, including a joint process by MHRA and NICE to assess medicines and accelerate access

- improving adoption and spread of innovations with an 'innovator passport' by 2026 to avoid repeated assessments of products and moving to a single national formulary (SNF) for medicines in the next 2 years.

A series of measures is also aimed at supporting clinical trials in the UK by making it easier for patients to enrol and organisations to set them up. These include:

- publishing a monthly scorecard for the NHS showing progress on clinical trials
- promoting 'Be Part of Research', allowing patients to search clinical trials database and to request to be contacted. In time, clinical trial recruitment will be linked to the NHS App and SPR, so that patients are proactively notified of clinical trials that might help them
- making it easier for NHS organisations to participate in clinical trials by introducing standardised contracting processes and expanding the UK wide National Contract Value Review (NCVR) into out of hospital settings

Overview of potential costs and benefits

Technological change and health expenditure

The relationship between technological advances and health spending is complex. In many cases, new technologies improve length and/or quality of life for patients but at an additional cost to the health service with a price that is deemed cost effective. Over the longer term this can create a cost pressure via:

- new technologies to treat conditions for which there was previously no equivalent treatment (or the effectiveness of the treatment was low) meaning more money spent on a given condition or group of patients (with associated health benefits)
- new technologies which expand existing interventions to wider populations. Overall spend can increase if a new treatment is found to be suitable for wider medical uses meaning it can address previously unmet demand for care

The estimated impact of technological progress on health expenditure growth ranges significantly. Examples of this are found in:

- studies reviewed by the OECD[145] estimated that technological progress accounted for between 10 and 75% of observed annual growth in health expenditure. Most studies reported values between 25 and 50%

[145] Marino A and Lorenzoni L. 'The impact of technological advancements on health spending: A literature review' OECD Health Working Paper 2019: Volume 113.

- Smith, Newhouse and Freeland 2019[146] estimated that medical technology explains 27 to 48% of health spending growth since 1960

Technological cost growth may also be driven by the expansion of morbidity resulting from the growth in chronic conditions. For example, population ageing and lifestyle trends encourage the development of new technologies that delay mortality and improve quality of life for individuals suffering from chronic conditions. However, in terms of costs:

- the Health Foundation reports that while some innovations are purely cost savings, new technologies can increase per patient costs or bring more patients into scope of treatment[147], suggesting that health spending will increase as individuals live longer in ill-health

The 5 big bets

A collaboration by researchers from the Health Foundation, Institute for Fiscal Studies, The King's Fund and the Nuffield Trust has previously considered aspects of 4 of the 5 big bets (robotics was not considered as part of this study)[148]. All were identified to have key opportunities, summarised as follows:

- big bet 1: improved patient-level health data. The research identified 4 major opportunities from the ability to link and analyse the abundance of NHS data: (i) reduced variation in clinical practice, (ii) understand how and why diseases arise and how they can be detected early / prevented all together, (iii) evaluate treatment outcomes and develop targeted approaches to treatment, including making clinical decisions in real time, and (iv) using consumer devices to monitor the whole population in order to form population-level datasets and enable early intervention for at-risk patients

- big bet 2: increased use of AI. AI presents opportunities to improve the diagnostic process by using algorithms to interpret images produced from CT or MRIs to detect cancer. It also has the ability to support triage as well as more administration roles, for example ensuring all members of a surgical team are in the operating theatre at the same time or arranging the schedule of a community nurse. Some of these approaches are already being used in the NHS

- big bet 3: genomics and personalised health care. The research focussed on the use of genomics in enabling precision medicine which is when patients receive treatment

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[146] Smith S, Newhouse JP and Freeland MS. 'Income, Insurance, And Technology: Why Does Health Spending Outpace Economic Growth?' 2009.
[147] The Health Foundation. 'Health in 2040: projected patterns of illness in England' 2023.
[148] Castle-Clarke S. 'What will new technology mean for the NHS and its patients?' 2018.

based on their genetic, lifestyle and environmental information. At the time of the research (2018), there were still few treatments aimed at changing genes, and those that did, only worked on a very small number of people. If further research is capable of delivering precision medicine as intended, it will improve the quality of care and health outcomes, enhancing the effectiveness of treatment and making diagnoses more accurate

- big bet 4: expanded use of wearables. Digital technology is increasingly supporting patients to better manage and understand their condition through online health communities, apps, and wearable devices. Making this available to the NHS will increase the richness of data to understand conditions. Making the most of this data could also produce longitudinal data to be used for research.

Other studies have summarised the opportunities for robotics. Benefits observed for robotic surgery assistance include improving recovery time, reducing complications and potentially increasing access to these procedures[149]. Other clinical outcomes include greater precision, smaller incisions, reducing the requirement for blood transfusions and reducing the danger of infections related to medical care, all leading to faster recovery time and shorter hospital stays[150]. In pharmacy, the automated dispensing systems help reduce errors and dispensing time leading to an increase in pharmacist capacity[151]. Hospital evaluations also show improved workflow and optimised storage[152].

Healthcare system costs, benefits and risks

Mainstreaming the use of new medicines and treatments developed through research and innovation requires strong workforce knowledge and digital data systems. The Sinker Review[153] found that staff felt it "took too long or was too difficult to try something new in a way that worked for them" and didn't not feel there was the capacity, culture or partnerships to embed innovation. As with other technological trends, the cost of implementation - including training and infrastructure - could limit benefits in the short term, even as the cost of the technologies themselves decrease. Retiring ineffective products could reduce costs to the health system and there could be an assumed cost saving

[149] NICE. 'Cutting-edge robotic surgery gets green light as 11 systems are recommended' 2025.
[150] Handa A and others. 'Role of Robotic-Assisted Surgery in Public Health: Its Advantages and Challenges' Cureus 2024: Volume 16.
[151] Takase T and others. 'Evaluating the safety and efficiency of robotic dispensing systems' J Pharm Health Care Sci 2022: Volume 8.
[152] Wang YC, Tsan CY and Chen MC. 'Implementation of an Automated Dispensing Cabinet System and Its Impact on Drug Administration: Longitudinal Study' JMIR Form Res 2021: Volume 5
[153] NHS England. 'The Innovation Ecosystem Programme – how the UK can lead the way globally in health gains and life sciences powered growth' 2024.

efficiency from ensuring that the innovations that are not the most effective and that do not offer the best value are no longer used.

Increased access to research and innovation with more streamlined operations and optimised clinical pathways to adoption - including through an 'innovator passport' and through expanding NICE's technology appraisal process - could improve efficiency for both the NHS and industry. For example, the use of precision medicine can improve efficiency by delivering the care most suited to each patient rather than beginning with the same treatment for all. Where data is collected by patients from wearables and linked to their patient record, this could reduce the number of ultimately unnecessary tests ordered in the NHS, lowering system costs.

A new joint process by MHRA and NICE could cut administrative burdens for both the system and industry. However, continuing to promote adoption of new technologies will require a system-wide approach.

Genomics involves getting complete genetic information about an individual. The cost of sequencing whole genomes in 2025 has been reduced to $200 per genome[154]. Pharmacogenomics is the study of an individual's genetic response to medications. Being able to identify the effects of a certain medication, based on an individual's genetics, before prescribing it could reduce side effects. Side effects account for one in 16 hospital admissions and have been estimated to cost the NHS £2.2 billion annually[155] demonstrating how important pharmacogenetic testing and precision medicine could be.

The plan describes the intended aims of new global institutes, to establish the UK as a world leader in health research and translation. Regional health innovation zones are intended to use radical experimentation to improve the use of such innovation in the NHS. The zones will be cost neutral if funded through existing devolved budgets, transformation funds and improvement and digital budgets. Where successful approaches are found, sharing this practice nationwide could result in improved health outcomes and wider economic benefits, derived from using innovation more effectively in healthcare.

There is a risk that increased use of new technologies creates immediate financial pressures on already stretched healthcare budgets. For example, population health medicines for large patient cohorts have the potential to create significant long-term benefits in the form of health system savings and reduced economic inactivity. However, the cost of providing these treatments at scale across the entire eligible population presents a significant affordability challenge for the health system. More broadly, there are

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[154] UK Research and Innovation. 'Our contribution to sequencing and genomics' 2025.
[155] Magavern EF. ' A United Kingdom nationally representative survey of public attitudes towards pharmacogenomics' 2025.

risks to using innovation to drive efficiency if the NHS lacks the agility to adopt the 'right' technological advances over the next 10 years. It is likely that some experimental initiatives will fail to deliver their stated benefits given the emergent level of evidence for many new technologies.

Public and patients - costs, benefits and risks

Increased research and innovation, and the subsequent implementation of new technologies, will benefit patients through widening access and improved treatment. For example, precision medicine targets treatments to patients who are most likely to benefit from them, in contrast to the traditional 'one size fits all' approach to healthcare. This approach can lead to better patient outcomes, including reduced risk of side effects[156] by using the most effective treatment rather than needing to trial different options.

There may be benefits to patients in terms of spending a reduced amount of time in healthcare settings. More services delivered at home, as well as health markers collected from wearables and biosensors mean people will spend less time travelling to and attending appointments where information can be transmitted digitally. These savings will enable people to spend that time in other value-adding pursuits.

There are also benefits to patients from hospitals participating in research. Evidence comparing mortality rates across NHS acute trusts in England found that those participating in research had lower mortality rates after controlling for other structural factors[157].

Benefits to patients in receipt of healthcare that uses new technology will be partially offset by costs to others where spending on new technologies displaces investment in other services. The relatively high price of many new medicines compared to other NHS treatments such as surgical interventions means that more expenditure on new high priced products can displace other activity, which could result in lower net increases in health outcomes than would otherwise be the case[158].

Depending on implementation, moving to a single national formulary could support faster access to medicines for NHS patients and help to drive uptake in products following NICE medicines approvals. Moving away from 159 local formularies could increase equity in access to medicines by removing separate review processes, though local prescribers would retain clinical autonomy which may limit any effects. The median time to availability

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[156] European Federation of Pharmaceutical Industries and Associations. 'Precision medicine: Giving the right medicine, to the right patient, at the right time'.
[157] Ozdemir BA and others. 'Research activity and the association with mortality' PloS one 2015: Volume 10.
[158] Trigg LA and others. 'The Cost Effectiveness of Elective Surgical Procedures with Longer NHS Waiting Lists: A Targeted Review' Applied Health Econ Health Policy 2025.

of new medicines in England for medicines launched between 2020 and 2023 was 310 days.[159]. Proposals to streamline access to medicines, including the joint process by MHRA and NICE are expected to give patients faster access to new medicines, with potential benefits for health outcomes.

There remain some risks to inequality in access. Not all patients will be able or willing to engage with the latest technologies, and so digital or technological exclusion could remain a barrier for some. However, the plan seeks to mitigate this risk by trialling approaches to provide devices for free in areas where health need and deprivation are highest. The public may also have concerns and/or reservations about the ambitions for innovation highlighted in the plan. For example, they may be wary of the wider use of genomics and perceived risks to safety of leaner regulation.

Businesses costs, benefits and risks

As with any change to regulation, changes could affect business' sales to the NHS. For example, where less effective treatments are no longer funded by the NHS, this would reduce profits associated with those products. On the other hand, proposals that increase the opportunity for the NHS to increase or accelerate the adoption of new products will benefit the businesses producing and distributing those.

NICE evaluations of new medicines are funded by charges to companies. There is a risk that companies would not be willing to pay for a re-evaluation which could risk their product being decommissioned by the NHS.

Closer working between MHRA and NICE could reduce the regulatory burden for companies, including through more extensive information sharing between MHRA and NICE and enhanced advisory services through a better integrated NICE and MHRA offer. More streamlined operations and optimised clinical pathways to adoption of new technologies, such as through an 'innovator passport' and expanding NICE's technology appraisal process - could improve efficiency for industry, reducing the resource required to get products into use.

By seeking to position the UK as a world leader in health innovation, the plan aims to secure economic benefits by attracting investment, creating high value jobs, and exporting new technologies to the world. For example:

- the UK's domestic pharmaceutical industry drove £8.7 billion of private R&D investment in 2023 (making up 17% of total private UK R&D investment).[160], and the

[159] EFPIA. 'EFPIA Patients W.A.I.T. Indicator 2024 Survey' 2025. (viewed on 1 July 2025)
[160] Office for National Statistics. 'Business enterprise research and development, UK: 2023' 2024.

whole UK life sciences industry attracted £5.2 billion of foreign direct investment from 2019 to 2023[161], while also generating turnover of £108 billion in 2021 to 2022[162]

- in 2021 to 2022, it was estimated that the sector provided 304,200 jobs, with 89% outside of London[163]. Many of those roles which were high-skill, high-wage jobs, with pharmaceutical manufacturing businesses contributing a gross value-added of £428,000 per pharmaceutical worker in 2024[164]

Enablers - finance

Summary and rationale for intervention

Revenue

The current financial framework for the NHS is based on annual allocations. While these align with the government's annual budgeting process, the lack of longer-term certainty about budgets can limit the ability for organisations to undertake major service transformation and system re-design.

ICBs receive annual revenue allocations based on a formula. Of the approximately £205 billion allocated to NHS England in the financial year 2025 to 2026[165], almost £170 billion is subject to the ICB allocations formula[166]. Each year, ICBs have a baseline allocation and a target which is based on allocating 'fair shares' to each area. Systems are gradually moved towards that target using a convergence policy. This can be problematic for ICBs that are currently 'overfunded' because it may lead to lower funding growth than other ICBs or the national average and budget pressures can risk disrupting financial and operational plans for the year, to the detriment of services and patient care.

Funding for primary care is separate from system allocations. General practices receive funding through various routes including fee for service and via the Quality and Outcomes Framework (QoF), but the biggest single funding stream for most practices is the global sum payment which is determined by the Carr-Hill formula. The Carr-Hill formula allocates

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[161] Office for Life Sciences, Life Sciences Competitiveness Indicators. 'Life sciences competitiveness indicators 2024: summary' 2024.
[162] Office for Life Sciences. 'Bioscience and technology statistics 2021/22' 2024.
[163] Office for Life Sciences. 'Bioscience and health technology statistics 2021/22' 2024.
[164] Value calculated from Office for National Statistics (2025), GDP low-level aggregates and Office for National Statistics (2025), Employee and self-employed jobs by industry for businesses for standard industry classification 21: JOBS03, JOBS04.
[165] Department of Health and Social Care. '2025 to 2026 financial directions to NHS England' 2025.
[166] NHS England. 'Allocation of resources 2025/26' 2025.

funds to GP practices based on an estimate of their patient workload by assigning a weighted value to each patient.

GP practices serving England's most deprived quintile received on average £14 less in NHS payments per weighted patient in 2022 than their counterparts serving patients in the least deprived quintile.[167]. The Royal College of General Practitioners and the Nuffield Trust have previously recommended this formula be reformed to take socioeconomic deprivation into account.[168]

Payments to healthcare providers are based on different approaches according to care setting and activity type. The aims of payment systems are to incentivise behaviour, for example in 2003 to 2004, the Payment by Results (PbR) system was introduced, alongside elective tariffs to help to reduce waiting times for planned, non-urgent treatments.[169] by using financial incentives to encourage hospitals to meet waiting time targets. Typically, payments for units of activity are used in hospitals and drive more activity, whereas block contracts are used more in community services and create incentives for less activity.

The plan confirms the publication of a new financial framework for the NHS to be published later this year as well as steps being taken to restore financial discipline. The plan also signals:

- deliver 2% year-on-year productivity gains and, as a result, return to pre-pandemic levels of productivity by the end of the parliament

- a shift to longer-term planning, with associated revenue allocations. Systems will also be moved to their fair shares of funding more quickly

- funding changes aiming to support the shift towards neighbourhood care, including trialling year of care payments that could cover primary, community, mental health, specialist outpatient care and emergency activity as well as tariffs for community and mental health services

- extending the use of best practice tariffs to more clinical pathways

- patients' views influencing payments to providers, such as linking payments to inspection outcomes or patient satisfaction. The NHS will trial 'Patient Power

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[167] Health Equity Evidence Centre. 'Which ICB's have the greatest need for primary care?'.
[168] Nuffield Trust. 'Fairer funding for general practice in England: what's the problem, why is it so hard to fix, and what should the government do?' 2024.
[169] The Health Foundation. ' The future of the NHS hospital payment system in England: From recovery to transformation' 2021.

Payments' where patients decide whether a portion of tariff should be paid to the provider or held in a regional improvement fund

- new payment models for urgent and emergency care trialled with the aim of incentivising more same-day and out-of-hospital care

Capital

The UK spends less than many OECD countries on capital investment in healthcare. Different sources have estimated the capital shortfall, such as:

- Lord Darzi's Independent Investigation into the National Health Service in England estimated a historic shortfall of £37 billion across the UK over the period 2011 to 2020.[170]

- the Health Foundation estimate a £38 billion shortfall if real-terms funding increase in line with OBR assumptions to 2029 to 2030.[171]

In addition, in recent years money earmarked for capital spending is repeatedly having to be used to cover day-to-day costs.[172], further exacerbating scarcity of capital. Backlog maintenance stood at £11.6 billion in 2024.[173], the latest year of data available.

The proposals relating to capital expenditure are intended to improve capital planning by creating more certainty and streamlining capital approvals processes, they include reforms to improve the use and value of assets by:

- providing more details about the NHS infrastructure pipeline through a published 10-year health infrastructure strategy

- streamlining capital approvals processes to speed up new projects and clarifying rules associated with land disposals to maximise the use of the existing estate

- provide capital allocations to ICBs on a rolling 5-year basis (in line with wider government capital allocations)

- providing more flexibility for capital spending by provider organisations between financial years and further freedoms for new FTs to determine their capital expenditure independently

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[170] Darzi A. 'Independent investigation of the NHS in England' 2024.
[171] The Health Foundation. 'How much funding does the NHS need over the next decade?' 2024.
[172] National Audit Office. 'Review of capital expenditure in the NHS' 2020.
[173] NHS England Digital. 'Estates Returns Information Collection' 2024. (viewed on 4 June 2025)

The plan also signals changes to financing options for capital projects through future proposals for access private capital and a consultation on reforms to the use of Public Dividend Capital.

Overview of potential costs and benefits

Healthcare system costs, benefits and risks

Overall

Proposals in this chapter are intended to be cost neutral in financial terms and focus on re-distributing funding by changing allocations to ICBs or adjusting the tariffs for different services and treatments by providers. These proposals generally aim to improve system efficiency to generate better patient experience and outcomes. If realised, such efficiencies could result in more integrated and joined up care, with savings reinvested into further system improvements. There are generally implementation risks associated with proposals that create ‘winners and losers’, with those who may lose out likely to have limited appetite for such changes.

There will be transition costs within central organisations to design new allocations and payment approaches, and familiarisation and awareness costs within systems for financial regime changes, which typically take years to develop and bed in. There is a risk that administrative costs and challenges of operating some of the policies may out-weigh any service improvements at least in the short term. For example, implementing proposals such as tariffs for community and mental health services will be challenging initially due to the insufficient quality of data available. Year of care payments will become easier to implement and operate as the single patient record becomes established, increasing the availability of relevant data to calculate payments.

There is a risk that new payment systems create perverse incentives which could drive behaviours in unintended ways. For example, contracts will need to be managed so that organisations that are paid under different arrangements are incentivised to take a shared, system-wide view of cost and value. As with all policy development, risks such as these will be assessed, with relevant mitigations reflected in the final policy design.

There are a number of risks to the package of changes to day-to-day spending. The number of changes to different components of the financial architecture may undermine intentions to drive reform by destabilising NHS finances. The plan sets out a vision for financial stability, but this will need to be delivered at an appropriate pace of change, recognising that underlying system deficits will take time to eliminate. The new financial framework will need to clarify how the reforms operate in practice to create the incentives for the required service change to support the 3 shifts proposals. ICBs will continue to

commission services across a range of providers and so the financial architecture at system level will need to be kept under review.

The plan outlines proposals that require funding shifts, such as reducing the share of expenditure allocated to hospital care, with proportionally greater share of spending expected to go on primary and community care over the next 3 to 4 years and requiring all organisations to reserve at least 3% of annual spend for one-time investments in service transformation. These are intended to be cost neutral proposals, that set priorities for the system and, if implemented, will benefit those areas that funding is redirected to. In doing so, the areas funding is being displaced from could be adversely impacted. There is also the risk that the requirements to meet these targets reduce local flexibilities and discretion over planning and budget setting. As with other policies, this will be monitored to seek to understand if there are adverse impacts or perverse incentives created by these changes.

The productivity ambition in the plan is more than double the NHS' historic average and is likely to translate to a higher challenge in some settings. Based on historic evidence, this will be a stretching target and if not achieved, will hamper operational and financial performance.

Allocation formulae

Setting 5-year capital budgets on a rolling basis aims to support longer-term strategic decision-making. Logically, it is difficult for organisations to optimise investments, changes and innovations in the presence of high future uncertainty. While setting longer allocations limits to some extent the NHS's ability to make short-term allocative adjustments in response to new events and trends, these downsides are likely to be outweighed by the reduced short-termism and the improved budgetary incentives on the system.

Reviewing how health need is reflected in nationally determined contracts, such the Carr-Hill formula for general practice, could improve allocative efficiency. It would create opportunity costs as prioritising funding for some services means forgoing others. Ahead of the Carr-Hill formula being reviewed, the scale of such opportunity cost is difficult to estimate, but the age of the formula and underlying data mean that changes in practices' funding are likely to be significant. More radical funding options, such as a switch from a workload-based model to a need-based model for primary care services, would lead to a greater scale of change. Any change to allocations formulae, for a given envelope, results in some beneficiaries and others receiving lower allocations with the extent of redistribution depending on how adjustments for drivers of need are made, such as prevalence of complex needs and multi-morbidities.

Reviewing allocations to ICBs could improve allocative efficiency, improving outcomes and potentially reducing health inequalities. The Royal College of General Practitioners argue

that replacing the Carr-Hill formula with a needs-based formula is a sustainable way to make general practice funding more equitable[174].

Actual allocations to ICBs differ from the values determined by the formula and systems are gradually moved towards their target values using a convergence policy[175]. The plan intends for ICBs to reach their targets more quickly than under the current policy so that those areas with the greatest economic and health challenges receive levels of funding aligned to their population needs more sooner. Increasing the pace at which ICBs move to their target allocations will create winners and losers relative to the current convergence policy.

Payment approaches

A range of new payment approaches for providers are intended to change incentives, to improve outcomes, productivity, including by shifting care into the community.

The NHS payment scheme for secondary healthcare already includes a number of Best Practice Tariffs (BPTs) and the plan intends to increase the use of this approach. The use of BPTs more widely could spread this effective practice, providing incentives for providers to implement more efficient approaches to providing care and improve patient experience. BPTs have driven behaviour change and improved the efficient use of resources[176]. For example:

- research by Zogg and others (2022)[177] demonstrated the effectiveness of implementing BPTs on hip fracture outcomes in the NHS. The BPT was found to be associated with: reductions in mortality (365-day mortality prior to BPT implementation (2000 to 2006) was increasing by 0.3 percentage-points per year and decreased by 5.4 percentage-points following implementation); declining readmissions rates (from annual increases of 0.8 percentage-points to a decline of 1.4 percentage points within 30 days); improvements in length-of-stay (decreased by 2.7 days), and patients receiving a timely operation (increased by 15.1 percentage-points)

Secondary care payments will be further refined through changes for urgent and emergency care to incentivise same-day and out-of-hospital care. These will be developed at the same time as year of care payments (YCPs). YCPs are a single payment to a provider with the potential to cover all of a person's care, from primary services to

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[174] Royal College of General Practitioners. 'Breaking the inverse care law in UK general practice' 2024.
[175] NHS England. 'Technical guide to allocation formulae and convergence for 2025/26 allocations' 2025.
[176] NHS England. '2025/26 NHS Payment Scheme – Annex C: Guidance on best practice tariffs' 2025.
[177] Zogg CK and others. 'Learning From England's Best Practice Tariff: Process Measure Pay-for-Performance Can Improve Hip Fracture Outcomes' Annals of surgery 2022: Volume 275.

emergency admissions. This approach is intended to incentivise more proactive care for the eligible population, shifting care away from acute settings towards neighbourhood settings. Year of care payments create incentives to reduce costs because providers can also keep a share of any savings to invest in new services. If successfully implemented, this could improve overall system efficiency which may be seen through reduced waiting times and improved patient flow in acute settings, improving quality of care, patient experience and overall population health.

In addition to trialling YCPs in pioneer systems, payment approaches outside of hospital will also change with the expansion of tariffs to community and mental health services. Existing block contracts typically incentivise lower activity since providers are paid a fixed amount irrespective of activity, and so rationally, would seek to minimise costs which could mean treating fewer patients. A tariff-based approach could drive activity in these services that would support wider aims, such as clearing the elective backlog, encouraging problems to be solved in lower cost settings, or preventative interventions such as care planning or core care processes.

Implementing best practice tariffs for individual services in scope of a year of care payment would be challenging. Further consideration will need to be given to which services are most appropriate for each approach.

Patients with complex health and social care needs are often frequent users of many services and internal analysis of patient level data estimates that this group accounts for 18% of the population but represents 58% of secondary care costs. For further details see annex A. Changes to financial incentives that lead to the successful management of high intensity users of healthcare services could benefit patients, such as through increased independence, and reduced reliance on hospital care and long term residential and nursing home care.

Patient Power Payments

Patient Power Payments could create an incentive for trusts to prioritise patient experience to ensure they receive full payment levels. If trials are successful and these approaches are rolled out, they could help individual patients feel empowered and listened to, as well as creating benefits for future patients.

However, linking funding to patient feedback can create uncertainty for providers. Any money withheld and not paid following the receipt of feedback could result in budget pressures as costs have been incurred, but without the full anticipated payment. The worst performing services could be hit the hardest unless Regional Safety Improvement Funds are targeted at those services. Providers may also face perverse incentives to improve the most ‘visible’ aspects of care in order to attract such payments. The ‘test and learn’ approach to Patient Power Payments is intended to help identify and moderate the

likelihood and impact of these risks. There are also likely to be upfront development costs for funding infrastructure and developing and communicating the patient-facing feedback tools.

Capital

Some costs of the capital proposals would be administrative, with central government required to calculate system-level multi-year capital budgets and to develop a fair and transparent capital allocations formula. There will also be familiarisation costs, as commissioners and regional teams will need to understand the capital budgets for their local areas and how they impact service provision for their populations. Provider organisations will also need to understand how their capital allocations have been calculated and use that information to revise their multi-year capital plans. Those organisations who are not aware of the current flexibilities for land disposals will also take time to understand those options.

Greater certainty about future budgets could improve capital planning, enabling organisations to make more effective use of funding. The Institute for Government describes how short-term and volatile allocations for infrastructure projects can create stop-start projects and underinvestment in maintenance and replacement[178]. Longer-term certainty is important for establishing a comprehensive pipeline of both medium-sized and larger health infrastructure projects. This can improve market capacity and reduce the adverse impacts of funding 'cliff edges' with improved market confidence in the government's commitments on health.

Streamlining the approvals process for projects requiring central approval may also support efficiency. Anecdotally, the complexity of allocations processes and the extent of national control over them currently inhibits local organisations from pursuing some capital schemes that they think are a high priority but do not align with nationally ring-fenced priorities. In addition:

- a report by the NHS Confederation suggests that the slow pace and multiple layers in the existing system adds delays and complexity to the system, increasing project costs[179]

[178] Institute For Government. 'How to run the next multi-year spending review' 2024.
[179] NHS Confederation. 'Capital efficiency: how to reform healthcare capital spending: 16 practical recommendations across five key areas for reforming the NHS capital regime' 2025.

- the 2019 National Audit Office (NAO) report on NHS financial sustainability found that the capital funding system made it difficult to plan and acted as a barrier to investment.[180]

Over time, any increases in land disposals and the move to provide new FTs with more flexibility could lead to more effective and efficient use of existing assets as providers will be able to configure and use their assets to best meet their needs.

Allocating capital spending limits according to need is intended to create equity across the system, as those providers with the highest need will have sufficient budget capacity to accelerate the eradication of backlog maintenance and to conduct routine maintenance and equipment replacement. However, given the scale of capital need, there is an overarching risk that any realistic capital settlement will not fix the capital deficit and maintenance backlog across the health system. Changes to capital allocations formulae will inevitably result in winners and losers as capital spending limits shift to be based on different criteria than those used currently. As under the current model funding available for tackling maintenance backlogs will flow in line with their extent which risks rewarding those who have failed to maintain their assets. Planned mitigations for these risks include broad consultation on design of the formula, consideration of transitional protection for winners and losers, and a robust accountability regime for effective use of funding provided.

The use of alternative sources of capital could present some risks and costs to the taxpayer. Private finance is typically more expensive than public finance, because investors expect to earn a premium for risk taken and may seek high returns on risky investments. ICBs and trusts will need to ensure they have access to appropriate skills and resources to implement investment plans, manage contracts and avoid poor scrutiny or oversight. Organisations will also need to be clear on which risks they transfer to private providers, as seeking to transfer inappropriate risks would carry a high premium. Reflecting on previous lessons learnt in private finance.[181] will be important in mitigating these risks.

As the provider landscape becomes a more mixed economy of new FTs and those still progressing towards FT status, there will be a need to ensure capital investments by FTs do not crowd-out the spending requirements by other providers. Historically, FTs have principally been providers of acute activity and we cannot be certain that unconstrained capital spending will not result in greater investment only into secondary care, risking neighbourhood health ambitions.

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[180] National Audit Office. 'NHS financial management and sustainability' 2019.
[181] National Audit Office. 'Private finance for infrastructure' 2025.

Growth assessment

Successfully implemented, we would expect the plan to be positive for economic growth through 2 routes:

- firstly, improving the nation's health contributes to higher living standards and personal incomes. Interventions that speed up diagnosis or increase access to effective treatments will mean people spend more time in good health. This can increase the opportunity for people to contribute to society productively, driving up output and increased living standards

- secondly, the plan includes proposals that could improve both NHS productivity and the productivity of the wider economy by improving the environment for innovation and the development and diffusion of new technologies.

Fiscal impacts

Historically health spending has grown both relative to the size of the economy and as a share of government spending. For example:

- according to the IFS[182], the DHSC's day-to-day budget has risen from just over one-quarter (26%) of the all-departmental spending total (excluding annually managed expenditure (AME)) in 1998 to 1999 to over two fifths (43%) in 2022 to 2023

- the Office for Budget Responsibility (OBR) identifies increasing health spending as the biggest driver of long-term government debt increases[183]

There is value to the wider economy from expenditure on healthcare with research suggesting that every pound invested in the NHS is associated with £4 of gross value added in the economy[184]. However, for health spending to continue growing, the government will need to increase overall spending and/or reprioritise resources from elsewhere. This could be facilitated by wider economic growth, borrowing or additional tax revenue.

Analysis by the OBR shows that some of this pressure can be mitigated through improving the average health of the population and narrowing health inequalities. These outcomes can increase labour market participation and tax revenues and reduce health and welfare

[182] Institute for Fiscal Studies. 'The past and future of UK health spending' 2024.
[183] Office for Budget Responsibility. 'Fiscal risks and sustainability' 2024.
[184] NHS Confederation. 'Creating Better Health Value: understanding the economic impact of NHS spending by care setting' 2023.

spending, positively benefitting government revenue and spending. These positive fiscal impacts would be partially offset by some increases in pension-related spending as people live longer[185]. Proposals in the 10YHP that are successful in improving population health, such as the focus on prevention could contribute to slowing growth in health expenditure, increasing the government budget available for other priorities.

Labour supply

Implementing the proposals in the plan is expected to positively impact the ability of working age people to participate in the labour market by shortening the amount of time spent in ill-health such as by preventing the onset of illness and enabling better management of chronic conditions.

The Office for Budget Responsibility has noted how ill health affects UK labour supply:

> "Ill health has consistently been a bigger factor behind inactivity in the UK than most other advanced economies". - Fiscal Risks and Sustainability report 2023[186]

As of July 2023, the economic inactivity rate in the UK has increased from pre-pandemic levels by 0.5 percentage points. The UK's rise in inactivity rates is an outlier among advanced economies, who have seen working-age inactivity rates fall between 2019 and 2022. Underlying variation in working age population health likely explains some of this, along with the structure of welfare systems and other factors[187].

Proposals for changes to the NHS workforce proposals include increasing employment from local communities. This may support employment effects across different parts of the country, for example:

- analysis conducted by the Health Foundation shows that, without action, 80% of the increase in the number of working-age people living with major illness between 2019 and 2040 (from 3 million to 3.7 million) will be concentrated in more deprived areas (deciles 1 to 5)[188]

[185] Office for Budget Responsibility. 'Fiscal risks and sustainability' 2024.
[186] Office for Budget Responsibility. Fiscal risks and sustainability report - July 2023.
[187] Office for Budget Responsibility. 'Fiscal risks and sustainability: How does economic inactivity compare across advanced economies?' 2023.
[188] The Health Foundation. 'Health in 2040: projected patterns of illness in England' 2023.

Labour quality

As well as enabling more participation, improvements in population health would be expected to improve workforce productivity. Healthier people will require less time off work due to illness. Initiatives that improve the health of children and others that are looked after by workers can provide further productivity gains where people need to take less time off work for their caring responsibilities. According to the 2021 Census, around 4.7 million people provided unpaid care in England, with around 2.3 million providing 1 to19 hours of unpaid care a week, around 970,000 providing 20 to 49 hours and around 1.4 million providing 50 or more hours[189].

Within the healthcare system, training and development of the NHS workforce could be improved through the proposals in the plan, including developing skills to maximise opportunities in research and innovation. The emphasis on using digital technology, AI and other innovations to drive health opportunities will also create employment opportunities in high skilled jobs in the wider economy.

Life sciences sector growth

The government's consultation on the industrial strategy highlighted the significant potential of the life sciences sector to be a driver of future growth and productivity[190]. The plan outlines a package of proposals aimed at improving the incentives for innovation in the UK as well as strengthening the role of the NHS as a partner in research and increasing its adoption of new products. If successful, these measures could increase innovation in the life sciences sector and diffusion of those ideas, building on the growth the sector has experienced across a range of metrics from 2014 to 2015 to 2021 to 2022[191]:

- turnover has increased by 40%
- jobs by 24%
- numbers of businesses by 11%
- numbers of sites by 14%

The use of 'disruptive' technology discussed in the Innovation chapter of the plan represent proposals aimed at driving innovation and could both increase the stock of ideas

[189] Office for National Statistics census. 'Provision of unpaid care' 2021.
[190] Department for Business and Trade. 'Invest 2035: the UK's modern industrial strategy' 2024.
[191] Office for Life Sciences. 'Bioscience and health technology sector statistics 2021 to 2022' 2024.

and diffusion of existing ideas. For example, improving the quality and interoperability of datasets could enable the use of AI and provide the material needed for genomic discovery and increase the value of information from wearable health tracking devices. New AI tools could increase productivity through reducing the administration burden on clinicians and freeing up more time to care for patients. The increased use of genomics could enable more pre-emptive, personalised care. For example:

- a pilot study[192], led by Genomics England and Queen Mary University of London and undertaken in partnership with the National Institute for Health Research (NIHR) BioResource, found that using whole genome sequencing led to a new diagnosis for 25% of the participants. Of these new diagnoses, 14% were found in regions of the genome that would be missed by other conventional methods, including other types of non-whole genomic tests

Continuous monitoring of patients by wearables and proposals that accelerate the delivery of information and treatments directly to the patient or clinician would improve the efficiency of care delivery. Several proposals (such as the Healthstore, NHS App and single patient record) require bringing in entrepreneurs to develop products that improve their functionality, increasing the stock of ideas in the economy.

NHS productivity

The plan aims to return the NHS to 2019 to 2020 productivity levels by the end of the current spending review period. The NHS has delivered an annual average of 0.6% productivity growth over the last 2 decades[193]. Consistently delivering 2% growth annually over 5 years would represent a step change in productivity delivery but is credible.

The NHS currently faces challenges relating to both the quality and quantity of capital assets. For example, the poor quality of the NHS estate has been identified as a contributing factor to care being disrupted at 13 hospitals a day[194]. Furthermore, the UK has just 10 CT scanners and 8.6 MRI scanners per 1 million people, compared to the average number in OECD EU nations of 20.5 and 12.4 respectively[195].

The plan aims to reform the capital regime, including publishing a new 10-year health infrastructure strategy to give greater certainty to the NHS and industry on projects and

[192] Genomics England. 'Whole genome sequencing improves diagnosis of rare diseases and shortens diagnostic journeys for patients, according to world first study' 2021.
[193] UK Parliament. 'NHS financial sustainability: Fifth Report of Session 2024-25' 2025.
[194] Darzi A. 'Independent investigation of the NHS in England' 2024.
[195] British Medical Association. 'NHS delivery and workforce: NHS diagnostics data analysis' 2025.

programmes and to allow better coordination of industry and supply chains across government.

The intention is to test new private finance models which could help boost productivity growth by enabling the NHS to acquire and implement new technologies and equipment, improve the estate and facilities and address existing capital funding gaps. This, in turn, provides staff with the capital they need to work more efficiently, which could lead to reduced waiting times and better patient outcomes which ultimately boosts productivity.

More investment in digital technologies and improving data accessibility will support higher quality care more efficiently provided, hence boosting productivity. For example, approximately a third of a community-based clinician's time (or 88 days per working year) is estimated to be spent on administration and patient coordination[196]. Ambient voice technology could have the potential to boost productivity by reducing the time clinicians spend collecting and entering information and instead enabling them to spend more time providing care and helping the patient. For example:

- the use of ambient voice technology at the Calderdale and Huddersfield NHS Trust saved 2,500 hours in one 6-month period that would have previously been required to type up the information[197]. Internal reporting from across 53 GP surgeries showed that ambient scribe technology could save an estimated 1 to 2 minutes per patient contact

Conclusion

The plan outlined is a broad, ambitious set of proposals for the long-term future of the nation's health and the NHS. The proposals have been informed by widespread engagement with the public, patients, staff and system experts, both through formal engagement and through the policy working groups which brought together a cross section of health system leaders.

Successfully implemented, the potential impact on the public, patients, the healthcare system, wider society, and the economy overall is large. If citizens engage more effectively with their own health and with healthcare services, they could see benefits in terms of healthier lives, longer lives and an overall higher quality of life. There will be benefits for the health system where these proposals manage demand, move towards financial

[196] Department of Health and Social Care. 'Busting bureaucracy: empowering frontline staff by reducing excess bureaucracy in the health and care system in England' 2020.
[197] The Health Informatics Service (THIS). 'NHS health informatics specialist launches voice recognition technology at Yorkshire hospitals trust' 2022.

sustainability and rationalise the oversight of healthcare delivery. This would translate into benefits for wider society across England.

However, delivery of the plan will require coordinated, joined up action across multiple actors and against a complex and changing landscape of regulation, system oversight and technological innovation. There are a number of risks articulated throughout this document and below which will need to be mitigated as action is taken to implement proposals over the next 10 years.

Overarching risks and assumptions

The plan is being introduced in the context of a health system under pressure. These pressures, and their effect on current performance was described as part of Lord Darzi's Independent Investigation[198]. Successful delivery of the plan will require management of a number of overarching risks:

Public support for change

The plan places expectations on the public in terms of managing their own health and in their future health service interactions. When the public and workforce were surveyed through the Change NHS portal commencing October 2024, there was broad support for the 3 shifts: hospital to community, analogue to digital, and sickness to prevention[199]. The same support was found in a separate survey conducted in November 2024 with the public. Building trust to maintain support from the public will be important to drive the level of change needed.

Competing priorities and change capacity

The plan outlines a significant package of NHS reform while the healthcare system is attempting to recover performance in elective activity and other areas. Proposals in the first few years will be delivered at the same time as a major change to the structure of the NHS with the abolition of NHS England and transition of functions into the Department of Health and Social Care. This central reform could create a risk to delivery of the plan at the pace required. Alternatively, if the reforms create clearer lines of accountability, reduced duplication and more effective working at the centre of government this may help support effective delivery of the proposed reforms. The plans for the abolition of NHS England will need to consider how ongoing leadership for delivery of the plan will progress while DHSC and NHS England undergo significant headcount reductions and transformation.

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[198] Darzi A. 'Independent investigation of the NHS in England' 2024.
[199] See published Change NHS report on gov.uk.

Complexity

The plan acknowledges the difficulties in delivery given that commitments are complex and interdependent. Assumptions about new technology, innovation and scientific advances are uncertain and will change in ways that cannot fully be predicted. This complexity creates a high risk that the plan's ambition cannot be matched in delivery and implementation and results in insufficient pace of change. Further work is needed to clarify the phasing and implementation strategy for the plan, including through multi-year planning guidance and the 10 Year Workforce Plan.

Funding

At the time of publication, the NHS has a budget settlement until 2028 to 2029 for revenue funding and 2029 to 2030 for capital. Initiatives that require funding beyond these periods will be subject to future years spending reviews and as such, the deliverability of those proposals is less certain.

Legislation

A number of proposals in the plan are reliant on the introduction of primary or secondary legislation. Delivery of those proposals will be contingent on the timely passage of the required legislation as intended. Specific appraisals of legislative proposals will be carried out in the usual way.

Monitoring and evaluation

To understand whether the proposals in the plan meet their intended aims and are making progress towards the vision set out, a robust monitoring and evaluation process will be needed. The approach to evaluating the 10YHP will be informed by DHSC's evaluation strategy[200], reflecting the governments emphasis on evidence-based decision-making, continuous learning, and achieving its core objectives by using robust evaluation methods.

The plan outlines a package of reforms affecting the whole health system and so we are exploring 2 types of monitoring and evaluation, one for individual proposals and another for the plan as a whole. Approaches to monitoring and evaluation for individual proposals will vary in scale and scope. Some initiatives will be tested or piloted before full roll-out, as part of a ‘test and learn’ approach[201] and others will be evaluated in future as appropriate. In addition, we are considering the overall evaluability of the plan through work with the National Institute of Health Research (NIHR) Policy Research Programme[202]. Evaluability

[200] Department for Health and Social Care. 'DHSC: evaluation strategy' 2022. (viewed on 14 February 2025)
[201] Behavioural Insights Team. 'Test and learn: a playbook for mission-driven government' 2025.
[202] National Institute for Health and Care Research Policy Research.

assessments involve looking at the extent to which an intervention can be evaluated in a reliable and credible way[203].

It is our expectation that evaluation activity associated with the 10YHP will be added to the Evaluation Registry[204] once formally commissioned and agreed. The Evaluation Registry is a publicly available, online catalogue of all government evaluations. It contains details of all planned, live and published evaluations conducted or commissioned by government departments.

[203] Foreign, Commonwealth & Development Office. 'Planning Evaluability Assessments A Synthesis of the Literature with Recommendations' DFID 2013: Working Paper 40.
[204] Evaluation Registry is a service owned by the Cabinet Office and HM Treasury.

Annex A - prioritised population groups in scope of the neighbourhood health service

While the neighbourhood health service will be available to everyone, the roll-out will be prioritised for 6 patient groups, representing 1 in every 2 people in England. These are estimated below.

National cohort analysis used 2023 to 2024 person-level clinical segmentation data model produced by Outcomes Based Healthcare Ltd (OBH)[205] for population size, linked to Secondary Uses Service[206] for acute activity, and used NHS Payment Scheme[207] for costs. This only includes those registered with a GP practice since 2016 and so was supplemented by population estimates from other sources. Non acute activity and costs were estimated from the following sources with evidence-based assumptions used to assign to segments: Mental Health Services Data Set (MHSDS)[208], Community Services Data Set (CSDS)[209], NHS England: annual report and accounts 2023 to 2024[210], aggregate GP appointment[211], dental and prescribing data[212].

The 6 patient groups are as follows:

- people with long-term conditions: 17 million adults living in England have at least one long-term condition. The acute care costs of this group are an estimated £23 billion. Proposals for this group aim to reduce unplanned hospital use with more access to guidance and support and increasing proactive care

- people living in care homes or who have frailty: there are almost 0.4 million adults living in care homes and sheltered accommodation with an unknown number of people living in their own homes who need health services to come to them. A further 0.5 million are 75 years or older and frail; This sub-group is projected to grow at 2.3% per annum due to demographic factors[213]. Limited data is currently available about the care costs of this group overall but we estimate that those living in care homes account for around £2.8 billion of acute hospital expenditure each year, with 1.0 non-elective admissions and 1.3 A&E attendances per person annually. Variation analysis

[205] Outcomes Based Healthcare. 'NHSE Segmentation Dataset Reference Guide'. (viewed on 2 July 2025)
[206] NHS England Digital. 'Secondary Uses Service (SUS)'.
[207] NHS England. NHS England » NHS Payment Scheme (viewed on 2 July 2025)
[208] NHS England Digital. 'Mental Health Services Data Set (MHSDS)' 2025.
[209] NHS England Digital. 'Community Services Data Set (CSDS)' 2025.
[210] NHS England. 'NHS England: annual report and accounts 2023 to 2024' 2024.
[211] NHS England Digital. 'Appointments in General Practice' 2025. (viewed on 1 July 2025)
[212] NHS Business Services Authority. 'Dental prescribing dashboard' 2021. (viewed on 1 July 2025)
[213] Underlying data will be made available on: https://digital.nhs.uk/data-and-information/supplementary-information

indicates that areas with the highest rates of acute activity exceed those with lowest rates by factor of around 2, indicating potential for reductions in A&E attendances and non-elective admissions[214]. The aim of the 10YHP for this group includes reducing unnecessary hospital admissions

- people who are nearing the end of their life: there are 0.9 million people for whom palliative or end of life care is appropriate. The plan aims to support more people die in their home as well as to be treated in accordance with their care plan and to have faster access to symptom management

- people with severe and enduring mental illness: internal estimates suggest that there are around 0.7 million children and adults in England with a clinical diagnosis of serious mental illness (includes bipolar affective disorders, schizophrenia and psychotic disorders); the plan aims to improve their service access and continuity

- people with learning and/or physical disabilities: there are an estimated 0.6 million people living with both learning and/or physical disabilities. This group accounts for an estimated £1.4 billion of acute spend with over half of that related to A&E attendances and non-elective admissions (£72 million and £680 million respectively). The plan aims to improve their life outcomes through more holistic support

- parents and their children: the population of expectant mothers and children up to 5 years old is approximately 3.5 million people and children from 5 to 17 years is 9.5 million. The aims of the plan for this group include improved prevention and vaccine uptake in early years, supporting them to get rapid response in a crisis in community settings and access to holistic care in the community. For children up to 5 years, there are 0.5 A&E attendances per person per year but only 0.2 non-elective admissions. This difference in the rate of A&E attendances to the non-elective (NEL) admission rate is mirrored in children from 5 to 17 years. Furthermore, variation analysis for this sub-segment shows areas with the highest rates of non-elective bed days exceed those with lowest rates by factor of around 4.2, indicating potential for reductions[215]

Benefits to specific patient groups

Implementation of the neighbourhood health service will initially focus on 6 groups of patients. The expected benefits for these groups are:

- people with long-term conditions could benefit from the increased access to multidisciplinary teams and more advice and support. For example, care plans that

[214] Underlying data available at: https://digital.nhs.uk/data-and-information/supplementary-information
[215] Underlying data available at: https://digital.nhs.uk/data-and-information/supplementary-information

summarise care needs, outcomes and actions can improve consistency of care and ensure risk management, enabling individuals to have certainty about the service they are receiving. Patient participation also means that their needs are taken into account[216], improving their experience of healthcare. Those who become entitled to personal health budgets are also likely to benefit from improved quality of life and wellbeing[217]. The Greater Manchester Community Pharmacy Care Plan supported adults with one or more long-term conditions through tailored care plans aimed at achieving health goals and self-management of conditions. NHS service use per patient dropped by approximately £200[218]

- care home residents and those who are frail: the plan proposes that these people will be supported by 'care that comes to them'. A recent report demonstrated that access to additional clinical input by named GPs and primary care services and/or multidisciplinary teams may be a key element in reducing emergency hospital use by patients in care homes[219]. Evidence indicates proactive and coordinated planning and assessment can reduce hospital attendances and admissions and reduce care costs[220] [221]

- people who are nearing the end of their lives: studies relating to palliative care identified in a rapid research review found that shifting these services into the community can reduce hospital admissions, though the strength of this evidence is mixed[222] [223]

- people with severe and enduring mental illness are likely to see improved outcomes and experience if the new service model better meets their needs and makes care more accessible. A 2001 systematic review assessing the benefits of community mental health team (CMHT) management in severe mental illness found that in all 5 studies included, the total cost of care was between 12 and 53% less for those treated with CMHT management. The mean duration of psychiatric hospital admissions

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[216] The Fremantle Trust. 'What is a Care Plan & Why is it important?'.
[217] Nuffield Trust. 'Personal health budgets: challenges for commissioners and policy-makers' 2013.
[218] Seston EM and others. 'Supporting patients with long-term conditions in the community: Evaluation of the Greater Manchester Community Pharmacy Care Plan Service' Health Soc Care Community 2020: Volume 28.
[219] The Health Foundation. 'Emergency admissions to hospital from care homes: how often and what for?' 2019.
[220] Nord M and others. 'Costs and effects of comprehensive geriatric assessment in primary care for older adults with high risk for hospitalisation' BMC Geriatr 2021: Volume 263.
[221] Health Innovation West of England. 'New frailty service in South Gloucestershire is helping patients better manage their health' 2023. (viewed on 17 June 2025)
[222] McCarroll S and others. 'The impact of specialist community palliative care teams on acute hospital admission rates in adult patients requiring end of life care: A systematic review' European Journal of Oncology Nursing 2022: Volume 59.
[223] Yosick L and others. 'Effects of a Population Health Community-Based Palliative Care Program on Cost and Utilization' Journal of Palliative Medicine 2019: Volume 22.

showed that less time was spent in hospital following CMHT management, but the data were not homogeneous[224]. The duration of hospital treatment was also significantly less in patients from CMHT management in other settings and, despite the skewed data, it is reasonable to conclude that such management reduces hospital stay

- disabled people: Care from a wider team including a GP may improve their life outcomes through more holistic support. A 2024 study examining the impact of integrated intensive support in North West of England estimate 95% of potential admissions for individuals at high risk of admission were avoided[225]

- parents and their children: This group may benefit from increased access to prevention and vaccinations as well as addressing any potential developmental concerns. Vaccine hesitancy was identified by the World Health Organization (WHO) as one of their top 10 biggest threats to global health in 2019[226]. If 95% of children receive the MMR vaccine, it is possible to get rid of measles but measles, mumps and rubella can quickly spread again if fewer than 90% of people are vaccinated[227]. There are encouraging system impact results for neighbourhood MDTs for children and young people (CYP)[228], however, financial evidence is lacking

[224] Simmonds S and others. 'Community mental health team management in severe mental illness: A systematic review' British Journal of Psychiatry 2001: Volume 178.
[225] Durand M, Hanna M and Mills R. 'Characteristics of individuals using an integrated intensive support team within an adult community learning disability team' Advances in Mental Health and Intellectual Disabilities 2025: Volume 19.
[226] World Health Organisation. 'Ten threats to global health in 2019' 2019.
[227] NHS Queens Road Partnership. 'Importance of Childhood Immunisations' 2025.
[228] NHS England. 'Guidance on neighbourhood multidisciplinary teams for children and young people' 2025.

Annex B - prevention interventions analysis

Background

Poor diet and obesity are major drivers of ill health in England. Children living with obesity are around 5 times more likely to be living with obesity in adulthood, increasing their risk of a range of conditions. Currently, more than 1 in 3 children (35.8%) aged 10 to 11 are living with overweight or obesity, and children in the most deprived areas are more than twice as likely to be living with obesity as those in the least deprived areas.

No single intervention will reduce obesity prevalence alone. Instead, a package of policies has been proposed in the plan to reshape the food environment and support healthier choices.

This annex outlines internal DHSC analysis used to estimate the impact of:

- increasing the value of the Healthy Start scheme
- tightening advertising and promotion restrictions
- healthy food targets for the largest grocery retailers

While policies are often modelled independently, in reality they interact with each other in complex ways. The combined impact of multiple policies may either reinforce or undermine the individual effects of each measure, as such these policy impacts cannot simply be added together to give a combined impact.

Increasing the value of the Healthy Start scheme

Approach

Forecasting analysis estimates the expected annual cost of changes to the Healthy Start scheme. Data is provided by DWP to inform the number of households with a child under 4 eligible for universal credit, and from NHS Business Services Authority to inform the number of households accessing legacy HRMC benefits. These are combined to estimate the number of individuals eligible for the Healthy Start scheme. Relevant uptake assumptions are then applied to this to estimate the number of beneficiaries. The expected annual costs are calculated by multiplying the payment value by the number of beneficiaries forecast and relevant redemption rate assumptions are applied. In 2026 to 2027, it is estimated there will be around 360,000 beneficiaries on the scheme in England.

Limitations

This forecasting is only based on limited sub-set of eligibility data, which was the most robust data available to us at the time the analysis was conducted, due to the recent issues relating to the eligibility statistics[229]. We therefore apply rounding to our estimates to reflect the level of uncertainty.

Tightening advertising and promotion restrictions

Current advertising and promotion restrictions use the Nutrient Profile Model 2004 to 2005[230] to determine which food and drink products are classified as 'less healthy' and in scope of the restrictions. The model was reviewed and consulted on in 2018 to bring it in line with current UK dietary recommendations[231].

Applying the proposed NPM 2018 would bring more products in scope of the restrictions and strengthen the impact of current policies, for example:

- indicative analysis estimates that applying the proposed NPM 2018 to current advertising and promotions restrictions could increase the per person per day calorie reduction of the policies by up to 30% compared to using NPM 2004 to 2005
- a calorie reduction of this scale translates into reducing obesity prevalence by up to 2 percentage points, equivalent to reducing cases of adult obesity by 940,000 and childhood obesity by 170,000

Approach

Existing impact assessments for HFSS Advertising[232], Volume Price Promotions[233] and Location Promotions[234] estimate the potential calorie reduction from each policy based on reduced sales or exposure to products classified as 'less healthy' using NPM 2004 to 2005.

Indicative analysis has estimated the additional calorie reduction from each policy which could be achieved by using proposed NPM 2018. This was carried out by updating the

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[229] UK Parliament Written questions, answers and statements. 'Healthy Start Uptake Data' 2024.
[230] Department of Health and Social Care. 'The nutrient profiling model' 2011.
[231] Public Health England. 'UK Nutrient Profiling Model 2018 review' 2018.
[232] Department for Digital, Culture, Media and Sport. 'Introducing a 2100-0530 watershed on TV and online restriction for paid advertising of food and drink that are High in Fat, Salt and Sugar (HFSS) products' 2021.
[233] Department for Health and Social Care. 'Restricting checkout, end-of-aisle, and store entrance sales of food and drinks high in fat, salt, and sugar (HFSS)' 2020.
[234] Department for Health and Social Care. 'Restricting checkout, end-of-aisle, and store entrance sales of food and drinks high in fat, salt, and sugar (HFSS)' 2020.

classification of a sample of products to update assumptions in the existing impact assessments.

The DHSC BMI Prevalence Model[235] has been used to simulate the change in obesity prevalence from this change in calorie intake at population level. The model is based on equations by Henry (2005)[236] and is calibrated for the population in England using 2019 height and weight data from Health Survey for England (HSE)[237] and population data from Office for National Statistics (ONS)[238].

Limitations

Indicative estimates are subject to change following robust analysis within options appraisal and impact assessment. Estimates should therefore be used to give a sense of scale of the benefits of this change.

Key sources of uncertainty:

- the analysis is based on a sample of products from 2021, and sales and advertising data remain the same as used in the existing impact assessments. This may not account for changes in the consumer market, the impact of COVID-19 or the introduction of location promotions

- the analysis relies on a smaller sample of products than the original impact assessments due to the ingredients data required to calculate the proposed NPM 2018

Healthy food targets for the largest food businesses

Implementing mandatory targets for the largest food businesses aims to improve diets across the population by increasing the average healthiness of sales.

Businesses will have flexibility in how to achieve a target, for example through reformulation, changes to shop layouts or customer incentives.

External modelling by Nesta[239] estimates that an ambitious target, to elevate the sales-weighted average converted NPM score to 69 or less (up from the current average of 67),

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[235] Department of Health and Social Care. 'Technical Consultation Document: Calorie Model' 2018.
[236] Henry CJK. 'Basal metabolic rate studies in humans: measurement and development of new equations' Public Health Nutrition 2007: Volume 8.
[237] NHS England. 'Health Survey for England, 2022 Part 2' 2024. (viewed on 3 June 2025)
[238] Office for National Statistics. 'Population Estimates' 2023. (viewed on 1 July 2025)
[239] Blueprint by Nesta. ' Regulate large retailers to change their sales-weighted converted NPM score to ≥ 69 across their entire food product portfolio' 2024.

could lead to a calorie reduction of up to 50 kcal per person per day across the population, and up to 80 kcal in those living with overweight and obesity.

The impact of the target could vary depending on the level at which it is set, and how businesses choose to achieve it. For example:

- as an illustration, if a calorie reduction of 40 to 50 kcal per person per day were achieved in adults and children, it could reduce obesity prevalence by around 4 percentage points

- this is equivalent to reducing cases of adult obesity by 2 million and childhood obesity by 340,000

Approach

As the detail of the target is still to be agreed, illustrative analysis has been included to give a sense of scale of the benefits of a target.

This illustrative analysis is informed by external modelling by Nesta with some adjustments, including accounting for partial food wastage and adjusting calorie reductions for children.

The DHSC BMI Prevalence Model has been used to simulate the change in obesity prevalence from this change in calorie intake at population level. The model is based on equations by Henry (2005)[240] and is calibrated for the population in England using 2019 height and weight data from Health Survey for England (HSE)[241] and population data from Office for National Statistics (ONS)[242].

Limitations

Indicative estimates are subject to change following design of the target, consultation with industry, and further policy appraisal. There is uncertainty due to limited evidence on how children may be impacted by a target, impacts on children are estimated based on estimated impact on adults. This assumes indirect effects through household purchasing, parental influence, and product reformulation

[240] Henry CJK. 'Basal metabolic rate studies in humans: measurement and development of new equations' Public Health Nutrition 2007: Volume 8.
[241] NHS England. 'Health Survey for England, 2022 Part 2' 2024. (viewed on 3 June 2025)
[242] Office for National Statistics. 'Population Estimates' 2023. (viewed on 1 July 2025)