The Royal Society of Medicine

Community for Health Equity

Session 2 Report
‘Implementing the 10 Year Health Plan’

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Executive summary

This report captures learning from the second session of the Community for Health Equity programme, focusing on how policy, delivery and innovation interact to shape equitable outcomes in practice. The session focused on what implementation of the NHS 10 Year Health Plan means in practice for equity, prevention, patient voice and inclusive information.

Presentations examined how equity and prevention are being embedded within national and regional implementation through the Office for Health Improvement and Disparities (OHID) and NHS England, how system turbulence affects delivery and how innovation, patient voice and trusted information can be operationalised within neighbourhood and digital models.

Across presentations and discussion, participants highlighted a consistent risk. Ambitious reform will succeed or fail at practical delivery points: how access routes are designed, how information is produced and distributed, how digital channels are implemented and how accountability and metrics shape behaviour. Without equity by design, reforms risk improving averages while leaving underlying gaps unchanged.

Digital transformation emerged as both a major opportunity and a significant risk. Participants stressed that digital-first approaches must retain non-digital routes, trusted intermediaries and clear pathways back into care if they are to support equity rather than exacerbate exclusion.

This report provides a set of practical actions for the programme. These focus on improving visibility of resources and support across the system, strengthening standards and infrastructure for patient-facing information, embedding patient partnership into delivery rather than consultation and ensuring that metrics and accountability mechanisms support narrowing gaps rather than shifting activity.

Programme overview

The Royal Society of Medicine (RSM) and the NHS have a shared commitment to reducing health inequalities, as outlined in the NHS Core20PLUS5 initiative and the NHS 10 Year Plan. The Community for Health Equity (CHE) Programme builds on this partnership, recognising that healthcare industry professionals (pharmaceutical, biotechnology and medical technology companies) possess unique resources and expertise that can support NHS goals. This includes supporting the adoption and spread of innovation and improving how equity considerations are built into value propositions, evidence generation and implementation.

By engaging industry, patients, clinicians and other stakeholders this programme aims to bridge gaps between commercial innovation and public health NHS needs. The RSM, as an independent professional body, provides a neutral convener platform where industry, NHS leaders and other stakeholders can dialogue and co-create solutions. This alignment ensures that NHS leader's priorities – such as equitable access to medicines and advancing national strategic goals – are informed by industry insights, while industry is guided toward addressing unmet needs in underserved communities.

Ultimately, the initiative seeks to deliver tangible health improvements on the ground through a series of targeted engagements and outputs.

Co-development and status

This report has been co-developed with programme members.
It reflects perspectives shared during the session and does not represent formal policy positions of the Royal Society of Medicine or participating organisations.

Financial contributions and independence

We would like to thank Bayer plc, which has financially supported the delivery of this programme through a sponsorship agreement. Bayer plc provided insights to inform the initial scope of the programme, with no further involvement in the content, programme, or organisation of this meeting.

We would like to thank our Industry Members [AstraZeneca, Boehringer Ingelheim, Gilead, Merck Group, Novartis and Pfizer] for their financial support of this event.

Organisations represented across this session

AstraZeneca
Boehringer Ingelheim UK
Brook
Cheshire and Merseyside Cancer Alliance
Faculty of Pharmaceutical Medicine
Friends, Families and Travellers
Gilead Sciences
Health Inequalities Improvement Team, NHS England
Health Innovation Network
Imperial College London
Marie Curie
Merck Group
North Central London Cancer Alliance
Novartis
Office for Health Improvement and Disparities
Patient Information Forum
Patients Association
Pfizer UK
Royal Society of Medicine
The Association of the British Pharmaceutical Industry (ABPI)

Context and background

Health inequalities in England include differences in health status, access to care and experience and outcomes from services. They are systematic, avoidable and shaped by socioeconomic factors, geography, protected characteristics and socially excluded groups. In recent years, national policy has placed greater emphasis on addressing these inequalities through how services are planned, commissioned and delivered, rather than primarily through monitoring and reporting differences. NHS England now sets clearer expectations that inequalities data and patient insight are used to inform commissioning, service design and implementation, and that impact is evaluated rather than assumed.[1]

The NHS 10 Year Health Plan sets out three system changes intended to reshape how health and care are delivered over the next decade: a shift from hospital to community, from analogue to digital and from sickness to prevention. Each shift has direct implications for equity, particularly where innovation reshapes access routes, care pathways and patient experience. Community-based models raise questions about who is reached and how neighbourhoods are defined in practice. Digital delivery introduces new access routes alongside new risks of exclusion. Prevention depends on engaging people earlier, including those who may not currently be in regular contact with services.

Alongside the plan, the recently published impact statement makes explicit that these reforms are not guaranteed to deliver equitable outcomes. It highlights uncertainty, time lags and trade-offs, including the risk that changes improve average performance while leaving gaps unchanged or widened.

This session also builds on existing frameworks that support action on inequalities. Core20PLUS5 continues to provide a practical structure, combining the most deprived 20 percent of areas with locally identified "PLUS" groups who experience poorer access, experience and outcomes and may not be identified through area-based deprivation alone. National guidance now places greater emphasis on improving data completeness, disaggregation and use, alongside triangulation with frontline and community insight, to make unmet need visible and actionable.

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[1] NHS England, *NHS England's statement on information on health inequalities*

Context and background

The implementation challenge is further shaped by the delivery context. The 10 Year Health Plan is being taken forward during a period of organisational change, workforce pressure and financial constraint. Participants noted that this increases the importance of clarity on priorities, metrics and accountability. Without explicit attention to equity at points of delivery, there is a risk that reforms prioritise scale, pace and throughput over distributional impact.

Patient voice and health information, including how people are informed about services, access routes and decisions affecting their care, form a critical part of this context. The 10 Year Health Plan places renewed emphasis on patient power, choice and partnership, alongside increased use of digital channels to deliver information, test results and feedback mechanisms. Evidence continues to show, however, that access, agency and trust are unevenly distributed.[2] Where information assumes high literacy, digital confidence or stable access to technology, access gaps widen even when services exist.[3] The growth of digital-first and AI-enabled delivery therefore increases the importance of inclusive design and multiple routes into care.

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[2] NHS England, Tackling digital exclusion and health literacy: How libraries can help bridge the gap

[3] NHS England, Inclusive digital healthcare: a framework for NHS action on digital inclusion

Presentations

This section provides a summary of presentations given during the session and key insights gained. These informed the later discussion and provided framing to think about the recommendations and action to be taken.

1. Implementing the NHS 10 Year Health Plan: what it means for OHID

Overview

The Office for Health Improvement and Disparities (OHID) is the government's expert public health function for health improvement and health disparities in England. It operates through blended teams across national, regional and local levels, working alongside NHS England, Integrated Care Boards and local authorities to translate prevention and equity policy into delivery.

Presentation summary

The presentation examined what the NHS 10 Year Health Plan and its Impact Statement mean for implementation, particularly in relation to prevention and health equity. Rather than focusing on policy intent, it emphasised how the plan embeds these priorities within the core NHS operating model, including changes to financial flows, accountability and system architecture.

OHID supports delivery across national, regional and neighbourhood levels by translating broad prevention ambitions into practical decisions about prioritisation, service design and evaluation. The Impact Statement was positioned as a tool to support realistic implementation, explicitly recognising uncertainty, long time lags and the risk that reforms may improve overall performance without narrowing inequalities unless distributional effects are actively monitored and addressed.

Key insights

- **The 10 Year Health Plan and its Impact Statement explicitly acknowledge that large-scale system reforms may improve average outcomes while leaving inequalities unchanged or widened, reinforcing the need to assess distributional impact alongside overall performance.**
- **Evidence supporting large-scale shifts to community-based care, digital delivery and prevention is emerging but remains incomplete, with benefits often realised over long timeframes. This means implementation decisions will need to proceed with partial evidence and be monitored transparently over time, rather than assuming equity gains will automatically follow.**
- **Historic financial incentives have favoured acute activity over prevention and community care, creating a structural risk that implementation choices continue to prioritise short-term activity unless new or adapted financial flows and payment models are aligned with equity outcomes.**
- **Digital, AI and data-enabled delivery offer significant potential for productivity, earlier diagnosis and population health management, but also introduce new exclusion risks linked to access, capability, confidence, user preference and data security.**
- **Equity outcomes are shaped by early design choices, including language, literacy, accessibility, disability access and the availability of non-digital options, rather than being effectively mitigated after implementation.**
- **Test-and-learn approaches are central to the plan's delivery, but without shared metrics, clear baselines and openness about limited or uneven impact, there is a risk of scaling interventions that improve efficiency without narrowing gaps.**

If you only read one resource: Impact statement: the 10 Year Health Plan for England

2. Embedding healthcare inequalities improvement into 10 Year Health Plan delivery

Overview

NHS England's Healthcare Inequalities Improvement Programme sets national direction on reducing healthcare inequalities, supports system delivery through capability building and guidance, and drives accountability across regions, Integrated Care Boards and Providers. The programme operates across commissioning, service delivery and oversight, embedding health inequalities within statutory duties, planning frameworks and performance management.

Presentation summary

The presentation outlined the policy and delivery context, acknowledging significant system change and constraints while emphasising the tools already available to support action. It positioned Core20PLUS5 as the ongoing framework for action and linked it to the Medium Term Planning Framework, Strategic Commissioning Framework and refreshed expectations on information on health inequalities.

Priority enablers included digital inclusion, translation and interpreting services and improved ethnicity data recording, all framed as foundations for safe and equitable delivery.

Key insights

- **Core20PLUS5 remains the primary framework for NHS action on healthcare inequalities, but the refreshed Statement on information on health inequalities moves away from a fixed set of metrics towards a menu of measures aligned to national priorities, enabling systems to use local analysis while demonstrating compliance with statutory duties.**
- **NHS bodies are expected to demonstrate how inequalities data is used to inform decisions, planning, commissioning and service delivery, supported by clearer guidance on annual reporting and a structured set of review questions that set minimum expectations and reduce the risk of selectively reporting positive trends.**
- **Data quality remains a critical constraint on effective action. Incomplete and inconsistent data on ethnicity and other indicators of unmet need limit the ability to identify unmet need, target interventions and evaluate impact, reinforcing the need for timely, granular and comparable recording as a delivery priority rather than a technical exercise.**
- **Digital inclusion is positioned as a core delivery requirement, underpinned by a cross-departmental Digital Inclusion Action Plan covering access, ease of use, skills and capability, beliefs and trust, and leadership, with a clear expectation that multiple access routes are maintained by default.**
- **The expansion of AI within health services increases the importance of inclusive design, transparency and patient safety, with NHS England updating digital inclusion frameworks to address bias, accessibility and trust, and to ensure equity considerations are built in from the outset.**
- **Language access and translation are patient safety issues as well as equity concerns, with evidence showing that lack of translated written communications contributes to medication errors and avoidable harm, reinforcing the need for consistent standards and system-wide implementation.**

If you only read one resource: NHS England's statement on information on health inequalities

3. The patient voice in the 10 Year Health Plan

Overview

The Patients Association is a national patient charity focused on patient rights, experience, and influence within health and care. Its work aims to strengthen patient voice and ensure that people can understand, navigate, and act within the health system.

Presentation summary

The presentation used patient testimony to illustrate how power dynamics shape whose voice is heard in care. It examined the 10 Year Health Plan's commitments on patient power, choice and experience, including new structures such as the Office of the Patient and a Director of Patient Experience. It also raised questions about independence, governance and how patient insight will influence strategy and delivery.

Key insights

- **Patient voice is unevenly represented in current engagement models, with feedback mechanisms tending to favour confident, articulate individuals who are already engaged with services.**
- **Access and agency are prerequisites for meaningful patient choice, meaning that patient power initiatives will have limited impact unless barriers to access are addressed first.**
- **Patient testimony highlights how power dynamics within clinical encounters influence whose concerns are taken seriously, with implications for shared decision-making and trust.**
- **Proxy feedback from carers and family members is important, particularly in end-of-life care, and complex need, but is not consistently weighted or integrated into decision-making.**
- **Accountability for acting on patient insight remains unclear, weakening trust where engagement does not result in visible change.**
- **Patient experience data is most useful when it reflects wider social factors, including housing, education and employment, which shape health outcomes before NHS contact occurs.**

The Patients Association led an interactive session, asking participants to identify common barriers to strengthening patient voice, alongside practical actions to address them.

- **Process and resource constraints** continue to limit engagement, including complex ethics, risk and compliance requirements, lack of dedicated staff time, and limited funding to support VCSE partners or compensate community representatives.
- **Trust and representation gaps** persist, with patients often feeling their feedback does not matter or fearing negative consequences. Engagement mechanisms frequently rely on confident or "expert" patients, while feedback by carers or families is undervalued despite its importance.
- **Access and literacy barriers** affect who participates, including health literacy, survey fatigue, cultural sensitivity, and limited routes to engage people not currently using services or engaged in primary prevention.
- **Organisational culture matters**, with paternalistic assumptions and low prioritisation of patient voice reducing impact. Participants emphasised the need to listen and act visibly on feedback and to share examples where patient involvement has led to change.
- **Practical actions identified** included working more closely with VCFSE (Voluntary, Community, Faith and Social Enterprise) and community partners, simplifying engagement processes, investing in internal capability, and developing more coherent, neighbourhood-based approaches to capturing population voice.

If you only read one resource: Being a Patient

4. Why patient involvement matters

Overview

Patient Information Forum (PIF) is a membership organisation for anyone producing health information and support. The organisation promotes access to trusted, evidence-based health information for patients, carers, the public and healthcare professionals.

Presentation summary

The presentation positioned patient information as delivery infrastructure for access, safety and prevention. It highlighted the growing impact of misinformation and AI on how people find and trust information. PIF TICK, created to help the public quickly and easily identify trusted health information, was described as a process-based standard focused on evidence, accessibility and user engagement.

Practical examples showed how co-production, simplification and community-based distribution improve reach. Risks of digital-only routes were illustrated through examples where test results or diagnoses appear without context or support and where barriers to accessing maternity services are increased for women in digital poverty.

Key insights

- **Health information quality and accessibility directly affect access, safety and prevention, particularly for people with lower health literacy, limited digital confidence or language barriers.**
- **Standards-based approaches such as PIF TICK improve consistency by assessing information production processes rather than individual materials, reducing variability in quality and usability.**
- **Translation alone does not ensure accessibility. Simplification, cultural adaptation and co-production are required to ensure information is understood and usable in practice.**
- **Community-based delivery routes, including libraries and community hubs, can act as trusted intermediaries for digital onboarding and health information access.**
- **Digital-first information delivery increases the risk of exclusion where diagnoses or test results are provided without context, explanation or clear routes back into care.**
- **The growth of AI-driven information discovery is increasing exposure to misinformation, making trusted sources, clear signposting and rapid correction mechanisms more important.**

If you only read one resource: Knowledge is Power

Discussion

Translating neighbourhood health, prevention and patient voice into equitable delivery

The discussion explored how the ambitions of the NHS 10 Year Health Plan can be translated into equitable outcomes in practice through new delivery models, commissioning approaches, digital systems and prevention pathways, and how these innovations shape equitable outcomes. Drawing on presentations and a chaired panel discussion, participants focused on how prevention, patient voice, digital delivery and neighbourhood health models interact at the point of implementation, and where delivery choices either narrow or reinforce existing inequalities.

A consistent theme was that progress depends less on the existence of new policies or innovation and more on how definitions, data, culture and incentives shape everyday decisions across systems.

Access, equity and the meaning of the postcode lottery

Participants agreed that the “postcode lottery” is not primarily about different services existing in different places, but about how close systems come to universal access to what is already on offer. Improving average performance was seen as an unreliable proxy for equity, as gains are often driven by people who are already better able to navigate services, while those facing the greatest barriers see little change.

Neighbourhood health was viewed as a potential mechanism to improve access for underserved populations, with the expectation that improving access for those most affected by inequality would improve outcomes for the wider population. However, participants cautioned that a successful neighbourhood service or centre does not in itself demonstrate equity unless there is evidence that gaps in access, experience and outcomes are being identified and addressed.

There was strong consensus that national ambition and standards are essential to reduce unwarranted variation, but that these must be combined with local flexibility in delivery. Participants emphasised that neighbourhoods differ significantly, for example between urban, rural and coastal areas, and that approaches must be shaped by local context rather than applied uniformly.

Defining neighbourhood health and commissioning for outcomes

The discussion reflected ongoing uncertainty about how neighbourhood health should be defined. Participants consistently described it as a way of working rather than a physical building, encompassing health, social care, community services and wider determinants such as education, employment and housing.

There was concern that early narratives around neighbourhood health risk overemphasising physical infrastructure, while underplaying the relational and cultural change required. Participants stressed that neighbourhood health will not succeed if it focuses narrowly on clinical services without integrating social care, palliative care, social prescribing and community assets.

The shift towards ICBs acting as strategic commissioners was seen as a critical enabler. Participants suggested that commissioning must move decisively towards outcomes rather than activity, as activity-based approaches risk reproducing existing inequalities. Without this shift, neighbourhood models were seen as likely to entrench variation rather than reduce it.

Data, metrics and system integration

Data was recognised as essential but insufficient on its own. Participants highlighted persistent gaps in data coverage, particularly for people experiencing multiple disadvantages, digital exclusion or unstable contact with services. There was concern that reliance on averages can obscure unmet need and give a false sense of progress.

There was strong support for the use of shared, meaningful metrics to maintain focus and enable comparison across systems and partners. Participants cautioned that proliferating bespoke measures can dilute effort and slow action, particularly during a period of system change.

System fragmentation was identified as a major barrier to neighbourhood working, with examples cited of basic information not flowing between services, even within the same organisation. However, participants also pointed to emerging progress through shared care records and place-based data partnerships. While there was broad support for the ambition of a single health and care record, participants stressed the need for clarity on what information is included, how it is shared, and how it supports whole person care rather than simply aggregating data.

Digital delivery, inclusion and patient choice

The analogue-to-digital shift was seen as one of the most advanced elements of the 10 Year Health Plan, but also one of the most complex in equity terms. Participants emphasised that digital access is increasingly unaffordable for some groups due to device and connectivity costs, while confidence, skills and trust remain significant barriers.

There was concern that assumptions about digital readiness risk reinforcing inequality. Digital inclusion is nuanced, with evidence that many people in deprived areas do have access to digital tools, while others face persistent barriers related to cost, skills, confidence or trust, meaning it cannot be addressed through a single intervention. Choice was seen as essential, with digital routes needing to sit alongside non-digital options as a safety net rather than a fallback.

There was frustration with the proliferation of digital tools that do not interact, creating confusion for patients and additional burden for staff. The shared view was that digital tools must be designed around patient needs from the outset, rather than expecting patients to adapt to systems.

Patient voice, trust and meaningful partnership

Participants agreed that patient voice is increasingly visible in policy but remains uneven in practice. There was concern about over-reliance on confident or “expert” patients, which can inadvertently exclude those with the greatest unmet need.

Trust was identified as a critical factor shaping engagement. Participants emphasised that tokenistic engagement undermines confidence and makes future participation less likely. Meaningful partnership was described as requiring time, resource and feedback loops that show how patient input has influenced decisions.

The discussion also highlighted the importance of proxy feedback, particularly in end-of-life care and for people unable to advocate for themselves. Participants noted that such feedback is often undervalued despite its relevance to quality and experience.

Culture, leadership and collaboration across sectors

Culture was repeatedly identified as a determining factor in whether neighbourhood health can succeed. Participants emphasised that the key question is not who is formally “in charge”, but whether leadership creates the conditions for collaboration, shared accountability and mutual respect across roles.

Empowering frontline professionals was seen as essential, alongside valuing all contributions within multidisciplinary teams equally. Hierarchies between roles were viewed as undermining integrated working and patient-centred care.

Participants also highlighted the role of industry as part of the wider system, particularly in relation to information provision, innovation deployment and countering misinformation. However, tensions were noted between the need for accurate, accessible information and regulatory frameworks that limit how industry can engage without being perceived as promotional.

Overall, the discussion reinforced that reducing the postcode lottery through neighbourhood health requires national clarity combined with local flexibility, shared metrics aligned to outcomes, integrated systems, and sustained attention to culture, trust and patient partnership.

Suggestions

The suggestions below reflect where participants identified the strongest opportunities to strengthen equitable delivery of the NHS 10 Year Health Plan through practical, collaborative change. They focus on improving shared understanding, reducing duplication, and supporting implementation choices that embed equity by design rather than retrospectively addressing gaps. Taken together, these suggestions describe the delivery conditions needed to ensure that new innovative approaches, tools and models introduced improve equity in practice.

1. Strengthen shared approaches to prevention and equity metrics

Participants consistently highlighted the importance of shared metrics to maintain focus, enable comparison, and support accountability across systems and partners. There was recognition that bespoke or proliferating measures risk diluting effort and slowing action, particularly during a period of system change.

Ideas

- Support the development and adoption of a small, shared set of prevention and equity indicators aligned with national frameworks such as Core20PLUS5, to guide prioritisation and evaluation across programmes and partnerships.
- Encourage partners participating in pilots, test-and-learn initiatives, and prevention accelerators to align reporting against these shared measures and to share learning, including where interventions do not deliver expected impact.

2. Embed equity considerations earlier in digital, data and innovation design

Participants emphasised that digital, data and innovation-enabled approaches are progressing rapidly, but that equity outcomes are shaped by early design choices. Retrofitting mitigations was seen as less effective than building accessibility, inclusion and trust into tools from the outset.

Ideas

- Promote equity-by-design principles across digital, data and AI initiatives, including accessibility, language, literacy, and non-digital alternatives as standard design considerations.
- Encourage partners, including industry, to share disaggregated impact data where possible, to support understanding of who benefits, who does not, and why.
- Use forums such as this series to test emerging tools and approaches with patient organisations, VCFSE partners and frontline practitioners before wider rollout.

3. Strengthen meaningful patient partnership beyond formal engagement mechanisms

Participants noted that while patient voice is increasingly recognised in policy, translating this into meaningful influence on service design, commissioning and delivery remains uneven. There was concern about over-reliance on confident or "expert" patients and the risk of tokenistic engagement.

Ideas

- Support approaches that broaden whose voices are heard, including engagement through community organisations, proxy feedback from carers and families, and localised engagement in familiar settings.
- Share practical examples of how patient insight has shaped decisions, including changes to pathways, information design, or delivery models, to demonstrate value beyond consultation.
- Explore mechanisms for feedback loops that show participants how their input has influenced outcomes, to build trust and sustain engagement.

4. Support neighbourhood-based collaboration as a network rather than a structure

Neighbourhood health was consistently described as a way of working, with participants cautioning against defining it solely through buildings or formal structures. Participants highlighted the importance of relationships, local knowledge and shared purpose, alongside clarity on core entitlements and flexibility in delivery.

Ideas

- Capture and share examples of neighbourhood approaches that integrate health, social care, community services and non-clinical partners, including pharmacies, employers and voluntary organisations.
- Support clarity on the core offer expected from neighbourhood health, alongside space for local adaptation based on population need and geography.
- Encourage leadership models that value multidisciplinary contribution equally and support frontline autonomy within shared outcomes and joint accountability.

5. Improve access to trusted, inclusive patient information and reduce duplication

Participants identified persistent duplication in the development of patient-facing information and ongoing barriers to access where materials are complex, poorly signposted, or digitally exclusive. Trusted standards and central visibility were seen as enablers.

Ideas

- Explore options to improve visibility and access to trusted patient information resources across stakeholders, reducing duplication and supporting consistent quality.
- Encourage wider adoption of recognised standards for inclusive health information, including certification where appropriate.
- Support learning on reforming patient information formats, including medication leaflets and digital communications, to ensure clarity, accessibility and routes back into care.

Additional resources

British Red Cross, Exploring the high intensity use of Accident and Emergency services

Government:
- Equalities impact assessment: 10 Year Health Plan for England
- Fit for the future 10 Year Health Plan for England
- Impact statement: 10 Year Health Plan for England
- Digital Inclusion Action Plan: First Steps

Health Equity Evidence Centre, Good intentions, risks and missed opportunities: What the NHS plan means for health and care inequalities

Health Innovation Network:
- Forging a more equitable future through digital and data
- Forging a more equitable future through Patient and Public Involvement and Engagement
- Ten principles of health equity for innovators

NHS Confederation, Implementing the 10 Year Health Plan: ensuring an effective approach to change

NHS England:
- NHS England's statement on information on health inequalities
- Neighbourhood health guidelines 2025/26
- Inclusive digital healthcare: a framework for NHS action on digital inclusion
- National Healthcare Inequalities Improvement Programme
- Medium Term Planning Framework
- Tackling digital exclusion and health literacy: How libraries can help bridge the gap
- Strategic commissioning framework

Stiebahl, Sonja and Balogun, Bukky. Inequalities in life expectancy. House of Commons Library Research Briefing, 29 August 2025.

Patient Information Forum:
- Patient Information Forum homepage
- Fit for the future? What does the government's 10 year health plan need to succeed
- Knowledge is Power

Patients Association:
- Being a Patient
- Engaging patients to understand their experiences and expectations of rewards, recognition and remuneration for patient involvement
- Improving health equity for patients living with cancer and/or blood disorders

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This report has been produced by the Health Innovation Network on behalf of the Royal Society of Medicine