

The NHS in England at 75: priorities for the future



A report from the NHS Assembly

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Summary

The NHS's 75th anniversary is an important moment to look back at where the service has come from; to consider where it stands today; and to look forward to how it needs to change to meet future needs.

This report from the NHS Assembly draws on the feedback of thousands of people who have contributed to a rapid process of engagement with patients, staff and partners (the NHS@75 engagement – see page 6). It also draws on the huge breadth of experience within the Assembly itself.

The report aims to help the NHS, nationally and locally, plan how to respond to long term opportunities and challenges. It is not a detailed policy prescription. But it does set out what is most valuable about the NHS, what most needs to change, and what is needed for the NHS to continue fulfilling its fundamental mission in a new context.

Where have we come from?

The NHS was born from hope. It was founded on the simple principle of providing universal care, based on people's need, not their ability to pay. Today, this resonates as strongly as it did in 1948. In opinion polls, 19 out of 20 people say they want the NHS to remain free at the point of delivery.¹ Those who responded to NHS@75 highlighted the underlying principles and values of the NHS as the most important feature to celebrate and retain.

It is striking how much the NHS has adapted to meet changing needs. Treatments for heart

attacks and cancer have helped dramatically raise life expectancy. Mental health provision has moved from around 100 Victorian 'asylums' to more humane and effective care provided largely in the community, although still not at the levels of provision needed. The NHS has also been at the forefront of innovations including helping pioneer hip replacements, the first test tube baby and new gene therapy treatments for childhood leukaemia. More than half of those who responded to NHS@75 celebrated these improvements.

At the heart of this history are the people who provide care: the NHS workforce of 1.3 million staff from over 200 different nationalities, alongside around five million unpaid carers who support their friends and family. Behind these numbers, our engagement highlights the diversity, daily resilience and adaptability of those who work in the NHS, despite the pressures they are under. The response to the COVID-19 pandemic is just the latest example of that.

Where are we now?

Today, there is immense pride in how the NHS and its partners continue to develop services. For example, the recent creation of 9,000 virtual-ward beds to provide care at home supported by new technology and ways of working.

The NHS has enduring strengths, such as universal general practice, its links to science and research, and its education and training system. The service has recently made a big

shift to integrate the care provided by GPs, hospitals and community services, working more closely with local government, social care, the voluntary, community and social enterprise (VCSE) sector, and other partners, through the creation of Integrated Care Systems (ICSs).

There is also clear recognition in the NHS@75 engagement that, despite the best efforts of frontline staff, the NHS is not always providing timely access to advice, diagnostics and treatment to all those who need it. Waiting lists are at an all-time high. Public satisfaction is the lowest since the late 1990s.² The NHS, and social care, face very significant challenges of rising demand, constrained capacity and the need to recover from COVID-19. Taken together, this is a unique set of challenges in NHS history.

Although some of these challenges are partly a consequence of the pandemic, they also have deeper causes. Processes can often be too complex. There are too many vacancies for permanent staff. Growth in service capacity has not matched the rapid rise in the number of people with severe chronic health conditions and frailty. Inequality in access and health outcomes is too wide. The NHS's estate and digital infrastructure need investment and renewal.

The NHS will only thrive when wider economic, social and environmental conditions support good health and there are strong social care and public health services.

Where is the NHS going?

The NHS is starting to recover from the long legacy of the COVID-19 pandemic. The feedback from patients and staff in NHS@75 highlighted the importance of continuing to improve access to treatment and making it easier for people to navigate and communicate with different NHS services. Supporting staff and investing in training the workforce of the future remain high priorities.

There is now also an opportunity to look to the longer term. The NHS has made a number of significant shifts in how it has delivered care in the past – tackling infectious disease in the 1950s, closing asylums in the 1980s and radically expanding treatments in the 2000s. These shifts succeeded when the NHS had a clear vision for transforming the way care is delivered, supported by the resources needed to implement new ways of working. Each vision has been rooted in an understanding of patient needs and local innovation and improvement.

Today there is a growing consensus around the need for three big shifts. Shifts that respond to the continuing rise of chronic ill-health and frailty, the need for people to have greater involvement in their own health and wellbeing, and the opportunities offered by new technology, data and modern forms of care.

The three shifts are:

- **Preventing ill health**

Shifting funding to evidence-based measures to prevent and manage coronary heart disease and other causes of poor health, such as smoking and obesity. Working far more effectively with others to reach those at greatest risk and using NHS insights to advocate for effective action in tackling the wider determinants of health.

- **Personalisation and participation**

Ensuring people have control in planning their own care, supported by a continuity of relationship with clinical teams and an NHS accountability framework giving greater priority to patients' experience and voice, particularly those who have been marginalised historically.

- **Co-ordinated care, closer to home**

Accelerating plans to strengthen general practice, wider primary care and community services in every neighbourhood.

Universalising much better care for those with complex needs and frailty based on community teams and hospital at home services, supported by outreach from hospitals.

These are all developments which started some time ago and they must now be more firmly rooted, more quickly, in every aspect of healthcare.

This will require sustained transformation and long-term investment across a range of different elements, within the NHS, and across public health and social care:

- a thriving workforce and better supported carers, in line with the forthcoming Long Term Workforce Plan
- stronger partnerships with others, harnessing the opportunities from the creation of ICSs
- better use of digital technology and data
- a modernised infrastructure, particularly in primary care, supported by a long-term infrastructure plan
- maximising the value of care and treatment, alongside greater efficiency
- creating a well-led, learning, and self-improving service.

Above all, it will rely on strengthening the conditions for locally led innovation and renewing the mutual relationship of support and engagement between the NHS and the public. The lesson of the last 75 years is that when the NHS brings all these components together to support far reaching change, the service renews the way it delivers its fundamental principles for the next generation. This is the task the NHS once again faces.

The NHS Assembly

The NHS Assembly brings together individuals from across the English health and care sectors at regular intervals to provide independent advice to the board of NHS England.

Its members are a unique group of NHS clinical and operational leaders, frontline staff, patients, unpaid carers and those who work for charities and community organisations. Members of the Assembly attend in a personal capacity, rather than representing organisations.

The NHS@75 engagement process

75 years is quite a milestone, and the NHS belongs to all of us. So, we wanted to know how people felt about what the NHS has achieved so far, and what people want from it in the future. The NHS Assembly therefore reached out to those who work in the NHS and those who use the NHS, and wider partners. This was called the NHS@75 engagement process.

We received over 700 responses to our online survey, around 200 from organisations and 500 from individuals. Organisational responses often reflected the views of many people. In total the views of many thousands of people fed into this process. The NHS@75 engagement included specific contributions from key partners such as Healthwatch, National Voices, the Patients Association, Carers UK, the Race Equality Foundation, and networks representing particular groups, such as older people, people with a

learning disability and people with autism. We held interviews with NHS leaders and NHS clinical staff, and we benefited from the collective advice of a wide group of leaders.

We are very grateful for all those who have contributed to the process. A summary of the responses is published alongside this report, including more detail on the methodology.

This report

This report is authored by Clare Gerada and Chris Ham, the co-chairs of the Assembly, with support from Eugene Yafele, Claire Fuller and Rob Webster and secretariat support from NHS England. It aims to reflect the themes from the NHS@75 engagement process together with deliberations of the NHS Assembly as a whole. It does not necessarily reflect the view of every Assembly member.

Where have we come from?

1

The NHS was born out of hope and determination to build a better society after the devastation of the Second World War.

It was established to end the gross inequity of access to healthcare being determined by your ability to pay for care.

The NHS was based on simple principles. A service for everyone, providing care from cradle to grave, free at the point of use, based on need, not ability to pay, funded mainly through taxation.

The enduring importance of the founding principles

As a nation, we continue to strongly support these principles.² The NHS is the institution that makes us most proud to be British.³ And the single biggest response to the NHS@75 engagement process was the importance of celebrating and preserving these principles.

A constantly changing NHS to meet changing needs

When we asked people what the NHS has improved most, they highlighted how the NHS has constantly adapted over the last 75 years to meet changing disease patterns and needs.

In 1948, infectious diseases like tuberculosis and polio were the biggest killers, particularly in childhood. Antibiotics and immunisations changed all that.

Insights from our NHS@75 engagement:

“The founding principle that anyone who needs care can get it free at the point of delivery is the absolute best thing about our healthcare service that should be celebrated and never lost sight of.”

“In 1948 the NHS foundation gave hope to people. It responded to an international disaster (War) and opened its doors to everyone. Sometimes it seems like that spirit has been obscured. I would like to see the NHS return to that spirit of hope, of trust, and of confidence.”

“Free at the point of delivery. A friend remembers what it was like before and only those with money or in an area with a “club” hospital got what they needed. My family would not be here if it weren’t for the NHS. I had cancer, caught early, and [as a result], have had over 30 years I would not have had.”

Now the biggest killers are cancer, heart disease and chronic respiratory diseases, many linked to lifestyle choices and the wider determinants of health. There is also significant growth in mental health issues.

In 1948 average life expectancy at birth was 66 for men and 70 for women.⁴ Boys born in 2020 are now expected to live for 80 years and girls just over 83, and the risk of children dying before their first birthday is nearly 90% lower.⁵

Today this means that over 5.4 million of the English population are over 75 – when demand for healthcare is greatest – compared to under 2 million in 1948.^{6,7}

The basic building blocks from 1948 – hospitals, GPs, and community services, alongside a separate social care system – remain. But a huge amount has changed: services and treatments; how and where care is provided; and the relationship between clinicians and patients. These have all been transformed.

Changes in treatments

The range of new treatments developed over the last 75 years is astounding. Treatments for asthma, high blood pressure and psychiatric conditions and the arrival of the contraceptive pill have changed millions of lives.

New technologies have brought kidney, heart and liver transplants, joint replacements, and minimally invasive surgery. 1948's X-rays have been transformed into CT and MRI scans, revolutionising diagnosis and treatment.

The NHS has a proud, world leading record in developing many of these innovations – such as the world's first successful total hip replacement, test tube baby and vaccine against Group C meningococcal disease.

This record of innovation continues. In 2015, for example, the NHS was the first to use gene editing to successfully treat childhood leukaemia.⁸

Changes in how and where we provide care

In 1948, 100 Victorian asylums looked after around 150,000 service users with mental illness, many compulsorily detained.⁹ Today those old-fashioned institutions have gone, with more humane and effective care provided in the community, although there are still too many whose needs are not being met quickly enough. Care for common conditions such as diabetes, high blood pressure and heart disease, previously only delivered in hospitals, now takes place in primary care. This means around 100 million more GP appointments every year, a 50% increase compared to 25 years ago.

Children's services have also been transformed with care now predominantly in community settings, with a strong focus on development, education and prevention, rather than long stays in hospital.

The recent development of virtual wards, using remote diagnostic technology, means the NHS can now treat at home thousands of people previously treated in hospital beds.

A key theme of the NHS@75 engagement was the enormous pride in these improvements in treatments and care that the NHS has made possible.

Insights from our NHS@75 engagement:

"There were a lot of diseases around in the 1940s/50s that have gone away with vaccination, a combination of Public Health and NHS resources, things that were not possible 75 years ago."

"We have seen vast improvements in patient care linked to new technology and medicines. This is leading to reduced length of stay in hospital and improvements in life expectancy. The NHS is now much better at how we manage long term conditions – caring for people at home to prevent them being admitted to hospital. This would never have happened years ago."

"Some of the technological advances have been phenomenal. You can do a CT scan and an MRI scan in a way that gives you incredible diagnostic detail. It has revolutionised how we can treat people. Similarly, advances in drug tech make a world of difference to patient care and survival rates."

Changes in relationships between clinicians and patients

In 1948 “doctor knew best”. A paternalistic relationship that, at its most extreme, meant some doctors did not even disclose a cancer diagnosis to their patients.

Rising levels of education and social changes mean that today’s patients are much better informed. Clinicians increasingly share treatment decisions with their patients, with growing numbers recognising the positive impact of patient participation.

Today, over six in ten adults have signed up for the NHS App, enabling people to access their medical records and take much greater control of their own care. Last year, 1.9 million people measured their blood pressure at home and shared the reading with their GP, reducing the need for appointments and lowering their risk of heart attack or stroke.¹⁰

Another key theme from the NHS@75 engagement was the opportunity to go further in sharing responsibility with patients for improving their own health and wellbeing and using NHS services wisely.

Insights from our NHS@75 engagement:

“[In] critical care – patients over 70 used to be sent away and not treated in ITU, but now we are working to get families involved in their relative’s care and treating people at older ages, including working to extend life where it may not be able to be saved.”

“Over the years, I have been able to get to know more and more about my own condition. I now feel like I can be in charge of my own care.”

“...the NHS is beginning to break through on issues like patient/doctor shared decision making but it still has a mountain to climb...”

A single NHS

Being a single NHS has made the service an attractive partner for developers of new treatments, drugs and technologies, and helped stimulate our world class life sciences sector. And it has meant that the NHS is one of the most efficient health systems in the world,¹¹ for example negotiating single commercial deals for new drugs and treatments, a major cost for any health service.

Being organised as a single NHS has made it much easier to deliver important changes. For example, the shift from asylums to community care in mental health simultaneously required major changes to the NHS estate, and far-reaching transformation of clinical practice. More recently, national co-ordination has been central to delivering world-leading HIV and Hepatitis C elimination programmes.¹²

The NHS workforce

The most important factor of all in making these changes has been the dedication, skill and professionalism of the NHS workforce. Respondents to our NHS@75 engagement were immensely proud of the NHS's 1.3 million staff.

They praised the resilience of the workforce. They highlighted how staff have changed the way they work to meet new needs. They emphasised the difficult decisions clinicians take every day, including identifying the right diagnosis and resulting treatment. And they stressed the important contribution that every

Insights from our NHS@75 engagement:

"We must celebrate our staff and the teamwork that goes on every day in the NHS. It is the people that make our health service, and the NHS would be nothing without its staff. People feel very proud of staff and how adaptable, amenable, and resilient they are."

"Homage to and acknowledgement of the Windrush generation and all those who have come and are still coming from all over the world to care for us. NHS is training the nation in valuing diversity – a place where we meet people from all nationalities and cultures as they care for us or are our colleagues."

single member of staff – from pharmacists and porters to anaesthetists and accountants – makes to the NHS's success.

There was a strong emphasis on diversity. Respondents felt that the NHS has been a key contributor to diversity and equality in our nation. They highlighted the contributions of the Windrush generation of the 1940s and the south Asian cohorts who arrived in the 1960s, as well as their descendants.

Staff of more than 200 nationalities work in the NHS and social care,¹³ reflecting the attraction of the UK as a place to work and train. This diversity has helped the NHS more effectively meet the needs of different communities and do more to tackle the health inequalities that the recent COVID-19 pandemic has highlighted.

The NHS and the wider determinants of our national health

When proposals for a national health service were drawn up in the late 1940s, the NHS was just one of the measures needed to tackle “the five giant evils” that stood on the road to post-war reconstruction.¹⁴ The others were better education, better housing, full employment and the abolition of poverty.

This is an important reminder, strongly echoed in the NHS@75 engagement, that prevention and treatment of disease are only two of the elements that determine the health of our nation. Disparities in the wider determinants of health – such as income, housing, education, employment – are also crucial, by some measures accounting for 80% of health outcomes¹⁵ and account for many of the inequalities in these outcomes.¹⁶

In summary:

- ▶ The enduring power of the NHS’s founding principles.
- ▶ The way the NHS has constantly adapted to meet changing needs, harnessing new technologies and treatments.
- ▶ Realising the advantages of being a single national health service.
- ▶ The central importance of the NHS workforce.
- ▶ The need to address the wider determinants of health and tackle health inequalities.

Where are we now? What is our new context?



What the NHS delivers

There is huge pride in what the NHS has achieved over the last 75 years. There is similar pride in what the NHS delivers today.

Those who participated in the NHS@75 engagement process often talked about the extraordinary response of the NHS to the COVID-19 pandemic. They also recognised just how much the NHS continues to deliver day in, day out.

The challenges

But there was recognition, too, of the big challenges the NHS faces and where access and treatment need to be improved. Like every health system around the world, the NHS is recovering from COVID-19, the worst global pandemic in a century.

The NHS also needs to rise to the challenge of growing demand for healthcare driven by an ageing population with more complex needs and advances in medicine and technology.

The NHS@75 engagement highlighted six important areas where the NHS needs to do better or faces significant challenges.

Every working day in the NHS:

1.3 million

people are seen in general practice

250,000

people have an outpatient appointment

Nearly **67,500**

people attend an A&E department

9,000

A&E patients are transferred to hospital for unplanned care

47,000

have an episode of planned care like a surgical procedure

Around **60,000**

people have a diagnostic test

Around **285,000**

people are seen by a community health professional or therapist

One baby is delivered every **54** seconds

Over **7,000**

adults access psychological therapies

1. Access and communications

Many respondents to NHS@75 recounted stories of outstanding, compassionate care once they had accessed that care. But we know that recent waiting times for treatment in many key areas – cancer, accident and emergency, ambulance – remain at, or close to, the highest recorded in twenty years.¹ People are struggling to access NHS dentists. And despite the best efforts of frontline NHS staff, too many people are waiting too long for treatment.

The rise in waiting times is in part due to the legacy of the pandemic on delays in treatment and similar challenges are seen in other countries, such as France, Canada and Australia. But well before the pandemic, waiting times had been rising for several years as the gap between available capacity and demand widened.

A key message from the NHS@75 engagement is that issues of communication and service fragmentation matter almost as much as waiting times. There are too many instances where people cannot get through on the phone, receive confusing information, or must navigate complex and fragmented services.

And we heard that the NHS is often not good enough at listening to people about what matters to them most. This means that NHS staff are not able to make the best use of their time and skills, a point which can add to staff frustration.

Insights from feedback collated by Healthwatch England

Healthwatch England has looked at trends in sentiments (that is, how people feel about services) using 75,663 pieces of feedback shared with them by local Healthwatch branches between April 2019 and March 2023. The work highlights the biggest areas of concern as:

- access to GPs and dentists and, more widely, delays for treatment remain the most cited public concern
- last-minute cancellations and a lack of personalised information.

In addition, the NHS@75 engagement process heard from charities and patient groups around their specific experiences.

Insights from our NHS@75 engagement:

“No-one should have to call 50 times to get through when a GP practice opens to be told there are no appointments then have to call another number.”

“[We should] cut waiting times so that patients are treated before their conditions become chronic and life limiting.”

“The pace is too quick. We can’t give the patients the time they need because we’re so busy. We’re seeing hundreds more patients every week. Some patients slip through the net.”

2. Supporting the NHS workforce

The second very clear message from NHS@75 is that more must be done to support staff in both the NHS and social care. Respondents highlighted the commitment and dedication of frontline NHS staff and their sense of vocation.

But staff reported that there were too many occasions when they faced difficulties in performing to the best of their abilities in the face of intense workloads and a lack of time to recover and reflect. This has given rise to concerns around burnout, early retirement and staff leaving due to ill health.

Respondents pointed to the importance of ensuring each member of staff has a reasonable workload, they are rewarded appropriately and they can work more flexibly and have appropriate time for training and development. The NHS needs to fill current vacancies and reduce the inefficient use of locums and temporary staff. And it needs to create an inclusive workplace that tackles bullying, harassment and discrimination and improves opportunities for Black, Asian and minority ethnic staff.

Without action, shortfalls in staff will continue to grow. For example, in 2021/22 there were 4,200 GP vacancies and some forecasts suggest that, without action, this will grow to 8,800 by 2030/31.¹⁷

3. The rise in chronic disease, multimorbidity and frailty

Our population is living longer – a cause for celebration. But this means the numbers living with chronic conditions, and more than one of them, is rising rapidly. These conditions can be controlled, but rarely cured. Need is most acute among the rapidly rising number of

people in advanced old age. Analysis by The Health Foundation suggests that with current models of care, this growth in frailty and chronic ill health is likely to require between 20-40,000 more hospital beds by 2030/31.¹⁸

In addition, it appears that growing numbers of younger people are unable to work because of ill-health.

The rise of chronic conditions:

<p>It is likely that over 5 million people in the UK are now living with diabetes, including 850,000 who are not yet diagnosed, compared with fewer than 4 million in 2015. Prevalence is increasing in people under 40.^{19 20}</p>	<p>Around 15.5 million people in England, 34% of the population, are thought to be living with chronic pain.²³</p>
<p>2.25 million were living with and beyond cancer at the end of 2020.²¹</p>	<p>By 2030, over 1.1 million people are projected to have dementia, affecting one in two of us either directly or through caring responsibilities.²⁴</p>
<p>Around 7.6 million people in the UK live with heart or circulatory disease and 1.4 million have already survived a heart attack.²²</p>	

4. Inequalities in access, experience and outcomes

The higher death rates among people already disadvantaged during the COVID-19 pandemic illustrated starkly how far, as a nation, we still have to go in tackling inequalities in access, experience and outcomes, which is a long-standing problem. For example, men with a learning disability are likely to die 14 years earlier than those without, often from conditions that are treatable if identified. For women the gap is worse – 17 years.²⁵

Black women are up to four times more likely to die during pregnancy or childbirth compared to their white counterparts, and Asian women twice as likely.²⁶ Although women in the UK live longer than men, they spend a greater proportion of their lives in ill health or with a disability.²⁷ Health inequalities both reduce wellbeing and life expectancy for individuals and increase costs for society and the NHS.

The NHS also needs to consistently achieve Aneurin Bevan's ambition to "universalise the best", successfully tackling the current excessive unwarranted variation in outcomes from treatment.

Recent developments such as the NHS Race and Health Observatory;²⁸ Core20PLUS5, a programme to target the biggest causes of unequal health in the most deprived neighbourhoods;²⁹ and Getting It Right First Time programme (GIRFT)³⁰ have started to address these issues. But there is a lot more to do.

5. Capital investment

Almost a fifth of the primary care estate (GP practices) was built before the NHS was founded and some mental health buildings date back to the 19th century.³¹ Too many hospitals have leaking roofs, failing heating systems and too few diagnostic scanners.

The NHS also remains behind on technology, still lacking a fully interchangeable electronic health record, while just logging into the multiple IT systems in some trusts can feel like working in the 1990s. 14% of NHS trusts still do not have an electronic patient record (EPR) system.³²

6. Wider determinants of health and wellbeing

The nation's health depends on much more than just the NHS. NHS@75 highlighted that a more joined-up approach to tackling the wider determinants of health is needed.³³ It also highlighted the pressures on key partners such as local government, public health, social care and the VCSE sector.

The NHS will only thrive when wider economic, social and environmental conditions support good health and there are thriving and sustainable social care and public health services. And while the NHS relies heavily on around five million unpaid carers who support family and friends each day in England,³⁴ these carers need more support.

The strengths and opportunities

The first 75 years of the NHS have shown the enduring strength of its founding principles; the adaptability of the service to meet changing needs, harnessing technological and medical advances; the advantages of a single national service; and the power of the commitment and professionalism of the NHS workforce.

The NHS@75 engagement exercise highlighted a wide range of further current strengths and opportunities the NHS can draw on to meet these challenges. These include:

- Universal general practice as a foundation for co-ordinating high-quality, continuous care within the NHS.
- The clinical and cost-effectiveness analyses of the National Institute for Health and Care Excellence (NICE), plus our national purchasing power, which helps ensure the NHS gets good value for its budget.
- The UK's world class education and training system and vibrant life sciences industry, working in partnership with both universities and the NHS.
- The NHS's unique database of patient interactions and records to draw on to improve care and outcomes and for trusted research.

- Recent innovations in automation and artificial intelligence that can free up significant time for staff and patients. Leading digitally enabled hospitals are now around 10% more efficient.³⁵
- The NHS has, ahead of other countries, commenced an ambitious programme to become a net zero health system, making an important NHS contribution to reducing pollution and improving air quality.

The NHS also now has the organisational structure it needs to address the challenges it faces. 42 ICSs provide strategic leadership to bring all the previously disparate parts of each local health and care system together to plan and budget to improve the health of their populations.

Each of these systems also recognises the importance of integrating care services at both place and neighbourhood levels, supported by Primary Care Networks. Provider collaboratives are enabling all the NHS providers in a local area to work together to transform the pathways where they deliver care and improve efficiency by sharing clinical staff and back-office services.

Many of these strengths were illustrated during the COVID-19 pandemic. The pandemic showed that the NHS can rapidly achieve deep, transformational change by working differently:

- One in six staff took on new roles.
- Eighty per cent of outpatient appointments went online by June 2020.
- General Practitioners (GPs) adapted the way they delivered hundreds of thousands of appointments every day.
- Every hospital in the country took part in the Recovery trial aimed at finding a treatment for COVID-19. Dexamethasone has since saved over a million lives worldwide. The NHS COVID-19 vaccination programme saw the NHS working with local government, as well as hundreds of thousands of volunteers and thousands of VCSE organisations and businesses to provide vaccination not just at vaccination centres but also through community centres, churches, mosques and other venues.

Insights from our NHS@75 engagement:

“During the pandemic the NHS throughout the UK was able to alter to accommodate new urgently required streams of working. This involved local clinicians and avoided the usual multi-layer planning bureaucracy, particularly for commissioners of services. Many current service planning mechanisms serve to promote the status quo rather than allow change when it is necessary. The NHS has shown it can change quickly to meet needs when it needs to do so and this needs to be “built in” for the future.”

In summary:

The NHS faces major challenges: to improve access; increase workforce supply and support; meet rising demand and reduce inequalities; renew its estate and infrastructure; and work with others to address the wider determinants of health.

Meeting these challenges will require a major change. But the NHS has made big changes before, not least in its response to COVID-19.

What are the shifts required and how will the NHS make them?

Where is the NHS going? Shaping the future of healthcare

3

Beveridge's original vision for the NHS in the 1940s was for 'a national health service for prevention and comprehensive treatment available to all members of the community'.³⁶

Our NHS@75 engagement strongly reinforced the central importance of care that is easy to access and simple to navigate, provided by a compassionate and skilled workforce supported to work to the best of its abilities. The engagement also highlighted the ongoing importance of addressing health inequalities in access, experience and outcomes.

The response to NHS@75 also challenged those advocating alternative funding mechanisms or abandoning the NHS's key founding principles, for example by charging for services or introducing co-payments. Responses to NHS@75 and opinion polls clearly show that these changes are rejected by most of the public.³⁷

Our engagement does, however, show that the NHS must now make a new set of shifts in how care is delivered – to address the acceleration in chronic ill-health and frailty we face in the coming decades.

Three big shifts

There is growing consensus that three big shifts are now needed. These shifts are all already under way in many places and were featured in the NHS Long Term Plan in 2019. However, none are yet at sufficient scale or speed.

These are:

- 1) preventing ill health
- 2) personalised care and participation
- 3) from hospital care to coordinated care closer to home.

Preventing ill health

There is widespread agreement that more could, and should, be done to support people to remain healthy through better and earlier intervention. Over the coming years the aim should be to improve healthy life expectancy and reduce inequalities in health outcomes, with measurable goals.³⁸

Many of the factors that affect health are not within the NHS's direct control. Inequalities in employment, income levels, housing quality, green spaces, air pollution, diet and education all have a much greater collective impact on our health and wellbeing than NHS treatment of illness. The Government has a central role to play, through an integrated cross government strategy, including using action through investment programmes, public services and partnerships with business. Its key levers include taxation and regulation to moderate the impact of major risk factors, such as smoking, misuse of alcohol, gambling, and excess sugar and salt in processed foods. The challenges posed by obesity and excess weight, and their unequal impact in society, are a good place to focus.

Supporting individuals at risk of disease or worsening health – ‘secondary prevention’ – is an area where the NHS has a direct role. The NHS should seek to identify people at risk of premature mortality, building on existing work, including those at risk of cardiovascular diseases and certain cancers.

The NHS already has important tools to respond to risks, including vaccination, and support for people to stop smoking and manage their weight. The service has been developing these programmes in recent years and learnt from the targeted efforts during the pandemic.

The Assembly recommends that, over time, the NHS increases investment in evidence based preventative programmes. The forthcoming Major Conditions Strategy being developed by the Department of Health and Social Care is an important opportunity for taking the next steps.

The NHS also has a vital role to play in partnership with other agencies in tackling these wider determinants of ill health and inequalities. It needs to collaborate with local authorities, VCSE organisations, businesses, educational institutions and other stakeholders. Given rising ill health in the working age population and 2.5 million people not working due to ill-health,³⁹ there is a particular need and opportunity to work with employers to help improve the health of their staff. This applies to better supporting NHS staff too.

A high priority is to give children the best possible start in life, including supporting parents and guardians, by recognising the importance of the early years and the role of

Insights from our NHS@75 engagement:

“We are too focussed on illness rather than prevention and promoting health.”

“Life expectancy is falling despite our best efforts. We still don’t focus sufficiently on prevention and there is significant under investment in public health.”

“We need to focus on prevention – including a series of public health measures (both nudge and legislation) to tackle obesity, sedentary lifestyle, alcohol use and smoking. Minimum alcohol pricing is effective. We can target a smoke free country. High calorie products should not be seen as food and society needs to be modified to encourage activity. The NHS should offer greater support to lifestyle modification.”

affordable childcare, nurseries and schools in making this happen. Early action is of particular importance for children and young people with learning disabilities or autistic children where access to assessments and support in the community fail to keep pace with demand.

NHS leadership in this area should include delivery of the Core20PLUS5 approach, which is designed to address inequalities in health outcomes in the population, as well as ICSS fulfilling their wider legal duties to address

health inequalities across services more broadly. Equally important, the NHS has a role in tackling threats from climate change, a global health emergency, by delivering commitments to reduce its carbon footprint.⁴⁰

What does the shift to prevention mean?

- i. Over time, spending more NHS funding on evidence-based preventive programmes to prevent coronary heart disease and other risks.
- ii. Reaching more people with the greatest risks through better outreach, by innovating in local partnerships with local government and the VCSE sector.
- iii. Supporting, and advocating for, concerted action across government, society and industry to address wider determinants of ill-health.

Personalisation and participation

The delivery of care should be tailored to the mental, physical and social needs of different communities. And it should draw on the insights and priorities people have for their own care. Personalising care for those from marginalised and disadvantaged communities is essential for addressing health inequalities.

The value of personalised care⁴¹ is increasingly understood, for example using personal health budgets in health and social care and offering choice of where and how treatment is provided, where appropriate. Shared decision making between patients and the clinical teams who care for them is rapidly growing. Advances in tailored medicines and genomics will become increasingly important as they enter clinical practice.

The use of healthcare technologies that enable people to monitor their health and exercise more control over their treatment should be accelerated. Services should be planned in partnership with patients and carers, and their experience should be actively sought and valued by care providers.

Those who responded to the NHS@75 engagement felt that too often, for example, inappropriate medical interventions take place towards the end of life. Patients and carers should be fully involved in decision making about treatment options based on an understanding of risks and benefits.

Throughout the NHS there should be a shared commitment to ‘nothing about me without me’ in the relationship between patients and those who care for them. The carers

and families of someone in ill health or with a lifelong condition told us they do not feel consistently listened to, respected or included. Every change should be assessed by asking, 'will it be an improvement for patients and carers and has it been planned with their needs in mind?'

Making a reality of these opportunities requires changes in culture and practice across the NHS.

Leaders should work with patients and carers to simplify how the NHS works and 'make the right thing the easy thing to do'. This is particularly important as the number of people with multiple conditions increases and patients seek advice and support from different teams.

Helping patients to navigate services and ensuring care is well co-ordinated is essential, with a lead clinician and team as the central point of contact a key foundation. That should extend to social care, given its importance in promoting independence.

Embracing technologies that enable patients and carers to make and change appointments more easily, order prescriptions online, monitor their conditions and receive advice remotely where appropriate is a further important building block.

The NHS should learn from other sectors at the forefront of transforming relationships with customers. Its accountability systems should give greater emphasis to patient experience and outcomes, rather than just the amount and timing of treatment delivered.

Insights from our NHS@75 engagement:

"My recovery started when my clinician asked me what I really wanted."

"We need to re-think care in the last year of life, currently resource intensive and heavily medicalised and often not in accordance with patients wishes. Frequent and early conversations with patients would establish their wishes, needs and priorities into the last phase of life. Care would improve and resources [would be] liberated."

"We are failing to have a conversation with our patients and the public about the values they place on healthcare particularly at the end of life."

What does the shift to personalisation mean?

- i. Giving all patients a greater say, ensuring they can jointly plan their care and share in decision-making.
- ii. Every person requiring complex care has a continuity of relationship with a lead clinician or team.
- iii. Better measuring patient experience, engagement and outcomes in the NHS system of accountability for high quality care.

From hospital care to co-ordinated care closer to home

As society faces an increase in chronic diseases, the focus of the NHS should shift towards providing support for mental and social wellbeing alongside physical needs. This includes considering the impact of deprivation and tackling the rise in mental health issues following the pandemic.

To achieve these goals, it is essential to allocate resources, including staff, closer to home. By bolstering general practice, wider primary care and community services, individuals can receive appropriate care in their own communities, reducing the need for hospitalisation.

The Fuller stocktake⁴² outlined the future direction for general practices based on integrated primary care bringing together previously siloed teams in neighbourhoods. This includes adopting a holistic model of care, reaching out to those at greatest risk. It involves ensuring that primary care has the

digital and physical infrastructure, training opportunities and leadership capacity to fully achieve this blueprint.

The involvement of pharmacists and other staff is important in delivering this vision. It also includes strengthening community mental health teams and their relationships with schools and other services for children and young people. In the future, these services and others can be located in a new generation of community health centres, which can act as hubs for care and wellbeing.

A shift towards a more integrated, co-ordinated and community-centred approach to care means breaking down the historic artificial boundaries between different parts of the health system, especially between primary and community and secondary/hospital care. This includes better enabling discussions of individual cases between neighbourhood teams and specialists.

Virtual wards allow hospital nurses and specialists to monitor patients at home.

In many cases treatment can be adjusted without a hospital visit or stay. Around the world, such hospital at home services have been shown to achieve similar or better outcomes, at greater satisfaction and lower cost.⁴³ The NHS has recently established over 9,000 virtual ward beds. The potential is much higher still.

As part of this, it will be crucial to enhance the effectiveness of hospitals in delivering excellent treatments, and in their roles as hubs for specialist care, surgery and advanced treatment, and centres of innovation and research. This will play to their strengths and the institutional knowledge and capacity they have developed over recent decades.

Hospitals are community assets too. They are not only places for acute care, but also can provide preventive care, health education and health promotion. By enhancing a community-oriented approach, hospitals can better understand and respond to the unique healthcare needs of the populations they serve and become part of a larger network in their locality.

Care closer to home must involve closer collaboration between health and social care focused on supporting people to remain independent, avoid hospital admissions and to recover after treatment. In turn, that relies on a thriving and supported workforce in social care. With volunteers and VCSE organisations also playing a vital role alongside statutory agencies.

ICSs are now planning for each neighbourhood to have a multidisciplinary

Insights from our NHS@75 engagement:

"A significant amount of work is to be done to strengthen primary care, but the NHS is lucky to have outstanding primary care, especially pharmacy services with great accessibility."

"A culture shift – take the service to the patient more rather than expect the patient to come to the service."

"...patients as partners supported to prevent and manage illness close to where they live."

team able to use patient data to anticipate potential crises and intervene accordingly. And there is scope to further develop integrated community-based crisis response services, which includes close collaboration with the ambulance service.

The provision of a range of housing options for people with disabilities and those in their later years is also essential. Continued progress must be made to end long stays in hospitals for people with a learning disability and autistic people, working alongside local authority partners.

What does the shift to co-ordinated care closer to home mean?

- i. Strengthening primary care and community services in every neighbourhood in the country.
- ii. Better integration with local government services, especially social care; fully implementing the Fuller stocktake; and building a new generation of community hubs.
- iii. Breaking down the historic divisions between primary and community and acute care; and enabling specialists and GPs to work together more effectively.
- iv. Accelerating the current growth of hospital at home services and virtual wards.
- v. Valuing the role of volunteers and VCSE organisations.

Creating the conditions for change

4

The history of the NHS shows that big changes only happen when a series of different factors enabling change are delivered simultaneously. Individual initiatives, by themselves, will not be enough.

We have identified seven crucial enablers from our engagement. Each of these would benefit from a plan of action across the NHS, where they do not currently exist, and being part of NHS accountability frameworks.

1. Supporting those who provide care

The NHS is nothing without the 1.3 million staff who care for patients. Finding a resolution to the current pay disputes is crucial. All NHS organisations must value and support staff and tackle cultures that work against these objectives by delivering the NHS People Promise.⁴⁴ This means rewarding staff fairly, providing equal opportunities to learn and gain promotion and ensuring staff have a voice.

Staff need to be able to work flexibly in an inclusive, safe and healthy environment while supporting each other. We will not efficiently transform health and care outcomes without tackling workforce inequality.

The promised Long Term Workforce Plan should be a notable development to address gaps in supply in the medium term. The Assembly is pleased to have fed into the development of this plan, alongside many others. Those who responded highlighted the benefits of developing such a plan for social

care too. The NHS should also continue to support a significant expansion of volunteering – building on the 400,000 who stepped up to help during the pandemic.

A strong message from NHS@75 was that unpaid carers are the unsung heroes of health and social care and have faced many of the same pressures as staff during and after the COVID-19 pandemic. Better supporting carers is essential and any diminution in their contribution would place even greater burdens on an already over stretched health and social care system. Building on the work done during COVID-19, the NHS should aim to better identify and support unpaid carers, and the Government can increase its support too.

Insights from our NHS@75 engagement:

“[We need to] build up and support staff so that they can continue to work and do their jobs well, without sacrificing their own health and wellbeing.”

“Often the carers’ agenda is seen as a moral issue, but it’s actually economic. The NHS is doing more work than it needs to because it’s not supporting carers enough.”

2. Building partnerships

The NHS cannot achieve the three shifts we have advocated alone. This is why ICSs have such a key role in strengthening partnerships. Local authorities must be at the heart of these partnerships because of their role as community leaders and providers of a wide variety of key services, including social care and public health.

As statutory bodies, ICSs bring NHS organisations, local authorities and other local partners together to plan and deliver joined up health and care services to improve the lives of people in their area. They will need time to mature, but there are already good examples of progress in changing pathways; building partnerships with the VCSE sector and patients and carers; sharing budgets; creating single teams; and collaborating with leading digital innovators.

Partnerships with VCSE sector organisations must now become part of the mainstream to ensure that the best use is made of all assets in each community. This, combined with actively involving patients and carers in developing the health and care system, will ensure appropriate support for minority groups and that the voice of marginalised communities is heard more effectively. The NHS must also find ways of supporting the work of hospices, which play a key role in the provision of care at the end of life.

It is important to recognise the role of NHS and other public sector bodies as anchor institutions with considerable economic and

Insights from our NHS@75 engagement:

“Operating through systems provides an opportunity for the local NHS to more clearly set out what it is seeking to achieve with cross-sector partners, including industry, and how it is delivering against those objectives... emphasis on delivering against this agenda will generate significantly more productive collaborations between the NHS, local statutory partners, patient organisations, voluntary groups, and the pharmaceutical and life sciences industries to improve patient outcomes and the effectiveness of NHS service delivery.”

“The voluntary sector [VCSE] is close to people and hears their concerns. The NHS improves when it shows humility and listens too.”

social leverage in their communities. Working in effective partnership with others can multiply the NHS’s beneficial impact in these communities and support economic growth and development.

Partnership working is essential for maintaining and accelerating the innovation in treatment and care which has characterised the last 75 years. The UK has a leading life science sector and growing expertise in digital health technology. The opportunity for the NHS is to create an environment which makes the UK the best research and innovation partner in the world, to the benefit of patients, NHS value for money and our economy.

3. Harnessing the power of digital and data

Healthcare provision is on the cusp of a data and digital technology revolution. The NHS has begun to take advantage of these opportunities but needs to go further faster.

The COVID-19 pandemic accelerated the adoption of digital and other technologies to enable patients to access care and support remotely. It also demonstrated how data can be used to improve population health in the NHS COVID-19 vaccination programme and in targeting support to groups at risk.

Digital and data are playing key parts in recovery from the pandemic and must be at the heart of how the NHS and its partners work to prevent ill health and meet the needs of people with chronic medical conditions.

Opportunities include creating a fully connected electronic patient record across hospital, primary and community care, with key elements visible to social care. More widespread use of the NHS App to enable patients to access their medical records and services is another important opportunity. Digital means of consulting with care givers needs to be accelerated. Investment is needed in information systems to help identify and respond to need, as well as to ensure interoperability between different systems.

We are already beginning to see how AI can help clinicians identify cancer earlier, make better referrals and identify healthcare risks across whole segments of the population.

Insights from our NHS@75 engagement:

“The introduction of virtual clinics is completely changing how people use and access planned services and reducing the need to travel to hospital.”

“The NHS is good at measuring effectiveness and using data, insights and learning to improve patient outcomes. Advances in clinical audit programmes has driven major quality improvements in care and services.”

The NHS in England, as a single national system, is well placed to adopt a strategic approach to the implementation of AI, including the management of risks.

There is a danger that some groups in the population may be excluded by lack of access to digital and other technologies. It is important that the NHS continues to offer choice in how to access care, alongside support to ensure that as many people as possible have access to digital communications and new technologies. Staff training in digital technologies is also critical.

Used effectively and wisely, digital and data are a powerful means of enabling patients and carers to take more control of their health and wellbeing in partnership with health and social care teams.

4. Investment in infrastructure

The shifts to more personalised care closer to home with a much greater focus on preventing ill health can only be delivered in a modern infrastructure.

Building on the recent Government announcements for a rolling programme of capital investment in new hospital infrastructure, the Assembly believes that the NHS needs a long-term infrastructure plan. This plan would complement the Government's commitment to publish an NHS Long Term Workforce Plan.

As we set out in section 2, the NHS@75 engagement process highlighted the way that outdated buildings, equipment and technology are holding back better and more productive ways of working in general practice, community services, ambulance services and hospitals.

ICs are now developing single estate plans for their systems, and these now provide a good basis for a more developed national approach.

An infrastructure plan would include measures to address the current backlog in NHS maintenance, support the modernisation of primary and community care, ensure appropriate investment in modern equipment, and enable the NHS to fully harness the power of data and digital. It should give particular focus to facilitating the shift of care closer to home and to ensuring the NHS has the capacity to respond to shocks, such as a new pandemic.

Insights from our NHS@75 engagement:

"Estate improvements and the transition from old NHS estate into newer premises enables the benefits of new technology to offer more services and make primary care fit for the future."

"The level of funding in technology and infrastructure needed to manage the population profile changes created by the successes of the NHS's first 75 years is significant. Lots of our estate and equipment is aging rapidly."

5. Maximising the value of care and treatment

All healthcare systems, including the NHS, need to reduce waste and tackle unwarranted variations in care. As a taxpayer funded system, the NHS has a particular obligation to maximise the value of every pound spent. Freeing up resources in some parts of the system is also needed in order to fund greater investment in prevention.

The NHS spends 2p in every pound on administration compared to 4p in Germany, 6p in France and 9p in the USA.⁴⁵ But there is scope to improve efficiency further by reducing duplication between organisations.

NICE helps ensure that when new technologies are introduced into clinical practice, they are cost effective. But sustained action on unwarranted variation, for example through the GIRFT programme, has the potential to improve outcomes and release resources.

Poor communication and services that are difficult to navigate waste patients' time and are a poor use of staff time and NHS resource more widely. There needs to be sufficient management capacity to support simplification of services, with associated training. Maximising value also requires leaders being trusted to do the right thing more generally.

Maximising value means not allocating resources to care that provides little or no benefit to patients. Those who responded to the NHS@75 engagement shared concerns that there are areas of unnecessary treatment.

Insights from our NHS@75 engagement:

"[We should celebrate the] development and implementation of systems, processes, procedures/policies and structures that enhance the effectiveness and efficiency of the NHS e.g. quality assurance, governance and accountability."

'We should consider the ways public funds are spent across some of the NHS organisations that exist. Do we need them all? Can we use our money more wisely?'

They recognised that, at times, less intervention can actually improve patient experience and outcomes, for example in care towards end-of-life.

One promising way of making progress is by involving patients in decisions on treatment options and alternatives. Shared decision making between people and their clinicians about their tests, treatments and support options leads to more realistic expectations, a better match between individuals' values and treatment choices, and fewer unnecessary interventions.

Above all, greater value hinges on investing in general practice, delivering more care closer to home, and intervening early to prevent the onset of ill health. By providing more care in lower cost settings, the NHS will be able to deliver better outcomes with the resources at its disposal.

6. Leadership and learning

To make a reality of the changes we have described, national and local leaders must be fully committed to the NHS becoming a more effective learning and continuously improving system. This means ensuring that staff and local leaders have the time, space and support to give priority to prevention and care which is personalised and closer to home. It requires trusting, valuing and training managers who play a vital role alongside clinicians and other staff.

Moving in this direction means acting on the recent report of the NHS delivery and continuous improvement review, now being implemented as NHS Impact.⁴⁶ The report put forward ten recommendations consolidated into three actions on how to support the development of a learning and improvement culture:

- Describe a single shared NHS improvement approach.
- Co-design with health and care partners a leadership for improvement programme.
- Establish a national improvement board to agree the small number of shared priorities on which NHS England, with providers and systems, will focus improvement-led delivery work.

These actions are aligned with the new Operating Framework for NHS England and the Hewitt Review, and they recognise the need to strengthen horizontal and bottom-up

Insights from our NHS@75 engagement:

“Trusts and staff need to be empowered and supported not just to better manage day-to-day pressures but also to continually focus on how to improve the way they deliver care in the future. Within NHS organisations we need cultures of openness and transparency so that staff and patients feel empowered to raise concerns and are reassured that their concerns will be acted upon – while also needing to learn from when care goes right, rather than just learning from when things go wrong.”

“We don’t transform – we bolt an addition on. How do we change some of our models so that it’s true transformation, rather than just adapting a traditional model.”

approaches to improvement to enable the NHS to reform from within. Expertise in think tanks, royal colleges and other organisations should be harnessed in the delivery of NHS Impact.

The most advanced ICSs are actively progressing their efforts to enhance care within and between systems and strengthen collaboration. It is important to recognise that these developments are still in their early stages and will require time and perseverance to become fully ingrained.

As this happens, NHS England must demonstrate unwavering commitment to promoting learning and continuous improvement as the means of addressing performance challenges in all systems and organisations, including those facing the greatest challenges. The effectiveness of NHS Impact will ultimately depend on leaders embracing cultural change at all levels. At the same time, leaders should be leading all of the people all of the time, and yet we know that parts of the workforce often have poorer experiences in the workplace.⁴⁷ We must do more to increase accountability for inclusion.

Getting the basics right by supporting operational and clinical leaders to put in place and sustain established best practices in service delivery is essential. This includes work on admitting and discharging patients to and from hospital, managing demand for care in general practice, and tackling variations in clinical care described by GIRFT. Partners outside the NHS, for example in local government and the VCSE sector, have a key role to play in this work.

The many examples of change that occurred in the first 75 years of the NHS were possible because of innovation and research. There are multiple opportunities to do that now, working with universities and industry. In doing so, the NHS will make a positive contribution to economic growth.

7. A new relationship between the NHS and the public

Running through the changes we have described is a golden thread: the need to see people and communities as assets with a positive contribution to make in improving health outcomes and care. Instead of being passive recipients of care, the public should be supported to play an active role in their health and wellbeing and care. At a time when chronic medical conditions are becoming more prevalent, there is much scope for people to share responsibility for managing their own health, in partnership with health and care teams.

Shared responsibility is different from personal responsibility, which can fail to recognise that people's behaviours are influenced by the environment in which they live and work and the resources at their disposal. It challenges over dependence on health and care professionals by seeing people as partners in the therapeutic relationship. Shared responsibility recognises that our active participation is essential in improving health outcomes and care delivery. It also recognises the important role of central and local government in tackling the wider determinants of health and providing leadership in improving the health of the population.

An example of shared responsibility is the work of general practices which in some areas have coached patients with type 2 diabetes to make changes in diet and other behaviours to achieve remission. Many practices use group consultations with patients who have the

same conditions and draw on the expertise of patients alongside the professional skills of clinicians. Self-management support is another way in which people are being encouraged to take an active role in their care alongside peer counselling and support.⁴⁸

The NHS Assembly believes that these ideas can be taken forward with a compact with the public setting out what people can expect and what they can contribute – the reciprocity that remains vital to the NHS and its future.

On the NHS side, this involves all that is set out above. Taking services to where they are needed. Involving patients in decision making. Providing choice over treatments, where there are different options, including end-of-life care. Working hard to integrate all aspects of social and health care better, with a key aim being to make both systems easier to navigate. Tackling health inequalities. This reinforces the existing NHS Constitution, which includes the promise that all patients, regardless of ethnicity or culture, will be treated with compassion, dignity and respect.

On the public's side, there needs to be the reciprocal promise to treat staff with the respect that patients themselves expect. To use services wisely and recognise the contribution they can make to care delivery in partnership with staff. Beyond that, people need to be willing, as far as individually possible, to adapt their own engagement with the health service as it changes, both digitally and in other ways, and recognise that, in any healthcare system, there are limits to what can be offered.

ICs are well placed to engage the populations they serve on what a compact should include and how it can be tailored to the needs of different communities.

Next steps

There is growing agreement that the shifts set out in this paper, and the conditions for change needed to deliver them, are the right ones. That growing agreement is shared at local and national level, across those who use services and those who provide them, within the NHS and amongst its partners. The task for the coming years, as the NHS fully recovers from the pandemic, is to align this consistency of purpose with concrete delivery of change.

The history of the NHS is replete with examples of plans setting out powerful visions that have not been delivered. Trusting leaders and staff across the NHS and building on lessons from the COVID-19 response offers the best prospect of avoiding this happening.

In a complex, adaptive system such as the NHS, leaders must be agile in responding to events and adapting to challenges as they arise. In doing so, they need to work collaboratively with partners, patients, staff, volunteers and unpaid carers. By embracing the ideas

expressed here, the journey of renewing the NHS for the next generation can be accelerated now.

By the end of June, all Integrated Care Boards (statutory boards that bring together all NHS providers in a local area to plan and manage health services for that area) will publish their first Joint Forward Plans. These will outline the strategic aims that they have agreed with their partners for the next five years. We expect that these will echo the key shifts we have set out here, although tailored for local services. Some of the thousands who took part in our rapid engagement work will themselves be working on delivering plans locally.

The Assembly will continue to draw on the insights gained from the many thousands of people who took part in the NHS@75 engagement, explore the key challenges and shifts outlined in this document and advise and support NHS England in taking forward the necessary changes.

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