INDEPENDENT POLICY BRIEF

NHS ENGLAND / SEPTEMBER 2026

# Fixing the NHS

## Break the cycle of decline.

Reliable information sits beneath almost every decision the NHS makes. Today that foundation is fragmented, making good decisions, coordinated care and continuous improvement harder than they need to be. Make information a major NHS strength and the same foundation can support better clinical decisions, clearer pathways, integrated services, reliable measurement, research and continuous learning.

Do this through three linked steps: build a shared NHS EHR that reduces fragmentation at the source; organise the system around it so improvement is built into how the NHS works; and give staff the support, capability and authority to turn those foundations into excellent care.

The first step is contained: commission a small, dedicated expert team to build and test the model in real care. If it cannot demonstrate safety, usability and value, stop. If it can, scale deliberately. The proposition is ambitious. The first decision is not.

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|---|---|
| **Break the cycle** | Change the underlying trajectory |
| **Build the foundations** | Make information a strength |
| **Design for improvement** | Centralise capability, devolve delivery |
| **Deliver excellence** | Attract, develop, support and empower |
| **From ambition to action** | Commission, build, validate and scale |

A practical, staged plan for the Secretary of State for Health and Social Care

# Break the cycle of decline

Incremental improvement is not enough to secure lasting recovery



## Sustained pressure demands a change in trajectory.

The NHS is failing too many patients and staff. Individual improvements matter, but isolated gains cannot secure sustained excellence while the underlying foundations remain fragmented. The task is to change the conditions in which care is delivered.

**7.33m**

**Treatment pathways waiting**

Around 6.21m people.
England, July 2026.[6]

**42.4%**

**Staff made unwell by stress**

Work-related stress in the past year.
England survey, 2025.[4]

**26%**

**Public satisfaction**

Satisfied with how the NHS runs.
Great Britain, 2025.[7]

These indicators show persistent pressure on patients, staff and public confidence. Darzi's investigation documented wider failures in access, performance and staff experience.[1,7]

**BREAK THE CYCLE THROUGH EXCELLENCE**

**Minor improvements can leave the underlying pattern of decline intact. Start where stronger foundations can support wider progress: reliable information. Build the capacity to coordinate care, measure results and learn, so each improvement makes the next easier.**

## Why start with information?

Information sits beneath almost every decision the NHS makes. It shapes clinical judgement, patient choice, coordination between services, planning, funding, measurement and improvement. When information is fragmented, each part of the system has to work harder to understand what is happening and act together.

Make information a major NHS strength and much more becomes possible from the same base: better clinical decisions, clearer pathways, coordinated services, reliable measurement and continuous learning. That is why information is the right place to start breaking the cycle.

So how do we create a shared information foundation that is reliable, usable and puts everyone on the same page?

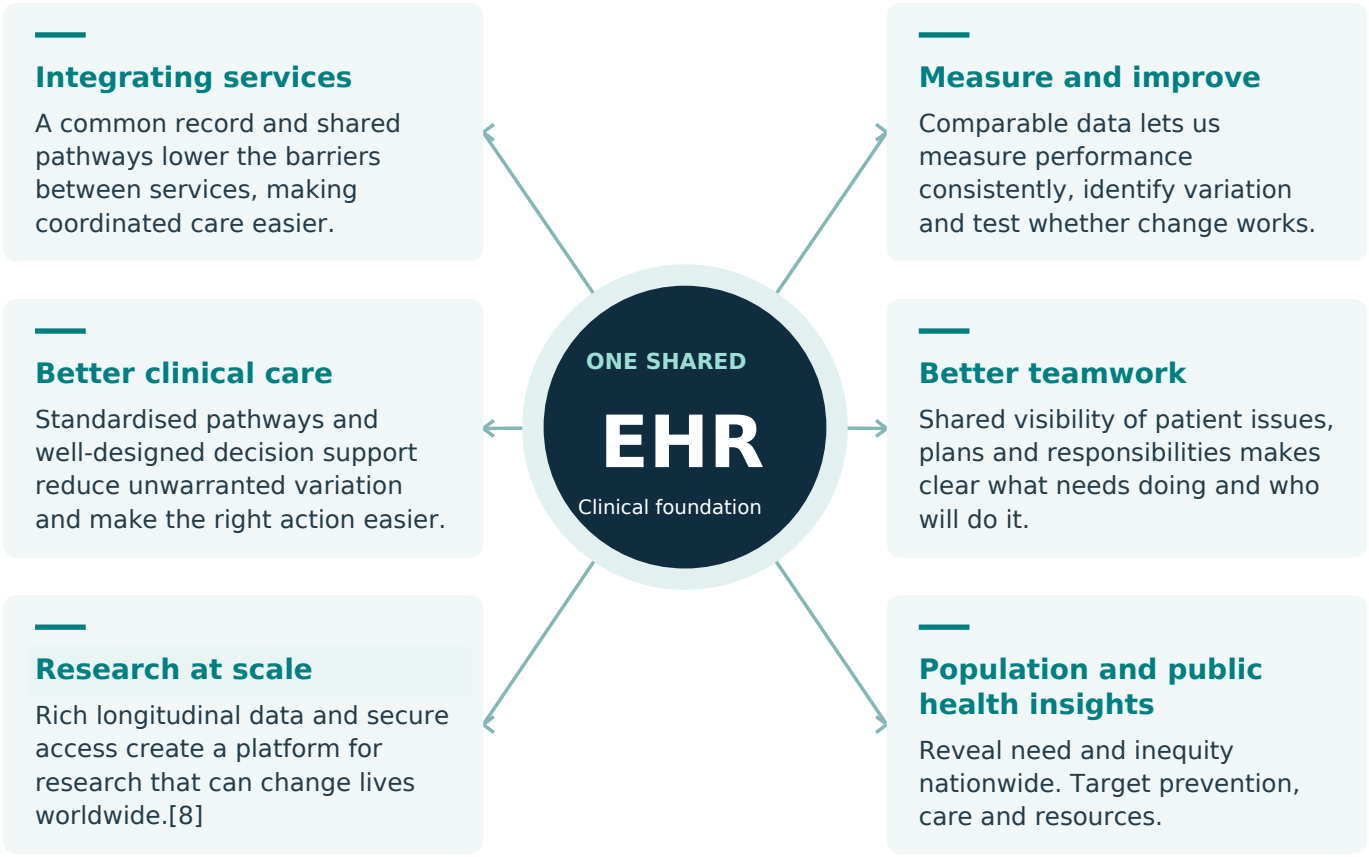
A shared NHS EHR is the practical answer. Designed well, it brings information together in one clinical workspace and makes it usable for better decisions, coordination, measurement and continuous improvement. It is not the whole solution; it creates the foundation on which people and services can deliver excellent care.

# Build the foundations

Make information a major NHS strength



One NHS-owned EHR across primary, hospital, community and mental health care, with appropriate social care access. It is the shared clinical and data foundation, not the whole solution: it gives people reliable information to coordinate care, measure results and improve.




Goldacre described the potential to “help prevent suffering and death, around the planet, on a biblical scale”.[8]

**Design, architecture and interface determine success.** The system must fit how people think and work: make information reliable, responsibility visible and the right action straightforward. Build with users, test in real care and make continuous improvement part of the design.

**Go beyond connecting records.** Interoperability helps fragmented systems work together. A shared EHR removes much of the fragmentation itself. The Single Patient Record programme primarily connects existing source systems.[2] The Federated Data Platform connects information across systems.[3] That makes fragmentation more workable, but it does not remove it: staff still work across different records, interfaces and workflows, while measurement, standardisation and research still depend on reconciling data between systems. A shared NHS EHR changes that default: one clinical workspace, common information structures and shared tools make coordination, measurement, learning and research easier to build into everyday care.

The next step is to organise the capabilities, decisions and incentives around that foundation so these benefits are realised and improvement becomes built into the system, rather than forced through it.

# Design for improvement

Centralise shared capabilities. Devolve delivery and local decisions.



A shared foundation creates the opportunity; the system must be designed to realise it. Centralise capabilities that benefit from scale, while using common outcomes, practical support and local freedom to improve care.

## Four central capabilities working as one

### Technology and software

Maintain one NHS ecosystem: the EHR, rotas, workforce planning, theatres and patient flow. Own the architecture; use open interfaces, exportable data and replaceable components.

### Analytics

Centralise analytical expertise, definitions and measurement. Compare need, equity and outcomes; identify what works. Maintain data quality and support local analysts.

### Clinical standards

Agree evidence-based care standards. Work with software and analytics teams to embed best-practice pathways in the interface, then evaluate and refine them.

**Shared output:** best-practice care built into usable tools, measured consistently and improved as evidence develops.

### Central NHS consultancy

A permanent NHS-owned team that learns from every area. Diagnose problems, support implementation, evaluate local innovations and spread effective practice. Feed lessons back to the standards, software and analytics teams.

**LOCAL FREEDOM WITH SHARED ACCOUNTABILITY**

**Give local NHS services, neighbourhoods and public health teams freedom over delivery, using shared tools and standardised outcomes.**

Use a small, audited scorecard for **safety, access, outcomes, equity, staff experience and cost.** Adjust comparisons for population need and case mix.

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|---|---|
| **SUCCESS** | Financial rewards for strong performance and improvement on common outcomes. |
| **INNOVATION** | Financial rewards for strengths in up to two pre-agreed local priorities. Evaluate results and spread what works through the central consultancy. |
| **DATA** | Under this model, financial restrictions apply only to persistent failure to maintain reliable data. Support compliance first; protect essential patient care. |
| **FAILURE** | Poor outcomes trigger review and central consultancy support. Persistent, independently verified failure brings temporary loss of autonomy, with clear recovery criteria. |

# Deliver excellence

Healthcare is delivered by people. Give them the conditions to excel.



**PEOPLE TURN FOUNDATIONS INTO EXCELLENT CARE**

**Attract, develop, support and empower capable people and real teams. With the right tools and system, they can deliver excellent care.**

## Challenge four assumptions about wellbeing

### External fixes

Purchased solutions will sustain wellbeing on their own.

### Annual snapshots

Yearly scores can guide daily decisions.

### Individual burden

Staff must fix their own wellbeing.

### Teams by name

An MDT label means identity, trust and cohesion already exist.

**Make wellbeing a system responsibility.** Replace individual burden and external fixes with sustained operational support. The deepest mistake is assuming cohesive teams already exist.

### Reward and motivate

**SECURITY AND ATTRACTION**

Pay nurses, lower-band staff and apprentices to live comfortably. Recognise contribution, attract capable leaders and fund recurrent pay sustainably.

### Develop capability

**PRIDE AND PROGRESSION**

Protect training and apprenticeships. Offer progression through clinical excellence and quality improvement, not just management, so staff grow with pride and stay.

### Operationalise wellbeing

**FEELING VALUED**

Use daily and, where useful, hourly feedback on workload, breaks and capacity. Enable managers to act so staff feel valued and supported.

### Support real teams

**BELONGING AND TRUST**

Build identity from within through purpose, reflection and mutual support. Give teams time, skills and authority; back sound judgement and protect against unfair scrutiny.

**SECURITY + GROWTH + SUPPORT + BELONGING**

### A learning culture that improves care

These conditions build psychological safety: people can speak up, exercise proportionate judgement and learn together. Review decisions fairly, distinguish honest error from misconduct and feed learning back into team routines, training and tools. Better care then reinforces pride, trust and motivation.

# From ambition to action

Build and test a contained model. Scale only on evidence.



**THE MINISTERIAL DECISION**

**Commission a small expert team to build and test a shared NHS-owned EHR model in real care, within an agreed scope and budget. This does not authorise national rollout. Stop if the model cannot demonstrate safety, usability and value; consider staged expansion only if it can.**

**BUILD**

Give one leader authority over a bounded build. Co-design with patients and staff; map costs and contracts, reuse proven components and deliver a testable first release.

**Gate: agreed budget, scope, clinical milestones and evaluation criteria.**

**VALIDATE**

Test one complete care pathway in diverse localities. Fund training, migration and protected staff time. Compare against baseline and suitable services; publish failures and gains.

**Stop unless independent evaluation demonstrates safety, usability and value.**

**SCALE**

Expand in funded waves, aligned with contract exits and local readiness. Mandate adoption as gates are met; maintain safe interoperability and validate before retiring legacy systems.

**Gate: evidence and delivery capacity continue to support expansion.**

## Funding and ownership

Keep the first build lean and bounded: a small expert team, proven components and disciplined scope. Own the direction, not every component. The NHS should control the architecture, standards and roadmap while using proven commercial components where they add value. This limits lock-in, preserves flexibility and keeps accountability with the NHS.

Fund migration, dual running, infrastructure, training and maintenance explicitly. Stage further funding against independently verified safety, usability and whole-life value. Design from the outset to reduce avoidable licensing, procurement, integration and reporting costs.

The previous national IT programme shows why cost, capability and governance must be credible from the outset.[5]

## Scale safely

Scale only when the evidence supports it. Require resilient services, tested downtime procedures, role-based access and audit logs.

Keep direct-care access separate from research permissions.

Keep common standards while allowing justified specialty workflows. Expand in stages around local readiness and contract exits. Start in England; agree any wider UK adoption with devolved governments.

A shared digital foundation is an enabler, not a substitute for adequate capacity, estates, social care or prevention.

**SOURCES AND SCOPE**

1. Darzi, Independent investigation of the NHS in England, September 2024.
2. DHSC, Health Bill single patient record fact sheet, May 2026.
3. NHS England, NHS Federated Data Platform explained.
4. 2025 NHS Staff Survey national results, March 2026, questions 3e and 11c.
5. National Audit Office, Digital transformation in the NHS, May 2020.
6. BMA, NHS backlog data analysis, NHS England data for July 2026.
7. The King’s Fund and Nuffield Trust, Public satisfaction with the NHS in 2025, March 2026.
8. Goldacre, Better, broader, safer: using health data for research and analysis, April 2022.

England is the proposed starting point. Timings, institutional design and incentives are recommendations; no quantified savings estimate is asserted. Sources checked 24 September 2026.