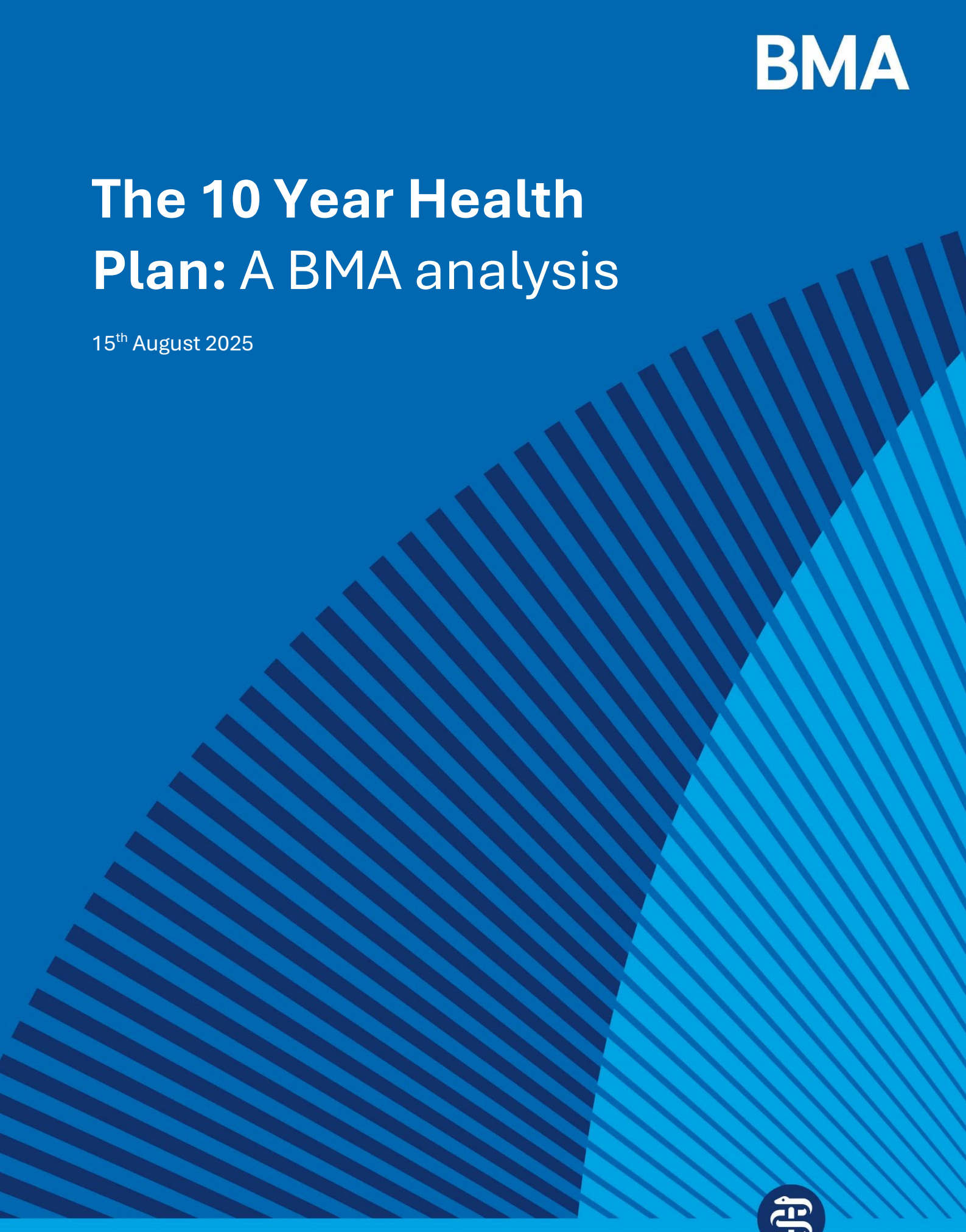
BMA

The 10 Year Health Plan: A BMA analysis

15th August 2025



British Medical Association
bma.org.uk

Table of Contents

Introduction 3
BMA priorities – a plan that values doctors 3
The initial BMA response 4
Next steps on the 10 Year Health Plan 5
BMA analysis 6
Hospital to community and the Neighbourhood Health Service 6
Analogue to Digital 14
From Sickness to Prevention 17
Devolving the NHS and a new operating model 26
Transparency and quality of care 29
The future NHS Workforce 31
Innovation and driving reform 42
Productivity and a new financial foundation 44
Appendix 1 – Stakeholder responses to the 10 Year Health Plan 48
Appendix 2 – Relevant ARM policy 53

Introduction

The UK Government's 10 Year Health Plan was published on Thursday 3rd July, with speeches from the Prime Minister, the Chancellor and the Health Secretary – all of whom emphasised that the plan is intended to deliver fundamental changes to the way health services in England are structured, funded and delivered.

The plan is framed as the prescription to Lord Darzi's diagnosis of the problems facing the English NHS in his 2024 review, with an overarching message from Government that they believe their reforms are needed to preserve the NHS.

The plan is substantial. Across its 166 pages it covers a significant array of issues and proposes a raft of new policies and reforms. The reforms set out in the plan are centred on – but not limited to – the Government's three 'shifts':

- **moving care from hospitals to communities**
  - focusing on providing more care outside of hospitals, with an emphasis on the development of neighbourhood health centres.
- **moving from analogue to digital**
  - focused on major expansion of the NHS App and greater use of AI and other technology.
- **moving from treatment to prevention**
  - focusing on preventing ill health rather than treating the cause.

In addition, the plan covers several other major areas of reform including:

- developing a new operating model.
- introducing additional hospital performance transparency.
- creating a new workforce model.
- a new innovation strategy.
- reforming NHS finances.

BMA priorities – a plan that values doctors

The BMA engaged with the development of the plan as much as possible, including submitting a comprehensive response to the initial Change NHS consultation, as well as making a more specific submission to a later, secondary survey.

These submissions set out clearly what the BMA felt needed to be in the plan, including:

- delivering pay restoration, reforming the DDRB and addressing pensions and childcare disincentives.
- increasing training places, specialty training and the use of the specialist role
- enhancing clinical leadership and giving doctors a greater voice.
- reviewing the role of MAPs and pausing recruitment to those roles.
- addressing sexism, racism, and ableism in medicine.
- bringing back the family doctor.

- ensuring the shift of care into the community is managed and funded safely, emphasising the need to increase investment in general practice and community care while maintaining the capacity needed in hospitals.
- greater revenue and capital investment in the NHS – including to improve GP premises, NHS estates, and IT infrastructure.
- genuine social care reform.
- improving collaboration and the interface between services.
- investment in public health services.

The initial BMA response

Across the reforms set out in the plan there are steps being taken to address major concerns for the BMA. These include UK medical graduate prioritisation and a move towards increasing specialty training numbers, though crucially by too few to make sufficient difference.

Likewise, there are references to introducing new standards for NHS staff wellbeing, supporting doctors to move into the specialist grade, enacting some aspects of social care reform, clinical negligence reform, and taking small steps to tackle obesity and reducing alcohol harms.

However, there are major questions about the absence of detail from the plan and several of its key proposals raise significant concerns. The drive to establish a neighbourhood health service is likely to have major implications for GPs and the partnership model of general practice, which must be addressed. Meanwhile, the suggestion of creating of a new workforce model - including contractual change, workplace change and changes in working hours - is significant and will cause alarm across NHS unions.

This is not helped by the fact that much of the plan lacks detail, the specifics of the financial backing of the plan is uncertain despite commitments made by the Chancellor and the details of its underlying workforce assumptions are still unclear. These are just some of the many issues analysed in more detail below.

There are also a number of crucial issues that are overlooked or under-recognised within the plan. This includes a notable failure to include any commitment to adequately fund general practice and to address doctors' pay or pensions. The plan also falls short on social care reform, largely deferring this pivotal issue to 2028 at the earliest.

A chapter on the delivery of the plan had been expected to be included, but this was notably absent from the final publication – meaning the plan lacks essential details on when it will be implemented, by who, and with what money.

Next steps on the 10 Year Health Plan

Due in part to the significant risks and potential opportunities posed the plan, as well as the outstanding questions regarding many of its proposals, the BMA has announced a dedicated SRM (Special Representative Meeting) to determine the association's position on, and approach to, the plan moving forward.

This analysis is intended to help support that process. Alongside this document, the BMA's initial response to the plan's publication and our previous work on its development have also been published on a dedicated NHS reform webpage.

Appendix 1 also provides an overview of various external stakeholder responses to the plan, including Royal Colleges and think tanks.

It is also important to note that while this plan is specific to England it is likely that some of the policies it contains could be, or already are being, considered in Northern Ireland, Scotland, and Wales. Therefore, BMA members working in all four UK nations are encouraged to engage with the BMA's work in this area.

Please contact the BMA's Healthcare Delivery Team with any questions regarding this work at: info.healthcare.delivery@bma.org.uk.

BMA analysis

This analysis examines each of the 10 Year Health Plan's substantive chapters against existing BMA policy and positions, with the intent of supporting member-led development of future BMA policy.

Appendix 2 contains the relevant existing BMA ARM (Annual Representative Meeting) policies referred to in this document, for reference.

Hospital to community and the Neighbourhood Health Service

Neighbourhood healthcare

- Two new contracts will be introduced from next year:
    1. **Single neighbourhood providers** – covering a single 'neighbourhood' (around 50,000 people) to deliver enhanced services for groups with similar needs. Existing PCNs may be a foundation for these.
    2. **Multi-neighbourhood providers** – covering multiple 'neighbourhoods' (more than 250,000 people) and delivering care across a wider area, these providers are expected to utilise greater at-scale working and take advantage of shared back-office functions, digital transformation, estates plans, and data analytics. They will also be expected support struggling practices, including by taking over their functions if needed.
- The plan does not specify eligibility for these two new contracts, but suggests they could be held by PCNs, GP Federations, or NHS trusts.
- The services (e.g. diagnostics, minor urgent treatments, some outpatient services) will be delivered in NHCs (Neighbourhood Health Centres) – framed as 'one stop shops', open 6-days a week, at least 12-hours per day and staffed with multi-disciplinary teams. NHCs are to be rolled out nationally by 2030.
- NHCs are intended to draw staff from primary, community and acute backgrounds, and involve social care professionals and voluntary organisations. The types of staff employed within these providers is expected to be based on population insights and predicted demand.
- The centres could offer services like day surgery, urgent treatment centres, pharmacy, physiotherapy, specialist clinics, outreach services, evening and weekend GP appointments, and consultant-led outpatient clinics.
- Over the next 3 years, NHCs will partner with a range of charities to deliver formal support that helps people with a new diagnosis manage their condition and live their lives. This will initially be rolled out to groups most failed by the current system.

- NHCs will be supported to work with the NHS Genomic Medicine Service and to act on insights from genomics - this may include supporting patients to make behavioural changes based on future clinical risk.
- The plan pledges to improve pay, terms and conditions for social care staff through Fair Pay Agreements, and to create a National Care Service over the longer term.
- The plan sets a new target that, by 2027, 95% of people with complex needs will have an agreed care plan, co-created with patients and with involvement from unpaid carers.
- The number of people offered PHBs (Personal Health Budgets) is expected to double by 2028/29, grow to 1 million by 2030, and be made a universal offer from 2035.
- Start for Life services will be extended from conception to age 5, with the goal of enabling additional health visitor and speech and language support for children and their families.

BMA analysis:

Although the concept of delivering more care in the community is something the BMA has broadly supported, the plan's proposals to deliver it raise a range of serious concerns and leave a number of critical questions unanswered. The proposals for neighbourhood services and the development of NHCs are particularly concerning. Besides the lack of clarity and detail around how either single or multiple neighbourhood providers will operate, what funding will be provided or how such ambitions will be delivered, there is a significant risk they could undermine the partnership model of general practice.

The plans for at-scale providers also appear to contradict the UK Government's stated ambition to 'bring back the family doctor', with a risk that acute trusts, rather than practices, will take these on due to their scale and scope. Whilst PCNs or GP Federations may be one option for practices to effectively manage the proposed contracts, many are not incorporated bodies and so the financial and contractual details of any such arrangement may be complicated.

The proposal for trusts – and potentially other providers – to take on neighbourhood contracts is a major point of apprehension for GPs. If NHS trusts were to manage GP practices within a given area it would undermine the partnership model, the independence of GPs and their decision making, and also lose the significant value for money and proven financial management currently provided by GP practices. It could also risk bankruptcy for GPs if they were to lose services outside the GMS scope (e.g. LES or DES).

It is essential that GP practices are not pressured to commit to operating under either neighbourhood provider model, particularly given the serious lack of clarity about how these models will operate and, crucially, what their contractual terms will be. While the plan does not explicitly state this, it is also crucial that those contractual terms rule out the possibility of NHS trusts holding patient lists in place of GP practices, as this would be the end of the current model of general practice.

The BMA's view is that neighbourhood teams should be based around existing GP practices, reinforcing existing relationships between practices and their communities, and should not divert resources, whether staff or finances, from existing provision. Achieving this will require a modern and sustainable GP contract for decades to come, to help facilitate and expand practice services and to support GPs and their teams. If the Government is genuinely committed to delivering meaningful transformation of care over the coming decade, then it is crucial that it listens to and engages with GP leadership at all levels, to shape and inform the direction of travel.

It is unclear how the proposed NHCs will be effectively and safely staffed, given that they sit alongside many other existing services with which they would share a workforce pool and the ambition that they would be open 6 days a week for 24 hours. Any move to relocate staff from their existing places of work to NHCs must be subject to negotiation and agreement with trade unions and we will closely monitor any developments in this area.

It is also unclear what the contractual or clinical interaction between GP practices and proposed neighbourhood health providers will be, or what role existing PCNs and GP federations may play. Clarity is needed on how this will be addressed and exactly how NHCs will be expected to interact with existing services before any such organisations can begin to be put into place.

Clarity is needed on how medical education and training could be impacted by the introduction of the proposed neighbourhood models, including which organisations will hold educational accountability within them. Further details are also needed regarding the potential for multi-site models to be introduced within neighbourhood services and, specifically, what impact this could have on the development, location of work, and job stability of staff, including GP registrars.

The pledge to improve pay in the social care sector is something that the BMA has called for, but the lack of significant proposals for social care in general is disappointing, as is the persistent deferring of this issue to the publication of the Casey Review in 2028. Crucially the plan is silent on improving pay and conditions for healthcare staff, full pay restoration and resources for general practice.

The BMA does not have recent policy on PHBs, however, in 2014 the ARM passed a resolution calling for their full evaluation before further rollout, citing evidence that cast doubt on their health benefits and cost effectiveness.

General practice

- The plan restates the Government's prior commitment to bring back the family doctor and to end the '8am scramble' for appointments.
- This includes a broad aim to train thousands more GPs and to shift the emphasis of overall NHS recruitment into primary and community care.
- The plan states that the traditional partnership model will be retained where it is working well - but also seeks to set alternative 'neighbourhood health' models (covered above), with the aim of delivering at-scale services over larger areas.
- The Carr-Hill formula is due to be reformed alongside wider shifts in funding to help target resources at areas with disproportionate economic and health challenges.
- With the intent to free-up GP capacity, the recommendations of the 'Red Tape Challenge' (a programme designed to cut 'unnecessary' bureaucracy) will be implemented, and technology like ambient 'AI Scribe' voice technology, digital telephony and the SPR (single patient record) will be deployed.
- Advice and guidance will be rolled out to additional specialties over the next 10 years – as a means of reducing referrals.
- GPs will be supported to carry out research via the NIHR (National Institute for Health and Care Research) School for Primary Care and Primary Care Commercial Research Delivery Centres opening in 2026.
- AI advice will also be added to the NHS App to offer patients alternative options for support with the intent of reducing demand for GP appointments.
- My NHS GP – an AI-enabled tool in the NHS App – will be launched by 2028 to help patients to access appropriate care via a GP or pharmacist, particularly as an alternative to attending an A&E department. Before attending, patients can book into the most appropriate urgent care service for their needs by calling NHS 111 or using the app.

BMA analysis:

The BMA is clear that the independent contractor model of general practice must be protected and strengthened if the Government is going to achieve the aim of bringing back the family doctor (ARM policy 2022). This must begin with a renewed and reinvigorated GMS contract, developed between the Government and GPC (General Practitioners Committee) England, which sets the baseline for general practice within

England. However, as above, the specific proposals within the plan appear to undermine its stated commitment to the family doctor as we know it.

The Carr-Hill formula is widely recognised as being outdated and particularly disadvantageous to practices serving populations in areas of high deprivation, so the commitment to reform it is welcome. However, practices must not be destabilised by any subsequent transfer of resources and the impact of any changes to the formula across general practice must be carefully considered.

Using AI to transcribe patient consultations poses risks associated with patient safety and governance. General practice should carry out comprehensive data protection and clinical safety checks before using new technologies. Additionally, GPs need protection from NHS resolution indemnity if the Government's policy leads to data breaches. Finally, it is crucial that GPs are not liable for any mistakes made by AI introduced into general practice.

A&G (Advice and Guidance) has a role within patient care pathways, but we are clear that it cannot be used as a replacement for referral to a specialist where the GP deems it clinically necessary. It also cannot become an expectation that GPs begin undertaking the work of specialists, thereby increasing workload in one part of the system whilst decreasing it in another, without appropriate provision of resources to support it. The impact of the newly introduced A&G enhanced service must be assessed in any subsequent expansion, including whether the level of funding currently provided is adequate to meet the requirements of the service.

The planned increase in the use of A&G will also impact doctors working in secondary care and require additional time to be dedicated to delivering this service. This time will need to be appropriately job planned and accommodated into consultant and SAS (specialist, associate specialist and specialty) doctor DCC (Direct Clinical Care) workloads, which could reduce the time available for other clinical activity, including the delivery of clinics.

It is positive that the plan commits to conducting more research in general practice, which the BMA has called for previously.

Secondary care

- The plan's overarching aims for secondary care focus on preventing demand, improving efficiency and productivity, and moving away from what it calls a model of 'hospital by default'.
- The plan states that resources spent in the community will be increased, decreasing the amount spent in hospitals.
- The plan aims for most outpatient care to happen outside of hospitals by 2035.
- To try to reduce demand in urgent and emergency care more patients will be able to book urgent care appointments via 111 or the NHS App before attending hospital or A&E.
- Same-day emergency services and co-located urgent treatment centres will also be expanded.
- MDTs (multi-disciplinary teams) working with people with long-term conditions, greater use of wearables and in-home hospital care, and expanded neighbourhood mental healthcare are expected to reduce A&E attendances.
- PIFU (patient-initiated follow up) will be made the standard approach for all clinically appropriate pathways by 2026 to reduce outpatient appointments.
- Patient choice of providers will be expanded, with more information available to them on journey times, waiting times, quality, patient outcomes, and patient experience through the NHS App.
- Further expansion of the NHS App is also aimed at allowing consultant-led and GP services to be delivered entirely virtually where clinically appropriate.
- The plan aims to tackle corridor care by addressing 'poor' management of hospital flow, expanding urgent and emergency care services at home, expanding same day emergency care, and by splitting emergency and urgent care into distinct streams.
- Reducing demand is also framed as a means of freeing up hospitals to invest in new technology to improve care, including new robotics and AI tools (including for note taking and discharge summaries).

BMA analysis:

The BMA recognises that reducing demand on secondary care is an appropriate aim, but we have stressed that this must be managed carefully and delivered safely, including by ensuring that hospitals have the capacity they need to meet demand before it is shifted to the community.

As the BMA has argued previously, initial transitional funding will be needed to facilitate any shift of hospital care into the community. Without this, there will be serious concerns about the capability of secondary care services to meet their current targets. The BMA has also emphasised that medical leadership is essential to ensuring the

safety of any shift of care from hospital to community, which will require consultants and senior clinicians to have adequate time allotted for this work in their job plans.

However, the plan's limited focus on secondary care is focused entirely on reducing hospital demand, appointments, and attendances rather than setting out a positive vision for hospital services. This proposed reduction in demand is also rooted in highly optimistic predictions on the benefits of AI, the NHS App and other digital tools, as well as optimising patient flow in hospitals. Insufficient detail is provided on how staff will be trained to effectively deploy digital tools and other new technologies in their workplaces, which may undermine their potential effectiveness and, critically, their usability and efficiency for already overworked staff.

The plan's assessment of the benefits of these interventions are speculative and will not address the immediate concerns of those doctors working in frontline services, including those managing corridor care crises. Concrete and immediate material support for overstretched hospital services is essential to address demand and allow for any genuine advantages of demand-reduction efforts to be realised.

It is crucial that efforts to reduce demand do not hinge on rationing, discourage patients from seeking care, or undermine the freedom of doctors to refer to the services that they believe are best suited to a patient's needs.

Mental health

- The plan aspires to shift mental health services into a 24/7 neighbourhood model, with an emphasis on improving assertive outreach care, expanding access, and narrowing mental health inequalities.
- 85 dedicated mental health emergency departments are expected to be established by 2030 supported with £120 million in investment.
- Virtual therapists are expected to be available to assist patients with mild or moderate needs 24/7.
- Patients with more serious mental health issues will receive remote monitoring, to help deliver pre-emptive responses in emergencies.
- A new tool, *My Specialist,* will allow patients to make self-referrals to specialist care where clinically appropriate – starting with self-referral to talking therapies.
- The plan reiterates commitments to roll out mental health support teams in schools and colleges, reaching full national coverage by 2029/2030. Mental health and wellbeing support will also be available through new Young Futures Hubs.[1]

[1] The UK Government have announced that Vulnerable young people who are at risk of being drawn into gangs, violence or knife crime will be given the help they need when the first Young Futures Hubs get up and running later this year. https://www.gov.uk/government/news/young-futures-hubs-to-launch-offering-vulnerable-young-people-lifeline

- The plan also re-commits the UK Government to hiring an additional 8,500 mental health staff, focussed on reducing long waits for both children and adults.

BMA analysis:

While the BMA supports the ambition of ensuring patients get fast, same-day access to specialist support in an appropriate setting, we are concerned that dedicated mental health emergency departments will result in further division of physical and mental health care and may be counterintuitive. Currently, those with mental ill-health wait longer in A&Es for treatment and they often present with co-occurring physical health needs. People with a mental illness should have the same right to timely and effective treatment in A&E as anyone else.

The Government's continued commitment to expanding mental health support for children and young people, including through new Young Futures Hubs, is important. Mental health support in the community is vital.

Improving access to mental health support via the NHS App and AI, while possibly helping some people to maintain their wellbeing, is no substitute for in-person evidence-based care, especially for those who have more complex mental health needs and for those who need more immediate care or support. It is also essential for any mental health-specific AI tools to be rigorously tested and evaluated before they are deployed. While the plan mentions that patients will be able to self-refer to mental health talking therapies as soon as the My Specialist tool is rolled out, patients are already able to self-refer to the NHS's main talking therapies programme in England.

We support ambitions to transform mental health services and to improve assertive outreach care and treatment, with a focus on narrowing mental health inequalities. It is crucial that these services receive adequate funding to make this ambition a reality. We also support ambitions to ensure that all children and young people can access mental health support when and where they need it, such as through Young Futures Hubs. The initial roll out of mental health support teams (MHSTs) in schools and colleges has been promising, and we look forward to seeing the latest evaluation (currently underway) of how they are working. We would like to see whether concerns have been addressed regarding gaps in service provision for children and young people with more severe problems (beyond the 'mild to moderate' MHST criteria) who do not meet the threshold for specialist help, as well as variation among MHSTs due to lack of resourcing or guidance.

Analogue to Digital

- The NHS App is a central part of the plan, which aims to significantly expand its functionality and introduce a range of additional 'tools' for patients.
- This includes allowing patients to view their data; book, move, cancel and hold appointments; communicate with their healthcare team; manage medications and vaccinations; and manage long term conditions and care via the app.
- Direct messaging via the app is also set to replace most SMS and letter contact between the NHS and patients.
- The various 'My' tools proposed in the plan include:
    - **My NHS GP** – providing AI-based advice and signposting to services.
    - **My Choices** – allowing patients to view data on providers across the country – including waiting times, outcomes and proximity to home.
    - **My Specialist** – to make self-referrals, initially to services such as mental health talking therapies, MSK services and podiatry, and allowing patients to leave questions for a specialist without making an appointment.
    - **My Consult** – allowing remote consultations with clinicians via the NHS App.
    - **My Companion** – to help patients needing more support to communicate their health needs and preferences, including support for translation.
    - **My Medicines** – to manage repeat prescriptions for delivery or collection, receive reminders of what to take and when, and provide information on drug interactions.
    - **My Vaccines** – to check whether vaccines are up-to-date and book appointments if needed, and to find information about travel vaccines.
    - **My Health** – to gather a user's health data in one place, including blood pressure, heart rate, and potentially data from wearables.
    - **My Children** – to help parents collect their children's health information in one place, and to provide advice throughout childhood.
    - **My Carer** – to allow users to prove they are providing care and gain access to the NHS App on behalf of the individuals they care for.
- It will be possible for patients to leave feedback on a service, clinical team or provider – with AI expected to translate this into actions for managers and clinicians.
- New technology is also intended to support clinicians in their working lives, including a single sign on for NHS software and the roll out of ambient voice (scribing) technology in 2026-27.
- The aim to deliver an SPR (single patient record) is restated, to be enabled by new legislation and reform of the legal framework for the use of health data. This would bring together all of a patient's medical records into one place.

- The SPR will be accessible to clinicians across the healthcare system, but also for patients from 2028. Over time, the data is expected to extend to include a personalised account of health risk, drawing from lifestyle, demographic and genomic data.
- The SPR will be first rolled out in maternity care, ensuring that teams have all the necessary information about previous consultations, medical history and stated preferences.
- A national, AI-led quality issue warning system will be established in NHS trusts to help highlight and address safety issues.

BMA analysis:

The plan emphasises technology and innovation, yet few of the ideas are new, with many having been proposed or attempted previously, including the SPR.

A nationally controlled direct care record has been an ambition of successive Governments. This has often been on the basis that, in addition to providing a single point of access for a patients' whole record, the data collected could also be more easily used for secondary purposes, including research and planning.

It is unclear how the barriers that have prevented the success of technological change within the NHS previously will be overcome this time. If those barriers are not addressed, it is uncertain if even the most basic of ambitions of the plan will be realised.

The Government's proposed shift from analogue to digital hinges on ensuring the free flow of information between disparate parts of the health and social care system. In order to achieve this, the BMA believes two essential things are needed: the infrastructure to support data sharing, and the necessary information governance arrangements to facilitate sharing in a safe and legal way. We believe the NHS lacks both.

At present, data controllers exist at the GP, Trust and National (i.e. NHSE) level with GPs covering the GP record, Trusts covering hospital data and, nationally, NHSE covering data compiled from general practice and HES (Hospital Episode Statistics) data for the purposes of research and planning. In practice, this means that data sharing remains a frequently complex task, both legally and technically.

The closest the NHS has come to an SPR previously is the ShCR (shared care record), a more limited form of data sharing across the health and care system. Most ShCRs have existed as a read-only collection of data from different services, which have been largely incomplete and had no agreed-upon standards for sharing information.

The BMA has also been clear that present IT and estates infrastructure impedes the extent and speed of technological advances in the NHS, including the adoption of more comprehensive data sharing. For example, a 2022 survey of BMA members identified critical issues regarding software being unfit for purpose, a lack of interoperability preventing digital transformation, the physical condition of NHS estates limiting the use

of modern technology, and serious challenges posed by slow internet speeds and a lack of WiFi.

Significant questions also remain over who will have access to what information via the proposed SPR. As the BMA made clear in our submissions to the 10 Year Health Plan consultation process, we believe a role-based access model is needed. It is essential that the attempt to establish an SPR fully adheres to a model that controls who has access to information and what information can be accessed under what circumstances.

The plan also leans heavily on the expansion of the NHS App and the use of its proposed 'My' series of tools to reduce pressure on services, in part by allowing patients greater insight into, and control over, their care. These tools may be helpful to some patients if introduced successfully but, as the BMA has argued, they are fundamentally not a means of increasing or improving access to services. Assisting patients to better track waiting times or book appointments will only be meaningful if services are adequately supported to deliver those services in practice – something which the plan does not address. Moreover, the potential success of these 'My' tools is heavily dependent on the roll out of the SPR which, as noted above, is not a given.

Furthermore, as the BMA argued in our submission to the first Change NHS consultation, the rapid digitalisation of health services carries a risk of widening inequalities for some groups, and particularly those least able to navigate digital care. Any move to a 'digital by default' health service must be accompanied by appropriate interventions to support digital inclusion.

The plan's ambitions also centre on promised productivity gains generated by the rollout of AI across the health and care system. If these gains can actually be realised, then it could transform care and free-up clinical time for direct care. However, with minimal information available about the products the Government hopes to employ or how AI will be applied, it is difficult to make an evidence-based assessment of the potential role that AI will play in the NHS.

Any deployment of AI must be made in line with the BMA's principles on the use of AI in medical settings. This is especially important in respect of any potential liability attached to decisions or advice given by an AI tool and, more widely, the many ethical issues still surrounding the use and governance of AI.

It is crucial that the Government and local providers determine the terms upon which AI tools will operate, rather than being dictated to by suppliers. Done well, AI could well precipitate a drastic shift in the delivery of care, although the risks are undeniable and failing to engage with them directly may irrevocably damage patient trust in the NHS.

The proposals for patients to be able to leave questions or comments for specialists to respond to outside of appointments also need further consideration and clarification, particularly regarding the potential impact of this on doctors' workloads and how it will be addressed in job planning.

From Sickness to Prevention

Another major part of the plan is the shift from sickness to prevention. This is focused on tackling drivers of ill health (including measures on obesity, tobacco and vaping, alcohol and air quality); better screening and improving access to vaccinations.

Obesity

- The plan recommits to a number of previously announced policies or commitments targeted at children and young people's health, including limiting junk food advertising aimed at children, banning the sale of high caffeine energy drinks to under 16s, extending the Soft Drink Industry Levy (the 'sugar tax') to milk-based products, restricting multi-buy promotions of unhealthy food, and authorising councils to ban new fast-food outlets near schools.
- The plan includes new announcements aimed at tackling obesity including introducing new targets of healthy food sales and mandatory reporting of sales of healthy food in large food businesses. The plan also commits the UK Government to updating the nutrient profile model to modernise the existing twenty-year-old model.
- The NHS Digital Weight Management Programme will be extended to 125,000 more people to support weight loss. The UK Government has also committed to seeking further collaboration with medicine suppliers to widen access to weight loss medications, on a pay by impact basis, focusing not just on weight lost but on key outcomes such as fewer strokes, heart attacks, and cancer diagnoses.
- The plan pledges a shift to a 'place-based' approach to physical activity through £250 million of investment into 100 places by Sport England, at least £400 million of investment into local community sport facilities, new partnerships on school sport, and local health plans. DCMS will set out detail on the strategy for physical activity in due course.
- The plan proposes a new health reward scheme to incentivise healthier choices, and to 'encourage citizens to play their part.'

BMA Analysis:

The BMA has supported banning energy drinks for children and limiting junk food advertising and promotions, so the recommitment to these policies, along with new mandatory healthy food sales reporting and mandatory health targets, is welcome. Re-commitments to extend free school meals,[2] review School Food Standards, restrict new hot food takeaways, and review the Soft Drinks Levy are also positive, although they are not new policies.

More information is needed on how the Government intends to update the 2004 nutrient profile model, which categorises which foods are healthy, and which foods therefore

[2] BMA strongly reacted to the decision not to extend free school meals over half-term in 2020.

fall under food and advertising and promotion restrictions. We are particularly keen to see what food and drinks will be newly included.

The inclusion of mandatory healthy food sales reporting and mandatory targets to increase the healthiness of sales in the plan are positive, as we have repeatedly seen that voluntary measures do not work, but it is critical that they are implemented rapidly. Requiring large companies in the food sector to report on the sales of healthier and less healthy products could achieve greater transparency and consistency of this data, which should support efforts to increase the healthiness of sales – via reformulation, introducing new healthy products, or changes to customer incentive and loyalty schemes. The BMA has previously called for the price of fruit and vegetables to be reduced and for free fruit and vegetable initiatives to include all primary school children, ensuring these items are available five days a week (ARM, 2013).

We are cautious of the proposed new health reward scheme to incentivise healthier choices, as there is limited evidence on its efficacy and it shifts the focus heavily onto individual responsibility, whereas we remain clear that the diet of the population will not improve until healthy food is both accessible and affordable. It is also essential that the Government ensures its plans are implemented in full and are not watered down by food industry lobbyists.

The BMA continues to argue that weight-loss drugs are not – and should not be framed as – a silver bullet, and that it is vital that weight-loss services across the UK are appropriately funded and resourced. Obesity is a complex condition, and ongoing wrap-around care is needed to ensure patient safety and sustainable health benefits (ARM policy 2015, 2011, 2007.

Smoking and Vaping

- The plan reiterates that the Government aims to create a smoke-free generation and significantly reduce smoking rates – including via its Tobacco and Vapes Bill. The Bill ensures that children turning 16 this year (2025) and those younger than them will never legally be sold tobacco products.
- New programmes such as Health Coach and AI tools will be rolled out with the aim to help people quit smoking and make healthier choices, while hospitals will provide quit smoking support as part of routine care, especially before surgery to reduce health risks.[3]

BMA Analysis:

Smoking is the leading cause of health inequalities and accounts for half the difference in life-expectancy between the most and least affluent communities in England, so it is positive that the plan reiterates the Government's aim to create a smoke-free

[3] A resource and guidance programme to support people to quit vaping and smoking.

generation. We have consistently advocated for anti-smoking policies and look forward to the passing of the Tobacco and Vapes Bill without delay and urge the Government to ensure regulation is not influenced or diluted by the tobacco industry.

The commitment to consult on regulations on the use of vapes is also a positive step, due to the growing epidemic of vape use in the UK, particularly by children and young people. The BMA position on vapes outlines that it is crucial that stronger regulation of vapes is introduced to curb youth vaping, including restrictions on flavours, marketing and advertising, and tackling illegal sales.

Health coaching and AI tools may prove to be useful smoking cessation aids, but it is vital that all smoking cessation services receive adequate funding to meet the needs of their population. While the recent increase in public health grant funding is welcome, it has come after over a decade of decline and local authorities are struggling to provide the public health services their communities need, including local smoking cessation services.[4] The plan does not commit further resources for this, or public health in general.

Alcohol

- Alcoholic drinks will be required to display consistent nutritional information and health warning messages.
- The Government will consult on changing the upper strength threshold at which a drink may be considered 'alcohol free' to 0.5% ABV, bringing it into alignment with international standards (it is currently 0.05% ABV).
- The Government will explore options to restrict access to 'NoLo' products, so they are treated in the same ways as all alcohol products, including banning sales to under 18-year-olds.

BMA Analysis:

The lack of ambition and detail in the 10 Year Plan around tackling alcohol harms is disappointing. While it is positive that the plan includes a commitment to mandatory health warnings and nutritional information on alcohol labels, more effective policies for reducing alcohol harms (which we have campaigned for) have been omitted.

With alcohol deaths at a record high, having risen by 38% since 2019, meaningful action against alcohol harms is needed now and we know that evidence-based policies like MUP (Minimum Unit Pricing) are proven to reduce alcohol deaths and cut health inequalities - yet the plan makes no mention of them. The BMA has campaigned for the

[4] This was highlighted in the BMA King's speech briefing July 2024.

introduction of MUP for some time and, in 2015, deplored the decision of the then UK Government to renege on a commitment to introduce it (ARM, 2015).

It is especially concerning that some policies, such as further restrictions around alcohol marketing, were reportedly dropped from the plan following intense lobbying from the alcohol industry (BMA ARM policy since 2007 has called for this lobbying to end). If the Government hopes to protect the health of millions of people, and reduce pressure on the NHS, it must stand-up to industry lobbyists who profit at the expense of the nation's health.

Reducing alcohol-related harms requires both prevention policies at the population-level to reduce overall alcohol consumption and bolstering and improving alcohol treatment and mental health services for individuals. Along with other members of the AHA (Alcohol Health Alliance), we want the UK Government to urgently revisit its approach and introduce a comprehensive national alcohol strategy. This should include policies such as MUP across the whole of the UK, greater restrictions on alcohol marketing to protect children and vulnerable people, and better access to specialist support for at-risk drinkers.

The BMA is supportive of changing the upper strength threshold at which a drink may be considered 'alcohol free' to 0.5% ABV. These products must also be clearly and comprehensively labelled, including their strength in ABV, the number of units, and the Chief Medical Officers' Low Risk Drinking Guidelines. The AHA's position is that 'NoLo' products should fall under the same or similar licensing regulations as alcoholic products, and caution should be urged around allowing unregulated marketing of 'NoLo' products.

Climate change, Air quality, and the Environment

- The plan reiterates wider Government commitments on air pollution, including decarbonising the transport system, rolling out clean technologies, and supporting active travel.
- The plan also restates a previous commitment to invest £616 million to build and maintain walking and cycling infrastructure up to 2030.
- The Government will consult on reducing emissions from domestic burning (e.g. log fires) as previously announced by the last Government.
- The Government is seeking to improve the standard of rented homes, with a focus on damp and mould.
- DESNZ (the Department for Energy Security and Net Zero) is also developing a new Warm Homes plan and Fuel Poverty Strategy, with £13.2bn of investment intended to help improve the warmth, comfort, and energy efficiency of homes.

BMA analysis:

The plan's re-commitment to the NHS' Net Zero targets recognises the significant impact of air pollution on the population's health, and is in-line with BMA position on Net Zero and aims for UK to be zero-carbon by 2030 (ARM 2022). Upcoming work with DEFRA, such as the review of the Government's Environmental Improvement Plan, has the potential to improve air quality and save lives, so the Government must be willing to fully enforce the actions needed.

There are several mentions of 'active travel' in the plan, noting that it is an effective way to reduce emissions, while also supporting physical activity. However, alongside national investment, the Government must also ensure that all local authorities have the resources to invest in local active travel schemes, and that affordable and accessible low-emissions travel is made available in all UK communities.

The Government intends to take action to improve the standard of rented homes, including requiring social landlords to promptly fix housing hazards, which has been called for by BMA ARM policy from 2014 and 2022. Action must also be taken to address hazards in housing owned by private landlords. While not a new commitment, we support the aims of the Warm Homes Plan and hope it will contribute to a reduction in health conditions which are exacerbated by living in cold and damp homes.

The plan sets out a clear aim to have more NHS staff working across or in multiple locations, closer to patient homes and communities, but this is not accompanied by a strategy for how to ensure this increased movement of staff fits into wider goals around delivering net zero. As found in BMA research into NHS estates, environmentally friendly travel options are often limited at NHS facilities – including the availability of EV (electric vehicle) chargers – and this will need to be addressed to ensure the Government's 'shifts' do not undermine wider goals around emissions and net zero.

Screening and Immunisation

- The plan commits to introduce new models of delivering vaccines where health visitors can administer vaccines to babies and children in under-served groups, to increase uptake.
- To support the goal of cervical cancer elimination, community pharmacy will be given a bigger role in prevention by expanding their role in vaccine delivery, including catch-up vaccines for those who missed the HPV vaccine at school.
- The Government will work with local government, civil society, voluntary organisations, and community groups to improve the public's trust in vaccines.
- They will also work with families and schools to improve the consent process to help children get vaccines at school, and help parents book vaccinations and check they are up to date through the NHS App.
- The plan aims to end new HIV transmissions in England by 2030 – further details are to come in the Government's new HIV action plan later this year.

- A new genomics population health service will be established by 2030, with universal newborn genomic testing and population based polygenic risk scoring, to target early detection and intervention for people who pose a higher risk of developing common diseases.

BMA Analysis:

The plan's aims to restore public trust in vaccines, improve immunisation rates, and to improve vaccine accessibility and uptake are all important and the BMA would broadly support them, pending the details of how these improvements will be delivered.

The BMA supports ambitions to make access to vaccines easier and so the Government's aim to reach currently under-served communities is welcome. Additional routes to access immunisation will be a welcome addition to prevent gaps where people do not present at the GP for routine vaccinations, or when vaccination opportunities are missed at school. They may also support improving coverage and reducing health inequalities, however the significant reduction in health visitor numbers in recent years may be an impediment to the Government's ambitions in this area.

However, we believe that receiving a vaccine at a GP practice comes with additional benefits, in terms of face-to-face contact with a health professional, and the Government must ensure there are no adverse health outcomes from removing this contact point.[5] New vaccine delivery models must supplement, not replace, GP-led vaccination. The Government must also consider how to avoid embedding further health inequalities in areas with limited access to community pharmacies.

The plan's restated ambition around improving the uptake and access of cancer screening is positive as screening remains one of the best tools for early detection and prevention - but the detail of how these changes will be implemented is needed. We hope that the previously announced HPV self-sampling will also help more people take up screening as part of efforts to eliminate cervical cancer, but we urge the Government to ensure there is adequate workforce to appropriately manage any significant growth in screening uptake.[6]

The plan clearly identifies genomics data as key to healthcare reform but there are a number of significant outstanding ethical concerns around holding and using patient's genomic data, as well as sequencing the genomes of somebody who cannot give informed consent. Clarity is also needed on what oversight the National Screening Committee – which advises Governments and health services in all UK countries on screening – will have over the proposed expansion of genomic data collection and use. We have further concerns about how patient data will be safely stored and managed,

[5] As we discuss in Improving immunisation coverage rates report (2020) and in GPC England's Focus on Vaccinations and Immunisations.

[6] The BMA has lobbied for appropriate investment in workforce and diagnostic infrastructure, and continues to monitor this.

including by organisations such as Palantir.[7] The Government must address these concerns urgently.

Public Health

- The plan sets out the expectation that, from 2026, every single or upper tier local authority will participate in an external public health peer review exercise, on a 5-year cycle, with the results directly informing local plans.
- The Government also pledges to work with the LGA (Local Government Association) and other improvement experts to help local government public health services improve and adopt best practice.

BMA Analysis:

We agree that evidence-based public health initiatives are crucial for preventing ill health and will be essential to support the shift from sickness to prevention. However, public health services face significant financial and workforce pressures, and public health funding has not kept up with demand. The public health grant was 26% lower per person in 2024-25 than in 2015-16 and, while the most recent grant allocation was a real-terms increase in funding, years of underfunding have impacted capacity.

Placing additional responsibilities on public health, such as external public health peer review exercises, without additional resource will further exacerbate the pressures they face. Public health professionals must also be able to advise freely in the interest of the population's health, without fearing retribution from political bodies. If the Government is serious about moving from sickness to prevention, it must ensure that public health has the funding, resourcing, and influence that it needs.

The BMA has called for major reforms of the public health system in England – including in our submissions to the 10 Year Health Plan consultation process and our 2025 'Rebuilding Public Health' report – and so the lack of any significant content on this issue is disappointing. Likewise, the plan fails to commit to embedding independent public health leadership into key NHS structures, notably ICBs, which risks undermining the progress towards a more preventative system.

Inequalities

- The plan includes a range of policies – including reforms to funding distribution (the Carr-Hill-Formula) – that aim to focus support on deprived and working-class communities.
- The shift to neighbourhood services is expected to enable holistic ongoing care, particularly for disabled people and those with complex needs.

[7] BMA AI in Healthcare report includes principles on the potential use for genomic data and data management.

- The new operating model - with ICBs acting as strategic commissioners – is intended to allow local use of budgets to match their population's specific needs and to address local inequalities.
- A HIV action plan will be published later this year and will include actions to address inequalities in accessing HIV preventative measures and pre-exposure prophylaxis, particularly in Black African and Black Caribbean communities.
- DHSC (Department of Health and Social Care) will partner with charities to provide formal support for people after they receive a new diagnosis, to address inequalities in accessing empowering support for patients.
- The Government wants to more closely connect support from health, work, and skills services, and will test models in which NHS systems receive extra support and are held responsible for helping people stay in work.
- The plan also commits to extending free school meals to more children (those with a parent who received Universal Credit), revising the school food standards and restoring the value of the Healthy Start scheme from 2026 to 2027. Pregnant women and children aged between one and four will each receive £4.65 per week (up from £4.25). Children under one year old will receive £9.30 every week (up from £8.50).
- Working with the DfE (Department of Education), health services are expected to introduce a single unique identifier for every child to better enable preventative and joined-up care across different public services.

BMA analysis:

The BMA broadly supports the concept of targeting extra funding to areas with disproportionate economic and health challenges (ARM policy 2020), and has long-called for reform to the Carr-Hill funding formula. In our submission to the second 10 Year Health Plan consultation, we highlighted the particular challenges rural, remote and coastal communities face in accessing healthcare and (in line with ARM 2024 policy) called for the plan to explicitly address the needs of those groups. We would also urge the Government to ensure that all parts of the country receive adequate funding to invest in treatment, care, and prevention services and have the resources to invest in long-term workforce planning.

The plan rightly notes that social determinants significantly contribute to the country's widening health inequalities and that the social determinants of ill health cluster in more deprived parts of the country. However, it makes no note of Commercial Determinants of Ill Health, which also disproportionately affect those experiencing preexisting inequalities.[8] The Government must ensure that the public are better protected from commercial activities that lead to negative health outcomes and stand

[8] BMA has worked in particular on campaigning for better regulation on vaping and tobacco

strong in the face of lobbying including from the alcohol, tobacco, gambling, and food industries.

The plan suggests that digital solutions, including an SPR (Single Patient Record) and the NHS App, will play a significant role in improving access and outcomes. As noted earlier in this document, these ambitions are as yet unproven, and risk being an additional barrier to care for those who are not familiar or comfortable with digital solutions.

Many health inequalities begin from an early age, so initiatives that focus on rebuilding early years support are positive, notably including plans to improve uptake and access to vaccinations via health visitors and extending Start for Life services to age five. We urge the Government to work with patients and with those currently delivering these services to ensure they successfully reach as many people as possible and that they do not further entrench health inequalities (ARM policy 2010).

Although the plan cites the new ICB operating model as supporting the use of budgets to help address local inequalities, ICBs are facing significant cuts to budgets and staffing, which risks undermining this work.

Employment support

- If existing Health and Growth Accelerators prove successful,[9] all ICBs will be expected to develop targets on their contribution to reducing economic inactivity and unemployment.
- There will be further piloting of employment advisors and work coaches integrated within neighbourhood health centres. As part of this, a patient's employment goals will become part of their care plans.

BMA Analysis:

The plan states that 'good work is good for health'. The BMA believes that good work can be good for a person's health and wellbeing, if that work promotes dignity, autonomy and equality, has fair pay and conditions, and ensures people are properly supported to develop their talents and have a sense of community. For people to be able to access good work that may benefit their wellbeing, good and accessible work must exist, and people must be supported into it – rather than coerced by a punitive welfare system.

We await clarity on where exactly in the health system the advisors and work coaches referred to in the plan will be based. The Government must monitor the impact of

[9] Announced in 2024, there are 3 pilots currently running in areas identified as most affected by economic activity drive ill-health. HGAs aim to increase local employment by targeting health conditions which impact ability to work.

employment advisors and work coaches at neighbourhood health centres, to ensure that nobody is dissuaded from accessing health care because of their presence.

ICBs are facing significant pressure, as a result of population health pressures and recent large cuts to funding. If ICBs are expected to monitor and contribute to tackling economic inactivity and underemployment, this may be an additional burden. ICBs should not be penalised for failing to meet targets around reducing underemployment, as this will likely impact the areas with the worst health outcomes the hardest.

Devolving the NHS and a new operating model

- The plan – in line with already-announced plans on the structure of the NHS – sets out a new operating model based on a smaller 'centre' based in DHSC, with authority and finances increasingly devolved downwards to ICBs and providers.
- The integration of NHS England and DHSC will commence in the coming months. The abolition of NHSE will be complete within the next two years.
- The number of ICBs is being reduced significantly as part of a move to recast them as 'strategic commissioners' - as part of this process, the Government plans to amend legislation to remove provider organisations (i.e. NHS trusts) from ICB boards.
- A system of 'earned autonomy' is intended to reward well performing providers with greater freedoms (e.g. to innovate and develop new services) - and ensure that poor performance is subject to a 'failure regime'. This will entail a new diagnostic process to better understand the causes of under-performance.
- DHSC hopes that every NHS provider (i.e. NHS Trust) will become an FT (Foundation Trust) by 2035, with freedoms set to include determining their own board composition, retaining and reinvesting surpluses, and borrowing for their own capital investment. A new wave of FTs will be authorised in 2026.
- High-performing FTs will have the opportunity to become IHOs (Integrated Health Organisations) with responsibility for all services within a wider area. This is a new iteration of the ACO (Accountable Care Organisation) and Integrated Care Provider contract models attempted previously. The first IHOs are set to be agreed in 2026 and go live in 2027.
- Resources allocated to providers and commissioners will be increasingly tied to outcome-based targets (e.g. elective activity rates).
- NHS leaders' pay will be tied to performance metrics too.
- The plan sets out a desire for a 'plurality of provision' – with traditional boundaries blurred and, for example, GPs running hospitals, nurses leading neighbourhood providers, or acute trusts running community services.

- Private providers will continue to be used – particularly to support improved access and to clear waiting lists – and the plan outlines potential efforts to expand private provision of NHS care in more deprived areas.
- The plan does specifically state that 'cherry picking' – the targeting of simplest, most profitable services – by private providers will not be tolerated.
- League tables will be reinforced, with more information on provider and commissioner performance published and ranked publicly - these rankings will have an emphasis on patient experience, outcomes, and feedback.
- A new 'choice charter' is intended to emphasise patient experience, including by making NHS funding flows increasingly sensitive to patient voice, expanding the use of PHBs (Personal Health Budgets), expansion of the NHS App, increasing access to direct referral into diagnostic services, and expanded patient choice. This will be rolled out progressively in England, starting in areas with the highest health need.
- The NHS will be expected to work more closely with local government, which will be supported by making ICB boundaries coterminous with local authorities where possible - Strategic Authority (i.e. elected) mayors will also have a defined position on ICB boards.
- CSUs (Commissioning Support Units) will be closed.
- ICPs (Integrated Care Partnerships) will also be abolished, with ICBs instead producing population health improvement plans to inform commissioning decisions.
- The BCF (Better Care Fund) will be reformed in 2026-27, to focus funding on services considered most essential to delivering 'fully integrated' care – including discharge, intermediate care, rehabilitation, and reablement.

BMA analysis:

The plan confirms the 2-year timeline of the already announced merger of NHS England into DHSC. The BMA has engaged at a regional and national level since the original announcement in March 2025, including the previous BMA chair of council giving evidence to the House of Commons Health and Social Care Select Committee on this issue. The BMA has a significant interest in this merger, and we responded at the time of the merger being announced that it could be an opportunity to focus priorities, streamline working, and could see the UK Government take political responsibility for the condition of the NHS and its services, something the BMA has supported (and campaigned for during the passing of the 2022 Health and Care Act).

However, the BMA response also noted that trying to make these major changes to the operational model could be a costly, time-consuming distraction from the critical issues facing patient care, and risks losing some of NHSE's important functions, such

as workforce reporting and support programmes. Since ICBs became statutory we have been clear that they need time and money to succeed (including in our response to the Hewitt Review recommendations) neither of which are provided by the Government's reforms. Reducing the number, funding, and staffing of ICBs also puts BMA members employed by ICBs directly at risk of redundancy and could severely undermine clinical leadership within ICBs.

The BMA has also raised concerns regarding the potential impact of the abolition of NHS England and the cuts to ICB funding and staffing on public health in particular. Specifically, the BMA has noted that these changes risk worsening population health and health inequalities through a potential large-scale loss of public health specialist posts and training, and that they could reduce capacity for locally-driven initiatives that require coordination across the health system (ARM, 2025).

The announcement of IHOs – a revival of the previously seen ACOs and other forms of contractual or vertical integration – is a major concern. The BMA has strongly opposed these models in the past, particularly due to the threat they pose to the partnership model of general practice.[10] We have also highlighted the potentially severe risk of privatisation should private-sector organisations be able to become an IHO or hold associated contracts.

The BMA has previously stated that all available capacity, including private provider capacity, should be used to help bring down NHS waiting lists, given their size. However, we have also been explicit that investment in NHS capacity should always be the ultimate priority and that any arrangements with the private sector must be time-limited and represent value for money – unlike, for example, contracts made with private providers during the COVID-19 pandemic. The BMA has also been consistently critical of 'cherry-picking' of profitable NHS services by private healthcare providers and so it is positive that the plan recognises this issue, although it is unclear how it will be addressed in practice.

The plan lacks any significant detail on the wider position of the private healthcare sector, barring a brief suggestion of supporting the expansion of private providers into more deprived areas. This is an omission and fails to address a growing issue regarding the interface between NHS and private healthcare services, which has become more pressing as greater numbers of patients opt to pay for aspects of their care – such as diagnostic testing – in the private sector before returning to the NHS for treatment. The present situation presents significant challenges for doctors working in the NHS and those working in private practice, including a lack of clarity over which doctor or service holds responsibility for a patient's treatment. If the plan aims to further expand the

[10] Including BMA submissions to the Government consultation of draft ACO contracts in 2018.

private sector, the Government must also account for these challenges and present solutions to them.

ICBs were previously seen as a means of introducing greater collaboration within the NHS, however, this plan, and its emphasis on FTs and league tables, appears to signal a move back towards a more competitive model. The BMA remains concerned about the negative impact of competition with the NHS, particularly its risks of creating perverse incentives and undue, downward pressure on staff to hit targets. We have ARM policy (2019) which states that emphasising performance outcomes and league table positions must not be a distraction from fixing the NHS' problems and must not put even greater pressure on already overstretched staff.

Transparency and quality of care

- The plan points to a range of patient safety scandals across the history of the NHS and points to 'consistent failings' underpinning them, including incompetent leadership, toxic culture, blame, workplace bullying, a failure to learn from mistakes, and a lack of transparency. The Government intends to address these issues by focusing specifically on healthcare quality and transparency.
- All provider quality measures will be made publicly available and – from summer 2025 – quarterly league tables will rank providers on their overall performance.
- Eventually the public are expected to be able to search for and choose providers based on quality metrics (length of wait, patient ratings, outcomes).
- Patient experience and outcome data will be gathered in all services, to be published publicly and to sit alongside provider quality data on the NHS App.
- A national, independent investigation will be launched into maternity and neonatal services, alongside a National Maternity and Neonatal Taskforce.
- As part of plans to 'simplify' the range of care quality organisations, the HSSIB (Health Services Safety Investigations Body) will be merged into CQC while the PSC (Patient Safety Commissioner) will move into the MHRA (Medicines and Healthcare products Regulatory Agency).
- Healthwatch will be disbanded with its national functions moving into a Patient Experience Directorate within DHSC - local Healthwatch functions are set to be replaced by ICB and provider-run patient feedback systems.
- The National Guardian for Freedom to Speak Up will be removed.
- The time limit for CQC to bring legal action against providers will be extended beyond the current three-year limit (the new limit is not stated).

- In Autumn 2025 DHSC will carry out a review of the clinical negligence claims system and patients' experience of it - the Government has requested expert advice from David Lock KC on the rising legal costs of clinical negligence claims ahead of the review.
- The NQB (National Quality Board) will develop a new care quality strategy by March 2026.
- Providers will be allowed to make additional financial payments to clinical teams that have consistently excellent clinical outcomes and patient feedback or have significantly improved care – starting in 2027 and to be rolled out widely by 2030.
- Over the next year ICBs and NHS Regions will assess the quality of care across their commissioned services – with instructions to remove leadership teams or change providers for contracts if needed.
- A national, 'AI-led' warning system is outlined, which is hoped will analyse data to identify emerging quality issues and trigger CQC inspections.

BMA analysis:

The plan's recognition of the impact on patient care of incompetent leadership, toxic culture, rampant blame, workplace bullying, and a failure to learn from mistakes is important and reflects the BMA's longstanding positions on the need to create a caring, supportive, and collaborative workplace. However, it is unclear if all of the proposed measures in this chapter will have a positive impact – with the risk that some may in fact amplify the pressure on staff caused by the above factors.

The BMA has been broadly supportive of more comprehensive publication of NHS performance and patient safety data, and we have called for improved transparency on the standard of NHS and private healthcare services for some time.

However, as we stated in our immediate response to the plan, the aim to translate this data into wide-ranging league tables is concerning. The BMA has longstanding concerns about the role of league tables, including over how accurately they reflect performance and quality of care, the risk of gaming of statistics and trusts targeting resources at activity most relevant to rankings, and the downward pressure they place on frontline staff (ARM policy 2019).

The decision to merge multiple independent patient safety roles and organisations into DHSC raises a number of major questions – particularly regarding how they will remain impartial and have the freedom to fully and fairly investigate providers.[11] The reforms to Healthwatch may also contradict the plan's wider aspirations around empowering

[11] In the context of the Francis inquiry, ARM policy calls for action to ensure NHS has culture of openness to raise concerns, focusing on needs of patients above financial constraints.

patients by ending their independence and embedding the patient 'voice' within DHSC itself.[12]

The BMA is actively calling for significant reform of the clinical negligence system and raised this issue in our submission to the second 10 Year Health Plan consultation. We have highlighted that the current adversarial nature of the NHS clinical negligence compensation scheme does not work for doctors, patients, or the NHS and that reform of this system should be a key part of future plans for the NHS. Therefore, we welcome the commitment to review the system and the examination of its legal costs, which are significant. However, the review must lead to substantial reform, including moving away from a culture of blame and towards a no-fault scheme, as well as introducing a national system to investigate clinical errors and systemic failings.

The future NHS Workforce

- The plan argues that the workforce will be central to delivering the three shifts.
- This is directly linked to the pending publication of a new workforce plan (expected in Autumn 2025), which will be targeted at reshaping the workforce to deliver the aims of the 10 Year Health Plan.
- While most of the Government's workforce policy is likely to be included in the forthcoming workforce plan, the 10 Year Health Plan includes several workforce policy commitments.

Terms and conditions, wellbeing, and ways of working

- A 'big conversation' is set to begin between the NHS, DHSC, trade unions, the SPF (Social Partnership Forum) and others on significant contractual changes for all NHS staff. The plan also states that wider terms and conditions (such as HR policies) will be consolidated.
- A digital HR strategy will be implemented over the next five years, with the aim of enabling staff to access HR services more conveniently, including to book annual leave or to onboard to a new organisation digitally.
- Virtual HR 'assistants' will be introduced to free up HR professionals' time for more complex issues.
- A new 'state of the art' NHS payroll system is planned.
- The plan includes an aspiration to make the NHS the country's 'best employer', to improve staff experience, and to 'bring joy back to work'.
- New staff standards will be developed in collaboration with the SPF, to be implemented by April 2026, and are expected to cover:

[12] ARM policy from 2009 states patient safety and quality of care must take priority over financial and other targets.

- access to nutritious food and drink at work
- reducing violence against staff
- tackling racism and sexual harassment
- standards of 'healthy work'
- occupational health support
- support for flexible working.

- Staff Treatment Hubs will be rolled out, to provide occupational health services for all NHS staff, including for mental health issues and back conditions.
- The new staff standards and the Staff Treatment Hubs are intended to reduce sickness absence rates in the NHS, from 5.1% now to 4.1% in the future.
- Broad commitments are also included on improving flexible working for NHS staff, with an explicit link to the development of 6-days a week, 12-hours a day neighbourhood health services, and an ability for providers to take a more 'agile' approach to staff deployment. This includes through contract changes and making training more portable between organisations. Details are to be laid out in the forthcoming workforce plan.

BMA analysis:

The reference to a 'big conversation' on contractual reform for all NHS staff is significant, but no details are provided of what this reform could include, when it will take place, or how the intended engagement with trade unions will work. Our initial response to the plan highlighted that none of this can be done without full negotiations with unions, so the BMA will be monitoring this issue incredibly closely.

The aspiration to make the NHS the 'best employer' in the country is laudable, but it is crucial that the action taken to achieve this is tangible, meaningful, and addresses the issues that make many doctors feel undervalued – including pay, pensions, and their role within the wider health system.

Plans to introduce specific staff standards are – pending further detail – a welcome proposal. The BMA has consistently called for action to improve access to nutritious food and drink at work, to reduce violence against staff, to tackle racism and sexual harassment, for 'healthy work', occupational health support, and for flexible working (including in our submission to the NHS consultation in 2024 leading into this plan). However, we urge the Government and the NHS to extend these standards to include a commitment to tackling all forms of discrimination, including but not limited to racism, sexism, homophobia, transphobia, faith-based discrimination and ableism (passed as ARM policy 2025).

We welcome the specific commitment in the plan to address sexual misconduct via the proposed staff standards. Our 2021 Sexism in Medicine survey found that 31% of women respondents and 23% of men had experienced unwanted physical conduct, and that 56% of women and 28% of men had received unwanted verbal conduct relating to their gender. With this in mind, any standards developed must ensure more is done to prevent, investigate, and support those who report sexual harassment in medicine,

including via the introduction of a national anonymous reporting structure for sexual harassment (ARM, 2025).

Additionally, there should be strengthened obligations on employers to protect students, including ensuring protections are in place for whistleblowers and comprehensive sexual harassment is provided.[13] It is a requirement for medical students to undertake clinical placements, where they can be exposed to the same risks of sexual harassment as employees.

BMA research into the management of disability-related issues, including provision of reasonable adjustments and disability-related absence, has found continued use of a discriminatory practice of assessment of disability leave (the Bradford Factor) and inadequate disability-related sickness absence policies. These potentially discriminatory policies must not be perpetuated in the development of new standards and treatment hubs.

The plan's proposal to reduce sickness absences must effectively address the underlying causes of absences for its workforce, as flexible work and wellbeing support on their own are insufficient. Special leave policies must also be protected.

Staff Treatment Hubs are a welcome announcement, particularly since funding was cut from the popular Staff Wellbeing Hubs in 2023.[14] If these new hubs are to sit within occupational health services, assurance is needed that they will be independent, to assure staff of absolute confidentiality when accessing mental health support.

Support for flexible working for NHS staff could be welcome, depending on the detail of the specific proposals – which are not included in the plan. Against the backdrop of increasing workloads and longer hours on the job, doctors want a better work-life balance, with a growing appetite in medicine to work more flexibly. However, system leaders often view flexibility as an inconvenience instead of an opportunity to retain their workforce, even when refusal of less-than-full-time working requirements contributes to some doctors' decision to leave. Policy to support flexible working was passed at ARM 2022.

Any plans to change where and how doctors are deployed, however, must be voluntary and all changes to work patterns or places of work for staff groups must be subject to negotiations with the relevant unions, to protect staff wellbeing and terms and conditions (as we explicitly stated in our consultation submission). This is especially important in the context of the plan's aim for neighbourhood services to operate 6-days a week and 12-hours a day, which could lead to pressure for doctors to change their patterns of work.

The aim to establish 6-days a week and 12-hours a day services could also have significant pension implications for those doctors working in these services, particularly for senior staff, if they are expected to work for additional time. Therefore, this proposal

[13] Medical Student committee policy 2016, 2017, 2023.
[14] BMA report on Health and Wellbeing at work contains many of our recommendations for improving NHS staff support

must be accompanied by the removal of punitive pension taxation rules, which the BMA has been clear act as a significant barrier to doctors taking on additional work to support NHS capacity.

HR and payroll systems frequently pose problems for doctors – including delayed and incorrect pay and restrictive systems for booking annual leave – so reform could potentially be beneficial. However, the details of these changes and any use of AI in HR services will need to be thoroughly scrutinised.

Workforce planning

- The plan rejects the 2023 Long Term Workforce Plan projections of NHS staffing numbers and states that staff numbers in 2035 will be lower than previously planned - describing the workforce growth depicted in the last workforce plan as 'a fiction'.
- The plan suggests prevention of ill-health and changes to ways of working, including through the introduction of AI and other technologies, as well as experimentation with skills-mix, will free-up clinicians' time and reduce the number of frontline staff needed.
- 1,000 new speciality training posts will be created over the next 3 years, with a focus on specialities with the greatest need.
- UK medical graduates, alongside doctors who have worked in the NHS for a significant period, will be prioritised for foundation training and speciality training. International recruitment to the NHS will be reduced to under 10% by 2035.
- Overseas UK-registered professionals may be used to provide remote services for NHS patients - with further details to come in the 10-Year Workforce Plan.
- Local recruitment drives are set to emphasise bringing unemployed or economically inactive people into the workforce and to widen access to NHS roles.
- This includes widening access to the medical profession for people from underprivileged backgrounds, with the upcoming workforce plan set to explore how the admissions processes for medical schools can support this. Medical schools with a track record on widening access will be prioritised, and the Government are to explore how to improve financial support to students from the lowest socio-economic backgrounds.
- The use of agency staffing in the NHS is expected to end by 2029, with agency workers transferred to staff banks.

BMA analysis:

The BMA had several concerns about the 2023 workforce plan, including the approach taken to modelling (albeit we strongly called for modelling that was independently verified) and the projection of future demand for doctors - which included too few GPs). However, the Government appears to be relying heavily on action to prevent ill health, technological developments (including artificial intelligence) and unspecified changes to skill mix to free up clinical time so that fewer frontline staff will be needed than previously planned.

It is important to note that the 2023 workforce plan already contains stretching productivity assumptions, which NHS England labelled 'highly ambitious' at the time. And while there is a potentially valuable role for technology in easing pressures on the workforce – from applications of AI in imaging to automated administration in primary care – reducing staffing increases could undermine the implementation of this new technology if it prolongs workforce pressures in the short term. Staff need the training, skills and time to learn, use and oversee new technologies effectively. Extra staff time and capacity must come first.

Given the clear reliance in this plan on prevention, digitising healthcare and skill mix experimentation delivering significant productivity gains, it is essential that the workforce modelling in the forthcoming workforce plan is based on realistic assumptions including about the scale of gains from these proposed changes. Existing BMA policy is clear that any measure of productivity must be nuanced and account for a range of factors, including improvements in quality, increased complexity, and the actual capacity of the workforce, rather than focus on a simplistic measure of staff headcount (ARM, 2008). There must also be plans for what would happen if these assumptions do not materialise.

The Government must also be clear and honest about exactly how any successful productivity gains will be distributed. While the suggestion here is that increases to productivity will be used to substitute for planned future workforce growth, elsewhere in the plan it is suggested that improved productivity will be used to free clinicians up to pursue professional development and research.

It is positive that the Government has acknowledged issues with the post-graduate training pipeline, including the bottlenecks and competition ratios faced by resident doctors when applying for speciality training. The proposed solution, however, is insufficient. With an average of five applications for each of the 12,743 posts available last year, 1,000 extra posts over three years will not be enough to tackle the issue (as highlighted in our response when the plan was published).

The BMA's RDC (Resident Doctors Committee) has campaigned for speciality training expansion, UK graduate prioritisation, and this position aligns with recently passed ARM policy on access to the foundation programme and specialty training, but there is currently no detail on when or how the policy will be implemented. With doctors already facing un- and under- employment from these training bottlenecks, the lack of a timeline is particularly concerning.

It Is also unclear how the planned expansion of speciality training posts will meet future demand for consultants and GPs, especially given the stated ambition to reduce international recruitment.

The proposals in the plan to reduce international recruitment to 10% match those made in the 2023 workforce plan. Given global workforce shortages and ethical concerns about recruiting staff from countries with their own workforce shortages, the BMA has previously supported efforts to reduce international recruitment by increasing the domestic training pipeline (passed as policy at Medical Academics' Conference 2024). However, it is unclear exactly how the Government plans to reduce recruitment from the rates currently seen. In 2024, modelling by the GMC (General Medical Council) concluded that even if current commitments to double medical school places were used to replace internationally recruited staff with domestically trained staff on a 1:1 basis, 46% of the workforce would still be non-UK graduates by 2036. If the Government's plans to temper workforce growth includes a watering down of previous commitments to expand medical schools, this aspiration will become even more stretching.

Intentions floated in the plan – with no details – to make use of remote healthcare staff located in other countries are a major concern. It is crucial that any such recruitment is ethical and follows the DHSC Code or Practice (on international recruitment of health and social care personnel in England which the BMA recognises and supports) and aims to protect countries with chronic workforce challenges of their own. Although the plan does refer to ethical recruitment, it does not refer to the recruitment of displaced refugee and asylum-seeking doctors already in the UK, which remains a highly ethical recruitment model (ARM policy from 2025 advocates for a funded requalification pathway to support refugee doctors entering the NHS).

Widening access to medicine is a laudable aim, however, the BMA is clear that this must be done in a way that maintains high standards of medical education.[15] Previous attempts to widen participation through apprenticeships and shortened medical degrees, for instance, risk undermining quality and creating a situation in which those from underrepresented backgrounds are pushed towards one form of training, while those from more affluent backgrounds are encouraged to take a more traditional route (ARM, 2024). Widening participation in traditional medical education through streamlining the admissions process and increased financial support for students from the lowest socio-economic backgrounds, as suggested in the plan, could be more appropriate and we look forward to seeing the details of this proposal.

The BMA strongly supports widening participation in medical schools and supports proposals to expand this. However, the Government must view widening participation as a priority for all medical schools and should emphasise the need for all medical schools to scale-up and improve their widening participation schemes.

The expansion of medical school places will also need to be accompanied by significant reform to student finance arrangements, to ensure additional medical students are

[15] For example, in our response to the 2023 Workforce plan

appropriately supported to undertake their studies. In line with the BMA's Medical Students Committee campaign, this reform must ensure both undergraduate and graduate students are eligible for full maintenance loan provision for all years of study, and improve access to funding via the NHS Bursary.

Crucially, the system will also need to ensure that it has sufficient medical academic staff to educate and train additional medical students.

The numbers of foundation programme posts and placement positions will also need to be increased to match the expansion in UK medical school places, to ensure that there are posts and placements available for all students (ARM, 2025).

The BMA has previously described high spending on agency staffing as a 'false economy', but this will only truly be fixed through policy to train and retain NHS staff to meet demand over the long-term. Underinvestment in the workforce is the ultimate cause of NHS over reliance on temporary staffing.

Academic medicine, education, research, and innovation

- The plan includes an ambition to make research, development, and innovation a core part of everyday clinical work – rather than a 'nice to have' activity.
- The plan commits to reversing the decline in clinical academic roles, specifically via collaboration between Government and major charity funders which is expected to fund a year-on-year increase in the roles between 2025 and 2030.
- The Government also hopes to encourage additional funders to support Clinical Future Leader Fellowships.
- GPs and other staff considered central to neighbourhood health services will also be encouraged to carry out additional research, including via the NIHR School for Primary Care and, from 2026, Primary Care Commercial Research Delivery Centres specialising in commercial clinical trials based in primary care.
- Automation and freeing-up clinical time via the use of technology is framed as a means of facilitating increased levels of clinical research.
- The plan also commits to working with professional bodies and Royal Colleges to:
    - develop capability frameworks for innovation for all staff
    - introduce joint clinical research and innovation fellowship posts with industry
    - expand the Clinical and Patient Entrepreneurs Programme.

BMA analysis:

The BMA has existing policy (including ARM, 2019) highlighting the decline in medical (clinical) academic roles. The BMA has been calling for this to be addressed in long-term

NHS workforce planning, so the specific commitment within the plan to reversing the decline in these roles is important.

However, the plan lacks essential detail on how this reversal will be achieved. Universities are losing significant numbers of staff and the pipeline for the development of future academics appears broken. For example, the most recent MSC (Medical Schools Council) data shows that in 2024 clinical academics comprised only 3.4% of the UK consultant workforce, compared to 4.7% in 2009. Early career research posts are also decreasing for newly qualified clinical academics – with a 28.8% reduction between 2015 and 2024 of FTE clinical academics below the age of 36 - which threatens the integrity of the entire integrated academic training scheme for resident doctors. The reduction in medically qualified staff employed by universities risks medical students not being educated by doctors (ARM, 2025).

Whilst charity funders contribute significantly to medical academia, it is unrealistic that 'collaboration' with charity funders, alone, will be sufficient to address the scale of the issue. Existing BMA policy (ARM, 2023) calls for the career pathway to be properly funded, however, the current severe shortage of doctors working in medical academia threatens the delivery of research, education, and innovation throughout the entire plan.

Research and innovation being seen as a core part of healthcare, rather than being 'nice to have', is positive and should be integral to future-proofing UK research capacity. However, the plan lacks clarity on how this will be achieved. To implement this, there needs to be sector-wide change. The BMA has existing policy (MAC, 2025) endorsing the findings and proposed solutions in the OSCHR (Office for the Strategy Co-ordination of Health Research) report *Clinical Researchers in the United Kingdom: Reversing the Decline to improve population health and promote economic growth*. Crucially, despite further emphasis on freeing-up clinicians' time via the use of technology, it is also unclear exactly how – or by who – the desired additional innovation will be delivered given the workforce crisis in clinical academia.

The BMA also has ARM policy (ARM 2024) noting the importance of research in general practice and calling for action to expand it. The inclusion of a specific commitment to encourage GPs to undertake research is, therefore, positive. However, there is again a serious lack of detail on how sufficient capacity will be built to enable GPs to carry out this research. Clear detail on how this capacity will be built is needed, alongside specific funding for GP research – as called for in existing BMA ARM policy.

Regulation, education, and training

- Pending agreement from trade unions, NHS revalidation and appraisal systems will transition to a model based on continuous skill development and real-time feedback.
- DHSC will work to ensure a more streamlined path for experienced specialty doctors to develop and operate at the specialist level.

- DHSC will also work with the GMC to streamline pathways for experienced doctors to become consultants.
- Working with professional regulators and educational institutions, DHSC aims to reform education and training curricula over the next 3 years, to include:
    - comprehensive AI and digital tools
    - promote the generalist skills required for the Neighbourhood Health Service
    - focus on competencies and skills to deliver as soon as they are acquired rather than waiting until the end of formal training.
- There are plans to work with higher education institutions and regulators to review course length in light of technological developments.
- A targeted expansion of clinical educator capacity is planned.
- Funding for under and post-graduate placements will be reformed to support focusing clinical placements in priority settings, i.e. in the community.
- Changes to clinical placements will also begin to incorporate simulated learning.

BMA analysis:

The BMA has campaigned both for the expansion of the specialist grade and, more specifically, for a mechanism to better recognise the skills and experience of specialty doctors who are working at a specialist level (ARM, 2023 and 2025). Therefore, the recognition of the need to improve progression opportunities for this cohort is important and positive. Leaving the creation of specialist roles to local discretion has created something of a postcard lottery, where doctors are dependent on the willingness of employers to recognise the SAS workforce - we would be happy to work with DHSC to find a better model.

The plan's proposals to streamline pathways for experienced doctors to become consultants may also help to address the BMA's calls to improve access to the Portfolio Pathway, for example, but this should not become an alternative to offering funded training places. Similarly, while an expansion of clinical educator capacity is positive, we need more information to assess whether this genuinely would meet current need.

The plan's proposals around 'training to task' are highly concerning. As the WMA (World Medical Association) points out, shifting tasks to non-doctor professions can lead to decreased quality of patient care, particularly wherever medical judgement and decision making is transferred, alongside a range of other concerns. Training other professions to take on tasks normally undertaken by a doctor may also impede opportunities for medical students and resident doctors to learn. This is reflected in BMA policy from ARM 2025, which notes the impact of the development of the ACP (Advanced Clinical Practitioner) role on medical post-graduate training and calls on the BMA to lobby for a nationally agreed scope of practice for training opportunities for ACPs, as well as safeguarding training opportunities for doctors in this regard.

On education and curricula reform, the proposal to review course lengths will be a significant concern if medicine is under consideration. With the education and training advisory group, the BMA has set out our concerns with the four-year undergraduate degree proposed in the previous (2023) Long Term Workforce Plan.

The BMA is also clear (Medical Academics Conference, 2025) that the medical profession should lead the education and training of doctors, that medical schools should ensure consultant clinical academics, academic GPs, and SAS academics remain amongst their teaching staff, and that the leadership teams of medical schools should have a majority of medically qualified educators. Therefore, the BMA would call for these principles to be adhered to as part of any wider reform or review of medical education.

Regarding revalidation, the BMA has ARM policy calling for an independent audit of the processes of appraisal and revalidation and for a non-bureaucratic system. While the exact nature of the proposed changes to revalidation is unclear, it is positive that new systems will be agreed with trade unions.

The proposals on changes to ways of joining specialist registers are also of interest and have been the subject of previous BMA engagement with the GMC. We are keen to see further detail on these proposals and which organisations will be actively involved, due to concerns that employer roles in specialist registration would risk inconsistent standards to meet workforce needs.

The plan's suggestion of moving placements into the community lacks essential details and clarity must be provided on the specifics of this proposal – including whether this would apply to undergraduate placements, post-graduate placements, or both. Further details are also needed regarding the plan to incorporate simulated learning into clinical placements, which has the potential to significantly alter the quality and operation of placements.

Review of NHS leadership

- The plan aims to accelerate the delivery of the Messenger Review of NHS Leadership, with a new Management and Leadership Framework to be published by Autumn 2025.
- The Government aims to legislate for a new system that will disbar senior leaders from NHS leadership roles if they have, for example, exhibited dishonest behaviour, silenced whistle-blowers, or covered up unsafe practice.

BMA analysis:

The BMA has called for regulation of NHS managers for some time,[16] so progress on this issue is positive, however, we will need to review the details of the proposed new Management and Leadership Framework when they become available.

We firmly believe, for example, that frameworks and standards for NHS managers must include accountability for safe working environments free from discrimination and harassment (passed as policy at ARM 2025). The BMA has also previously raised concerns about accountability in NHS leadership for measuring disparities in workforce experience and outcomes, and for taking action to reduce disparities such as gender, race and disability pay gaps, reports of sexual harassment and discrimination, and to promote fair progression of doctors in all grades.

BMA reports including 'Delivering Racial Equality in Medicine' and Sexual Orientation and Gender Identity in the Medical Profession have made recommendations specifically on accountability, including that organisations responsible for the progression of doctors must publish their outcomes by ethnicity and that there should be a clear commitment from senior leaders across the medical profession and in medical schools to champion LGBTQ+ inclusion and challenge discrimination. In our report Bullying and harassment: how to address it and create a supportive and inclusive culture, we also argued for a comprehensive approach to eradicate bullying and harassment.

The BMA supports the development of a system that would disbar senior leaders from NHS leadership roles for the reasons outlined in the plan. Poor workplace cultures must be tackled at the same time to promote an environment where all staff have the freedom to speak up.

Staff employment data

- To support embedding local recruitment within the NHS, the plan sets out that employer level data on staff employment and recruitment, broken down by socio-economic status, sex and ethnicity will be published.

BMA analysis:

The BMA supports comprehensive monitoring of employer level data on staff employment and recruitment, but this must go beyond the listed characteristics of socio-economic status, sex and ethnicity to include gender and disability. Comprehensive monitoring supports effective gender, ethnicity and disability pay-gap reporting, and steps to resolve those gaps, as well as providing data about disparities in experiences and progression.

It is essential that employee data is broken down into professional groups with doctors as a distinct reportable category. Additionally, all employee data analysis by protected

[16] Including in our submission to the Change NHS 2024

characteristic should, where possible, look at the intersections between different characteristics to understand the barriers that must be tackled. For example, the intersection between race and gender as ethnic minority women may face a double disadvantage, with evidence suggesting that the pay gap for these women is greatest.

BMA research has found that there is considerable concern among disabled medical students and doctors about the potential consequences of disclosing their disability status to their employer. 77% of respondents said they were worried about being treated unfavourably if they disclosed a disability or long-term health condition at work or medical school. Employers should be required to make clear to employees the reasons why they are collecting disability data - i.e. to monitor and address inequalities within the organisation. Employers must also be aware that an employee's disability status may change throughout their working life, and so relying on information given upon starting employment is not feasible.

Innovation and driving reform

- This chapter is focused on an aim to increase the scale and pace of scientific and technological innovation in the country and within the NHS.
- The plan highlights factors that currently limit innovation, like a lack of national direction and strategy, insufficient incentives, and barriers to adoption.
- The NHS is also framed as a 'poor partner' to industry and hindering innovation by being risk adverse and focusing too much on compliance.
- With the aim of addressing this diagnosis, the plan sets out five 'big bets' on:
    1. Data delivering impact (greater sharing of and access to data)
    2. AI driving productivity (linked to patient choice and staff time)
    3. Genomics and predictive analysis (pre-emptive care from birth)
    4. Wearables making care 'real time' (for preventative, chronic, and post-acute treatment especially)
    5. Robotics supporting precision in surgery.
- The already announced HDRS (Health Data Research Service) is expected to help scientists, researchers and entrepreneurs' access 'deidentified' health data. It is also intended to ensure the NHS gets a 'fair deal' for sharing access to NHS data commercially, while maintaining patient privacy.
- Faster and wider access to data is also framed as a means of deploying and improving AI tools throughout the NHS – which is also expected to be supported by a new regulatory framework for medical devices including AI from 2026.
- From 2025-28, the Government plans to invest in AI infrastructure and develop then implement an NHS AI 'strategic roadmap', which is expected to enable ethical and governance frameworks for AI.

- From 2027, validated AI diagnostic and administrative tools (including AI-scribes) are expected to be deployed NHS-wide. More broadly, the plan aspires for the NHS to have integrated AI into most clinical pathways and to have widely adopted generative AI tools by 2035.
- The plan commits to the NHS being a global leader in ethical deployment of AI.
- The Government anticipates that by 2035 half of all healthcare interactions will be informed by genomic insights and predictive analytics.
- Existing genomics programmes will continue, including those focused on childhood testing, such as the Generation Study which sequences the genomes of 100,000 newborn babies, and a new study sequencing the genomes of 150,000 adults will be launched in 2025. This is expected to contribute to the NHS Genomic Medicine Service's development of a unified genomic record.
- From 2025-28, the NHS aims to expand hospital at home programmes and expand NICE's digital programme to consider more medical-grade wearables.
- The plan intends for wearables to be standard in a range of NHS treatment plans by 2035 and, at some point, for these and other biosensors (including smartwatches) to be connected to the NHS App.
- These plans also include a desire to trial new wearable technology and provide devices in areas with the greatest need and highest deprivation, as part of an effort to ensure equitable access.
- The plan stresses that, over the next 10 years, the NHS is committed to adopting robotic-assisted surgery as standard for a range of procedures, which it expects will help improve surgical precision. Robots are also seen as potential means of automating sanitation and delivering supplies, medications, and samples.
- NHS trusts will also be supported to increase their use of robotic process automation, to help automate tasks considered repetitive and rules-based, like data entry, inventory control, and referral management.
- With a view to strengthening research and innovation, new Global Institutes and Regional Health Innovation Zones will be set up and expected to encourage collaboration between the NHS, universities, and industry.
- The plan also aims to speed-up clinical trials and the adoption of new treatments and medicines, with an emphasis on cancer, obesity, and dementia.
- In line with the planned shift to prevention, the plan sets out that health research will also be encouraged to focus on primary and secondary prevention.

BMA analysis:

AI systems and large language models (LLMs) will only be as good as the data they are trained on and the level of human error and bias embedded in them. Biased, unrepresentative or incomplete data, and bias and error in model design will further entrench health inequalities and worsen outcomes for minoritised and vulnerable

groups. Furthermore, AI system limitations would need to be understood and worked with effectively (including human review of AI outputs), from the strategic to clinical level to ensure patient safety. The BMA has advocated for principles to ensure the safe, ethical and equitable use of AI in healthcare.

Utmost care will also need to be taken to ensure any patient's private, sensitive, and personal data is kept and managed in accordance with tight data governance policies and UK GDPR, and that any AI generated output about the patient is guarded as strictly confidential. Our Artificial Intelligence in Healthcare report discusses how some AI models have been shown to have concerning discriminatory patterns for minoritised groups - the utmost care would need to be taken to ensure the same does not transpire for our public healthcare system. We would encourage any systems to be co-created with minoritised patient groups and communicated effectively before they are rolled out, to build and then maintain trust.

Similarly, significant ethical concerns persist to holding and using patient's genomic data. Patient trust – particularly for minoritised groups – is lacking and a clear, accessible opt-in rather than opt-out system is needed for all patients. Given the NHS's contracts with Palantir, which the BMA continues to criticise heavily and passed a motion at ARM 2025 to lobby for all existing contracts between Palantir and the NHS to be terminated, it is concerning that little detail is given in the plan about how patient data would be appropriately managed or how the NHS plans to improve its cybersecurity to be equipped to deal with these changes.[17] There are potential ethical concerns over the sequencing of children's genomes, and clarity is needed over the exact terms any population genomic services would involve.

Productivity and a new financial foundation

- No new funding is announced in the plan beyond the spending plans announced in the comprehensive spending review.
- Over the course of the plan, funding is expected to gradually and proportionally move out of secondary care and into neighbourhood, community, and primary care – mirroring the intended shift in services.
- The NHS will be expected to deliver 2% year-on-year productivity gains for the next 3 years as part of an overarching aim for the NHS to deliver surplus budgets by 2029-30.
- Deficit support funding for trusts will also be phased out from the 2026-27 financial year. In its place, a transparent financial regime will be introduced that properly holds leaders to account for meeting their financial plans.
- All NHS organisations will be expected to deliver operational plans that are fully compliant with the NHS planning guidance from 2026-27.

[17] BMA position on the state of NHS IT infrastructure was evidenced in 2022 Building the Future report.

- Providers will be expected to produce 'realistic and robust' 5 year plans that demonstrate how financial sustainability will be secured over the medium term.
- All organisations must also reserve at least 3% of annual spend for one-time investments in service transformation – for example, for change management.
- Block contracts will be ended, with the intent of more explicitly linking the tariffs and payments for providers to the level and quality of care they provide.
- Beginning from the next financial year, the plan commits to increasing the number of new best practice tariffs year on year.
- Additionally, the plan aims to create new funding flows and payment mechanisms that direct the savings from improved quality of care to investment in new services in the community.
- With a view to establishing longer-term planning, a 3-year revenue and a 4-year capital settlement will run from 2026-27.
- From 2029-2030, 5-year rolling capital budgets will be introduced, to help with longer-term planning.
- NHS funding flows will be broadly shifted to target resources towards areas with the greatest health needs, with an emphasis on deprived and working class areas.
- NICE will be given new powers to withdraw treatments that are determined to no longer be cost effective.
- A pilot will be run in 2026-27 to test how patient voice could directly impact payments to providers, based on their experience of services – this has been modelled as a trial of Patient Power Payments.
- New Foundation Trusts will not receive capital allocations but will determine their own capital spending using funds generated through their operating activity.
- Funding for operational capital expenditure (e.g. routine maintenance and equipment replacement) will go to NHS providers determined by need.
- Capital allocations will be held regionally and allocated based on local population health needs, with NHS Regions, ICBs, and providers collaborating accordingly.
- Few capital budgets will be held nationally – with the notable exception of the New Hospital Programme budget which will remain with DHSC.
- Financial incentives and flexibility are intended to increase the use of existing estates and make it simpler for trusts to dispose of surplus land and reinvest that money.
- The Government will consider the use of PPP (Public Private Partnership) to secure funding for neighbourhood health centre capital projects in a limited set of circumstances and where they would represent value for money. The use of PPP has been ruled out for hospitals.

- YCP (Year of Care Payments) will also be tested as a means of supporting the shift of care into the neighbourhood and encouraging providers to keep patients healthy and out of hospital, by allocating a capitated budget (i.e. a set total amount) for a patient's care over a year, instead of paying a fee for a service.

BMA analysis:

The plan presents a significant overhaul of NHS services, which appears unrealistic in light of the health service's relatively limited funding settlement. The recent Spending Review committed to an average increase in the day-to-day NHS budget of just 3% a year in real-terms, with no further increases in capital budgets. As we responded at the time, this falls well below the 4.3% the BMA has calculated as being necessary for DHSC to meet the conditions of the previous long-term workforce plan, while also meeting key BMA demands, including full-pay restoration for salaried doctors and an appropriate uplift in GP contracts.

While amendments to long-term workforce planning may ease some of the financial pressures facing the NHS, health spending growth will still fall below the historic average and could be reduced further if the UK faces an economic shock over the next few years. However, the proposal for longer term revenue and capital funding settlements is positive and something the BMA has called for to enable longer term financial planning.

As set out in the chapter on neighbourhood care, the proposed shift in resources from secondary to primary care also needs to be managed carefully. Both hospitals and general practice are in crisis and reducing funding for hospitals while heaping more pressure on the community is not going to solve this.

The financial settlement expected to deliver the 10 Year Health Plan is underpinned by an assumption that the NHS will be able to deliver substantial improvements to productivity. The plan suggests the NHS will be expected to deliver 2% year-on-year productivity gains over the next 3 years. According to the ONS (Office for National Statistics) Quality Adjusted Productivity Index for public service healthcare, public service healthcare productivity grew by 20.8% between 1995/96 and 2019/20 after adjusting for quality, suggesting average productivity growth of less than 1% a year. While there are alternative models that attempt to estimate healthcare productivity, there are several intrinsic features of healthcare which mean services often have slower productivity growth than the economy more widely. It is not clear that the assumed productivity gains are feasible.

The prospect of PPP (Public Private Partnerships) for NHCs (Neighbourhood Health Centres) is a potential concern. The BMA has previously made clear that PFI (Private Finance Initiative), a model of PPP financing, was unsuitable for healthcare estates (with ARM policy from 2007, 2011, 2013, 2014 affirming this view). PFI contracts for hospitals in England were found to have generated costs of £80 billion for just £13 billion worth of investment, costs which have had a long-term impact on NHS finances. This should be a cautionary reminder of the challenges with private partnerships, and

the BMA has argued for greater transparency to ensure that public sector bodies have a clear understanding of any risks they are taking and expected benefits. It remains unclear why private finance would be preferable to public investment into publicly owned infrastructure, as this would count as a government asset and is within the scope of current fiscal rules. However, we will closely scrutinise the planned case for PPP models the Government is preparing.

Several of the financial initiatives proposed by the plan would potentially exacerbate financial pressures facing NHS trusts. Restoring financial discipline by removing additional resources to cover trust deficits assumes that those deficits are the result of financial mismanagement and fails to acknowledge the underlying cause of persistent deficits, which can be attributed to a lack of funding growth or significant health needs within the local population.

Alongside other suggestions in the plan, including best practice tariffs, Patient Power Payments, and the emphasis on financial incentives, the emphasis on financial discipline may impact the ability of doctors to make the best clinical decisions. For example, if a trust is on the verge of deficit due to underfunding, they may decide to focus on less costly procedures or set a firm limit on what they can achieve.

The proposal to test Year of Care Payments also raises a number of concerns, including the potential for the apparently 'sharp' focus of the payments on keeping patients out of hospital to act as a disincentive for patients to be referred to certain services, based on their cost, even if they may be the safest option for a given patient. The potential impact of YCPs on GP practice funding may also be significant, if they are rolled out, and will need to be monitored closely.

The plan references the introduction of new financial payment models but, beyond a move away from block contracts, it lacks concrete details about what these models could be. The potential implications of new financial payment models could be significant and additional information about the Government's plans is badly needed.

Appendix 1 – Stakeholder responses to the 10 Year Health Plan

The King's Fund: Truly Fit For The Future? The 10 Year Health Plan Explained

- The plan is patient-focused, with a strong emphasis on returning choice and control to patients.
- The least developed area is the shift from treatment to prevention, where the plan lacks bold measures to address the country's worsening public health and inequalities.
- Despite working on the plan for nine months, it fails to acknowledge the importance of 'getting the basics right'.
- The plan aims to balance basic improvements with major changes to care delivery, but it is unclear how its future goals will be achieved given current challenges - such as proposing genomic testing in NHS health checks without addressing current low participation rates.
- The plan is ambitious but silent on difficult trade-offs, especially with limited funding and workforce constraints.
- Social care reform remains delayed despite its critical role in relieving NHS pressures, with little detail on immediate action and no clear plans until at least 2028.
- The Government will need to break down the 10-year plan into smaller steps and be more clear what realistic goals will be met in the next three years.
- This plan is feasible and can improve the NHS, however it is vital the Government creates a practical delivery plan and is more transparent on the priorities of the plan and what will not be delivered by 2030.

Nuffield Trust: Nuffield Trust response to the 10 Year Health Plan

- The Darzi review is right in its diagnosis, but the claim that the NHS is close to collapse is exaggerated.
- The plan lacks detail on how its recovery steps will be delivered.
- Compared to previous plans, this plan places greater emphasis on patient experience e.g. through the NHS App, which is a positive sign.
- Acknowledging the unfair funding of GP practices is a step forward, if the Government follows through on its pledge, it could improve patient care.
- It is misleading to assume that better technology and a shift from sickness to prevention will save money. New technology is expensive to implement, and neighbourhood health services require significant investment. Therefore, the plan's cost-saving claims are too optimistic.
- Plans to stop recommending low-value drugs are a welcome.

- The Government must be realistic about what can be delivered. If it focuses only on short-term goals e.g. reducing waiting lists, it risks facing the same issues in 2029 that were diagnosed in 2024.

The Health Foundation: 10-year 'Plan for Change' or 'plus ça change'?

- The plan is on the right track and many proposals are reasonable, but some ideas such as patient-defined payment levels for hospitals are questionable and should be dropped.
- The plan lacks a clear path for implementation.
- Compared to New Labour's NHS plan, which had 6.8% annual real-terms funding growth, today's 2.8% makes this plan less promising and realistic.
- There is no acknowledgement of past attempts to shift care into the community or how to learn from those efforts.
- There is no strong catalyst driving system reform, such as coordinated action across NHS organisations.
- The plan includes no measures to evaluate initiatives or track progress.

Academy of Medical Royal Colleges: Academy statement: NHS 10 year plan

- The plan is ambitious, innovative, and worthy of praise.
- If well implemented, it could revolutionise healthcare, not just restore it.
- The plan's breadth and scale will take time to fully understand.
- Medical Royal Colleges and faculties are ready to support implementation of these changes.

The Royal College of Physicians: Royal College of Physicians responds to 10 year health plan | RCP

- The College is pleased to see the plan reflect several of the RCP's key priorities, including outpatient care reform, a shift toward neighbourhood services, more training posts, greater support for medical educators, and measures to help doctors continue their training within the NHS.
- However, the challenge is that there is no delivery plan with no clear timeframes.
- The proposition that staff numbers in 2035 will be lower than those projected in the 2023 Long Term Workforce Plan is alarming.
- AI is not a substitute for staff capacity.
- Digital tools and AI will only be successful if they are implemented effectively.
- A strong, well-supported medical workforce is essential to achieve this vision.
- Doctors need to be valued, properly resourced, and prepared for future challenges.
- The next generation campaign pushes for changes to post-graduate training.

- If fewer international doctors are recruited, the UK must expand medical school and training spots.
- International medical graduates already working in the NHS must be supported in their training and careers.

Royal College of General Practitioners: 'An encouraging vision but more details needed', RCGP responds to Government's plans to roll out Neighbourhood Health Services

- The RCGP is supportive of providing care closer to home, as it allows patients to access treatment more quickly than waiting for a GP appointment.
- However, there are concerns that for care in the community to be a reality, sufficient resources and many GPs will be required.
- GPs should be part of the decision-making process for delivery.
- The plan is very optimistic however it lacks clarity on what ideas will be delivered for patients or even the how it will be funded.
- An example is the need for more space in Neighbourhood Health Centres. However, much of the existing GP practice infrastructure is outdated and in need of renovation, failing to meet the needs of patients.
- How will shifting funding or focusing on building new health centres address the current challenges faced by general practice?
- The technology and AI shift looks promising however instead of focusing on new digital innovations, it is important to fix the basic IT systems which GPs are struggling to use effectively.
- While training more GPs is a step in the right direction, there are real issues with job availability, and many more GPs will still be needed.
- Awaiting the upcoming workforce plan to see if it will offer real solutions.

The Royal College of Surgeons: Surgeons: 10-Year Plan a 'critical opportunity' to tackle waiting times

- The plan includes measures to address the patient backlog, such as expanding care in community settings and adopting innovations like digital and robot-assisted surgery.
- Delivering on these ambitions will require sustained and balanced investment across the whole health system, including primary care, hospitals, infrastructure, and, most importantly, the workforce.
- Long waiting times are one of the most visible signs of pressure in the NHS and the plan offers a vital opportunity to lay out a credible path to recovery that also tackles the underlying causes.
- Further detail is immediately required on how the plan will be implemented, especially regarding an updated workforce strategy.

- Behind every delayed procedure is a patient living in pain or with a reduced quality of life.

Faculty of Public Health: **Faculty of Public Health Statement on the UK Government's 10 Year Health Plan**

- The Faculty of Public Health welcomes the 10-Year Plan, especially its aim to prioritise preventing illness and to empower both communities and health professionals to safeguard health at local level.
- They are positive on the proposals focusing on prevention such as expanding access to weight management programmes, increasing health screening opportunities, limiting children's access to energy drinks, and requiring large food companies to report certain data.
- Closing the gap in life health expectancy between the most and least advantaged communities is seen as necessary.
- To ensure the foundation of goof health, it is important to continue addressing the broader conditions that influence health, including good housing, fair wages, and income stability.
- Better systems for sharing and using health data, along with stronger NHS IT, are crucial to making the plan successful.

Royal College of Emergency Medicine: **The 10-year health plan - 'fit for the future'**

- The plan needs to be considered alongside the UEC plan and the upcoming refresh of the Long-Term Workforce Plan.
- The plan is ambitious and cannot disagree with the intentions.
- Improving transparency is an issue.
- Welcomes the idea of single patient record.
- Supportive of the plan's goal to increase vaccine uptake, although it could have done more on reducing alcohol-related harms.
- League tables are not a new concept.
- The plan doesn't address aligning hospital bed capacity with population needs, although strong management of acute trust flow could help reduce this.
- Social care is missing, however it is also perhaps not the plan's responsibility.
- Mental health emergency departments must be implemented carefully and collaboratively to avoid creating another isolated service.

Royal College of Anaesthetists: **RCoA response to the 10 Year Health Plan**

- Welcomes the initiative on supporting the workforce and focus on preventative care however this is still not enough.
- Due to increased competition, the 1000 new speciality training posts is not sufficient.

- The posts also need to prioritise anaesthetic training especially during a time where the Government is trying to improve non-elective waiting lists.
- The college welcomes the recognition of resident and SAS doctors and the commitment to support their career progression and professional development.
- Supportive of the shift toward community-based care, however, it is important to recognise that operations and non-elective care will continue to take place in hospitals, so funding must be balanced across all care settings.
- There is potential for the shift in technology to enhance care, however, it is essential that these solutions are co-produced with patients.

Royal College of Nursing: **Reset needed for NHS 10-Year Health Plan in England to succeed**

- The plan needs a fully funded strategy to expand the nursing workforce, especially in community roles, if it is to succeed.
- Ministers are urged to set out clear steps to end corridor care and tackle the decline in the nursing workforce.
- The Government wants nurses to lead a new neighbourhood health service, which must genuinely empower the profession.
- While advances in technology are welcome, the RCN warns that they cannot replace the need to fill tens of thousands of nursing vacancies.
- The RCN calls for better pay progression, including band six as the new minimum, and reforms to social care to support safer, better patient care.

Appendix 2 – Relevant ARM policy

Neighbourhood healthcare

- 293. That this Meeting notes that evidence from the Netherlands and the UK casts serious doubt on the health benefits and cost effectiveness of Personal Health Budgets and calls for the full evaluation of Personal Health Budget pilots in England before this scheme is rolled out further. (2014)

General practice

- 628. That this meeting supports GPs fighting to defend the GMS contract and NHS independent contractor status. The long-term GP patient relationship and the right for GPs to control their workload in a safe way, is essential for the future of general practice. We applaud the South Staffordshire motion passed at the 2021 LMC conference which called for GPCE to negotiate the end of the Primary Care Networks (PCNS) from 2023 as they 'pose an existential threat to independent contractor status' and this meeting:

  i) calls on GPCE and the BMA to organise the withdrawal of GP practices from the PCNs by 2023

  ii) calls for PCN funding to be moved into the core contract

  iii) instructs GPC England to act upon the GP ballot of 2021 and to organise opposition to the imposition of the new contact including industrial action if necessary. (2022) (England)

Obesity

- 794. That this Meeting recognises the health benefits of fruit and vegetables and:-

  i) calls on the BMA to campaign for a reduction in the price of fruit and vegetables;

  ii) urges Government to extend free fruit and vegetable initiatives to include all primary school children and ensure these items are available five days a week. (2013)

- 830. That this Meeting believes that the United Kingdom is suffering from an obesity epidemic and that voluntary measures by food industry and media are unlikely to address the problem and:

  i) calls for legislation to ban advertising of unhealthy food to children and a reduction of salt, sugar and hydrogenated fats added to pre-prepared food;

  ii) calls for a halt to the sale of assets such as school playgrounds and sports fields;

iii) deplores the promotion by sections of the Food and Drinks Industry of GDA (Guideline Daily Amounts) labelling to the exclusion of the "traffic light" system. (2007)

- 2127. That this Meeting notes with concern the significant influence private businesses have had in the Government's Responsibility Deal Networks and believes this has and will continue to prevent the creation of strong, effective, and evidence-based policy making in public health issues. It calls upon the Government to:

  i) place health organisations at the helm of chairing any current and future public health policy group;

  ii) consider within these groups' remit all possible options for improving the nation's health, including legislation, marketing bans, and price control measures;

  iii) create without delay, a comprehensive, transparent, cross-department and evidenced-based strategy for minimising the harm to UK public health caused by alcohol, tobacco, obesity, and inactivity. (2011)

- 826. Obesity That this meeting notes that the Foresight Group and Royal College of Physicians in 'Action on Obesity' describe the unsustainable burden the obesity epidemic places on the NHS, and this meeting therefore

  i) is concerned by the rapid rise in childhood obesity;

  ii) recognises that obese adults and children often have complex medical, iii) psychological and social needs;

  iv) calls for the appointment by government of one person to drive a coordinated v) obesity prevention strategy, including consideration of regulatory measures;

  vi) mandates the BMA to lobby for the commissioning of specialist multidisciplinary weight management units;

  vii) recommends that education in obesity and nutrition be made an essential component of medical education curricula;

  viii) urges UK governments and agencies to adopt the recommendations in the BMA board of science paper on childhood obesity. (2015)

Alcohol

- 39. That this meeting deplores that the Government reneged on their promise on the minimum pricing of alcohol. We congratulate the BMA on its continued campaign on this issue and notes with dismay the lobbying activities of the alcohol industry. (2015)

- 28. That this Meeting calls for the BMA to lobby the Government to prohibit organisations involved in healthcare delivery from promoting alcohol or tobacco. (2007)

Climate change, air quality, and the environment

- 486. That this meeting believes the NHS initiative on a 'Net Zero Health Service' is laudable in addressing the serious health problems that have arisen through climate change and asks:

  i) to know in clear terms how the BMA aims to achieve a similar target;

  ii) the NHS within the four nations to give regular reports on how targets are being achieved;

  iii) each government to commit funds to help achieve the net zero targets (2022) (UK)

- 266. That this Meeting notes the warning from the Board of Science that the UK is failing to adequately protect and promote its children's health and wellbeing, and believes that austerity measures and welfare reform are disproportionately affecting families and children. We call on the Government to:-

  i) provide adequate resources for community and family support schemes; ii) increase investment in programmes aimed at providing good parenting skills, with targeted funding for parents whose children have behavioural problems; i

  ii) strengthen the role of health visitors working closely with GPs in strong primary care teams;

  iv) increase and protect investment in child and adolescent mental health services (CAMHS), and ensure sufficient specialist CAMHS staff are available in each locality for assessments and interventions to be offered in a timely manner;

  v) improve the quality of social and other housing. (2014)

- 754. this meeting acknowledges the Levelling Up agenda but is seriously concerned there has been no reduction over the last five years in the number of years people in the UK live in poor health and believes:-

  i) it is vital the UK governments make a fundamental change in direction to achieve the pledge of increasing healthy life expectancy;

  ii) the UK governments must now urgently create social and economic conditions to enable healthier lives through assured jobs, satisfactory, acceptable housing, first class education and adequate incomes;

iii) health considerations must now be factored into all UK governments department policies. (2022)

Inequalities

- 502. That this meeting believes the Covid-19 pandemic and the Black Lives Matter movement has demonstrated the importance of addressing health inequalities and racism in the UK. This conference calls for:

  i) increased funding for public health to tackle ethnic, geographic and gender inequalities in the UK;

  ii) greatly improved recording and analysis of ethnicity in the NHS;

  iii) specific action based on culturally sensitive research to address the health, social and educational problems caused to Black, Asian and minority ethnic schoolchildren and make recommendations to reduce these inequalities;

  iv) all NHS trust and organisation boards should reflect the ethnic make-up of the workforce of the organisation which they manage;

  v) every person involved in NHS recruitment should have training on diversity and unconscious bias;

  vi) a mentorship scheme for Black, Asian and minority ethnic NHS managers and clinical leaders should be developed;

  vii) there should be transparent recruitment and promotion systems in all NHS organisations. (2020)

- 1935. That this meeting, recognising the challenges facing the provision of healthcare in rural, coastal and remote areas across the UK, therefore:

  i) considers that there is an overdue need for healthcare strategy for these areas in all four nations;

  ii) emphasises that joined up action needs to be speeded up across relevant government departments;

  iii) asks the BMA to highlight both the problems and solutions, and to lobby for national strategies and actions. (2024)

- 777. That this Meeting applauds the Marmot Review: 'Fair Society, Healthy Lives' and strongly urges the BMA to lobby government to:

  i) take forward the recommendation that expenditure on preventative services increase;

  ii) increase the proportion of overall expenditure allocated to the early years to give every child the best start in life;

iii) set a 'minimum income for healthy living';

iv) adopt fiscal policies to narrow the income gap between our poorest and richest citizens. (2010)

Devolving the NHS and a new operating model

- 1954. That this meeting believes that performance targets within the NHS:

  i) must be evidence-based and must not be driven purely by political agendas;

  ii) must not attract financial sanctions for non-achievement;

  iii) should not include the measurement of productivity. (2019)

- That, whilst this meeting cautiously welcomes further reversal of the disastrous Lansley reforms and 2012 Health and Social Care Act, it is deeply concerned about the implications for public health regarding the sudden abolition of NHS England as well as new austerity cuts to Integrated Care Board (ICB) funding. This meeting believes that this approach could hamper necessary work to deliver the Government's own plan to build a prevention focused health service. It may add a significant burden to many doctors' lives by disrupting key processes for medical training and revalidation. It risks worsening population health and health inequalities through a potential large-scale loss of public health specialists posts and training, and will decimate capacity for locally driven initiatives that require coordination across the health system. This meeting therefore calls upon the BMA to:-
  i) urgently support those public health consultants and other doctors affected and to lobby relevant bodies to ensure that these workers retain their jobs and that the relevant public health functions continue to be delivered and are enhanced, reversing post-2012 declines;
  ii) urgently lobby the UK Government to ensure there are an adequate and sustainable number of consultant posts available across the English public health system for those registrars completing their training there now and in the future;
  iii) promote a public health model featuring public health specialists embedded in all ICBs in England and throughout communities, government, universities and the NHS/HSCNI across the UK at a level of 30 whole-time equivalent consultants per million population;
  iv) lobby relevant bodies in England to ensure that public health registrar training needs regarding healthcare public health are met following these changes;
  v) call for any reorganisation to consider further reversal of the Lansley reforms by moving relevant public health functions back into the NHS as an independent public health agency (2025)

Transparency and quality of care

- 1954. That this meeting believes that performance targets within the NHS:

  i) must be evidence-based and must not be driven purely by political agendas;

  ii) must not attract financial sanctions for non-achievement;

  iii) should not include the measurement of productivity. (2019)

- 1130. That this meeting welcomes proposals in the People Plan, noted in NHS Employers' advice that employers and unions should work together to develop options for flexible working, but is concerned that flexible working is still not sufficiently supported at local level to make this a viable option for many doctors and calls for:

  i) urgent work to be undertaken with NHS Employers and Health Education England to produce guidance on shift patterns, multi-site working and contracts for medical staff with additional caring responsibilities, supported by a national campaign;

  ii) LNCs to work with Guardians of Safe Working Hours and Trusts to identify medical staff who have additional caring responsibilities and proactively support this cohort with reasonable adjustments to include job offers with reasonable working patterns and working locations, to be agreed in advance with individuals. (2022)

- 2181. That this Meeting agrees with Don Berwick's recommendation in the wake of the Francis Inquiry, for the NHS to promote a culture of learning and openness, not of blame and fear, and calls upon government to take action to:-

  i) eradicate the current bullying culture within the NHS which inhibits clinicians from raising patient safety concerns and demonises doctors, nurses and other healthcare workers for failures of delivery of healthcare;

  ii) remove the stigma surrounding whistleblowing which inhibits clinicians from raising patient safety concerns, and support staff and students to raise concerns without fear;

  iii) develop a culture in the NHS of transparency, respect, learning and continuous quality improvement by focusing on the needs of patients above financial constraints. (2014)

- 1957. That this Meeting:

  (i) believes that widespread use of centrally-imposed and clinically-inappropriate targets has many unintended consequences, distorts clinical priorities and harms patients;

(ii) calls for NHS organisations to be driven by excellence in patient care, led by patients and doctors. (2009)

Terms and conditions, wellbeing, and ways of working

- That this meeting calls on the BMA:-

  i) to affirm the right of all LGBTQ+ patients and staff to identity-based care and working conditions - defined as care and policies that actively account for the individual's lived, intersecting identities (including sexuality, gender, neurodivergence, race, and cultural background);

  ii) to produce pan-UK guidance and a lobbying strategy to embed this principle into NHS equality standards, training frameworks, and institutional policies. (2025)

- That this meeting recognises the new legislation placing a duty on employers to prevent sexual harassment of their employees, but more must be done to prevent, investigate, and support those who report sexual harassment in medicine. We call on:-

  i) NHS trusts, Health Boards and HSCNI to include Active Bystander Training within programs of mandatory training for all staff;
  ii) the BMA to lobby for a national anonymous reporting structure for sexual harassment;

  iii) NHS organisations to investigate reports of sexual misconduct with investigators trained in trauma investigations, external to the Trust, Health Board or HSCNI organisation;

  iv) the BMA to work with stakeholders, including Working Party on Sexual Misconduct in Surgery, to develop guidelines for providing ongoing support for victims as witnesses in tribunals. (2025)

- 258. That this meeting affirms that support for families and access to affordable childcare are key to child development and a productive and healthy society and workforce. This meeting calls for the BMA:

  i) to lobby Government to increase the eligibility for child benefit which has eroded against inflation;

  ii) to lobby Government to address the perverse disincentive of the eligibility cliff edge to free childcare hours and "tax free childcare" schemes;

  iii) to lobby and negotiate with key NHS and childcare stakeholders to improve access to workplace childcare with particular emphasis on enhanced hours of availability for shift workers and rotational staff;

  iv) to lobby for the continued advancement of flexible working including, but not limited to, less than full time, and compressed working patterns. (2023)

- 1130. That this meeting welcomes proposals in the People Plan, noted in NHS Employers' advice that employers and unions should work together to develop options for flexible working, but is concerned that flexible working is still not sufficiently supported at local level to make this a viable option for many doctors and calls for:

  i) urgent work to be undertaken with NHS Employers and Health Education England to produce guidance on shift patterns, multi-site working and contracts for medical staff with additional caring responsibilities, supported by a national campaign;

  ii) LNCs to work with Guardians of Safe Working Hours and Trusts to identify medical staff who have additional caring responsibilities and proactively support this cohort with reasonable adjustments to include job offers with reasonable working patterns and working locations, to be agreed in advance with individuals. (2022)

- 1139. That this meeting notes the importance of research in general practice compared to the relatively small proportion of academic GPs in the UK and calls for:

  i) development of a cross branch of practice working group to explore barriers to entry and progression in academic GP careers;

  ii) the implementation of ringfenced, targeted funding to support GPs to enter academic careers at any stage of their clinical career;

  iii) a mentoring programme to support GPs who do not hold academic positions, but would like to explore how they might develop an academic career;

  iv) universities to ensure that the agreed Senior Academic GP contract is offered as standard to all Senior Academic GP appointments;

  v) the NHS in each nation of the UK to clarify who should offer the honorary contract to Senior Academic GPs; vi) the BMA to negotiate an honorary NHS contract for junior academic GPs. (2024)

Workforce planning

- 368. That this Meeting demands that any measures of medical 'productivity' must take into account improvements in quality, increased complexity and the manpower actually available, rather than a simplistic head count. (2008)

- Whilst international medical graduates (IMGs) are a valued part of the UK's medical workforce, this meeting is concerned by exponentially increasing competition ratios for speciality training, driven primarily by overseas recruitment. This meeting therefore condemns the Government's failure in workforce planning which has left many medical students and residents in the

UK in the untenable position of facing unemployment in the near future. We therefore call on the four nations statutory education bodies and the Department for Health & Social Care to:-

i) guarantee all UK medical school graduates a foundation programme post for all future recruitment cycles and prioritise UK medical school graduates in the preference informed allocation ranking for UK Foundation Programme recruitment;

ii) introduce a process for medical speciality training recruitment where UK medical school graduates are offered posts first before any unfilled posts are opened to all other applicants;

iii) Introduce an exception to part ii for IMGs who are GMC registered and practicing in the NHS/HSC on or before the 5th of March 2025 and who have two years or go on to gain two years of NHS/HSC experience;

iv) expand foundation programme and speciality programme posts to match increases in UK medical school places with the appropriate workforce planning for expansion of GP and consultant posts. (2025)

- That this meeting deplores the lack of support given to refugee doctors In England who are currently reliant on charities (with only limited funding from DHSC) to help with their requalification training, mentoring and support. This meeting asks:-

  i) that the BMA liaises with DHSC, the GMC and the Medical Colleges to ask for the introduction of nationally funded training requalification pathways to help them work in the NHS.

  ii) for the restoration of CAPS (Clinical Apprenticeship Schemes for refugee doctors) that were discontinued years ago because of lack of funding. (2025)

- 1176. That this meeting abhors attempts to dilute the quality of medical standards in the UK and calls on the BMA to: -

  i) continue to oppose scope creep from professions without medical degrees and lead on setting out clear boundaries of practice;

  ii) continue to uphold that a medical degree must be obtained by a traditional route of at least 5 academic years medical training or 4 years by graduate entry medicine (3 years for qualified dentist), or IMG equivalent, and excluding apprenticeship models;

  iii) discontinue any support of, and lobby to end all medical apprenticeship courses or pilot schemes immediately with an option to convert anyone already on such a course to a traditional medical degree. (2024)

Academic medicine, education, research, and innovation

- 1143. That this meeting notes with concern the decrease in academic doctor numbers and asks for any workforce strategy to consider the positive contribution of academic medicine to the UK. (2019)

- While acknowledging the contribution of staff who are not medically qualified to the education of future doctors, this meeting reasserts that undergraduate medical education should primarily be developed and delivered by medical academics, putting doctors at the heart of teaching the next generation of doctors. This meeting also notes with concern the increasing proportion of staff who are not medically qualified in leadership positions in medical schools. This meeting, therefore, calls for:-

  i) the profession to lead the education and training of its future members;

  ii) medical schools should ensure that consultant clinical academics, academic GPs and SAS academics remain amongst their teaching staff;

  iii) medical schools to ensure that their leadership teams are comprised of a majority of medically qualified educators. (2025)

- 1142. That this meeting recognises the severe shortage of doctors working as clinical academics which threatens the future of both research and medical education. It calls upon to the BMA to:-

  i) renew its commitment to maintaining parity of salary for clinical academic staff with comparable NHS doctors;

  ii) ensure that the principle of pay-parity is maintained in current and future branch of practice negotiations, in conjunction with MASC, so that clinical academics are not disadvantaged;

  iii) lobby the UK Government to address inequalities in total remuneration that disincentivise clinical academia as a career path. (2023) (UK)

Regulation, education, and training

- 2301. That this meeting is concerned about the apparently small numbers of new Specialist grade posts being created in all NHS organisations following the introduction of the new SAS contracts in 2021 and that many experienced Specialty doctors are prevented from developing in their careers and progressing to Specialist grade posts because organisations are not creating these opportunities. This meeting calls on the BMA to:

  i) campaign for an objective national process for Specialty doctors to develop and progress to be appointed as Specialist

ii) provide a national model for the development of Specialty doctors for appointment to the Specialist grade to be used by LNC representatives locally;

iii) have a formal and independent mechanism by which Specialty doctors can prove they meet the generic capabilities framework of a Specialist.

iv) negotiate for financial recognition at the appointment as a Specialist of additional years worked as a speciality doctor whilst practising independently at a senior level with immediate escalation through the Specialist pay scale. (2023)

- That this meeting acknowledges the vital contribution of specialist doctors to the NHS and calls upon the BMA to:-

  i) advocate for the creation and promotion of specialist roles in all NHS trusts and health boards to provide experienced SAS doctors with meaningful career progression opportunities;

  ii) lobby employers and relevant royal colleges to establish a transparent and structured pathway for progression from specialty doctor to specialist, based on skills and experience rather than CCT (Certificate of Completion of Training) requirements;

  iii) ensure NHS trusts and health boards are held accountable for the implementation of specialist roles and that a sufficient number of posts are created to meet workforce demands;

  iv) campaign for greater recognition of the specialist role, ensuring it is valued equally to consultant positions in terms of professional esteem and responsibilities. (2025)

- That this meeting recognises that the development of the Advanced Clinical Practitioner (ACP) role has had significant impact on medical post-graduate training, and calls on the BMA to lobby for a nationally agreed scope of practice for training opportunities for ACPs as well as safeguarding training opportunities for doctors in this regard. (2025)

- That this meeting affirms that the General Medical Council (GMC) is no longer fit for purpose and does not represent the interests of the public or the medical profession. It therefore calls for:-

  i) the resignation of the GMC's chief executive and a performance review of the current senior management team;

  ii) a review of the appointments and appraisal processes for the GMC's senior management team;

  iii) a review of the Council and its appointment processes, including considering the restoration of a medical majority on the Council;

iv) the BMA to set out a vision for a reformed GMC or a new, alternative regulator and to lobby for this. (2025)

- 597. That this meeting:

  i) believes the pause in appraisal and revalidation has not resulted in any detriment to patient safety or standards of care;

  ii) demands a reduction in the GMC regulation imposed by annual appraisal and five yearly revalidation to encourage experienced clinicians to retire later;

  iii) demands a proper independent audit of the processes of appraisal and revalidation to examine any alleged benefits and detrimental effects. (2020)

Review of NHS leadership

- That this meeting recognises that NHS and broader healthcare managers including those in non-clinical roles (hereafter referred to as "managers") should have a responsibility to enable delivery of safe and effective healthcare provision, and at present make decisions that significantly impact upon the public's health and wellbeing with relative impunity. It also recognises that resident doctors are often put in high-risk positions through dangerous staffing practices by managers and through contraventions of their working rights and terms and conditions. We therefore insist that the BMA lobbies relevant stakeholders, including lobbying for legislative change, to ensure that:-

  i) a new statutory register is promptly formed for all managers not on the medical or dental registers;

  ii) a new and separate regulator is formed for all such managers so as to constitute the requirements of statutory regulation, including ensuring adequate training and revalidation is completed to perform these roles to a demonstrable standard;

  iii) it would become an offence to perform in these manager roles whilst not registered;

  iv) a robust investigatory and tribunal service is established, which may erase managers from the register to protect the public and NHS from acts including but not limited to: misconduct, incompetence, negligence, and failure to staff healthcare facilities safely;

  v) managers are appropriately scrutinised, and held directly accountable for their actions in post by a regulatory body and the public whom they serve;

  vi) significant penalties would be incurred by managers who do not take reasonable steps to ensure safe staffing, including adequate recruitment, use of bank or agency staff, and where required, closure of units and facilities. (2025)

Innovation and driving reform

- That this meeting believes that Palantir (inclusive of any associated companies) is an unacceptable choice of partner to create a Federated Data Platform for the NHS. It recognises that this partnership threatens to undermine public trust in NHS data systems, due to a lack of transparency in how the data will be stored and processed, a track record of creating discriminatory policing software in the US, and close links to a US Government which shows little regard for international law. Furthermore, there is a lack of evidence surrounding the efficacy of the proposed systems - for which the NHS is paying a large premium to test on Palantir's behalf. We call upon the BMA to:-

  i) lobby at a national level against the continued introduction of Palantir's software into health data systems, and to terminate all existing contracts that the NHS holds with Palantir;

  ii) write to all relevant parties outlining these concerns;

  iii) encourage local, and regional BMA bodies to lobby their local trusts and ICBs to terminate existing contracts they may hold with Palantir;

  iv) call on DHSC to create a full, publicly available audit detailing the progress of the uptake, and the efficacy of these systems throughout the NHS;

  v) support members in taking actions against Palantir by creating guidance regarding rights to refuse to use data products supplied by companies associated with warfare and human rights violations, such as Palantir;

  vi) raise support for suitable, publicly-owned alternatives to Palantir's FDP. (2025)

Productivity and a new financial foundation

- 1908. That this Meeting deplores the improperly researched, non evidence-based, current wave of private finance initiative schemes, which are mortgaging the NHS of the future, and believes any further such schemes will make the NHS unsustainable in the future. It calls upon the government to:

  i) put a halt to any further PFI schemes;

  ii) produce long-term (10 and 25 year) projections of the costs of these schemes;

  iii) include future debts to PFI companies when calculating the NHS deficit;

  iv) introduce and deliver a policy of public ownership of all future NHS hospitals. (2007)

- 1905. That this Meeting believes with regard to the Private Finance Initiative in the NHS that:-

  i) it represents unaffordably poor value for money in the current financial climate;

ii) NHS PFI contracts should be renegotiated to ensure better terms, better value for money for the NHS and to release resources for patient care;

iii) the BMA should lobby for all health PFI contracts to be made public. (2011)

- 1802. That this Meeting believes that Private Finance Initiatives (PFI) continue to be a drain on the public purse and demands that:-

  i) government directly fund new NHS capital projects;

  ii) government renegotiate PFI contracts to ensure a better deal for the taxpayer;

  iii) government enables existing PFI schemes to be bought out by the NHS. (2013)

- 1904. That this Meeting:-

  i) notes the enormous burden of PFI debt that threatens to sink the NHS;

  ii) demands that government legislates to rescind all NHS PFI debt;

  iii) demands that government does not enter into any new PFI scheme. (2014)