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Internal Management Consulting in the NHS in England

– Landscape and policy options

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Executive Summary

The context

- Specialist management capability and capacity are crucial for the success of the NHS to deliver its services to patients and the community, especially to support change.
- This can be provided in different ways, including the use of external consultants, but recent research in the NHS shows that it is usually more efficient and effective to use internal sources, with externals used sparingly and in limited contexts. This also echoes UK government policy and Cabinet Office guidelines as well as developments in other public sector contexts internationally.
- Although the label internal consultancy is not always used, specialist, project-based advice and support in management and organisation exists across the NHS. However, little is known about the overall provision and its different forms.
- This report is, to our knowledge, the first attempt to map the internal consulting landscape in the NHS in England. The aim is to inform and stimulate policy as well as alert potential clients and partner organisations (e.g. externals) to current provision.

The research

- Based on a workshop, exploratory interviews and web-based research, it maps consultancy supply across the NHS reflecting different levels of internality-externality but focuses on internal provision. In particular, it reviews the different dimensions of the internal consulting landscape; sets out implications for providers, clients and policy makers and summarises the characteristics of a diverse range of internal consulting organisations.

A variety of insiders and outsiders

- The source of specialist advice – in terms of being NHS insiders or outsiders and forms of ownership - can be important. Supply varies from global, generalist private sector firms to small specialist not-for profit organisations and, within the NHS, national, regional and trust-based units and even individuals (see Table 1).
- If internal consultancies are to operate as system assets, reducing reliance on external firms and retaining and developing capability within the NHS, there is a need for more proactive and strategic choices about ownership arrangements and capacity building.

Governance and funding

- Governance of consulting units typically sits within host trust boards, hosted-services boards, or NHS England directorates, with varying degrees of operational autonomy for consulting organisations. This diversity allows for some coordination, but also innovation and enterprise.
- Funding models fall into four broad types: trust-funded; self-financing / income-generating; NHS England or regional “envelope” funding (services free at point of use); membership or subscription-based. There is sometimes a tension between behaving commercially while remaining public-service organisations. Without clearer policy choices about the role of funding (e.g. reducing reliance on external providers), financial fragility is likely to persist.

Competition

- Apart from some specialist areas, competition is seen as being external providers. Other internal units are not typically regarded as competitors, but peers and potential collaborators. Indeed, there is also collaboration with external consultancies and scope to develop this further. However, the low visibility to clients and lack of coordination of internals adds to a perceived relative disadvantage among providers. A level playing field could be sought through better communication and clarifying procurement rules for using internals.

Services offered

- While the overall service offer from internal consultancies is diverse, activity is concentrated in a number of core areas: strategy, transformation delivery (e.g. project management) and data analytical support. In addition, common areas include quality improvement and leadership and organisational development services. In addition, a range of highly specialised services are offered as well as the generic role of knowledge transfer or sharing which internal providers are relatively well placed and motivated to provide (see also Table 2). The balance of provision needs to be linked to workforce planning activity and management and leadership development at NHS and local levels as well as the development of the NHS as a learning system

Geographical reach and clients

- Internal consultancies function primarily as regional system assets rather than fully national resources (see Table 3). If greater consistency of access and learning is desired, there may be a need to improve visibility, coordination and connectivity across regions, while preserving the locally grounded relationships that underpin effectiveness.
- Most internal consultancy clients are within the NHS. However, if integrated care, prevention and cross-sector collaboration are to be strengthened, there may be a need to enable internal consultancies, through clearer mandate, funding or governance, to engage more consistently beyond NHS organisational boundaries, while preserving their core role in strengthening NHS capability and delivery.

Collaboration

- Internal consultancies sometimes act as translators and integrators in collaborations with external providers, tasked to ensure that NHS context, clinical voice and considerations of sustainability are reflected in delivery. There is considerable potential for all parties in internal-external collaboration but risks too for internals such as being by-passed or substituted over time.

Measuring value

- Internal consultancies reported using a mix of formal approaches to evidence impact such as financial measures, client feedback and follow up reviews but there is a misalignment between the kinds of change the NHS increasingly seeks, such as system transformation, leadership capability and cultural change, and valid metrics. There is a need to support more proportionate, credible and shared approaches to impact assessment and recognise that this also applies to external consultancy.

The workforce

- Many internal consultancies operate with very small core teams (less than 10) although a minority have grown to the low hundreds and associates are widely used. Staff retention is high because of the nature and importance of the work, but challenges exist from the inability to compete with private-sector pay and reliance on fixed-term or uncertain funding and headcount controls. Systematic workforce planning, more flexible employment models and clearer career pathways are needed.

Advantages and challenges

- Internal consultancies claim key advantages: deep NHS and system understanding; trust, legitimacy and, in many cases, strong clinical credibility; lower cost; and a focus on resolution and capability building rather than dependency. However, they also report challenges associated with a lack of clarity over procurement procedures; financial insecurity; weak national coordination and visibility; small scale and limited scope for partnerships; and a structural tension with NHS employment models.
- This report raises a key strategic question: whether internal consultancies are to remain fragmented, hidden, semi-formal responses to local need, or whether they should be more explicitly recognised, communicated, coordinated and supported as part of the NHS's core improvement infrastructure while maintaining local variation and client autonomy.
- If you are interested in further details of the research or plans to establish a network of internal consultancies in the NHS (to communicate to clients; facilitate partnerships and support management development), contact details are provided at the end of the report.

Contents

Introduction

Internal consultancies in the field of management and organisation are an important feature of the NHS landscape in England. Many emerged in response to repeated structural reform, financial pressure and growing demand for improvement and transformation. These teams sometimes operate across trusts, systems, regions and national bodies. They have a wide variety of forms and titles, ranging from small, trust-embedded teams to national organisations, and deliver services spanning strategy, transformation, improvement, analytics, leadership development and clinical service and pathway review. Yet despite their growing, and sometimes longstanding presence, internal consultancies remain less visible and understood than their external counterparts, and their role within the NHS policy, learning and improvement ecosystem is often implicit and therefore, not fully recognised. The low profile is, in part due to the fact that the term 'consultancy' is not always used to refer to this form of **specialist, project-based advice and support in management and organisation**, which is the definition that we are using (Sturdy, Wright, and Wylie, 2015). For example, we include consortiums and organisations such as improvement and transformation teams, acute provider collaboratives, NHS Elect, Advancing Quality Alliance, and Commissioning Support Units.

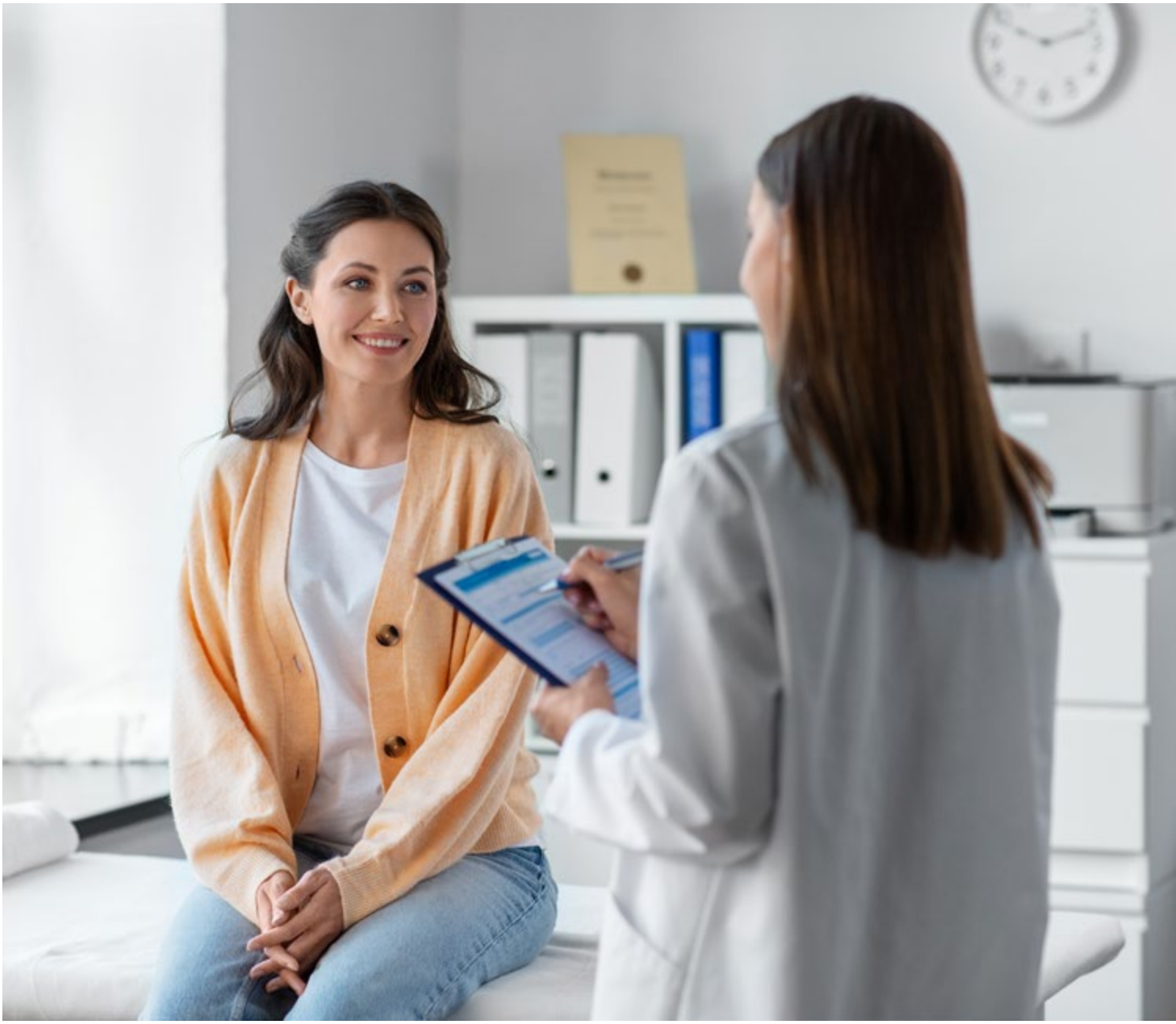
This report is, to our knowledge, the first of its kind. It examines the internal consultancy landscape in the NHS in England, drawing on interview data from a diverse set of organisations or units gathered in 2025-26, a period of significant re-organisation across the NHS. Although we sought to cover the full range of organisational types, we relied partly on 'snowball sampling' (asking interviewees for names) and our list is by no means exhaustive (see Appendix A). In particular, small units embedded within Trusts were sometimes hard to find. Indeed, it is not clear whether a central database of internal consulting suppliers exists.

However, and importantly, the study builds on ongoing quantitative research at the Universities of Bristol and York on the relative value (financial performance) of internal consultancy in the NHS in England (Sturdy, Armit and Kirkpatrick, 2025). Here, initial findings suggest that in general, internal consultancy performs better, but limited use of external consultancy can also have some positive outcomes. In short, optimal results are associated with a blend of internal resources with limited external use. These findings echo longstanding (e.g. Cabinet Office) policy on consultancy use (Cabinet Office, 2022) across government and led us to explore in more detail the nature of specialist internal management and organisational advice available in the NHS.

Although we mention and detail some specific organisations (see Appendix A), the report focuses on identifying cross-cutting patterns, forms and tensions that shape what internal consultancies are able to do and how they contribute to system priorities. Policy and practical implications for internal consultancies, clients, and policymakers are considered throughout the document which is organised in terms of the following dimensions:

- Ownership/embeddedness
- Governance
- Funding
- Competitors
- Services and products
- Geographical reach
- Clients
- Service areas of growth and decline
- Experiences of working with external consultancies
- Measuring impact and value
- Workforce, recruitment and retention
- Advantages and challenges of the internal consultancy model.

The analysis is particularly timely, as national policy in the NHS and public sector more widely (NHS England, 2025, 2026; National Audit Office, 2025) emphasises: locally led improvement; digital transformation; the NHS as a 'learning system'; and the importance of management capacity and capability (Kirton, 2026). Internal consultancies are potential assets in all these areas, not least because they often focus more on knowledge sharing and avoiding client dependency. At the same time, we shall see how they face persistent structural challenges relating to funding security, governance, procurement processes, workforce sustainability and impact measurement. By examining these issues, the report aims to inform more deliberate conversations among internal consultancies, clients and senior leaders and policymakers about how internal consultancy capability can be sustained, coordinated and deployed to greatest effect across the NHS. For example, how might a network of providers be established to support NHS clients; collaboration between units and with external organisations; and the development of management capability and capacity more generally? (Sturdy et al, 2025)



The research

Overview

As noted above, the focus on internal consultancies developed from a programme of research examining how management expertise is sourced and used in the NHS. Early work identified inefficiencies associated with reliance on external management consultancy (Kirkpatrick et al, 2019), prompting wider consideration of alternative sources of expertise, including internal consultancy, broadly defined. Current research comparing internal and external provision indicates that, while internal specialist expertise is generally more efficient, limited and targeted use of external consultancy can also add value, highlighting the importance of blending rather than substitution. This insight informed an exploratory qualitative applied research project in 2024-5 looking at how internal and external consulting resources are combined in practice across NHS organisations (see Sturdy et al, 2025 for more detail). The resulting typology of blending (see Table 1) illustrates varying degrees and forms of integration within the NHS consulting ecosystem. A notable finding was the apparently wide range of internal consultancy forms operating across the NHS, which prompted further investigation in 2025-2026. This involved a workshop of over 70 clients and consultants in June 2025 and 35 interviews with senior practitioners in internal consultancies of different types. Other documentary sources and websites were used, including in preparing the profiles of illustrative consulting organisations (see Appendix A). Together, this has culminated in the present report, which offers a detailed account of consulting roles, configurations and contributions to organisational capability.

Table 1 – Internality and externality of 'consultancy' in the NHS – organisational illustrations[1]

Source	Description	Examples
Internal - Trust Only	Individuals or units with 'clients' within Trust	QI, transformation and innovation teams
Internal - Trust Plus	.... with clients within and beyond Trust	The Strategy Unit (Mid- and South Essex NHS FT); SLaM Partners (South London and Maudsley NHS FT); Tavistock Consulting; Northumbria Healthcare NHS Foundation Trust
Internal - Sub-National	Hosted at Trust/regional/ CSU level, but clients beyond host (includes membership models)	CSU's - Arden and GEM; South, Central and West; North of England Care System Support; and Midlands and Lancashire CSU (encompasses The Strategy Unit, The Transformation Unit, Proud2bOps, NHS Horizons); The Health Economics Unit; RUBIS.Qi; Advancing Quality Alliance (AQuA); NHS Elect; Mersey Internal Audit and Assurance (MIAA); Transformation Partners in Health and Care; Health Innovation Networks ; 33n; Acute Provider Collaboratives; Clinical Senates
Internal - National	Hosted by NHS nationally (includes membership models)	NHS Interim Management and Support (IMAS); Q Community, NHS Alliance
Internal - External Hybrid	National – private sector/ NHS hybrid	NHS Shared Business Services
External - Healthcare Oriented	Private sector, VCSE's, think tanks and other providers with clients in NHS and related organisations	UK voluntary, charity and social enterprises (VCSE): Healthcare Quality Improvement Partnership (HQIP), King's Fund, Health Foundation, Kaleidoscope Health and Care, National Association of Primary Care, PPL. Private sector: Carnall Farrar. International Not for Profit: Virginia Mason Institute, Institute for Healthcare Improvement
External - Public Sector Oriented	Providers with explicit and exclusive public/not for profit sector focus and espoused values	The PSC
External - Healthcare / Public Sector Function	Medium-large providers with specialist healthcare division/department	Deloitte; KPMG; PWC; PA Consulting
External – Generalist / Technical	Providers of general or specialist skills, but not specific to NHS/health	Engineering, legal, architectural, IT firms, (e.g. Arup)

1 This is not an exhaustive list of all consultancies within or providing to the NHS and not all the above use the term consultancy to describe their services.

2 Health Innovation Networks (HINs) are commissioned by NHS England and the Office for Life Sciences, and each network is locally hosted (often by an NHS Trust or partnership) and structured as a distinct entity, while collectively governed at national level. Variation in hosting, governance and commissioning arrangements across regions shapes how HINs align within this typology; for the purposes of this table, they are positioned within the internal, sub-national policy category reflecting their regional footprint and system-facing role. More generally, hosting may not match geographical reach of services delivered or clients (see Table3).

Dimensions of landscape

There are multiple ways of categorising and describing the organisation of internal consultancy within organisations. For example, existing frameworks, including from an ongoing UNESCO study of internals in national governments, distinguish forms based on factors such as purpose, structural location, degree of formalisation and independence and relationship to organisational strategy (University of Bristol, n.d.; Sevciuc, 2025). Building on these, we also drew on factors which were identified as important to our interviewees. This led to the development of a set of dimensions that reflect how internal consultancies are constituted and function in practice, capturing differences in their roles, capabilities, positioning and degree of integration with organisational processes. These categories provide a NHS context-sensitive typology that complements existing models.

Ownership/embeddedness

"Because we're part of the NHS, we understand the culture and the challenges our clients face. That gives us a level of trust and credibility that external consultancies often lack."

– NHS internal consultancy leader

As the term implies, internal consultancies are predominantly owned by and embedded within the NHS, with most hosted by:

- NHS Trusts (acute, mental health, or integrated)
    - Embedded with services only provided internally
    - Embedded with services provided internally and externally
    - Trust-owned but work is predominantly external to the organisation (within and beyond NHS).
- A consortium of NHS organisations, often operating at a regional level (e.g. Acute Provider Collaboratives).
- NHS England (e.g. CSUs, IMAS): operating at regional or national levels[3].

A smaller number operate as hybrid or arm's-length entities (e.g. Clinical Senates), or joint ventures (e.g. NHS Shared Business Services, some Health Innovation Networks). Nevertheless, overall, their form prioritises public value, NHS alignment, and reinvestment over profit.

[3] Note that significant change is under way in the NHS such as the closure of NHS England. These have implications for the structural location or hosts of internal consultancies (e.g. in CSUs).

For **internal consultancies**, anchoring within public bodies is widely viewed as a strength as NHS ownership/embeddedness confers legitimacy, trust and value alignment. However, being situated within the NHS requires compliance to particular public sector arrangements which places constraints around autonomy, risk appetite and commercial freedom. These issues are explored in the following sections.

For **clients**, NHS ownership/embeddedness influences consultancy behaviour and experience as NHS-owned and arms-length consultancies can be relied on to be oriented towards long-term system benefit and capability building, fostering trust and continuity, but may be perceived as less independent or less scalable in certain contexts.

For **policymakers**, the findings underline that ownership is not a neutral design choice. Different ownership models enable different types of contribution, and if internal consultancies are to operate as system assets, reducing reliance on external firms and retaining and developing capability within the NHS, there is a need for more proactive/strategic choices about ownership arrangements and capacity building.

Governance

"Our governance is aligned with NHS structures, which means we're accountable to the same standards and oversight as the rest of the organisation."

– NHS internal consultancy leader

Governance arrangements have sometimes evolved towards greater formalisation, as many internal consultancies originated informally (for example as taskforces, project teams or functions) and later developed clearer governance structures in response to NHS restructuring, including the introduction of Integrated Care Boards, Commissioning Support Unit consolidation and trust mergers. As well as structural changes, several organisations emphasised that governance shifts were driven by increased financial scrutiny, and the need to justify legitimacy and value relative to the claims and reputation of external consultants. Some models are explicitly designed to preserve clinical or advisory independence (e.g. Clinical Senates).

Governance typically sits within host trust boards, hosted-services boards, or NHS England directorates, with varying degrees of operational autonomy for consulting organisations.

For **internal consultancies**, governance design shapes their ability to act as credible, responsive partners, requiring them to balance autonomy, speed and challenge with accountability to host organisations and compliance with NHS financial and assurance expectations.

For **clients**, clear governance arrangements such as mandates, decision rights and escalation routes may enable efficient delivery and support constructive challenge, while less well-aligned governance may affect responsiveness or create uncertainty around accountability.

For **hosts and policymakers**, if internal consultancies are to operate as enduring organisation and system assets rather than ad hoc solutions, governance arrangements need to be considered, balancing oversight and flexibility, and supporting sustainability of these teams and the extent of their contribution to improvement.

Funding

"So, with consulting, the team has no budget, so the team only exists in the same way the industry does - to the extent that it can sell, deliver work and get paid for it."

– NHS internal consultancy leader

While some advice is given without consideration of payment or funding - with goodwill or in helping to develop relationships or return favours – funding models fall into four broad types:

1. Trust-funded – The host organisation provides core funding for the team, with an expectation that it will lead to or support improvements and transformation aligned to strategic objectives, often with the aim of reducing costs or improving efficiency and productivity.
2. Self-financing / income-generating: Consultancy must recover full costs through client work (often at not-for-profit rates). This was common among trust-hosted consultancies and hybrid organisations. Rates are typically much less than external firms of all types.
3. NHS England or regional "envelope" funding: which often meant services were free at point of use (e.g. Clinical Senates, IMAS), but such internal consultancies are vulnerable to national budget pressures and priorities.
4. Membership or subscription-based funding models: often combined with consultancy project income (e.g. improvement organisations). This has the advantage of giving some financial stability and developing client relations.

Across models, financial fragility is common as few internal consultancies have secure core funding and many face pressure to break even or generate surplus while operating under NHS pay, procurement and workforce constraints.

For others, their capacity is linked to transformation and cost improvement programmes within host organisations.

For **internal consultancies**, the prevalence of self-financing and mixed funding models creates persistent uncertainty, shaping behaviour towards cost recovery and short-term delivery while constraining investment in staff, capability and innovation. Consultancies reliant on envelope funding face a different risk profile, with stability closely tied to national priorities and budget cycles, limiting long-term planning and capability development.

For **clients**, funding models influence how value is experienced as well as both access and commissioning behaviour: fee-based consultancy requires explicit trade-offs and prioritisation, while free-at-point-of-use services risk being oversubscribed or abruptly constrained when funding tightens.

For **policymakers**, the findings highlight a structural tension in expectations. Internal consultancies may in some cases be expected to behave commercially, breaking even or generating surplus, while remaining public-service organisations. Without clearer policy choices about the role of core funding, acceptable levels of commerciality, and how internal consultancies contribute to reducing reliance on external providers, financial fragility is likely to persist, limiting their effectiveness as stable system-wide assets. At the same time, some market discipline and client autonomy over sourcing helps ensure service quality.and supporting sustainability of these teams and the extent of their contribution to improvement.

Competitors

"We do compete with external consultancies, but our unique selling point is our NHS experience and our not-for-profit ethos."

– NHS internal consultancy leader

As one might expect, the primary competitors to internal consultancies are external providers, particularly large multi-national consulting firms and specialist providers, but also more generally. Internal consultancies rarely view other NHS consultancies (or other NHS employees) as direct competitors; instead, they are more often seen as complementary, potential collaborators, or peers facing similar structural conditions. Some distinct models (such as Clinical Senates and specialist evaluation units) reported minimal direct competition, operating in niches that external firms struggle to occupy credibly or where internal independence is required. Together, these patterns highlight that competition for internal consultancies is shaped less by rivalry within the NHS and more by comparison with the private consultancy market.

"I've worked in a large acute trust that brought one of the Big 4 in and, don't get me wrong, they've absolutely got a place to play... The bit I would say that we've got that maybe they don't always have... I'm not sure they always leave (the client) having built capacity and capability in the teams...They get more business by being needed."

– NHS internal consultancy leader

For **internal consultancies**, this competitive context reinforces the importance of articulating a clear value proposition grounded in NHS knowledge, trust, and system alignment and learning rather than scale, branding, or marketing power associated with some externals. The emphasis on complementarity rather than competition within the NHS also points to opportunities for collaboration and joint working (with externals as well as internals), while underlining shared structural challenges, particularly around procurement (see also Advantages and Challenges section below), visibility and perceived legitimacy relative to external firms.

For **clients**, the landscape creates both choice and complexity: external consultancies may be selected for perceived independence, speed, capacity or specialist expertise, while internal consultancies offer continuity, contextual understanding and reinvestment of value within the system.

For **policymakers**, these findings suggest that competition in consultancy markets is not occurring on a level playing field, including where external organisations are engaged to provide credibility or assurance rather than capability. If reducing reliance on external firms and strengthening NHS-based capability is a policy objective (as it is elsewhere in the public sector), there is a need to recognise internal consultancies as strategic system assets, support collaboration rather than fragmentation, and ensure commissioning and procurement practices/ perceptions do not inadvertently favour external providers (again, see Advantages and Challenges section below).

Services and products

"We give guidance, we're a critical friend, we will review and give an opinion."

– NHS internal consultancy leader

The services provided by internal consultancies are shaped by a range of factors: NHS strategic priorities (national, regional, trust level); internal capability and credibility; and organisational values (e.g. improvement, independence, public good). Indeed, some consultancies avoid offering services where they cannot add distinctive NHS value, even if they are in demand and commercially attractive. Furthermore, as noted earlier, internal consultancies also often provide informal advice and guidance to peer organisations on a goodwill basis, reflecting sector norms of collaboration and mutual support. This can help strengthen relationships with existing partners as well as build connections with potential future clients, sometimes leading to more formal engagement over time. At the same time, it has resource implications.

While the overall offer from internal consultancies is diverse, activity is concentrated in a number of core service areas, with additional specialist functions provided by only a few organisations (see also Table 2).

"We offer a range of services, from process improvement to digital transformation, tailored specifically for NHS organisations."

– NHS internal consultancy leader

Core services

From our sample, the most frequently offered services relate to strategy, *transformation delivery and analytical support. Strategic advice and transformation support* form the backbone of most internal consultancy portfolios, typically addressing system priorities such as access, productivity, service reconfiguration, and financial sustainability. This is closely coupled with programme and project management, arguably a core management (rather than consultancy) skill enabling organisations to move from strategic intent to implementation.

Data analytics and modelling capabilities are also widely embedded, ranging from decision support analytics to more advanced modelling and evaluation. In many cases, these analytical services underpin strategic and transformation work rather than being offered as standalone products.

Common services

A second tier of services is present across some organisations. *Quality improvement and improvement capability building* feature prominently among trust-hosted and regionally focused consultancies, often framed as long-term partnerships rather than associated with discrete projects. In several Trust-embedded models, as with consultancy in general, work extends beyond advisory roles into direct delivery of improvement, performance and financial recovery programmes. Relatedly, *leadership and organisational development services*, including coaching, facilitation and team development, are offered by a substantial subset of consultancies, particularly those with an explicit improvement or people centred ethos.

Digital transformation and automation services also sit within this middle tier. Some internal consultancies provide end-to-end digital and automation support, while others focus on advisory or enabling roles, often working alongside separate digital teams or external suppliers. *Clinical service redesign and pathway optimisation* is similarly common but not universal, appearing most strongly in organisations with established clinical credibility or links to provider collaboratives.

Specialist and niche services

Some services are delivered by a small number of organisations, reflecting the specialist capabilities, governance arrangements or resource models required. Senior interim leadership provision and turnaround support is a clear example, concentrated in a single national internal consultancy with a distinct mandate and funding model. Likewise, independent clinical review, particularly in politically sensitive service reconfiguration contexts, is confined to arms length structures designed to preserve perceived independence. Highly specialised forms of organisational development, such as system-psychodynamic consultancy or evaluation also fall into this category.

Services are delivered through a range of approaches, from desk-based analysis and advisory input to providing in-depth expert reviews and recommendations. Delivery can also involve facilitation and co-design activities (such as workshops and stakeholder engagement), programme and project management support, or training and capability-building. In some cases, internal consultancies work alongside teams to support implementation, provide evaluation or assurance, or offer expertise through embedded roles or secondments within operational settings. In the latter case, there can be ambiguity between consultancy and interim management which is associated with 'business as usual'.

Knowledge sharing

Neither internals nor externals are always tasked by clients for knowledge transfer/sharing. This is a common failing across sectors and needs to be better managed. Indeed, consultancy use from whatever source can play a key role in management development by exposing staff to different approaches, tools and ways of thinking, often through joint working on projects. In particular, consultancies can support capability building by embedding learning in day-to-day work, helping managers to develop skills in areas such as problem-solving, change leadership and data use while delivering improvement. This is reflected in the call in central government to 'buy once' and is a particular strength of internal consultancy where there may be less incentive to sell on and more to reduce client dependency risk.

Internal consultancies, collectively demonstrate significant depth in strategic, transformational, analytical and improvement-oriented work, areas central to current NHS priorities. However, the relative scarcity of some specialist functions means that systems continue to rely on a small number of internal providers or, in some cases, external consultancies when needs arise that require scale, neutrality, or highly distinctive expertise.

For **clients and policymakers**, these patterns suggest opportunities to better recognise and deploy internal consultancy capacity in core service areas, while also being realistic about where specialist provision is rare and structurally constrained. It adds to the need for very clear workforce plans, in line with those being developed across the public sector (National Audit Office, 2025). For internal and external consultancies alike, the findings underline the importance of clarity about comparative advantage, collaboration across organisational boundaries, and purposeful commissioning aligned to the nature of the work being undertaken.

Table 2 – Summary of selected NHS internal consultancy services (see also Appendix A)

	Acute provider collaboratives	Advancing Quality Alliance (AQuA)	Clinical Senates	MIAA (Solutions)	MSE Strategy Unit	NHS Elect	NHS IMAS	NHS ML CSU - NHS Horizons	NHS ML CSU - NHS Strategy Unit	NHS ML CSU - NHS Transformation Unit	NHS Shared Business Services	NHS SCW CSU - Transformation Team	NHS Alliance	Northumbria Healthcare NHS Foundation Trust	Q Community	Rubis.QI	SLaM Partners	Surrey and Sussex Healthcare NHS Trust	Tavistock Consulting	Transformation Partners in Health and Care	A Health Innovation Network	University Hospitals of Liverpool Group - Transformation Delivery Unit	Internal Sub-national consultancy
Strategy / Advisory	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
Transformation / change	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quality improvement (QI)	✓	✓		✓	✓	✓		✓				✓		✓	✓	✓	✓	✓	✓	✓	✓		
OD / leadership development		✓		✓		✓		✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓			
Analytics / evaluation	✓	✓	✓	✓	✓				✓	✓		✓		✓		✓				✓	✓	✓	✓
Digital / automation				✓	✓				✓	✓	✓	✓		✓						✓	✓		✓
PMO / delivery support	✓			✓						✓		✓				✓				✓		✓	✓
Clinical service redesign	✓		✓	✓	✓				✓	✓		✓		✓						✓	✓	✓	✓
Finance and corporate services				✓						✓	✓	✓								✓			
Interim leadership				✓			✓																
Engagement / consultation	✓		✓	✓				✓	✓	✓		✓	✓		✓				✓	✓			

Geographical reach

"What we're trying to do is make sure we're financially stable where we are and delivering great work in the NHS, but at the same time thinking really carefully about... are we going to have an international market."

– NHS internal consultancy leader

As implied by their different forms and ownership, internal consultancies operate across different geographical scales (see Table 3). Some are embedded within individual trusts and provide limited consultancy outside trust boundaries, although some large provider organisations operate internally across multiple sites or group structures. Others are hosted by trusts but operate primarily beyond those boundaries, working across multiple organisations or at regional level. A further set of consultancies work across multiple levels, including trust, regional, national and, in some cases, international or cross-sector contexts.

Most internal consultancies do not operate uniformly across the country, although their work often aligns closely with national policy priorities. Hosting arrangements play a significant role in shaping geographical reach. When ICS-level and NHS England regional activity are considered together, regional and Trust-level geographies emerge as the awareness vary widely, and expansion beyond regional boundaries is typically driven by relationships rather than formal mandate. Regionally anchored models enable deeper contextual understanding and strong relationships but can limit opportunities to scale learning and impact systematically across the NHS.

For **internal consultancies**, these patterns suggest that their ability to create impact at scale depends less on formal mandate and more on networks, reputation and collaboration, placing importance on stronger coordination and knowledge-sharing across the system.

For **clients**, geography shapes access and experience: regionally embedded consultancies often bring significant local credibility and insight, but availability of support can vary depending on location, awareness and existing relationships, even where challenges are shared nationally

For **policymakers**, the findings suggest that internal consultancies function primarily as regional system assets rather than fully national resources. If greater consistency of access and learning is desired, there may be a need to improve visibility, coordination and connectivity across regions, while preserving the locally grounded relationships that underpin effectiveness. Without such attention, geographical variation in access to internal consultancy capability is likely to persist.

Table 3 - Summary of geographical reach of services/clients delivered by selected NHS internal consultancies

	Acute provider collaboratives	Advancing Quality Alliance (AQuA)	Clinical Senates	MIAA (Solutions)	MSE Strategy Unit	NHS Elect	NHS IMAS	NHS ML CSU - NHS Horizons	NHS ML CSU - NHS Strategy Unit	NHS ML CSU - NHS Transformation Unit	NHS Shared Business Services	NHS SCW CSU - Transformation Team	NHS Alliance	Northumbria Healthcare NHS Foundation Trustt	Q Community	Rubis.QI	SLaM Partners	Surrey and Sussex Healthcare NHS Trust	Tavistock Consulting	Transformation Partners in Health and Care	A Health Innovation Network	University Hospitals of Liverpool Group - Transformation Delivery Unit	Internal Sub-national consultancy
Trust based				✓					✓			✓		✓		✓	✓	✓	✓			✓	✓
Provider to provider		✓		✓					✓	✓				✓		✓	✓	✓	✓	✓		✓	✓
Regional	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓			✓	✓	✓			✓	✓		✓
National (England)		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓		✓	✓	✓	✓		✓
UK wide			✓	✓	✓		✓	✓	✓			✓	✓		✓	✓			✓	✓				
International		✓						✓					✓		✓				✓		✓			

Clients

"Whilst our work is primarily in health (whether that be NHS England, ICBs, providers, whether that be acute, community, mental health or indeed, primary care), we have done, and are starting to do more, work now for local government. We've also done work for … academia, a national agency … (and) people like … DHSC over the years as well."

– NHS internal consultancy leader

Most clients of internal consultancies are within the NHS, including: large trusts or trust groups; NHS England (at both national and regional levels); Integrated Care Boards; NHS trust boards and executive teams; provider collaboratives and networks; and clinical leaders and professional groups. Other, secondary clients include: local government; charities and voluntary sector organisations, universities and academic partners, and patients and the public, most visibly through evaluation-focused work and Senate models. Work with private sector clients does occur but is typically closely aligned to NHS values and objectives, rather than acting as a core revenue driver.

For **internal consultancies**, the dominance of NHS clients reinforces strong alignment with public value, policy priorities and clinical credibility. However, it also concentrates exposure to NHS financial pressures, commissioning behaviour and shifting national priorities, thus increasing vulnerability when funding or mandates change. Engagement with non-NHS clients can strengthen legitimacy, breadth of insight and system learning, but is often constrained by remit/mission, capacity and funding.

For **clients**, this NHS-centric model offers reassurance that support is grounded in system knowledge and public-service accountability, though it may limit the diversity of external perspectives and vary in its ability to bridge effectively into local government, the voluntary sector or wider place-based partnerships.

For **policymakers**, the findings underline the role of internal consultancies as NHS-focused system assets rather than general-purpose advisory bodies. If integrated care, prevention and cross-sector collaboration are to be strengthened, there may be a need to enable internal consultancies, through clearer mandate, funding or governance, to engage more consistently beyond NHS organisational boundaries, while preserving their core role in strengthening NHS capability and delivery. Here too, there is a role in purchasing and beyond for coordinating selected partnerships between internal and external providers for mutual learning and benefit.

Service areas of growth and decline

"Demand for our services has grown as NHS organisations look for more cost-effective consultancy options."

– NHS internal consultancy leader

Internal consultancies reported some clear areas of growing demand. These include:

- Digital, data and analytics work (including AI and automation);
- Major service reconfiguration and politically sensitive change;
- Productivity, efficiency, cost-improvement programmes particularly in organisations operating under financial recovery or regulatory oversight conditions;
- Leadership and organisational development during periods of system change;
- Complex system-level transformations such as waiting list recovery and workforce redesign.

By contrast, demand has declined or become constrained for: basic communications and transactional support; traditional classroom based training; discretionary improvement work without a clear return on investment; and some centrally funded work as a result of wider NHS financial tightening.

Across host organisations, capacity constraints, rather than lack of demand, were frequently identified as the primary limitation on internal consulting growth. These patterns of expansion and contraction have important implications for how internal consultancies position their offer and how they are used within the system as well as for sustainable capacity development.

For **internal consultancies**, the concentration of demand in high-impact areas reinforces the need to prioritise scarce capability, invest selectively in advanced skills (particularly digital, analytical and system-level transformation expertise), and consider choices about scaling back lower-value or legacy offers. Capacity constraints mean that decisions about what not to do are increasingly consequential, with growing pressure to evidence impact and return on investment.

For **clients**, these shifts imply a more focused but more strategic offer: internal consultancies are increasingly positioned to support long-term transformation.

For **policymakers**, the strong alignment between growth areas and national priorities on productivity, digital transformation, access and leadership capability presents both an opportunity and a risk. Internal consultancies are well placed not only to support delivery of these priorities but also to contribute to learning and the development of management capability, often through work that embeds skills in practice. This highlights the need to consider the management workforce more explicitly in planning, ensuring that capability development is aligned with service demand. Without deliberate alignment of mandate, funding and workforce development to areas of growth, rising demand may to outstrip internal capacity, undermining ambitions to reduce reliance on external providers and to build sustained improvement capability within the NHS.

Experiences of collaboration with external consultancies

"I genuinely believe that we've got an opportunity here to work with partners, experts and create something quite special"

– NHS internal consultancy leader

As noted earlier, our wider quantitative research suggests that some, albeit limited, use of external consultancy alongside internal provision can be beneficial, effectively blending both sources. This can include specific collaborations between internal consultancies and organisations external to the NHS. This is not uncommon but adopted cautiously. Still, in general, external consultancies are sometimes used where larger scale, speed, specialist expertise, and/or perceived independence is required. Internal consultancies sometimes act as translators and integrators in these arrangements, tasked to ensure that NHS context, clinical voice and considerations of sustainability are reflected in delivery. Working with external partners more directly can also provide access to specialist technical skills and, in some cases, controversially, political cover in sensitive or contested situations. However, a range of challenges were noted of collaborations, including high cost and the "juniorisation" of internal consultancy teams, misalignment with NHS culture, limited knowledge transfer, and the re-use of generic solutions across different systems. Beyond direct collaboration, many respondents expressed frustration that external consultancies are often commissioned despite equivalent or superior internal capability and quality. At the same time, in some contexts external providers were engaged less for capability gaps than for perceived neutrality, external assurance, benchmarking, credibility or additional analytical capacity.

For **internal consultancies**, their recurrent role as translators and integrators highlights a distinctive strength: the ability to embed external expertise in NHS realities and support sustainable change. At the same time, experiences of being bypassed despite comparable capability point to persistent issues of visibility, legitimacy and procurement bias, reinforcing the need to articulate comparative advantage and design collaborations where complementary expertise is used to meet client needs.

For **clients**, engagement with external consultancies can offer scale, speed or independence, but may come at the expense of cost-effectiveness, continuity and organisational learning. More deliberate consideration of when external independence is necessary, and when internal capability could deliver similar outcomes more sustainably, may improve commissioning decisions.

For **policymakers**, while external consultancies will continue to have a role in time-limited or politically sensitive contexts, internal consultancies represent an under-utilised system asset. If reducing reliance on external providers and strengthening NHS-based capability is a strategic objective, policy levers related to procurement, commissioning norms and expectations of knowledge transfer will be critical to ensuring that collaboration with external firms builds, rather than substitutes for, internal capability. This echoes the challenges within the public sector more widely, where guidelines to become an 'intelligent client' are readily available (Cabinet Office, 2022) but less visible in the NHS.

Measuring impact and value

"The difficulty for us is we don't have the counterfactual. So, if we hadn't been used to support a team in improvement, what? What's the difference? …. Would they have been slower, had a worse outcome not made the improvement? We'll never know that. So, it's really difficult."

– NHS internal consultancy leader

Measuring impact and value from consultancy is notoriously difficult in general and remains one of the most challenging areas for internal consultancies. Still, some indications of impact can be assessed. Hard financial return on investment is, for example, often easier to demonstrate in areas such as finance, automation and programme management, while the impacts of strategic, cultural and system-level transformation are typically more subjective and realised over longer time horizons.

Internal consultancies reported using a mix of formal frameworks, pragmatic operational measures, client feedback, follow up reviews at 6 to 24 months, and narrative case studies to evidence impact. Some organisations acknowledged a reliance on reputation and repeat business as proxies for value, alongside ongoing pressure from finance and other teams for metrics that do not align well with complex transformation work. These challenges shape how impact is assessed, communicated and contested within the system. It should also be noted that systematic evaluation of consultancy use by clients is not widely practised in the public sector as a whole, or even more generally (National Audit Office, 2025).

For **internal consultancies**, limitations in impact measurement may constrain their ability to demonstrate legitimacy, secure investment and prioritise work in an increasingly resource-constrained and measurement focused environment. This is particularly the case in organisations where impact is tied to delivery of financial targets, performance standards or recovery trajectories, even during long-term transformation. This can reinforce reliance on reputation and informal indicators of quality, disadvantaging newer or smaller teams and limiting comparative learning.

For **clients**, inconsistent approaches to measuring impact and a lack of transparency can make it difficult to assess value for money, compare options or feel confident investing in work whose benefits are relational, cultural or system-wide.

For **policymakers**, these findings highlight a misalignment between the kinds of change the NHS increasingly seeks, such as system transformation, leadership capability and cultural change, and the metrics commonly used for assurance. If internal consultancies are to play a sustained role in delivering improvement and complex change, there is a need to support more proportionate, credible and shared approaches to impact assessment that recognise qualitative and developmental outcomes. Likewise, it is important to recognise that these issues apply equally to external consulting use and the claims made of impact.

Workforce, recruitment and retention

"Recruitment can be challenging, but people are attracted by the opportunity to make a real difference within the NHS."

– NHS internal consultancy leader

Many internal consultancies operate with very small core teams (less than 10) although a minority have grown to considerable scale (into the low hundreds), particularly where they are nationally mandated or embedded within larger operational structures. Smaller teams often scale their capacity through the use of associates, secondees, networks of clinicians and improvement staff, or collaboration with other NHS bodies. Across consultancies, flexibility in workforce models was seen as essential to managing fluctuating demand.

Internal consultancies consistently valued NHS experience and system credibility, although members of their workforce often brought additional experience from other sectors and external consultancies. As noted, mixed model of permanent staff and associates was widely used to balance stability and flexibility. However, many organisations reported that recruitment was constrained by Agenda for Change pay structures, headcount controls and wider workforce pressures across the NHS.

Despite these constraints, internal consultancies described relatively strong retention, supported by opportunities to work on meaningful, high-impact projects aligned with staff values and public-service motivation. Exposure to varied and challenging work, coupled with opportunities for development, helped sustain engagement. At the same time, retention was challenged by the inability to compete with private-sector pay, financial instability leading to workload pressure, and reliance on fixed-term or uncertain funding.

For **internal consultancies**, these workforce patterns require relying on flexible staffing models to manage demand, but this can create challenges for continuity and long-term capability. Recruitment may remain challenging given NHS pay and workforce constraints, increasing the importance of non-financial benefits such as meaningful work and development opportunities. While retention is relatively strong, sustaining it and quality at the same time, depends on stable funding, manageable workloads and clear career pathways; without these, there are risks to both workforce stability and overall effectiveness.

For **clients**, these dynamics shape both capacity and continuity: internal consultancies often bring high credibility and commitment, but limited core staffing can restrict speed, scale and availability during periods of peak demand, and team composition may vary across projects. There is clear potential for collaboration, both with other internal resources, but also externally.

For **policymakers**, the findings highlight a structural tension between expectations of internal consultancies as delivery partners for major priorities and the workforce conditions under which they operate. If internal consultancies are to play a sustained role in delivering national priorities, reducing reliance on external providers and building long-term NHS capability, greater attention will be needed to workforce sustainability, through systematic workforce planning, more flexible employment models, clearer career pathways, and greater stability of funding, rather than continued reliance on small teams operating at the limits of capacity. These issues are echoed across government departments, from where lessons can be learned (Cabinet Office, 2022).

Advantages and challenges of the internal consultancy model

"We face some of the disciplines of the commercial side of life, but very few of its freedoms. And I think one thing I'm increasingly drawn to wondering about is whether the internal consultancy model can happen without deliberate nurturing. And in fact, I suspect it does need nurturing."

– NHS internal consultancy leader

Internal consultancies consistently identified a number of strengths, both generally and in relation to externals. Clearly, they cannot also speak for clients and externals, but their views do resonate with general assessments of the relative advantages and challenges of internal consulting (University of Bristol, n.d.).

Key reported advantages included: deep NHS and system understanding; trust, legitimacy and, in many cases, strong clinical credibility; lower cost; a focus on resolution and capability building rather than dependency; and reinforcement of NHS values through reinvestment of resources back into the system.

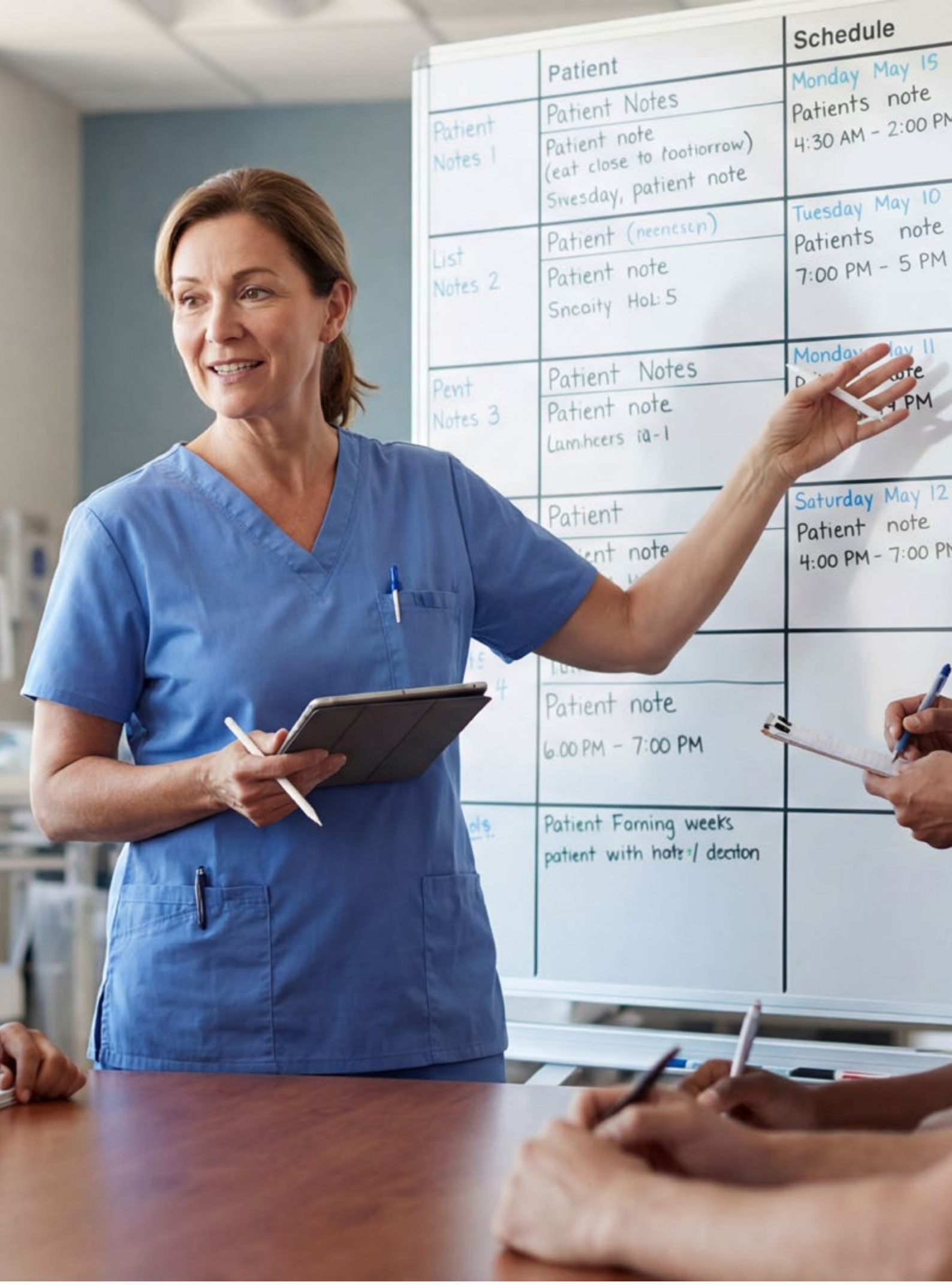
At the same time, they reported a common set of challenges. These included: procurement systems that seemed to favour external providers even if this may not always be the case[4]; financial insecurity and lack of secure core funding; difficulties in evidencing long-term impact; limited national coordination and visibility; small scale and limited scope for partnerships; and persistent structural tension between NHS employment models and expectations associated with consultancy delivery.

For **internal consultancies**, these findings suggest that they are well positioned to offer trusted, cost-effective and capability-building support within the NHS, but their impact is constrained by structural and systemic barriers. Addressing issues such as funding stability, visibility, procurement practices and alignment with NHS employment models will be important to enable them to operate at scale and realise their full potential.

For **clients**, internal consultancies can represent a compelling alternative to external providers, often offering better value for money, deeper contextual understanding and more sustainable change. This requires greater awareness of what is available; deliberate commissioning choices; tolerance of less immediate availability; and willingness to invest in longer-term partnerships.

For **policymakers**, particularly those seeking to reduce external spend and build internal capacity, the combination of clear advantages and persistent challenges presents a strategic choice. Treating internal consultancies as system assets will require action to address misalignment between employment models, funding and procurement, improve national visibility and coordination, and create conditions in which internal consultancy capability can be sustained, shared and scaled rather than continually reinvented in response to organisational change.

[4] Although not verified, we were advised that this may not always be a challenge. Specifically, funds can readily be passed between NHS organisations and do not constitute 'public contracts' under the Procurement Act 2023. This applies both to 'vertical' arrangements' (i.e. where the parties are effectively within the same legal entity such as NHS England) and to 'horizontal' cooperation (i.e. where separate NHS organisations have reason to collaborate). As such, the associated transfer of funding is exempt from procurement law requirements and can be awarded directly without breaching procurement legislation or internal policy.


Schedule
Patient
Patient Notes
Monday May 15
Patients note
4:30 AM - 2:00 PM
Tuesday May 10
Patients note
7:00 PM - 5 PM
Saturday May 12
Patient note
4:00 PM - 7:00 PM
Patient note
6:00 PM - 7:00 PM

Conclusion

The findings of this report outline for the first time a picture of internal consultancy provision across the NHS in England as a high-value but structurally constrained component of the NHS improvement ecosystem. Across ownership, funding, governance, service provision, geographical reach and workforce, internal consultancies demonstrate strong alignment with NHS values, deep system understanding, and an emphasis on sustainable capability building rather than dependency. Their successes, ranging from improved patient outcomes to influence on national policy and service redesign as well as reduced external consultancy spend/dependency, illustrate what is possible when internal capability is effectively mobilised.

At the same time, the analysis highlights recurring tensions that limit the ability of internal consultancies to operate as stable, scalable system assets. Financial fragility, uneven governance arrangements, the view that procurement practices favour large external providers, constrained workforce models, and underdeveloped approaches to measuring long term impact all shape what internal consultancies can realistically deliver. These challenges are not simply organisational shortcomings; they reflect structural design choices about how internal consultancy capacity is hosted, communicated, funded and legitimised within the NHS.

For **internal consultancies**, the findings underscore the importance of clarity of purpose, prioritisation of scarce capacity, including through collaboration, and articulation of distinctive value, particularly in relation to external providers. For **clients**, they point to the need for more informed commissioning decisions (and information and skills to support them) that recognise the strengths of internal consultancies in complex, system-level change, while being realistic about capacity and continuity. For **policy makers**, the report raises a strategic question: whether internal consultancies are to remain fragmented, hidden, semi-formal responses to local need, or whether they should be more explicitly recognised, communicated and supported as part of the NHS's core improvement infrastructure while maintaining local variation and client autonomy.

If internal consultancies are expected to help deliver national priorities, such as productivity, access, workforce sustainability and digital transformation, then greater proactivity is required from those in leadership positions. This includes clearer choices about ownership and governance; more stable and proportionate funding models; fairer and/or transparent procurement arrangements; and shared approaches to measuring impact that reflect the nature of complex change. Without such attention, internal consultancies will continue to deliver value despite the system, rather than as an integrated and sustainable part of it.

Notes

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Grant number and ethics approval

The research study (ref 21956) received a favourable ethical opinion from the University of Bristol Business School Research Ethics Committee and complies with NHS Health Research Authority requirements.

Use of AI

University AI-assisted tools were used to support the analysis of interview data, primarily to organise transcripts, identify recurring concepts, and extract provisional thematic patterns across interviews. The use of AI was complementary to, rather than a substitute for, researcher-led qualitative analysis: all outputs generated by AI were critically reviewed, interpreted, and refined by the research team to ensure analytical rigour and contextual accuracy.

To enhance credibility and accuracy, a draft version of the report was shared with interview participants for review ("member checking"). Participants were invited to comment on factual accuracy, clarify interpretations, and highlight any omissions or misrepresentations. Feedback received was incorporated where appropriate, helping to ensure that the findings accurately reflected participants' perspectives and experiences.

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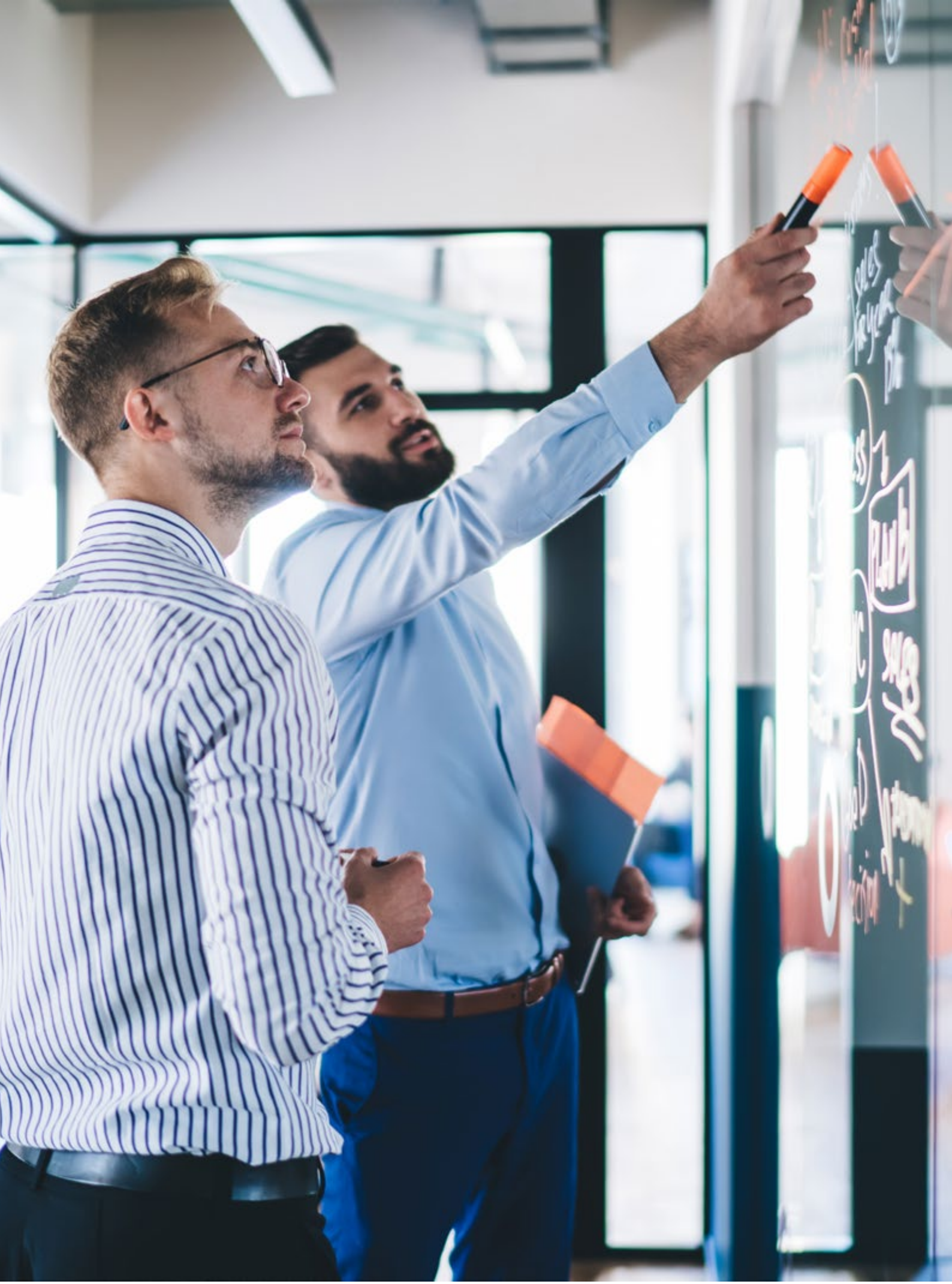

Appendix A – Examples of internal consultanciess

Acute Provider Collaboratives

https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf

Hosting and position: Jointly owned and funded by multiple acute trusts, with governance through a collaborative board.

Geographical reach: Regional / system level, spanning participating trusts and ICS structures.

Products and services: Transformation and improvement support, demand and capacity modelling, service redesign, pathway optimisation, and facilitation of clinical networks.

Distinctive features: Operates as a delivery platform rather than a traditional consultancy, enabling peer to peer improvement across providers.

AQuA (Advancing Quality Alliance)

https://aqua.nhs.uk

Hosting and position: AQuA is a not for profit improvement organisation hosted by the Northern Care Alliance NHS Foundation Trust.

Geographical reach: Its primary footprint is regional (North West England), with selective national and international work were aligned to mission.

Core purpose: AQuA exists to deliver meaningful, sustainable improvement in health and care outcomes through capability building rather than short term consultancy.

Products and services: Its offer spans governance and well led support, regulatory preparation, leadership and organisational development, quality improvement and productivity, innovation, learning collaboratives, PSIRF education, work on clinical variation, and mental health improvement at scale.

Distinctive features: AQuA is positioned as a long term improvement partner, emphasising co production, lived experience, evidence based methods and system level capability building.

Clinical Senates

https://www.england.nhs.uk/get-involved/get-involved/how/senates/

Hosting and position: Clinical Senates are hosted by NHS England, operating as arm's length advisory bodies to preserve independence.

Geographical reach: Regional, aligned to NHS England regions, with cross regional working to avoid conflicts of interest.

Products and services: Independent clinical reviews for major service redesign, quality and safety concerns, pathway reviews, and published advisory reports.

Distinctive features: High clinical credibility and perceived independence; one of the few internal models explicitly designed to operate outside procurement processes.

MIAA Solutions

https://www.miaa.nhs.uk

Hosting and position: MIAA Solutions is the consultancy arm of the Mersey Internal Audit Agency, hosted by Liverpool University Hospitals NHS Foundation Trust.

Geographical reach: Regional (North West) with national reach through frameworks and competitive bidding.

Products and services: Finance and corporate performance, workforce, OD and clinical transformation, PMO services, CHC/AACC reviews, governance, digital and BI support and strategic consultancy.

Distinctive features: Bringing together audit discipline and consultancy expertise, MIAA Solutions tackles complex challenges with innovation and integrity, supported by strong operational acumen. The organisation is recognised for delivering cost-effective, client tailored solutions to the financial, workforce, and transformational challenges facing the public sector.

Mid and South Essex NHS Foundation Trust - Strategy Unit

https://www.mse.nhs.uk

Hosting and position: The Strategy Unit is a self funded internal consultancy within Mid and South Essex NHS Foundation Trust.

Geographical reach: Its main footprint is sub regional at ICS level, with selective national and external engagements through innovation and evaluation work.

Core purpose: The unit supports Trust and system leadership in delivering strategy, innovation, population health and anchor institution commitments.

Products and services: Its services include strategy development and delivery, programme oversight for complex cross cutting initiatives, innovation testing and evaluation, data analytics and insights, population health work, and anchor programmes focused on workforce, employment and community outcomes.

Distinctive features: The unit specialises in work that cuts across organisational boundaries and combines strategic leadership with practical delivery and evaluation.

NHS Alliance (formerly NHS Confederation / NHS Providers)

https://thenhsalliance.org

Hosting and position: The NHS Alliance is an independent membership organisation representing and supporting the health and care system across England, Wales and Northern Ireland. Formed through the merger of NHS Confederation and NHS Providers, it acts as a national representative body for NHS trusts, integrated care boards, primary care, independent and voluntary sector providers, combining policy influence, member support and system leadership.

Geographical reach: England, Wales and Northern Ireland, with influence across the wider UK health policy landscape.

Products and services: Policy representation and advocacy, leadership development, organisational development, improvement support, evidence and insight generation, member networks, convening activities, strategic communications and advisory support, and capability-building programmes for health and care leaders.

Distinctive features: A membership body distinctive for its ability to bring together leaders from multiple sectors, shape national policy, represent frontline perspectives to government, and build leadership and organisational capability. While it offers advisory and development support, its primary identity is as a representative and advocacy organisation rather than a delivery-focused consultancy.

NHS Elect

https://www.nhselect.nhs.uk

Hosting and position: NHS Elect is hosted by an NHS trust and operating on a membership basis.

Geographical reach: It works nationally across all UK home countries.

Core purpose: NHS Elect supports individuals, teams and organisations in health and care to thrive through leadership and improvement.

Products and services: Its offer includes leadership development, organisational development, coaching, quality improvement support, consultancy style interventions, large-scale improvement collaboratives, peer learning networks and national events.

Distinctive features: NHS Elect combines national scale and convening power with relational, values driven support tailored to member needs across sectors.

NHS Interim Management and Support (IMAS)

https://www.nhsimas.nhs.uk/home

Hosting and position: NHS IMAS is hosted by NHS England within the Workforce, Training and Education Directorate..

Geographical reach: It operates nationally across England, delivering support locally and regionally to individual organisations and systems.

Core purpose: NHS IMAS provides a high-quality, cost-effective NHS alternative to private interim agencies while building future NHS leadership capability.

Products and services: Its core product is the deployment of senior interim leaders (Band 8d and above), including executive, turnaround, programme director and specialist intervention roles, alongside peer-to-peer mentoring schemes and specialist talent registers.

Distinctive features: NHS IMAS services are available at no fee, rely on NHS experienced talent pools, and explicitly combine service delivery with leadership development and talent retention.

NHS Midlands and Lancashire CSU - NHS Horizons

https://www.midlandsandlancashirecsu.nhs.uk/our-expertise/nhs-horizons/

Hosting and position: NHS Horizons is the longest standing change and improvement team at a national and local level in the NHS.

Geographical reach: It operates at local, regional, national and selective international levels.

Core purpose: NHS Horizons supports leaders, teams and systems to navigate complex change and accelerate improvement aligned to NHS priorities.

Products and services: Its services include system convening, network building, large group engagement, facilitation, events and workshops, change capability development, co-design support and the use of its Rapid Insight methodology to generate shared learning and insight for action.

Distinctive features: NHS Horizons connects the system to more of itself – building relationships through convening, facilitating and generating insight at scale to unlock collective leadership and accelerate change that lasts.

NHS Midlands and Lancashire CSU - NHS Strategy Unit

https://www.strategyunitwm.nhs.uk

Hosting and position: The NHS Strategy Unit is a specialist internal NHS consultancy operating on a pay for project basis.

Geographical reach: It has a national (England wide) remit, working with NHS England programmes, ICBs, trusts and partners.

Core purpose: The unit provides analytical depth and decision support to inform high-stakes strategic choices in health and care.

Products and services: Its services focus on complex analytics, modelling, data science, evaluation, demand and capacity modelling, and structured decision support for major national and system programmes.

Distinctive features: The NHS Strategy Unit is known for methodological innovation, open analytics, academic-quality capability, and leadership of national analytical networks that build system wide expertise.

NHS Midlands and Lancashire CSU – NHS Transformation Unit

https://www.midlandsandlancashirecsu.nhs.uk/our-expertise/the-transformation-unit/

Hosting and position: An internal consultancy hosted by NHS Midlands and Lancashire CSU, positioned within the Strategy Directorate alongside analytical and improvement teams.

Geographical reach: National, with work across ICBs, provider trusts, alliances and national programmes.

Products and services: Clinical service redesign, business case development, programme and project management, operating model design, analytics and modelling, communications and engagement, and strategic consultancy.

Distinctive features: Particularly known for large scale service reconfiguration and complex system transformation work, often in politically sensitive contexts.

NHS Shared Business Services (SBS) – Consulting

https://www.sbs.nhs.uk/services/nhs-consulting-services

Hosting and position: NHS SBS Consulting operates within a joint venture between the NHS and Sopra Steria.

Geographical reach: It works at regional and national scale across England.

Core purpose: Its purpose is to enable transformation of NHS corporate services, freeing up clinical and managerial capacity for patient care.

Products and services: NHS SBS Consulting provides operating model design, process excellence, change management, automation and AI, data and analytics, strategy and organisational design, and major programme delivery across finance, HR, estates, digital, IT, commercial and clinical support functions.

Distinctive features: Its position within the NHS shared services ecosystem allows it to link strategy directly to delivery and operate national scale digital and automation solutions, returning profits to the NHS.

NHS South Central and West CSU (SCW CSU) – Transformation Team

https://www.scwcsu.nhs.uk

Hosting and position: NHS SCW CSU's Transformation Team sits within a Commissioning Support Unit aligned to NHS England.

Geographical reach: It works locally, regionally and nationally across England.

Core purpose: The team provides scalable NHS consultancy capacity to support system priorities and reduce reliance on private sector consultancy.

Products and services: Its portfolio includes large scale transformation programmes, digital transformation, business cases, finance and analytics, urgent and planned care, population health and inequalities, primary care, mental health, pathway redesign, organisational effectiveness, and communications and engagement.

Distinctive features: The team operates as part of a wider CSU collaborative model, sharing expertise across regions and delivering work at scale while remaining NHS embedded.

Northumbria Healthcare NHS Foundation Trust

https://www.northumbria.nhs.uk

Hosting and position: An internal improvement and advisory capability led from within Northumbria Healthcare NHS Foundation Trust, reporting directly to the executive team.

Geographical reach: Regionally anchored in the North East and North Cumbria, with selective national advisory roles for key areas e.g. Elective Care, Outpatient Improvement.

Products and services: Performance improvement, clinical pathway redesign, access standards delivery, digital transformation, peer-to-peer implementation support, and operational planning.

Distinctive features: Clinically led and operationally delivered, with a devolved improvement model embedded in business units, moving away from PMO type approach or external consultancy-led approaches to developing more internal capability at all levels whilst also continuing to support key regional and national workstreams.

Q Community

https://q.thenhsalliance.org

Hosting and position: Q is a partnership-based, membership network established by the Health Foundation and partners, operating as a system-level improvement organisation with hybrid, network-led governance rather than formal NHS accountability. Now hosted by NHS Alliance and working in collaboration with the wider organisation.

Geographical reach: Q operates across the UK and Ireland at system level, working with ICSs, trusts, and national improvement organisations rather than being embedded in a single NHS body.

Products and services: Q provides system change and improvement programmes (e.g. labs), advisory support on system transformation, board development, quality management support, participatory insight projects and community-based learning and convening.

Distinctive features: Q is distinguished by its network and community model, emphasis on long-term system improvement and learning, partnership-based delivery, and a transition toward more formalised, scalable service "products" amid evolving funding arrangements.

RUBIS.QI

https://nhsrubisqi.co.uk/meet-our-team/

Hosting and position: RUBIS.QI is an internal consultancy hosted by Northumbria Healthcare NHS Foundation Trust, originally established as a collaborative initiative before consolidating within a single host.

Geographical reach: Primarily sub national, with work across the North East and increasing national engagements.

Products and services: Quality improvement consultancy, board development, staff and patient experience work, strategic improvement support, and bespoke training programmes.

Distinctive features: Strong emphasis on clinical leadership credibility and practical improvement delivered by NHS leaders with frontline experience.

South London and Maudsley NHS Foundation Trust - SLaM Partners

https://slam.nhs.uk/slam-partners

Hosting and position: An internal consultancy embedded within South London and Maudsley NHS Foundation Trust.

Geographical reach: Trust based with regional reach through partnerships across South London and King's Health Partners.

Products and services: Internal and external consultancy, leadership and management development, coaching, mediation, organisational development, and quality improvement.

Distinctive features: Deep mental health expertise and close integration with trust priorities, enabling clinically grounded OD and improvement work.

Surrey and Sussex Healthcare NHS Trusts

https://www.surreyandsussex.nhs.uk

Hosting and position: An internal consultancy embedded within SASH, aligned to the trust's strategy and quality improvement functions.

Geographical reach: Primarily trust based with provider-to-provider reach.

Products and services: Quality improvement, leadership and organisational development, Kaizen approaches, coaching, training, and strategic improvement support.

Distinctive features: Strong focus on continuous improvement and provider to provider learning rooted in operational delivery.

Tavistock Consulting

https://tavistockconsulting.co.uk

Hosting and position: A semi autonomous consultancy embedded within Tavistock and Portman NHS Foundation Trust.

Geographical reach: Trust based with national and international reach.

Products and services: Leadership development, executive and team coaching, organisational development, and system psychodynamic consultancy.

Distinctive features: Distinctive theoretical tradition and depth based OD offer, positioned differently from metrics driven management consultancy.

Transformation Partners in Health and Care (TPHC)

https://www.transformationpartners.nhs.uk

Hosting and position: TPHC is an NHS internal consultancy currently hosted by the Royal Free London NHS Foundation Trust.

Geographical reach: It operates primarily across London and other regions of England, with some wider public sector work.

Core purpose: TPHC aims to deliver high quality, NHS led consultancy that improves productivity, care and outcomes while reinvesting value back into the system.

Products and services: Its multidisciplinary offer includes strategy and transformation, service and business process redesign, programme and project management, digital and data analytics, automation and digital productivity solutions, operational and financial improvement, learning and organisational development, leadership pathways, and public health partnership programmes.

Distinctive features: TPHC combines consultancy delivery with scalable digital products (e.g. automation platforms) and emphasises long term partnerships, professional consulting standards and capability transfer.

University Hospitals of Liverpool Group - Transformation Delivery Unit (TDU)

https://www.uhliverpool.nhs.uk

Hosting and position: The Transformation Delivery Unit (TDU) is an internally funded transformation and consultancy function embedded within the University Hospitals of Liverpool Group, reporting through the Group Chief Transformation Officer to the Group Chief Executive.

Geographical reach: The TDU operates across the University Hospitals of Liverpool Group and the wider Liverpool health ecosystem, covering acute, specialist, and system-level activity, with no services delivered outside the Group.

Products and services: The TDU delivers cost improvement programmes, programme management, service integration, pathway redesign, merger integration, productivity improvement, strategic transformation, and financial recovery support.

Distinctive features: The TDU is characterised by its internally embedded model, strong operational understanding, integration of multiple legacy transformation teams, and growing emphasis on data analytics and productivity within financially driven transformation priorities.

University of BRISTOL

Business School