GK Look Ahead: Health and Social Care Policy

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INSIGHT | ADVOCACY

What to expect in health policy in 2026

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Labour marked its first anniversary in office, in July 2025, by publishing the *NHS 10 Year Plan*.

Alan Milburn (seen by many as the joint Secretary of State for Health and Social Care) said the document brought 'hope and clarity' to the sector but even the government's most fervent supporters agree it doesn't do both.

The Prime Minister regards success in health as getting back to the **NHS Constitution standard** of 92% of patients starting consultant-led treatment within 18 weeks of their referral by March 2029 (with interim targets of 65% by March 2026 and 70% by March 2027).

Ministers are by-and-large on track to meet the March target but the challenge for Health Secretary Wes Streeting remains that the extra funding secured from the Chancellor is front-loaded in this parliament (which is expected to end in 2029) whereas the targets get tougher towards the end.

When releasing the CSR, Chancellor of the Exchequer, Rachel Reeves was no doubt hoping that the economy would out-perform Office for Budget Responsibility (OBR) forecasts and Treasury would be able to give more funding to health in the latter years of the parliament. There is, however, no sign of the economy beating the projections to date; and resident doctors continue to go on strike.

It will be very hard to recover performance if the industrial action persists. We might expect a resolution (as the Scottish Government has shown is possible) and for the government to deliver improvements in performance but perhaps not enough for it to be sure of meeting its ultimate target. This will fuel feverish debate around public expectation and political consent for even more health spending.

2026 will be the year when long-term ambition collides with operational reality. The **10 Year Workforce Plan**, the forthcoming **10 Year Cancer Plan** (expected on February 4), big commitments around **neighbourhood health** and **digital promises** will all be judged less on intent and more on visible change for patients.

The central question remains; can the system genuinely shift from **firefighting to reform** while demand continues to rise?

Three things to watch:

1) The increasingly bitter dispute between the **Health Secretary and GPs**; will they move towards their own form of industrial action or even hand back contracts?
2) Tobacco, obesity and alcohol policies will be judged on implementation, not announcements, and doubts will persist around whether Number 10 has the political space to take on the **'nanny state'** protagonists.
3) Whether **Wes Streeting** remains as Secretary of State and the extent to which his policy agenda will survive transition to someone else.

The NHS will still command public loyalty but increasingly on the condition that it shows it can change – and deliver.

Political and policy outlook

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For the Department of Health and Social Care and health secretary Wes Streeting, 2026 must be a year of delivery.

The government's 10-Year Health Plan, published in July last year after a lengthy consultation process, set out a range of ambitions across digitalisation, prevention and neighbourhood-focused care. As we move into the crucial mid-point of the parliament, Streeting will need to demonstrate to the public tangible progress in each of these areas at a time when pressures on the health service continue to grow.

The health secretary's success will ultimately hinge on the NHS' ability to both respond to new and changing demands – people living for longer while managing multiple, complex conditions – and implement a package of reforms that shifts healthcare delivery out of acute settings and into the community in a meaningful way.

Doing so will not only modernise the NHS and put it on a more sustainable path for the future, but it will also give Streeting the political platform he needs to pursue his well-trailed personal ambition of succeeding Prime Minister Keir Starmer in No.10.

Dentistry – what's next?

Ministers published their version of the **dental recovery plan** just before Christmas.

This contained further structural changes to improve urgent care access, expand preventive measures (like supervised toothbrushing and fluoridation), and reform the NHS dental contract more substantially.

The plan also builds on the delivery of extra urgent dental appointments - 700,000 extra urgent and emergency dental appointments, targeted at "dental deserts" – and contract reforms in July 2025 to prioritise urgent and complex dental needs and incentivise dentists to provide more NHS work.

Stakeholders claim these reforms feel like another temporary fix with no new money. What does feel different and fundamentally important is the shift in language when it comes to NHS dentistry, with the government now speaking of "patients with the greatest need", "urgent and complex care" and "reducing unnecessary check-ups" through "creating capacity by prioritisation".

There has always been an assumption, vocalised by Tony Blair and repeated ad-nauseum since, that NHS dentistry was available to everyone even if access was patchy in practice. NHS dentistry is being reshaped as a targeted service around disease management and as a prevention service for children, rather than a universal service catering to the entire population.

Three things to watch:

1) **More Fundamental Dental Contract Reform** - reforming the NHS dental contract to shift away from UDA-centric (unit of dental activity) payments toward models that better reward prevention, urgent care, and long-term treatment. Proposals consulted in 2025 might begin to be implemented in April 2026.
2) **Workforce Incentives and Retention** – expect stronger incentives for dentists to take on NHS work and requirements for newly qualified dentists to provide NHS care for a period after training (as trialled by the last government).
3) **Public health and prevention scaling** – will preventive programmes, including supervised toothbrushing in early years education, be implemented by the sector and will ministers override local objections to expanded fluoridation schemes in the water supply?

Community pharmacy – what's next?

In March 2025, Community Pharmacy England (CPE) landed an impressive new funding settlement with the government which many saw as a vote of confidence in community pharmacy.

Despite the uplift, community pharmacists know the fragility of their businesses and the difficulty of the 30% real terms cuts in funding since 2014, backed up by the independent economic review of the sector published in March 2025.

The community pharmacy sector will feel encouraging signs for the future, such as the ambitions, outlined in the NHS 10 Year Plan, for it to play an integral role in the neighbourhood health service, prevention and, of course, long-term condition management.

Labour's manifesto commitment to a **'Community Pharmacy Prescribing Service'**, building on Pharmacy First - with the new generation of IP qualified pharmacists – fuels hope.

Why do we say the community pharmacy network remains fragile? The 19p increase to the SAF (Single Activity Fee) has largely been wiped out by the rises in the National Minimum Wage, Employer's National Insurance and inflation.

Analysis by CPE highlights reduced opening hours and continued closures which pose significant risks to the entire network. Yet, despite the challenges, because of reforms over many years, community pharmacy has a contractual framework that now finally realises the **clinical potential** of community pharmacy.

Expect a strong clinical and economic case to be made this year for the Discharge Medicines Service and the New Medicine Service. We also expect a case to be made for broadening the Hypertension Case-Finding Service into a hypertension management service, expanding its role in women's health, and in weight loss, and developing an open access stop smoking service.

In Pharmacy First, the Hypertension Case-Finding Service and Pharmacy Contraception Service show great potential to build for the future. It should be expanded to include integral roles for prescribers, widened to cover more minor ailments, with medication reviews and de-prescribing commissioned, all supported by increased pharmacist flexibilities to change prescriptions. This would be very popular with the public.

Finally, it's clear that community pharmacy could do much more to deliver a wider range of NHS vaccinations. Ministers will have to decide whether they want to better use what is a trusted and consistently productive part of the health sector.

Three things to watch:

1) As CPE heads towards a **new funding round** this year, we're going to witness a rear-guard action from Janet Morrison's (Chief Executive of CPE) team to KEEP existing clinical services - not add NEW ones.
2) Will community pharmacy watch and learn from the success pubs have had in forcing a U-turn on business rates courtesy of a **robust and punchy political campaign**?
3) Will **community pharmacy finally benefit** from the 10 Year Plan promise to do more in the community funded by a reduction in hospitals' share of total NHS expenditure?

What else should we expect?

Three other areas to watch:

1) **Technology, data and AI: from pilots to practice** – digital transformation will be less about shiny innovation and more about interoperability and basic data sharing, productivity gains from automation and AI in diagnostics, as well as public trust, governance and clinical accountability.

   The winners in 2026 will be technologies that save staff time and get anywhere near the kind of productivity shift HM Treasury will have insisted on via the Comprehensive Spending Review process - not just those which impress ministers.

2) **Workforce: retention over rhetoric** – this year the debate should move decisively from training pipelines to retention, productivity (again) and morale. Watch whether pay settlements and contract reforms stabilise staffing and for progress on promised reduction of reliance on agency staff and, critically, the impact of expanded roles (advanced practitioners, pharmacists, physician associates). Workforce will remain the binding constraint on every NHS ambition.

3) **Social care: unresolved but unavoidable** – health reform will continue to be constrained by the absence of a durable social care settlement. Hospital flow, delayed discharges and workforce duplication will keep social care central to NHS performance.

   Expect continued incremental reform even if comprehensive solutions, courtesy of the Casey Commission, remain elusive. That work will continue to look towards the Labour Party manifesto in 2029. The year ahead will not solve social care, nor will HM Treasury allow it to, but it will underline (again) that the NHS cannot succeed without it.

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